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FOR DMAP (DIVISION OF MEDICAL ASSISTANCE PROGRAMS) WORKER GUIDES, PLEASE VISIT THE DMAP WORKER GUIDES WEBSITE AT:

http://egov.oregon.gov/DHS/healthplan/data_pubs/wguide/main.shtml

FOR ADULT PROGRAMS INFORMATION, PLEASE VISIT THE SPD WORKER GUIDES WEBSITE AT:

<http://www.dhs.state.or.us/spd/tools/additional/workergd/index.htm>

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B. Application, Redetermination, Recertification, Verification

1. Application for medical assistance

Application assistance programs

The Division of Medical Assistance Programs (DMAP) administers application assister programs – the Application Assistance Program, the Outreach and Enrollment Grant program and the Volunteer Organization program, and the CHIPRA Reauthorization Application Assister program.

Application Assistance Program, Outreach and Enrollment Grant Program and Volunteer Organization, and the CHIPRA Reauthorization Application Assister program providers work with families to help them complete the application process for their children. Neither program will work with adult only applications. Each program will stamp the application with a stamp that will include their provider number.

Each application assistance organization date stamps the application. The stamp includes their provider number.

- The Application Assistance Program provider identification stamp will always begin with “AA” followed by numbers;
- The Outreach and Enrollment Grant Program provider identification stamp will always begin with “GG” followed by numbers;
- The Volunteer Organizations provider identification stamp will always begin with “VV” followed by numbers;
- The CHIPRA application assister provider identification stamp will always begin with “CC” followed by numbers.

CM system coding for application assistance programs

Two need/resource items are used to track families with children applying for medical and getting assistance from the Application Assistance Program.

- AAP (Application Assistance Program Pending) is used to track cases with an applicant under age 19 whose family is working with an Application Assistance Program provider. The AAP end date is the month/year the application would be denied or closed if the application is not completed. The need/resource provider number is the AA number stamped on the application. Do not worry about removing or changing the AAP code if the application is denied; it will drop off the case automatically;
- AAA (Application Assistance Program Approved) is used to track cases with a child under age 19 approved for medical assistance whose family was assisted by an Application Assistance Program provider. Once approved for medical, remove

the AAP need/resource code and add the AAA code. The AAA end date is the month/year the child was approved for medical. The need/resource provider number is the AA number stamped on the application. Providers will be paid \$50 for each approved application, so it is important to code cases correctly.

Two need/resource items are used to track families with children applying for medical and getting assistance from the Outreach and Enrollment Grant Program:

- GGP (Outreach and Enrollment Grant Program Pending) is used to track cases with an applicant under age 19 whose family is working with an Outreach and Enrollment Grant Program provider. The GGP end date is the month/year the application would be denied or closed if the application is not completed. The need/resource provider number is the GG number stamped on the application. Do not remove or change the GG if the application is denied; it will drop off the case automatically;
- GGA (Outreach and Enrollment Grant Program Approved) is used to track cases with a child under age 19 approved for medical assistance whose family was assisted by an Outreach and Enrollment Grant Program provider. Once approved for medical, remove the GGP need/resource code and add the GGA code. The GGA end date is the month/year the child was approved for medical. The need/resource provider number is the GG number stamped on the application. (Outreach and Enrollment Grant providers are not given a \$50 payment for approved applications.)

Two need/resource items are used to track families with children applying for medical and getting assistance from the Volunteer Organization Program:

- VVP (Volunteer Organization Program Pending) is used to track cases with an applicant under age 19 whose family is working with a Volunteer Organization Program provider. The VVP end date is the month/year the application would be denied or closed if the application is not completed. The need/resource provider number is the VV number stamped on the application. Do not remove or change the VV if the application is denied; it will drop off the case automatically;
- VVA (Volunteer Organization Program Approved) is used to track cases with a child under age 19 approved for medical assistance whose family was assisted by a Volunteer Organization Program provider. Once approved for medical, remove the VVP need/resource code and add the VVA code. The VVA end date is the month/year the child was approved for medical. The need/resource provider number is the VV number stamped on the application.

