

Appendix C

Household

Hospital Presumptive Eligibility

- To be eligible for Hospital Presumptive Eligibility, hospitals must determine an applicant to not:
 - Be receiving Supplemental Security Income benefits;
 - Be a Medicaid/CHIP beneficiary;
 - Have received HPE with an approval start date within 365 days prior to a new HPE start date;
 - Be entitled to or enrolled in Medicare benefits under part A OR B or Title XVIII of the Act;
 - For HPE MAGI CHIP, be covered by minimum essential coverage that is accessible;
 - For HPE BCCTP, be covered by any minimum essential coverage.
- The following information is required with or on the [OHP 7260](#):
 - Copy of the [OHP 3263A](#) (approval) or [OHP 3263B](#) (denial) notice
 - Approval or denial indication on the [OHP 7260](#)
 - Participant Name
 - Date of birth
 - Signature of Applicant or their guardian/representative (If no SSN is provided and you are unable to locate an SSN using system resources, a signature is not required)
 - Signature of Hospital Representative
 - Date of Notice
 - Previous period of HPE (If marked as “yes” but date is left blank, use system resources to resolve)

- HPE applications entered in ONE will not run through a rules engine for a determination like a full application and only the SSN will be verified against the HUB. There are only three reasons ONE will deny a hospital's approval:
 - The applicant already has active Medicaid or CHIP coverage in MMIS as of the HPE approval date;
 - The HPE application was sent by a non-participating hospital;
 - A date of death prior to the HPE approval date has been saved to the individual record in ONE.
- A new HPE ONE case will be created any time an [OHP 7260](#) is received. There is no reinstate/reactivate functionality in ONE for HPE.

✓ **See where Presumptive Eligibility is initiated in the ONE System**
([Example 1](#))

✓ **See where the “HPE Determination” screen is in the ONE System**
([Example 2](#))

- Data entry should be reviewed for accuracy prior to authorization. If there are any errors, workers will select ‘Restart Application’ to remove the current information to enter the correct information. There is no ‘Report a Change’ function available with HPE in ONE to make corrections after authorization.
- Providers, such as pharmacies, use the HPE approval notice as a guarantee of payment to deliver services to individuals before eligibility shows in MMIS. If contacted about a pharmacy's inability to be paid based on accepting the HPE approval letter, we must honor OHP Plus (HPE) for the date of the pharmacy claim as long as it is within the HPE eligibility period stated on the notice of eligibility ([OHP 3263A](#)).
- Hospital Presumptive Eligibility ends the last day of the month following the month in which the hospital presumptive eligibility period begins if no full application is received by that date OR the date the agency makes an eligibility determination for OCCS Medical and sends a basic decision notice when a full application is received by the due date.
 - Hospital Presumptive does not get due process or 10-day timely close notice during the presumptive period.

✓ See the HPE End Date and where Hospital Presumptive is identified on the Case Summary screen in the ONE System ([Example 3](#))

NOTE

! *The HPE End Date is not a guaranteed coverage end date. If an [OHP 7210](#) is received and processed prior to the HPE End Date and the participant is denied, HPE benefits will end the day the full determination is made.*

If the participant submits an [OHP 7210](#) prior to the HPE End Date and it is not processed but a task is associated to the HPE participant in ONE, the HPE benefits will remain active PAST the HPE End Date.

- Narrations in TRACS for HPE go under the participant who was approved for HPE.
- HPE participants may be enrolled in CCOs as long as they are not still inpatient. Unless they have identified themselves as being a tribal member or able to access tribal services on the [OHP 7260](#), they will be auto-assigned to a CCO through weekly MMIS enrollment processes. Tribal members may call to request CCO enrollment if they aren't auto-assigned, and those who do get auto-assigned can contact us to change plans if another one is available in their area.
- The HPE period begins the earlier of the date the qualified hospital determines the individual is eligible OR the date that the individual received a covered medical service from the qualified hospital, if the hospital determines the individual is eligible and submits the decision to the Authority within five calendar days following the date of service.

Blind/Disabled/Unfit for work

- The expected eligibility outcome and/or 'Non-MAGI Referral – APD Aged Blind Disabled' task generation criteria are as follows:
 - Participants who attest to receiving Supplemental Security Income (SSI) are denied medical in the Oregon Eligibility (ONE) system, triggering the generation of the 'Non-MAGI Referral – APD Aged Blind Disabled' task. This is because Medicaid based on the receipt of SSI precedes all medical programs determined in the ONE system;
 - Participants who attest to being blind/disabled and are determined ineligible for medical in the ONE system will have the 'Non-MAGI Referral – APD Aged Blind Disabled' generated;

- Participants who attest to receiving Social Security Disability (SSD/SSDI) income and are determined ineligible for medical in the ONE system will have the ‘Non-MAGI Referral – APD Aged Blind Disabled’ task generated;
- Participants age 65 or older and are determined ineligible for medical in the ONE system will have the ‘Non-MAGI Referral – APD Aged Blind Disabled’ task generated;
- Participants receiving Medicare regardless of the eligibility outcome in ONE will have the ‘Non-MAGI Referral – APD Aged Blind Disabled’ task generated;
- Participants who attest to needing assistance with daily activities regardless of the eligibility outcome in ONE will have the ‘Non-MAGI Referral – APD Aged Blind Disabled’ task generated.



