Hospital Presumptive Eligibility

Making Determinations

Oregon Health Authority

Agenda

This is the second of three modules hospital staff need to complete, prior to taking the quiz, in order to provide Hospital Presumptive Eligibility.

1. Overview
2. **Making determinations**
3. Reporting requirements

Objectives

In this module you will learn how to:

- Determine HPE eligibility
- Provide assistance with the full OHP application
- Notify OHP Customer Service of new HPE decisions or full OHP applications

ELIGIBILITY DETERMINATIONS

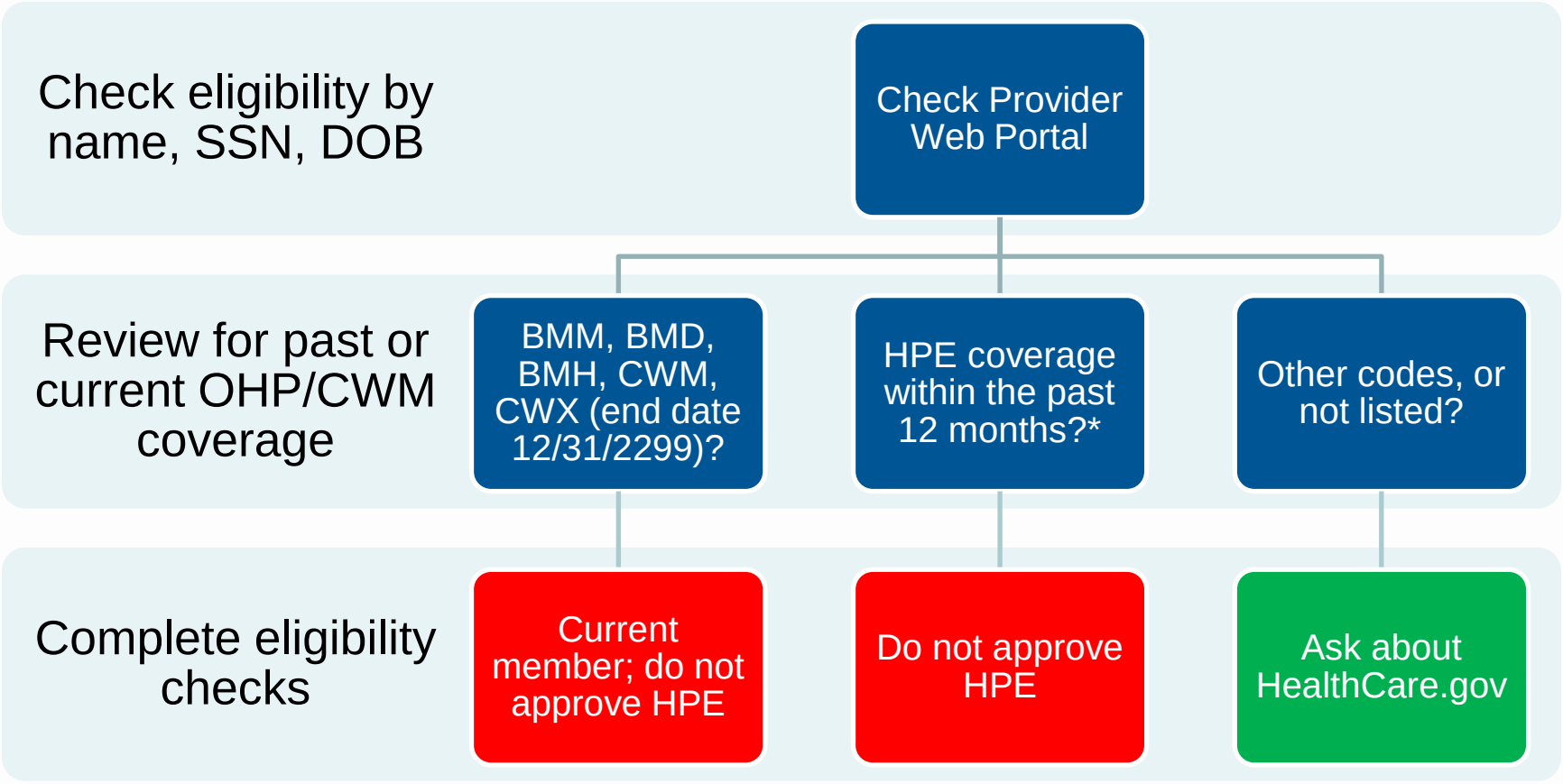
Steps for hospital employees

- Check the Provider Web Portal for current OHP or CWM eligibility
- Complete Part 1 of the HPE application (OHP 7260)
- Make eligibility determination
  - Review for eligibility exclusions
  - Review for current income requirements
- Complete the OHP 7260
- Notify the applicant