Two need/resource items are used to track families with children applying for medical and getting assistance from the CHIPRA Reauthorization Application Assisters Program:

- CCP – (CHIPRA Application Assister Pending) is used to track cases with an applicant under age 19 whose family is working with a CHIPRA Application Assister provider. The CCP need/resource coded should be placed on a child under age 19. The CCP end date is the month/year the application would be denied if the

application is not completed. Do not remove or change the CCP if the application is denied; it will drop off the case automatically;

- CCA – (CHIPRA Application Assister Approved) is used to track cases with a child under age 19 approved for medical assistance whose family was assisted by a CHIPRA Application Assister provider. Once approved for medical, remove the CCP need/resource code and add the CCA code. The CCA end date is the month/year the child was approved for medical.

Application process

Do not require an interview for medical applicants. If the client no shows a SNAP, TANF or other nonmedical related appointment, do not deny the request for medical. Complete the medical application process through the mail and/or by phone as needed.

Emergent medical needs, and those who are pregnant, have priority when processing applications for medical. They do not need to disclose the basis of their emergent need. The application should be pended, approved or denied by the eligibility worker within one business day whenever possible. If the applicant does not have a companion case in a local field office, fax the completed, date-stamped application to OHP at 503-373-7493.

Pend end dates

The department is committed to increasing the number of children in Oregon with access to health benefits. To support Healthy Kids, we need to do everything we can to ensure families have an opportunity to clear eligibility for their children, including providing sufficient time for parents to respond to the pend notice.

- For medical programs, the client is entitled to the full 45-day pend period. Unless you are sure it will not be an issue for the family, do not pend to have eligibility items returned earlier than the 45th day;
- If an additional pend is needed (for example, when processing a *Medical Notice: It's time to renew your medical benefits* ([DHS 945](#)) medical pend notice), pend for no less than 10 business days;
- Sometimes 45 days is not enough. If the pend notice is sent late for a reason outside the client's control (application temporarily lost, late processing because of workload, etc.), the original 45 days should be extended as necessary to allow for some extra time. The DOR remains the same;
- To extend the 45 days, narrate your decision and the reason it was outside the client's control.

Applications used for SSP medical program eligibility

New medical program applicants who already have an open DHS program case do not need to complete a new application. The application on file may need to be amended.

Brand new medical program applicants who are not receiving any DHS program benefits must complete a new application.

- ☞ SEE [#7](#) OF THIS SECTION FOR MORE INFORMATION ABOUT REDETERMINATIONS AND HOW TO PEND FOR AN AMENDED OR NEW APPLICATION.

MAA, MAF. The *Application for Oregon Health Plan and Healthy Kids* ([OHP 7210](#)), *Oregon Health Plan Application* (online application) ([OHP 7210W](#)) or the *Application for Services* ([DHS 415F](#)) may be used.

EXT. An application is not needed for EXT medical assistance.

SAC. There are several types of Substitute and Adoptive Care (SAC) programs. All are on the CM system under the C5 program code. Types of SAC programs include the following:

- Children receiving Foster Care and Adoption Assistance from other states who reside in Oregon;
- Chafee Medical Program for children aging out of state of Oregon Foster Care;
- Tribal CW children;
- Children in CW custody who are placed in Psychiatric Residential Treatment Services (PRTS).

Effective September 15, 2011, the Child Welfare Children's Medical Eligibility Unit (CMED) will assume responsibility for most SAC C5 applications. Although most of the cases will be CW's responsibility, SAC program cases will remain on the CM system and will remain under the C5 program code.

When a request is made for SAC medical assistance at a DHS/OHA office:

- Give the applicant the *Application for Children in Substitute Care* ([DHS 1462](#)) or the *Medical Assistance Application for Children Receiving Adoptive Assistance* ([DHS 1462A](#)).

