Appendix E – Nonfinancial

Primary caretaker responsibility

- The caretaker relative who is the primary caretaker of a dependent child living in the home may be eligible for the MAGI Parent or Other Caretaker Relative program and the Extended Medical Assistance program.
  - Parents (including adopted and stepparents) of their own dependent child have a qualifying caretaker relative relationship and are assumed to provide primary care of their children.
  - Nonparent caretakers must have a qualifying relationship to the dependent child and be the primary caregiver of a dependent child in the home. Qualifying relationships include:
    (a) Aunt
    (b) Uncle
    (c) Sibling/half-sibling/step-sibling
    (d) First cousin
    (e) Nephew/niece
    (f) Grandparent
    (g) Great-grandparent
    (h) Great-great-grandparent
  - A dependent child is child who is under the age of 18 or age 18 and a full-time student in a secondary school or equivalent vocational or technical training, if before attaining age 19 the child may reasonably be expected to complete the school or training.

- When there is no parent(s) in the home, the primary caretaker needs to be identified for each child. Additionally, if there is both a parent(s) and a caretaker relative of the same dependent child in the home and the caretaker relative
primarily provides care of the dependent child, the primary caretaker needs to be identified.

- Identify the primary caretaker in the ONE system by checking the “Primary Caretaker” box on the ‘Relationship’ screen in ONE.

See the Relationship screen where the primary caretaker is selected (Example 1)

**Service eligibility**

- There are different types of Long-Term Care Services plans.
  - Most participants eligible for Long-Term Care Services receive Services through the Home and Community-Based Care (HCBC) program, also known as K-Plan or K-Services. Participants can only receive K-Plan if also receiving an OHP Plus Medicaid benefit. Children receiving MAGI CHIP benefits and children receiving OHP Plus benefits through Cover-All Kids are not eligible for K-Plan. K-Plan eligibility is determined by APD/AAA. If the participant is receiving OHP Plus Medicaid in ONE and is eligible for K-Plan, the participant will have a Service only case in the CM-system.

Click here to access APD transmittal “APD/AAA Service Coding for MAGI Medical Eligibles”

See an example of what a Service-only case can look like in the CM system (Example 2)

- Participants can also receive services through Development Disability (DD) waivers, which is overseen by the Office of Developmental Disability Services (ODDS). Support Services Brokerage or Community Development Disabilities Program (CDDP) determine eligibility for DD Services. Eligibility for some DD Services is contingent on the receipt of OHP Plus Medicaid benefits. DD Services eligibility can be found in MMIS and the SELG screen in the CM-system, however, not all DD Services eligibility update to MMIS.

See what a service plan looks like in MMIS (Example 3)
See what a service plan looks like on SELG (Example 4)

- If the participant receiving K-Plan is losing their Medicaid coverage or a child receiving Medicaid is transitioning to MAGI CHIP, coordination with APD/AAA and Support Services Brokerage or CDDP is required as the loss of OHP Plus Medicaid will negatively impact the participant’s service eligibility. The participant must be reviewed for all medical and services programs before negative action is taken.
  - If at renewal or redetermination, the only medical program a child receiving both OHP Plus Medicaid and K-Plan can be eligible for is MAGI CHIP, coordinate with APD/AAA and the CDDP to confirm when the service eligibility will be reduced or terminated. MAGI CHIP eligibility must start the day after the service eligibility ends or on the effective date of the service eligibility reduction.

Current/Other benefits (in another state or in Oregon)

- When eligibility is run in ONE, the system reviews for active medical benefits from Oregon in MMIS during the time period being evaluated.
  - Out of state benefits are unable to be verified through ONE and are considered based on the participant’s self-attestation

- When transitioning benefits from CW, OYA, OSIPM, REFM, or any other OCCS medical program outside of the ONE system, benefits must first be shut down in Legacy systems before eligibility in ONE can start.

**NOTE**

Follow regular procedures when handling transitions of coverage between these types of programs.

- A participant receiving medical benefits from another state may only receive OCCS Medical if they now have Oregon residence and need to access care and the participant’s provider refuses to submit a bill to the Medicaid/CHIP agency of the other state. Otherwise, we should obtain proof of Medicaid/CHIP closure in the other state before approving OCCS Medical.
• The Office of Payment Accuracy and Recovery (OPAR) receives and works a quarterly PARIS report which lists individuals who have Medicaid/CHIP open in multiple states at the same time.

See where the current/other health coverage questions is asked in the ONE system (Example 5)

See the Health Insurance Policy screen (Example 6)

Other Health Insurance/employer-sponsored insurance

• When a participant has another minimum essential insurance plan (except for Medicare with appropriate coordination of plan compatibility), they may not enroll into a Coordinated Care Organization for medical.
  
  − The client will be put on an “open card” (also called “fee-for-service” or “FFS”).
  
  − OCCS Medical acts as a secondary insurance to help pay for things like copays, deductibles, and services not covered under the primary policy up to the allowable OHP payment rates and only to providers contracted with OHA.
  
  − If a provider is contracted with OHA and accepts a participant’s OHP coverage, even if OHP is the secondary coverage, the provider may not bill the client for charges unless they notified them up-front that the service wouldn’t be covered and that they would be responsible for the bill. For assistance with billing questions, participants may contact the Client Services Unit (CSU) at 1-800-273-0557.