Check for current OHP and CWM eligibility

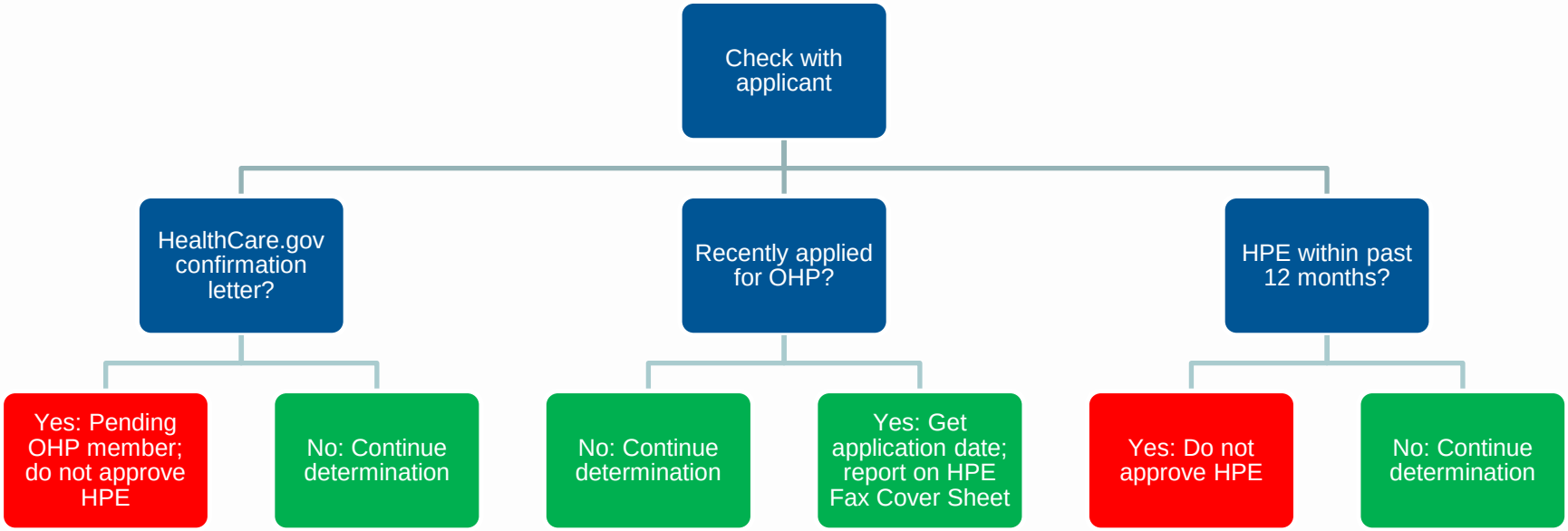
- Go to https://www.or-medicaid.gov and click “Eligibility”
- Enter the applicant’s information and click “Search”
  - First Name, Last Name, Date of Birth **or**
  - Social Security number and Name or Date of Birth
- Enter today’s date as the “To” date and 13 months prior as the “From” date
  - For example, a determination made on 8/31/2017 would have a “From” date of 8/31/2016 and a “To” date of 8/31/2017.
- Click “Search”

Check for current OHP or CWM eligibility



*Call Provider Services at 800-336-6016 to check for recent HPE coverage

Complete eligibility checks



Complete Part 1 of the OHP 7260

- Complete this section for all applicants.
- Use only information provided by the applicant or his/her representative. No documents are required.

PART 1 – REQUIRED INFORMATION – *Applicant attestation only; no documents required*

Legal name (first, middle, last and suffix):			Family size:	Household's gross monthly income:	
Date of birth:	Sex: ☐ Male ☐ Female			SSN:	
Home address:					
Mailing address (if different):					
Lives in and plans to stay in Oregon?	☐ Yes	☐ No	U.S. citizen, U.S. national or qualified non-citizen?	☐ Yes	☐ No
Primary caretaker for any child under age 19 who: 1) is your own child or relative and 2) lives with you?				☐ Yes	☐ No
Previous HPE coverage?	☐ Yes	☐ No	If Yes, when?		
If available, <u>also</u> tell us the following:					
Other medical coverage?	☐ Yes	☐ No	Pregnant? If yes, pregnancy due date:	☐ Yes	☐ No
Age 65 or over?	☐ Yes	☐ No	In Oregon Foster Care at age 18?	☐ Yes	☐ No
Receiving Medicare?	☐ Yes	☐ No	Eligible for or receiving SSI benefits?	☐ Yes	☐ No

Review for eligibility exclusions

- First, review for conditions that would exclude the applicant from eligibility.
- If any of the following is true, you must deny coverage:
  - Current Medicaid/CHIP coverage (OHP or CWM)
  - HPE coverage within last 12 months
  - Age 65 or over *(unless they qualify as a parent/caretaker relative)*
  - Not a U.S. citizen, U.S. national or qualified non-citizen
  - Receiving SSI or Medicare
  - Does not live in Oregon
- If none of the above applies, review income requirements.

