THE HOSPITAL PRESUMPTIVE (TEMPORARY) ELIGIBILITY PROCESS

Roles and Responsibilities of Hospitals and the Oregon Health Authority

Oregon Health Authority

Health Systems Division

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About the Hospital Presumptive (Temporary) Eligibility Process

The hospital's role

The Hospital Presumptive Eligibility (HPE) process allows qualified hospitals to act as eligibility determination sites. These sites will:

- Identify individuals who may be eligible for Oregon Health Plan (OHP - Medicaid/ CHIP) health coverage and could benefit from immediate temporary medical assistance;
- Make immediate temporary eligibility determinations for individuals who pend in the ONE system or who do not have access to the ONE system;
- Educate individuals about their responsibility to complete the full OHP application (OHA 7210) for health coverage within required timeframes when an application has not already been completed;
- Provide the OHA 7210; and
  - Assist the individual with completing the OHA 7210, or
  - Provide information on resources to help individuals complete the application within required timeframes.

Qualified hospitals

To become an approved HPE determination site, hospitals must:

- Be enrolled with Oregon Medicaid as a participating provider;
- Complete and submit (or re-submit) the "Declaration of Intent and Agreement to Serve" (OHP 3262);
- Agree to make determinations consistent with OHA policies and procedures;
- Notify the Authority immediately when a staff leaves your employ;
- Insure employees to be qualified meet necessary requirements; and
- Meet established quality standards.

Qualified hospital representatives

To be a qualified hospital representative with the ability to determine eligibility on behalf of the qualified hospital, the representative must:

- Be employed by a qualified hospital or an employee of a hospital's contractor,
- Complete training initially and annually, and
- Make determinations consistent with OHA policies and procedures.

Who can apply for coverage?

Any individual seeking immediate medical coverage who has pended in the ONE system or does not have access to the ONE system may apply. There is no requirement that the individual be admitted to the hospital or be seeking hospital services, or any medical services, in order to apply. HPE is a path to ongoing eligibility as well as temporary coverage.

How long does coverage last?

Coverage start date	If eligible, an individual's temporary coverage starts on the date the hospital determines the individual is eligible.
Coverage end date	Temporary coverage ends based on submission of the completed full OHP application. ■ If the full application is submitted and the agency determines MAGI Medicaid/ CHIP eligibility, HPE is in effect until the determination is made. ■ If the full application is submitted and the agency determines the applicant is not eligible, HPE is in effect until the date the determination is made. ■ If the full application is not submitted by the last day of the month following the start date of HPE coverage, HPE is in effect until the last day of the month following the start date.

Only one period of HPE coverage is allowed in any 12-month period, calculated from the first day of the most recent previous period of HPE. Refer to OAR 410-120-1140 to learn more about verification of eligibility and coverage.

What is covered?

In general, HPE covers all services covered under OHP, including dental, vision and mental health.

Exception: Pregnant women are covered only for "ambulatory prenatal care" (all OHP Plus services except inpatient labor and delivery). Labor and delivery are not covered under HPE.

- If women who had HPE when they were pregnant are determined to be Medicaid eligible, based on the timely submission of the full OHP application, the period including the date of birth and the labor and delivery will often be covered retroactively.
- For a pregnant woman applying while in labor, it may be best for the hospital to submit a full OHP application through the ONE portal or on an OHA 7210 retroactive to the first date medical benefits were provided.

Can newborns be covered?

A separate HPE determination is required to cover newborns.

- Newborns born to women during the hospital presumptive (temporary) period are not considered Assumed Eligible Newborns (AEN).
- If women who had HPE when pregnant are later determined to be eligible for OHP based on the timely submission of a full OHP application, the newborn's status changes to AEN.

What eligibility groups are included?

Hospital Presumptive Eligibility uses the following income guidelines in determining eligibility (see the Quick Guide to Income Eligibility for HPE Determinations):

- Parent and Other Caretaker Relative (specific $ limits, for any individual who is the primary caretaker for a relative child who lives with them; includes individuals under age 19 and over age 65)
- Pregnant Woman (through 185% FPL)
- Medicaid Children
  - Under age 1 (through 185% FPL)
  - Age 1 – 18 (through 133% FPL)
- CHIP Children
  - Under age 1 (above 185% through 300% FPL)
  - Age 1-18 (above 133% through 300% FPL)
- Newly Eligible Adults (through 133% FPL)
- Individuals (to age 26) formerly in Foster Care in Oregon (no FPL limit)
- Individuals in the Breast and Cervical Cancer Treatment Program (BCCTP) (through 250% FPL)

Income guidelines may change yearly. Please be sure you are using the most current version found at bit.ly/ohp-hpe.

Hospital responsibilities

What to do before making HPE determinations

Check MMIS to see if the applicant is currently receiving OHP, include the previous 12 months in your query.

If the individual currently receives OHP, then the individual is **not eligible** for HPE.