See where these three questions are asked on the Individual Information screen in the ONE System ([Example 4](#))

- When the ‘Non-MAGI Referral – APD Aged Blind Disabled’ is generated, the participant’s EDG Summary screen will reflect a “Yes” in the APD field.



See the APD field on the EDG Summary screen in the ONE System ([Example 5](#))

- If the participant was receiving medical in ONE and ONE determined the participant is no longer eligible and the ‘Non-MAGI Referral – APD Aged Blind Disabled’ task is generated, ONE will take action to close the medical in ONE with 10-day notice. Before medical can be closed, a final APD program determination must be made. OHP Statewide Processing Center staff must delete the ONE generated correspondence and retain the participant’s medical at the same program and benefit level received in ONE in the CM-system until a final APD program determination is made.
- Once APD/AAA has made a final APD program determination, the final eligibility outcome must be updated on the Non-MAGI Task screen and communicated back to the OHP Statewide Processing Center to coordinate the eligibility start or end date in the appropriate systems with appropriate notices sent.



See the Non-MAGI Task screen in the ONE System ([Example 6](#))

Former Foster Care Youth Medical Program (FFCYM)

- In addition to the foster care responsibility and age requirements, the applicant must also not:
 - Be eligible for MAGI Child (including at the Cover All Kids level), MAGI CHIP (including at the Cover All Kids level), MAGI Pregnant Woman, or MAGI Parent or Caretaker Relative benefits;
 - Be receiving Supplemental Security Income (SSI)
 - Be receiving adoption assistance or foster care maintenance payments
- There is no income test for FFCYM
- In ONE, the question “Was [Participant] receiving foster care in Oregon when he/she turned 18?” is only asked for individuals on the case who are age 18 to 26. This question determines when eligibility for FFCYM is reviewed for a participant meeting the first bullet above.
- ONE is not able to systematically verify if a participant was in Oregon foster care on their 18th birthday. When needed, this must be verified manually by looking at MMIS.
- If a child was in foster care under either Oregon Child Welfare, Tribal Foster Care, or Oregon Youth Authority as of their 18th birthday, they can be considered for FFCYM.
- ONE currently does not support FFCYM at the CAWEM level. If a participant needs to be coded with CWM FFCYM, their eligibility needs to be coded in the DHR system.
- Upon the 26th birthday of a participant in FFCYM, ONE will automatically redetermine eligibility to see if they can be moved to a different medical program. If so, they will be converted and will be sent a new notice of eligibility. If not, they will be closed with timely notice.



See this question on the Individual Information screen in the ONE System ([Example 7](#))

Pregnancy

- The number of unborn children that the individual is expecting are counted in both the mother's eligibility determination group (EDG) as well as the EDG of anyone else who is in the mother's EDG.
- ONE automatically runs a redetermination of eligibility at the end of the post-partum period.
- If initially found eligible for Medicaid/CHIP benefits, and circumstances change that would otherwise make the participant ineligible for benefits, a pregnant participant will continue to receive protected pregnancy benefits through the end of the pregnancy and, except for MAGI CHIP (including at the Cover All Kids level), through the post-partum period.
- For beneficiaries who report a pregnancy, the effective date of MAGI Pregnant Woman, MAGI Parent or Other Caretaker Relative for pregnant women, or MAGI CHIP (including CHIP at the Cover All Kids level) for pregnant individuals is the earlier of the Date of Request OR the date that a prenatal service related to the pregnancy was received. For beneficiaries of CAWEM-level benefits who report a change that results in eligibility for Plus-level benefits, the effective date of the change is the date that it was reported. Note: ONE will only make the change effective as early as the first of the month in which the change is being entered. If the date of reported change is earlier than this, an [MSC 148](#) should be sent to the Client Maintenance Unit to back-date the effective start date of the Plus-level benefits.
- A pregnant woman's income threshold is 185 percent of the federal poverty level.
- A pregnant participant whom does not meet the Citizen and Alien Status Requirements but is otherwise eligible for a Medicaid program will receive Citizen/Alien Waved Emergent Medical Prenatal (CAWEM Prenatal) through the last day of the pregnancy and then (effective no earlier than April 1, 2018) will receive Reproductive Health Equity Fund (RHEF) coverage through the end of the calendar month in which the 60th day following the last day of pregnancy falls. Both CAWEM Prenatal and RHEF provide CAWEM Plus-level coverage for the duration of the pregnancy and post-partum period.
 - Because services covered under RHEF during the post-partum period are provided in combination by Medicaid/CHIP providers and OHA Public Health Clinics, participants should visit www.healthoregon.or/rhclinics or call 211 to determine where to access services.
- For a New Participant, pregnancy benefits begin the first date of the month in which their DOR is in, although retro can be requested.