Review for income requirements

- Use the most current guidelines on the HPE website.
- If income is more than the limits that apply, you must deny coverage.
- If it is less than the limit, you may approve coverage.

Specific $ limits

- Parents and caretaker relatives

Through 133% FPL

- Medicaid adults
- Medicaid children (ages 1-18)

Through 185% FPL

- Medicaid children (under one)
- Pregnant women

Above 185% FPL

- CHIP children (through 300% FPL)
- Breast and Cervical Cancer Treatment Program (through 250% FPL)

No FPL limit

- Former Foster Care Youth Medical (ages 18-26)

Complete Part 2 of the OHP 7260

- Complete for all applicants (approved and denied).

PART 2 – DETERMINATION BY HOSPITAL REPRESENTATIVE – *Based on answers in Part 1 only*

Eligible?	If yes, select eligibility group:	
☐ Yes – Give approval notice ☐ No – Give denial notice	☐ Adult ☐ Pregnant woman ☐ Child - CHIP ☐ Child - Medicaid	☐ Former Foster Care Youth < age 26 ☐ Parent/caretaker relative ☐ BCCTP

Complete Part 3 of the OHP 7260 for all approvals

OHA needs all information in Part 3 to enroll approved applicants, only to the extent that the data is available and the individual chooses to disclose.

PART 3 – NEEDED FOR APPROVALS ONLY

Telephone number(s): ☐ Home: ☐ Work: ☐ Message:

Email (optional):

Answering this question is optional. We ask all members for information about racial and ethnic identity. This helps us guarantee that all members receive the highest quality care and the best service. This also addresses the differences in care. **What is your ethnic or racial identity?** Check all that apply.

American Indian or Alaska Native:
☐ American Indian ☐ Alaska Native ☐ Canadian Inuit, Metis or First Nation
☐ Indigenous Mexican, Central American or South American

Asian:
☐ Chinese ☐ Vietnamese ☐ Korean ☐ Hmong ☐ Laotian ☐ Filipino/a ☐ Japanese
☐ South Asian ☐ Asian Indian ☐ Other Asian

Black or African American:
☐ African American ☐ African (black) ☐ Caribbean ☐ Other black

Hispanic or Latino/a:
☐ Mexican ☐ Central American ☐ South American ☐ Other Hispanic or Latino/a

Native Hawaiian or Pacific Islander:
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Micronesian ☐ Tongan
☐ Other Pacific Islander

White:
☐ Western European ☐ Eastern European ☐ Slavic ☐ Middle Eastern ☐ Northern African
☐ Other white

Other: ☐ Unknown

☐ Decline to answer

If more than one ethnic or racial identity is chosen, please circle the one that best represents your primary identity.

Is the applicant an enrolled member of a federally recognized tribe? ☐ Yes ☐ No

Does any of the following apply to the applicant? ☐ Yes ☐ No

- Receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Programs?
- Has a parent or grandparent who is an enrolled member of a federally recognized tribe?
- Has a parent or grandparent who is a shareholder in a regional Alaska Native corporation or village?

Preferred spoken language (if not English):	Preferred written language (if not English):

Materials needed in:
☐ Audio tape ☐ Braille ☐ Computer disk ☐ Large print ☐ Oral presentation

Complete Part 4 of the OHP 7260

All approved and denied individuals (or their legal guardians) are required to sign.

PART 4 – READ AND SIGN

USE OF SOCIAL SECURITY NUMBER (SSN): These federal laws say that anyone applying for medical benefits must provide an SSN: Federal laws - 42 USC 1320b-7(a), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b). When you write your SSN on the application it means you give permission to DHS/OHA to use it and tell others about it for these reasons:

- To help us decide if you qualify for benefits. We will use the SSNs you provide to make sure the income and assets you listed on this application are correct. We will match information from other state and federal records, such as the Internal Revenue Service, Department of Revenue, Medicaid, child support, Social Security and unemployment benefits.
- To write reports about the Oregon Health Plan.
- To administer the program you apply for or receive benefits from, if necessary.
- To help us improve programs by doing quality reviews and other activities.
- To make sure we have given you the correct amount of benefits and to recover money if we have overpaid benefits.

SIGNATURES:

Applicant: By signing, you agree that the information you provided for this form is true as far as you know, and you received an Approval Notice that lists your Rights and Responsibilities, or a Denial Notice.