If the individual shows Hospital Presumptive Yes and a date anytime in the preceding year, then the individual is **not eligible** for HPE.

Making eligibility determinations

The hospital is responsible for making **immediate** eligibility determinations that:

- Are initiated using the OHP Hospital Presumptive Eligibility application (OHP 7260);
- Are based **only** on information provided by the applicant or his/her representative in **Part 1** of the OHP 7260. No additional documentation or verification may be required at the time of the eligibility determination. Applicant signature is required.

Always use the most current OHP 7260 application available at bit.ly/ohp-hpe

Completing the OHP 7260

Regardless of the HPE decision (approved or denied), the hospital is responsible for ensuring completion and legibility of the OHP 7260.

<table>
<tr><td rowspan="2">Part 1</td><td>REQUIRED INFORMATION: (applicant attestation only; no documents required)
Applicant’s full legal name
Family size
Household’s gross monthly income
Date of Birth
SSN (unless this is for a newborn)
Home address or city, State, and zip
Mailing address
Lives in and plans to stay in Oregon? (Yes/No)
U.S. citizen, U.S. national or qualified non-citizen? (Yes/No)
Previous period of HPE? (Yes/No)
If Yes, when?</td></tr>
<tr><td>The following information is not required to make an eligibility determination, but should also be completed if readily available:
Other medical coverage? (NOTE: precludes HPE for CHIP and BCCTP)
Pregnant? (Yes/No) If Yes, pregnancy due date</td></tr>
</table>

	■ In Oregon Foster Care at age 18? ■ Eligible for or receiving SSI benefits? ■ Receiving Medicare benefits?
Part 2	Record eligibility determination. If approved, mark the appropriate eligibility group.
Part 3	Applicant information including telephone numbers, Email and alternate format or language needs.
Part 4	Signatures – Applicant and witness signatures are required.

Notifying the applicant

At the time of the presumptive determination, the hospital gives the individual immediate written notice of whether s/he is approved, or denied, coverage under this program.

Notification requirements	For approvals	For denials
Copy of the completed Application (OHP 7260) – Complete Parts 1, 2, 3 and 4 for all applicants	X	X
Approval Notice (OHP 3263A)	X	
Denial Notice (OHP 3263B)		X
Full OHP (OHA 7210) application packet	X – Mark "Hospital Presumptive" at top of page 1	X – **Do not** mark with "Hospital Presumptive"
Help completing the OHA 7210, or information on resources to help the individual complete and submit the OHA 7210	X (required)	X (optional)
Explanation that the individual must complete and submit the OHA 7210 as soon as possible (must be received by OHA no later than the temporary coverage end date listed on the Approval Notice)	X	
Explanation that the denial is based on applicant statements and a simplified process which may *not* have the same outcome as the formal eligibility determination		X
Explanation that there are no appeal rights for an HPE decision. The hospital's decision stands for the presumptive period.	X	X

Notifying OHP Customer Service (Branch 5503)

Within 5 working days after the date of each eligibility determination (approval or denial), the hospital is responsible for submitting the following to OHP Customer Service in a single fax:

- The HPE Fax Cover Sheet
- A copy of the completed Approval Notice (OHP 3263A), including Rights and Responsibilities, or Denial Notice (OHP 3263B) issued to the individual, and
- A copy of the individual's completed OHP 7260.

- **Do not include the OHA 7210 with HPE documents, this is sent separate**.

How to notify OHP

Approvals:

- Fax to 503-373-7493; or
- If the individual has a need for prescriptions or immediate medical attention for a life-threatening condition, you may send the approval via secure email to hospital.presumptive@dhsoha.state.or.us.

Denials:

- Fax to 503-373-7493.
- Documents for denied applicants, including the Denial Notice (3263B) should never be sent via email.
- When the required documents are faxed to OHP Customer Service at 503-373-7493

For each individual applicant, send all HPE determination forms (OHP 7260 and OHP 3263A or OHP 3263B) together. **Do not include completed OHA 7210s with these forms.**

Verifying MMIS enrollment

Hospitals should check MMIS within about 7-10 days of submitting the OHP 7260 and OHP 3263A to confirm that individuals approved for HPE are now enrolled in OHP.

They will show as BMH for the benefit plan and you will see Hospital Presumptive Eligibility no, which means they have never been covered since June 11, 2018 forward or Hospital Presumptive Eligibility yes – start date, which means they have had HPE coverage. The start date is the most recent start date that the recipient was covered.

If the MMIS enrollment is not complete, contact the OHP Customer Service Hospital Presumptive Eligibility (HPE) Team by email at hospital.presumptive@dhsoha.state.or.us.

Submitting completed OHA 7210s to OHP Customer Service

Do not include the OHA 7210 application with the initial HPE documents to OHP Customer Service. Fax completed OHA 7210 applications for presumptively eligible individuals to the HPE Team at 503-373-7493 clearly marked *"Hospital Presumptive."*

If an individual approved for HPE has submitted their OHA 7210 application, but has not received a determination decision or an update on the status of their application, call OHP Outreach at 800-699-9075 and select option 4 (community partners), or email ohp.outreach@dhsoha.state.or.us.

