THE HOSPITAL PRESUMPTIVE (TEMPORARY) ELIGIBILITY PROCESS

Roles and Responsibilities of Hospitals and the 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 these individuals;
- Educate individuals about their responsibility to complete the full OHP application (OHA 7210) for health coverage within required timeframes;
- 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 the “Declaration of Intent and Agreement to Serve” (OHP 3262);
- Agree to make determinations consistent with OHA policies and procedures; 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 annually, and
- Make determinations consistent with OHA policies and procedures.

Who can apply for coverage?
Any individual seeking immediate medical coverage 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.
**Hospital Presumptive Eligibility**

**How long does coverage last?**

<table>
<thead>
<tr>
<th>Coverage start date</th>
<th>If eligible, an individual’s temporary coverage starts at midnight on the earlier of:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>■ The date the hospital determines the individual is eligible (for individuals not seeking/receiving immediate services); or,</td>
</tr>
<tr>
<td></td>
<td>■ The date the individual received a covered medical service, if the hospital submits the decision to OHP Customer Service within 5 working days following the date of service (for individuals receiving/seeking immediate services).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage end date</th>
<th>Temporary coverage ends based on submission of the completed full OHP application (OHA 7210).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>■ If OHA 7210 is submitted by the last day of the month following the month of the HPE approval, the agency determines MAGI Medicaid/CHIP eligibility, and HPE is in effect until the determination is made.</td>
</tr>
<tr>
<td></td>
<td>■ If OHA 7210 is not submitted by the date described above, HPE coverage ends on that day.</td>
</tr>
</tbody>
</table>

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.

**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 OHA 7210, 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 OHA 7210 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 an OHA 7210, the newborn’s status changes to AEN.
Hospital Presumptive Eligibility

What eligibility groups are included?

Hospital Presumptive Eligibility uses the following income guidelines in determining eligibility:

- 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. OHA will email HPE providers with updated income determination guidelines. Please be sure you are using the most recent version. These may also be 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. Do not treat the “Admin Exam” benefit package as current Medicaid/CHIP coverage.

If the individual currently receives OHP, 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.

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>
<thead>
<tr>
<th>Part 1</th>
<th>REQUIRED INFORMATION: (applicant attestation only; no documents required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Applicant’s full legal name</td>
</tr>
<tr>
<td></td>
<td>Family size</td>
</tr>
<tr>
<td></td>
<td>Household’s gross monthly income</td>
</tr>
<tr>
<td></td>
<td>Date of Birth</td>
</tr>
<tr>
<td></td>
<td>SSN</td>
</tr>
<tr>
<td></td>
<td>Home address or city, State, and zip</td>
</tr>
<tr>
<td></td>
<td>Mailing address</td>
</tr>
<tr>
<td></td>
<td>Lives in and plans to stay in Oregon? (Yes/No)</td>
</tr>
<tr>
<td></td>
<td>U.S. citizen, U.S. national or qualified non-citizen? (Yes/No)</td>
</tr>
<tr>
<td></td>
<td>Previous period of HPE? (Yes/No)</td>
</tr>
<tr>
<td></td>
<td>If Yes, when?</td>
</tr>
</tbody>
</table>

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
- In Oregon Foster Care at age 18?

Always use the most current OHP 7260 application available at www.oregon.gov/OHA/HSD/OHP/Pages/HPE.aspx.
Hospital Presumptive Eligibility

<table>
<thead>
<tr>
<th>Part 2</th>
<th>Record eligibility determination. If approved, mark the appropriate eligibility group.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 3</td>
<td>Applicant information including telephone numbers, Email and alternate format or language needs.</td>
</tr>
<tr>
<td>Part 4</td>
<td>Signatures – Applicant and witness signatures are required.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Notification requirements</th>
<th>For approvals</th>
<th>For denials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copy of the completed Application (OHP 7260) – Complete Parts 1, 2, 3 and 4 for all applicants</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Approval Notice (OHP 3263A)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Denial Notice (OHP 3263B)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Full OHP (OHA 7210) application packet</td>
<td>X – Mark “Hospital Presumptive” at top of page 1</td>
<td>X – Do not mark with “Hospital Presumptive”</td>
</tr>
<tr>
<td>Help completing the OHA 7210, or information on resources to help the individual complete and submit the OHA 7210</td>
<td>X (required)</td>
<td>X (optional)</td>
</tr>
<tr>
<td>Explanation that the individual must complete and submit the OHA 7210 as soon as possible (no later than the temporary coverage end date listed on the Approval Notice)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Explanation that there are no appeal rights for an HPE decision. The hospital’s decision stands for the presumptive period.</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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
Hospital Presumptive Eligibility

- 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.

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 coverage since June 11, 2018. 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.
**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.

<table>
<thead>
<tr>
<th>Description</th>
<th>Retain on file:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility determinations completed</td>
<td>Completed OHP 7260s</td>
</tr>
<tr>
<td>Approval Notices (with Rights and Responsibilities) issued</td>
<td>Completed OHP 3263As</td>
</tr>
<tr>
<td>Denial Notices issued</td>
<td>Completed OHP 3263Bs</td>
</tr>
<tr>
<td>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</td>
<td>As determined by hospital and approved by OHA</td>
</tr>
<tr>
<td>Record of applicants given, prior to leaving the hospital, OHA 7210s, and also given help completing the OHA 7210</td>
<td>As determined by Hospital and approved by OHA</td>
</tr>
</tbody>
</table>

**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.
**Hospital Presumptive Eligibility**

**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.

<table>
<thead>
<tr>
<th>Proposed quality standard</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| 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

As the HPE program progresses and standards and criteria are refined, OHA proposes to enforce the standards 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.