Signature of Applicant (or legal guardian) _____ Date _____

Signature of Witness (or legal guardian) _____ Date _____

Hospital Representative: By signing, you are attesting that you have accurately recorded the information provided by the applicant or someone representing the applicant, made a determination based on that information, and provided the applicant with an Approval Notice that lists their Rights and Responsibilities or a Denial Notice.

Signature of Hospital Representative _____ Date _____

Hospital Representative Name, Title: _____

Hospital Representative Contact Information: _____

Notify the applicant

- Give all applicants the following as soon as you complete the determination and application form:
  - Decision notice (OHP 3263A or OHP 3263B)
  - A copy of the completed HPE application (OHP 7260)
- Explain that:
  - This decision is final. Applicants cannot appeal or change the hospital's decision.
  - Denials are based on limited information. Applicants denied temporary coverage should submit a full OHP application so that OHP Customer Service can determine if they qualify.

OHP 3263A
Approval Notice

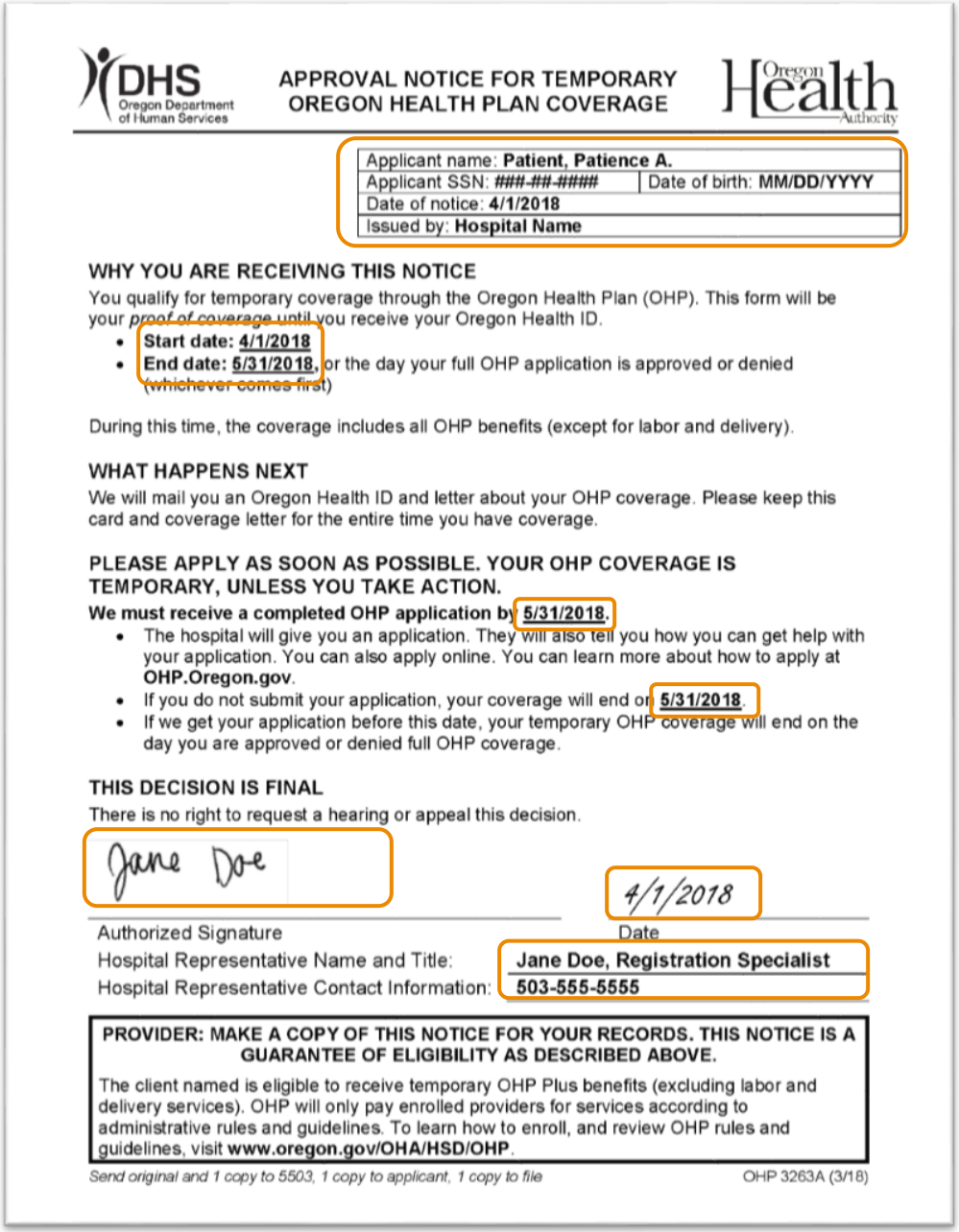
Complete all fields (outlined orange).