• When the question “Is anyone potentially eligible for a health insurance plan offered by an employer?” is answered ‘YES’ in ONE, the ESI Coverage Details page will open so that Employer-Sponsored Insurance (ESI) data can be entered
  
  − Except for participants in the MAGI CHIP program (including at the Cover All Kids level), adults and caretakers of children who could be potentially covered under the adult’s ESI who are OCCS medical program beneficiaries shall apply for, accept, and maintain cost-effective employer-sponsored health insurance unless they have good cause (see below);
  
  − With the exception of MAGI CHIP (including at the Cover All Kids level), a parent or caretaker of a child receiving OCCS medical program benefits
who fails to meet this requirement is ineligible for assistance. This does not apply to individuals when:

(a) The individual’s compliance would result in emotional or physical harm to the dependent child or to the caretaker. Accept the statement of the caretaker;

(b) The child was conceived as a result of incest or rape and efforts to obtain support would be detrimental to the dependent child. Accept the statement of the caretaker;

(c) Legal proceedings are pending for adoption of the child;

(d) The parent is being helped by a public or licensed private social agency to resolve the issue of whether to release the child for adoption;

(e) The individual is pregnant; or

(f) Other good cause reasons exist for noncooperation.

- All other health insurance must be coded on the Health Insurance Policy screen in ONE for proper eligibility determinations. The Health Insurance Group (HIG) at OPAR also verifies and codes other insurance information in MMIS. Insurance information in ONE and MMIS need to be kept in sync.

- Participants may report other insurance on their application, through their ONE Applicant Portal account, over the phone, in writing, or via HIG’s website at www.reporttpl.org. Participants should not be asked to report their coverage twice or in two different methods.

- If a participant reports some of the policy information but not all of it, such as just the few mandatory fields in ONE, HIG may not be able to verify their coverage or code their policy in MMIS. A participant must be pended to provide the rest of their policy information. In order to be considered complete, a participant must provide (and/or ONE will already know and derive based on the initial application and case structure):
  - Insurance company name*
  - Insurance company phone number
  - Policy ID number*
  - Group number*
- Source of insurance (Is it employer-sponsored?)
- Policy Type*
- Policyholder name – first and last*
- Policyholder SSN*
- Policyholder DOB
- Individuals covered by the insurance*
  (a) First and last name
  (b) Date of birth
- Relationship of each covered individual to the policyholder*
- Is there good cause to not use the insurance?

*The data elements marked with an asterisk above are required fields in ONE and, when entered, are sufficient to create a “skeleton” record on the TPL panel in MMIS which will prevent a participant from being auto-assigned to a CCO. However, the minimum required data for the skeleton is usually insufficient for HIG to fully verify the policy. Upon completion of the rest of the needed data fields on ONE, any existing MMIS skeleton record will be updated.*

- Except for MAGI CHIP (including at the Cover All Kids level), pending participants to provide other insurance information should be completed after initial eligibility is determined and approved for OCCS Medical programs. Initial eligibility should not be delayed due to the need to collect other insurance policy information.

- If a participant is pended to provide additional policy information about other insurance they or their household member has and fails to do so, they are ineligible for coverage and should have their coverage closed with timely notice.

- ONE does not currently pend participants for their other insurance policy information nor does it automatically close coverage if a participant does not supply it. This must be tracked and completed manually.

*See where the attested health insurance and potential employer-sponsored insurance plan questions are asked in the ONE system (Example 7)*
Absent parent

- The DCS cooperation requirement only applies to participants who are custodial parties of children approved for Medicaid benefits. Custodial parties of MAGI CHIP or Cover All Kids recipients are excluded from this requirement. Additional information regarding DCS cooperation requirements will be provided in the future.

- The ‘Non-Custodial Parent Information’ and ‘Non-Custodial Parent Relationship Information’ screens in ONE will queue when a child is not associated to two parents on the Relationship screen.
  - Enter absent parent information as reported, being sure to associate the child to the correct absent parent. If the absent parent is unknown, associate the child to the Unknown Unknown absent parent record.
  - If there is a signature on the application, select “Yes” to the question ‘Is the responsible individual cooperating?’

Pursuit of Assets

- A participant is not required to:
  - Apply for Supplemental Security Income (SSI) from the Social Security Administration
  - Borrow money
  - Make a good faith effort to obtain such asset if the participant can show good cause for not doing so
• Pursuable assets include, but are not limited to:
  - Claims related to an injury
  - Disability benefits
  - Healthcare coverage
  - Retirement benefits
  - Survivorship benefits
  - Unemployment compensation; and
  - Veteran’s compensation and pensions

• Except for those in MAGI CHIP (including at the Cover All Kids level), each participant shall make a good faith effort to obtain available coverage under Medicare.

• Except for those in MAGI CHIP (including at the Cover All Kids level), caretakers in an OCCS Medical program shall apply, accept, and maintain cost-effective employer-sponsored health insurance (determined by the HIPP group in OPAR), unless they have good cause. Upon enrollment of cost-effective coverage, the participant shall be referred to the HIPP reimbursement program for assistance paying the employee portion of the premiums. Participants may apply for HIPP reimbursements at www.reporttpl.org. Other health insurance must also be coded in ONE. See Other Health Insurance/Employer-Sponsored Insurance section for more information.

• A parent or caretaker of a child receiving OCCS Medical who has the legal right/authority to apply for a child’s available asset, per the above bullets, but fails to do so is ineligible for medical coverage until s/he does so or until the pursuit requirement no longer applies. Children are not penalized for non-pursuit of an available asset.

• Participants who fail to pursue a required asset and do not have good cause are ineligible for benefits until they meet requirements.

• ONE does not currently track or pend for available assets, nor does it contain coding to apply or track sanctions for non-compliance per participant. Review and follow-up for pursuit of assets must be determined and completed manually.

• If a participant has an unsettled or unopened claim for an accident or injury, s/he may comply with the requirement to pursue this asset by filing a claim and
providing the accident and claim details to OPAR at www.reportinjury.org or on the MSC 451 form.
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