- Verification of pregnancy is not required. Self-attestation of pregnancy, due date, and number of expected children is accepted as attested by the participant.
- If an application is received which indicates a pregnancy but is missing a due date, ONE will automatically assume and apply a due date which reflects eight months from the DOR month. This can be adjusted as appropriate.
- At the end of a woman’s post-partum eligibility period, ONE will automatically rerun eligibility to see if she qualifies for a different medical program. If so, she will be converted and will automatically be sent a new notice of eligibility. If not, she will be closed with timely notice.

✓ **See where the Pregnancy question is asked in the ONE System ([Example 8](#))**

✓ **See the Pregnancy Info screen in the ONE System ([Example 9](#))**

Medicare

- ONE pings against the federal hub to search for any active Medicare. Attested Medicare information should be entered on the ‘Health Insurance Policy’ screen.

✓ **See the Health Insurance Policy screen in the ONE System ([Example 10](#))**

- A participant can be eligible for MAGI Parent or Other Caretaker Relative while also receiving Medicare.
- Medicare Part A is considered to meet Minimum Essential Coverage.
- Except for those enrolled in, or being considered for, MAGI CHIP (or CHIP at the Cover All Kids level), Medicare is a pursuable asset if a participant is potentially eligible for it but is not yet receiving it. Note: The person with the legal right to apply for the benefit is the person who should be pended to pursue it, even if it’s on behalf of someone else (such as a child) and if they fail to do so, only their benefits would be closed or denied.
- If a participant is receiving Medicare, they are exempt from the requirement to verify citizen status.

Extended Medical Assistance (EXT)

The participant must meet the following requirements in order to be found EXT eligible:

- The participant was receiving MAGI Parent and Other Caretaker Relative (PCR) and went over income for PCR due to the receipt or increase in spousal support and the participant must have been eligible for and receiving MAGI PCR benefits for any three of the six months preceding the month in which the receipt or increase in spousal support caused the loss of PCR eligibility. Months in which PCR benefits were partially received can be counted as a PCR month; or
- The participant was receiving PCR and went over income for PCR due to the receipt or increase in earned income; and
- The participant is a caretaker relative caring for a dependent child in the home; and
- The participant continues to meet all other nonfinancial program requirements, such as Oregon residency, not incarcerated, etc.
- If the participant experienced any other change in conjunction with the receipt or increase in earned income or spousal support, and the other change by itself makes the participant ineligible for MAGI PCR, they are not eligible for EXT.

If determined EXT eligible, the EXT eligibility must be coded in CM. The EXT eligibility period is as follows:

- Start of EXT eligibility period: The month following the month in which the receipt or increase in spousal or earned income resulted in the participant going over income for PCR.
- End of EXT eligibility period:
 - Loss of PCR due to the receipt or increase in spousal support: Use the 'EMS' needs resource code with the fourth month following the first month of the start of the EXT eligibility period.
 - Loss of PCR due to the receipt or increase in earned income: Use the 'AE2' needs resource code with the 12th month following the first month of the start of the EXT eligibility period.

NOTE



If the participant continued to receive other medical program benefits during the EXT eligibility period, do not take any actions to change the program eligibility to reflect EXT on MMIS. These months are still counted as part of the EXT eligibility period.

NOTE



If when determining EXT eligibility, it is determined the participant has already received medical during the entire period of time in which the participant would have received EXT, i.e., the participant's EXT eligibility period, immediately redetermine eligibility, evaluating for all programs, and provide due process if the participant is not eligible to transition to a different medical program. Be sure to clearly document your actions in case notes/narrations.

Working the 'Non-MAGI Referral – OHA Extended' task:

- If the participant was receiving medical in ONE and ONE determined the participant is no longer eligible and the 'Non-MAGI Referral – OHA Extended' task is generated, ONE will take action to close the medical in ONE with 10-day notice. Before medical can be closed, a final EXT program determination must be made.
 - If determined EXT eligible, delete the ONE generated correspondence and ensure an EXT approval notice is sent.
 - If determined ineligible for EXT, ensure the closure notice meets 10-day notice requirements and consider if the ONE generated correspondence is appropriate to be sent. If the ONE generated correspondence is deleted, a manual closure notice must be sent.
- Research the ONE case to confirm the loss of PCR is either due to spousal support or earnings.
 - If the loss of PCR is not due to spousal support or earnings, this is considered an invalid referral and should be updated accordingly on the Non-MAGI Task screen.
 - If the loss of PCR is due to spousal support or earnings, manually determine EXT eligibility. The final EXT eligibility outcome must be documented appropriately on the Non-MAGI Task screen.