Include page 2 (Rights and Responsibilities).

This is the applicant's proof of coverage until OHA can mail them their ID card.

All dates must be entered so that providers can accept this as proof of coverage.

- The **Date of notice** and **Start date** is the date you made the determination.
- The **End date** and **Reply-by date must** contain the coverage end date. This date is the last day of the following month.



DHS Oregon Department of Human Services

APPROVAL NOTICE FOR TEMPORARY OREGON HEALTH PLAN COVERAGE

Oregon Health Authority

Applicant name: **Patient, Patience A.**	
Applicant SSN: **###-##-####**	Date of birth: **MM/DD/YYYY**
Date of notice: **4/1/2018**	
Issued by: **Hospital Name**	

WHY YOU ARE RECEIVING THIS NOTICE

You qualify for temporary coverage through the Oregon Health Plan (OHP). This form will be your *proof of coverage* until you receive your Oregon Health ID.

- **Start date: 4/1/2018**
- **End date: 5/31/2018**, or the day your full OHP application is approved or denied (whichever comes first)

During this time, the coverage includes all OHP benefits (except for labor and delivery).

WHAT HAPPENS NEXT

We will mail you an Oregon Health ID and letter about your OHP coverage. Please keep this card and coverage letter for the entire time you have coverage.

PLEASE APPLY AS SOON AS POSSIBLE. YOUR OHP COVERAGE IS TEMPORARY, UNLESS YOU TAKE ACTION.

We must receive a completed OHP application by 5/31/2018.

- The hospital will give you an application. They will also tell you how you can get help with your application. You can also apply online. You can learn more about how to apply at **OHP.Oregon.gov**.
- If you do not submit your application, your coverage will end on **5/31/2018**.
- If we get your application before this date, your temporary OHP coverage will end on the day you are approved or denied full OHP coverage.

THIS DECISION IS FINAL

There is no right to request a hearing or appeal this decision.

Jane Doe — Authorized Signature

4/1/2018 — Date

Hospital Representative Name and Title: **Jane Doe, Registration Specialist**

Hospital Representative Contact Information: **503-555-5555**

PROVIDER: MAKE A COPY OF THIS NOTICE FOR YOUR RECORDS. THIS NOTICE IS A GUARANTEE OF ELIGIBILITY AS DESCRIBED ABOVE.

The client named is eligible to receive temporary OHP Plus benefits (excluding labor and delivery services). OHP will only pay enrolled providers for services according to administrative rules and guidelines. To learn how to enroll, and review OHP rules and guidelines, visit **www.oregon.gov/OHA/HSD/OHP**.