Do not email OHA 7210 applications to OHA.

Recordkeeping requirements

The hospital is responsible for maintaining the following records for three years from the last date of billing for services associated with HPE determinations:

NOTE: All numbers should be broken out by:

- Hospital patients, or those seeking services from the determining hospital, and
- Non-hospital patients, or those not seeking services from the determining hospital.

Description	Retain on file:
Eligibility determinations completed	Completed OHP 7260s
Approval Notices (with Rights and Responsibilities) issued	Completed OHP 3263As
Denial Notices issued	Completed OHP 3263Bs
Record of applicants given, prior to leaving the hospital, OHA 7210s, with information on the requirement to complete the OHA 7210 and how to get help completing the application	As determined by hospital and approved by OHA
Record of applicants given, prior to leaving the hospital, OHA 7210s, and also given help completing the OHA 7210	As determined by Hospital and approved by OHA

DHS|OHA responsibilities

Processing Hospital Presumptive Eligibility approvals

Upon receipt of approved eligibility determinations, staff at OHP Customer Service will:

- Confirm hospital is a qualified hospital;
- Confirm hospital representative is a qualified hospital representative;
- Confirm individual reflects no OHP eligibility on MMIS;
- Confirm individual has not received Hospital Presumptive Eligibility within the past 12 months;
- Enter applicants in the system; and
- Start eligibility effective the date shown at the top of the Approval Notice

Processing OHA 7210s

Upon receipt of a completed OHA 7210, staff at OHP Customer Service will:

- Complete the determination of ongoing eligibility under the appropriate program, and

- Ensure that the individual is enrolled in a CCO or other managed care entity (DCO or MHO), as appropriate.

Ending Hospital Presumptive Eligibility coverage

Staff at OHP Customer Service will ensure coverage ends for all approved individuals as follows:

- **For individuals who submitted an OHA 7210 timely,** temporary eligibility ends the date the formal determination of Medicaid/CHIP eligibility (or ineligibility) is made.
- **For individuals who did not submit an OHA 7210 or who submitted an OHA 7210 untimely**, temporary eligibility ends on the last day of the month following the month of the HPE determination.

When HPE coverage ends, individuals do not receive a notice of their coverage ending. The approval notice they receive in the hospital serves as their notice that this benefit is temporary and will end, generally within two months of the approval date.

Recordkeeping requirements

OHA maintains records of the following:

- Number of individuals, statewide and by hospital, by hospital patients and non-patients, who:
  - Submitted an OHA 7210 within the required timeframes.
  - Were ultimately determined eligible for OHP.
  - Were ultimately determined ineligible for OHP.
- All claims and payments related to approvals for:
  - Individuals ultimately eligible for OHP, and
  - Individuals ultimately ineligible for OHP.

Applicant's responsibilities

When applying:

Provide true and accurate information for OHP 7260.

If approved for hospital presumptive coverage:

To pursue ongoing eligibility, submit completed OHA 7210 prior to the last day of the calendar month following the calendar month of hospital's HPE determination.

If denied for hospital presumptive coverage:

Option to complete OHA 7210 for full eligibility determination.

Standards and criteria

The hospital must target the following OHA standards for all individuals approved for HPE. Standards and criteria will be refined over time.

Proposed quality standard	Criteria
1. **90 percent** of all approved applicants (specify if a. or b.)	a. Are given an OHA 7210 and information on resources for assistance with the application process, or b. Are given an OHA 7210 and provided assistance with completing the OHA 7210.
2. **90 percent of the time**	The hospital's determination that applicants do not have current OHP is correct.
3. **90 percent of the time** ***(once hospitals are able to perform this function)***	The hospitals' determination that applicants did not receive temporary coverage within the past 12 months is correct.
4. **75 percent** of all approved applicants	Submit an OHA 7210 within the prescribed timeframes.
5. **75 percent** of all approved applicants who submit a full OHA 7210	Are found eligible for OHP benefits.

Sanctions and loss of qualification

Standards and criteria are enforced as follows:

If the prescribed standards are not met for a period of one calendar quarter, OHA will establish with the hospital a written Plan of Correction (POC) that describes:

- Targets and timelines for improvement;
- Steps to be taken in order to comply with the performance standards;
- How additional staff training would be conducted, if needed;
- The estimated time it would take to achieve the expected performance standards, which would be no greater than three months; and
- How outcomes would be measured.

OHA may impose additional correction periods, as appropriate.

If targets are not met after a sufficient period for improvement, as determined in discussions between OHA and the hospital, OHA may disqualify a hospital from making eligibility determinations under this program.

Resources by topic

For list of HPE resources, see our HPE Contacts and Resources list.