See the Non-MAGI Task screen in the ONE System ([Example 11](#))

Substitute Care

- As long as the participant is in the facility, a participant's household group consists of the participant only.
- There is no income test for SAC.
- Applications ([MSC 1462](#)) are completed by facilities and sent to 5503 on behalf of the participant. ONE does not evaluate eligibility for SAC benefits. A worker will manually process the [MSC 1462](#) and if approved, eligibility will be coded in DHR.
- SAC can be identified in MMIS under the benefit plan by the 'C5 Non-Cat Related under 21' Aid Category code.
- Children in the custody of Child Welfare and in a Behavioral Rehabilitation Services (BRS) facility and children in Psychiatric Residential Treatment Facilities (PRTF) may not be considered for SAC coverage.

Breast and Cervical Cancer Treatment Program (BCCTP)

- The Oregon ScreenWise Program certifies and trains a statewide network of health care providers who offer screening and diagnostic services for women. They can also help complete the eligibility and enrollment paperwork for BCCTP eligibility, however ScreenWise providers are not the only providers who can screen and refer participants for BCCTP.
- A participant or provider wanting to complete the BCCTP screening can access the application, referral form, and more information on the OHA Public Health website [here](#).
- After being determined presumptively eligible by a health care provider, a participant is required to submit a full application no later than the last day of the month following the month in which the determination of presumptive eligibility is made.
- Presumptive BCCTP eligibility ends:
 - On the last day of the month following the month in which presumptive eligibility begins, if the individual does not file an application by that date;

- The day on which a determination is made for other Medicaid/CHIP program benefits
- A participant who is determined presumptively eligible for BCCTP by a health care provider & who is then found ineligible for any other Medicaid programs will remain in ongoing BCCTP coverage (non-presumptive) as determined by DHS as long as she continues to need treatment and:
 - Remains uncovered for treatment by minimum essential coverage
 - Remains under the age of 65
 - Remains an Oregon resident
 - Has income under 250 percent of the FPL

NOTE



A participant who does not meet the Citizen and Alien Status Requirements can have CAWEM BCCTP, however CAWEM-level benefits do not provide coverage for ongoing treatment services.

- ONE does not evaluate eligibility for BCCTP benefits. A worker will manually assess BCCTP eligibility, and benefits will be coded in DHR. BCCTP can be identified in MMIS under the benefit plan by the 'BCP' Case Descriptor
- BCCTP eligibility as determined by DHS (non-presumptive) when the participant does not qualify for any other Medicaid/CHIP programs will be granted for one year at a time. Near the end of the year certification period, DHS must send a redetermination packet in the mail which will include form [DHS 1463A](#) so the provider can re-attest to the participant's continued need for treatment. The participant should be re-evaluated for all Medicaid/CHIP programs at renewal, and if ineligible, she should retain BCCTP coverage as long as treatment remains necessary.

Shared Custody

- When a child splits his/her time between two different parents/caretakers, for the purpose of medical eligibility, the child is considered to be living in the household where they spend the majority of time in a given month.

- A parent or caretaker's self-attestation of a child being in their home is accepted unless/until information contradictory to the self-attested information is received or found.
 - When contradictory information is presented or found, send a manual pend notice requesting proof of where the child spends the majority of time to the parent who is newly-reporting that the child is living with them.

NOTE



A court order indicating custody agreements is not necessarily proof of what's actually occurring. The pend due date should be:

- *For a new application, 30 days;*
- *For a reported change on an open case, 10 calendar days (or the first business day following if the 10th day falls on a weekend or holiday);*
- *For renewals, either 10 calendar days (or the first business day following if the 10th day falls on a weekend or holiday) or 30 days from the date the renewal was initiated, whichever is longer.*

- While a tax filer may apply for and request coverage for a child who doesn't live with them, consideration should be given about where the child should actually receive their benefits. Whenever possible, a child should receive benefits on a custodial party's case (after correctly determining eligibility according to proper tax filing groups). But, for scenarios where the custodial party doesn't have a medical case and has not applied for the child, the child may receive benefits on a non-custodial tax-filer's case (provided the non-custodial party is attesting that they intend to claim the child as their tax dependent).

CAUTION



- *A child's address in ONE is saved as part of the child's individual record and will be shared between cases. To protect against privacy breaches, code the child's street address as "no fixed address" when a child is part of two different cases.*