Send original and 1 copy to 5503, 1 copy to applicant, 1 copy to file

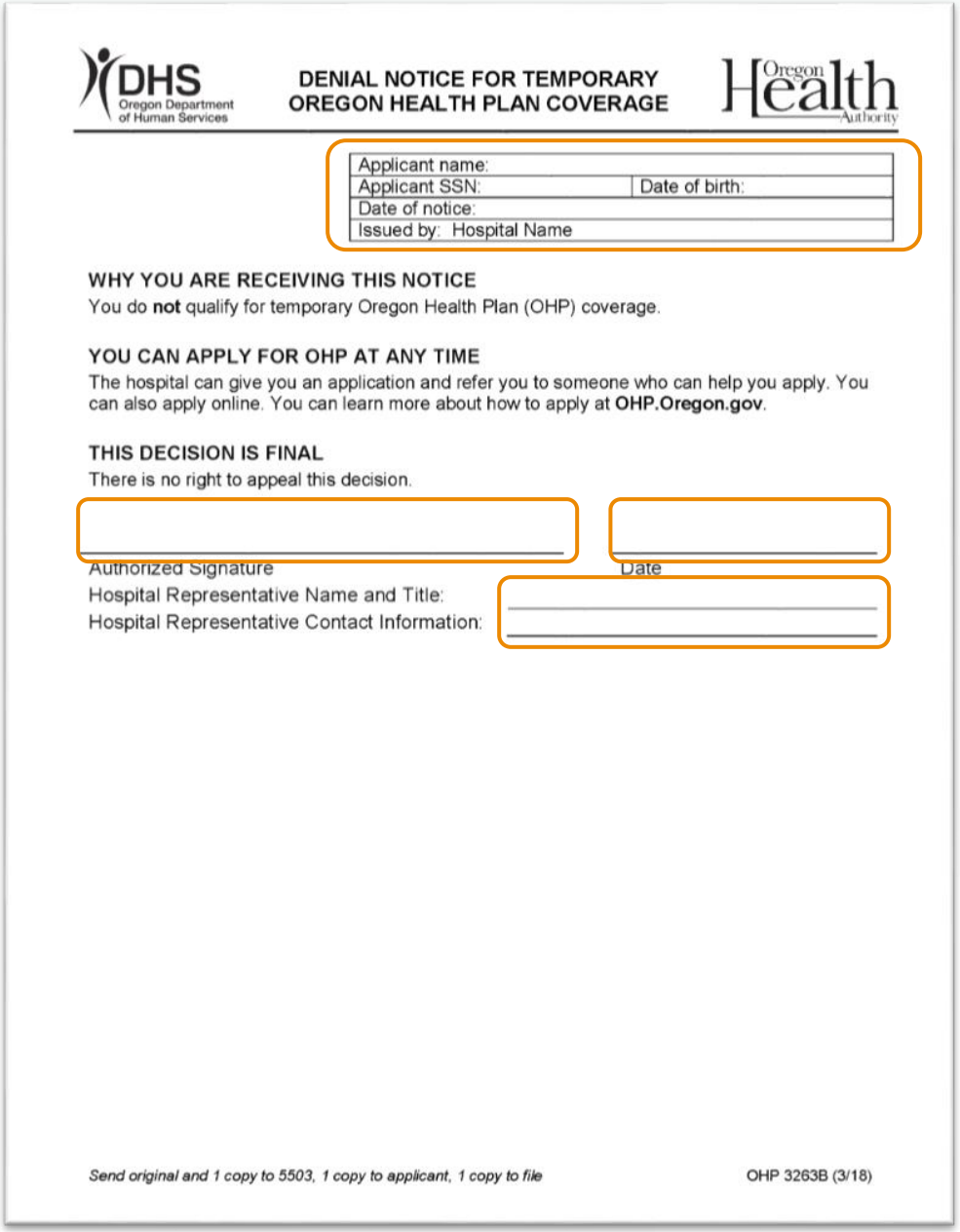
OHP 3263A (3/18)

How long does HPE coverage last?

- It starts at midnight on the Date of Notice:
  - The date the hospital determines temporary eligibility (if the person is not seeking services at the time); or
  - The date the person received a covered medical service, as long as the hospital notifies OHP Customer Service within five working days of the date of service
- It ends on:
  - The last day of the following month, or
  - The day OHP Customer Service makes a decision on the applicant's full OHP application (whichever comes first)

OHP 3263B
Denial Notice

Complete all fields (outlined orange).



DHS Oregon Department of Human Services

DENIAL NOTICE FOR TEMPORARY OREGON HEALTH PLAN COVERAGE

Oregon Health Authority

Applicant name:	
Applicant SSN:	Date of birth:
Date of notice:	
Issued by: Hospital Name	

WHY YOU ARE RECEIVING THIS NOTICE

You do **not** qualify for temporary Oregon Health Plan (OHP) coverage.

YOU CAN APPLY FOR OHP AT ANY TIME

The hospital can give you an application and refer you to someone who can help you apply. You can also apply online. You can learn more about how to apply at **OHP.Oregon.gov**.

THIS DECISION IS FINAL

There is no right to appeal this decision.

Authorized Signature _____ Date _____

Hospital Representative Name and Title: _____

Hospital Representative Contact Information: _____

Send original and 1 copy to 5503, 1 copy to applicant, 1 copy to file

OHP 3263B (3/18)

PROVIDING APPLICATION ASSISTANCE

Who can provide application assistance?

- Those who are qualified as application assisters and have received training to do so. This may include:
  - Hospital staff,
  - Contracted staff, and/or
  - Your site's application assister

The best way to apply: ONE.Oregon.gov

- Whenever possible, have the applicant complete the full application at ONE.Oregon.gov.
  - Fast, secure, easy
  - In many cases, gives real-time OHP or CWM eligibility determinations

If applicants cannot apply through ONE:

- Give them the following:
  - A full OHP application packet. Mark “Hospital Presumptive” at the top of Page 1
  - Help, or information on how to get help, completing and submitting the application
- Explain that:
  - They must submit the completed application as soon as possible, no later than the end date listed on their HPE approval notice
  - Applying through ONE is the fastest way to apply
- To check the status of these applications, call 800-699-9075 and select option 4 (community partners), or email Oregon.Benefits@odhsoha.oregon.gov

CONNECTING WITH OHP CUSTOMER SERVICE

Faxing to OHP Customer Service

- Fax the following to 503-373-7493 within 5 business days of the determination:
  - HPE Fax Cover Sheet
  - Decision notice (OHP 3263A or 3263B)
  - Completed HPE application (OHP 7260)

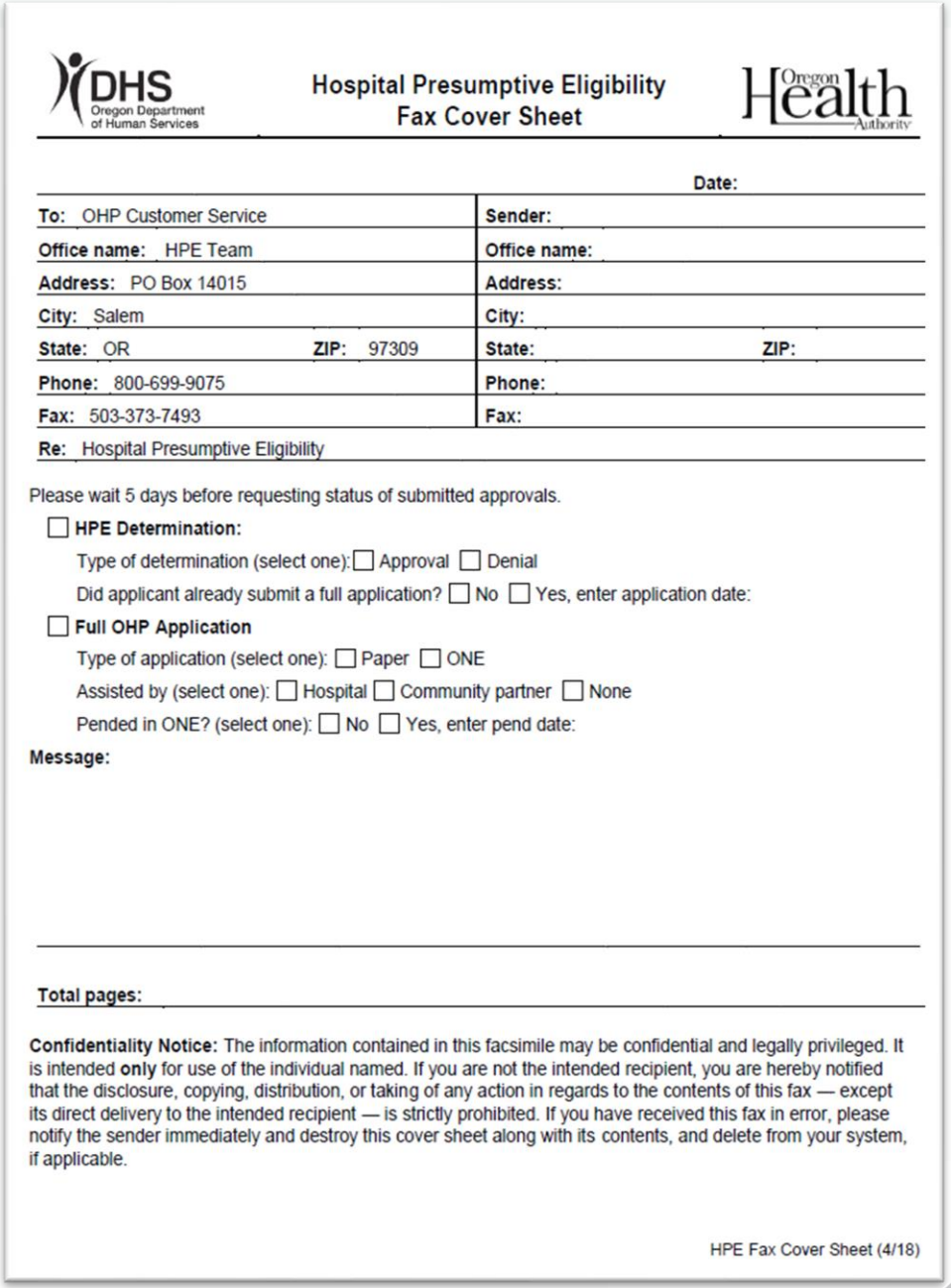
HPE Fax Cover Sheet

To report determinations: Complete all fields in the **HPE Determination** section, including:

- Whether they have already sent a full application to OHP Customer Service and if so, the application date

To fax full applications: Complete all fields in the **Full OHP Application** section, including:

- Whether the applicant applied through ONE or on paper
- Who helped the applicant with the application
- Whether the applicant is pended in ONE and if so, the application date



DHS Oregon Department of Human Services

Hospital Presumptive Eligibility Fax Cover Sheet

Oregon Health Authority

Date:

To: OHP Customer Service	**Sender:**
Office name: HPE Team	**Office name:**
Address: PO Box 14015	**Address:**
City: Salem	**City:**
State: OR **ZIP:** 97309	**State:** **ZIP:**
Phone: 800-699-9075	**Phone:**
Fax: 503-373-7493	**Fax:**

Re: Hospital Presumptive Eligibility

Please wait 5 days before requesting status of submitted approvals.

☐ **HPE Determination:**

Type of determination (select one): ☐ Approval ☐ Denial

Did applicant already submit a full application? ☐ No ☐ Yes, enter application date:

☐ **Full OHP Application**

Type of application (select one): ☐ Paper ☐ ONE

Assisted by (select one): ☐ Hospital ☐ Community partner ☐ None

Pended in ONE? (select one): ☐ No ☐ Yes, enter pend date:

Message:

Total pages:

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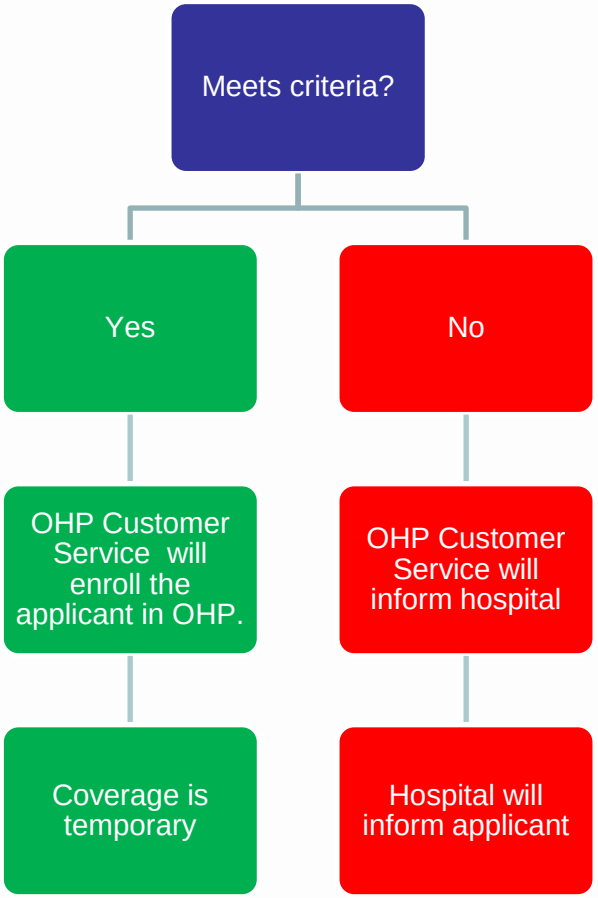
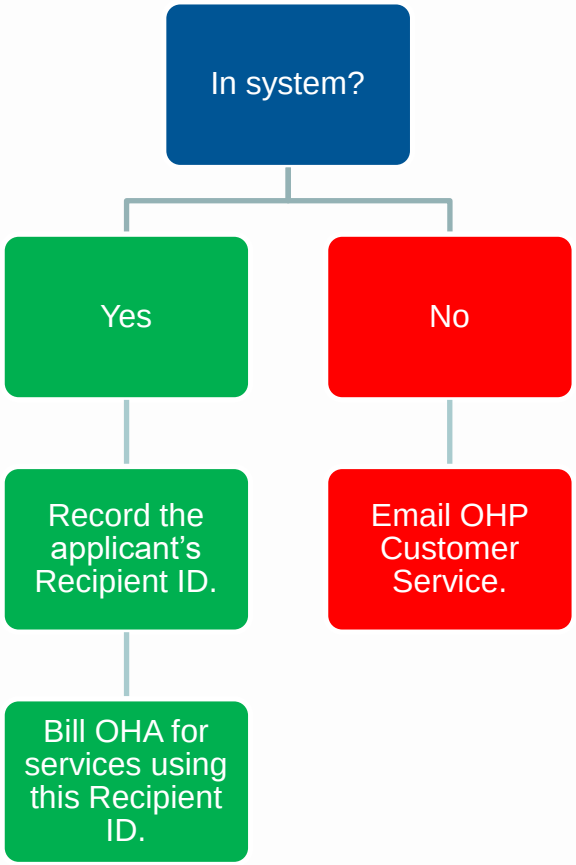
HPE Fax Cover Sheet (4/18)

Verifying HPE determinations

- OHP Customer Service will review documents to confirm:
  - Hospital is a qualified HPE determination site
  - The signer is a qualified signer known to OHA
  - Applicant does not have OHP (Medicaid/CHIP) coverage
  - The applicant (or their representative) has signed



Checking for OHP enrollment



- If you do not hear from OHP Customer Service within 7-10 days:
  - See if the applicant is in our system at https://www.or-medicaid.gov.
  - Use the applicant's name, SSN, and/or date of birth.
- To email OHP Customer Service, secure email hospital.presumptive@odhsoha.oregon.gov