Note: *If the need for a SAC medical program eligibility determination is identified after the [DHS 415F](#), [OHP 7210](#) or [SDS 539A](#) has already been completed, do not require the completion of the [DHS 1462](#) or [DHS 1462A](#). CMED can use the [DHS 415F](#), [OHP 7210](#) or [SDS 539A](#) to determine SAC eligibility.*

- [DHS 1462](#) applications are completed by facilities on the behalf of children in substitute care. The [DHS 1462](#) is also completed by foster care providers on the behalf of children approved for foster care in another state but who are currently residing in Oregon;

- [DHS 1462A](#) applications are completed by adoptive parents for children subject of an adoption assistance agreement between the parents and a public agency of another state. These children are assumed eligible for SAC medical assistance.

☞ SEE [MA B.6](#) FOR INFORMATION ABOUT HOW TO REFER SAC APPLICATIONS TO THE CHILDREN’S MEDICAL ELIGIBILITY UNIT IN CHILD WELFARE.

OHP. When people apply for OHP medical assistance and another program – for example, SNAP or child care – they use the [DHS 415F](#). When applying for medical only, they may use the [DHS 415F](#), [OHP 7210](#), [OHP 7210R](#) or [OHP 7210W](#).

HKC. The [OHP 7210](#), [OHP 7210R](#), [OHP 7210W](#) or the [DHS 415F](#) may be used.

BCCM. An application for the BCCM program is initiated only when an uninsured woman is found to need treatment for either breast or cervical cancer, or precancerous conditions, after being screened by the Oregon Breast and Cervical Cancer Program coordinated by DHS Health Services.

Note: *If a client receiving benefits under another state’s Medicaid Breast and Cervical Cancer program is moving to Oregon and inquires about Oregon’s program, refer the client to the Oregon Breast and Cervical Cancer Program of DHS Health Services at 971-673-0581 (staff only) or 877-255-7070 (staff or clients). DHS Health Services needs direct contact with the client to determine if she meets the criteria for Oregon’s program and to coordinate treatment services, if eligible.*

- The *Breast and Cervical Cancer Medical (BCCM) Program Application and Referral Form* ([DHS 1463](#)), form is completed by a woman who has been screened by the Oregon Breast and Cervical Cancer Program and is found to need treatment for breast or cervical cancer, or precancerous conditions. The application is provided to the woman by an Oregon Breast and Cervical Cancer Program Coordinator after the woman is diagnosed;
- The woman receives assistance in completing the application by an Oregon Breast and Cervical Cancer Program Coordinator. The Coordinator determines eligibility for BCCM and refers the application to the Statewide Processing Center;
- A woman eligible for the BCCM program will have her case coded as program P2 with a BCP case descriptor. A woman who has been screened by the Oregon Breast and Cervical Cancer Program and needs treatment but is eligible for another Medicaid program will have her case coded with that program coding and with a BCS case descriptor;
- A woman initially found eligible for BCCM may be required to complete and return an [OHP 7210](#) or other DHS application to determine if the woman is eligible for another Medicaid program. This [OHP 7210](#) application will be marked “BCP” on the label. If the woman submits the [OHP 7210](#) to a branch office, it should be forwarded to the Statewide Processing Center.

☞ SEE [MEDICAL ASSISTANCE E.15](#) FOR MORE INFORMATION.

Who must sign the application. The application must be signed by one adult member in the filing group or their authorized representative before medical benefits may be approved.

- Only one parent in a two-parent household need sign the application;
- Do not pend for a signature solely to deny the medical application;
- When there is not an adult in the filing group or an authorized representative, e.g., a homeless child applying for benefits, the person applying must sign the application.

Authorized representatives. A person or family may use an authorized representative to complete the application for them if needed. People who can be authorized representatives include a legally appointed guardian, a conservator, a person with power of attorney, a person authorized by the recipient and a person acting responsibly for the recipient. If needed, the branch may appoint a responsible person to be the authorized representative.

To designate an Authorized Representative or Alternate Payee, the client must complete the *Designation of Authorized Representative or Alternate Payee* ([DHS 231](#)) or the *Optional Assistance* ([OHP 7218](#)) at application and at any time the client requests a change. If health information is to be disclosed, an *Authorization for Use & Disclosure of Information* ([DHS 2099](#)) is required in addition to the above mentioned forms.

2. **Date of Request (DOR)**

Overview

To start the application process:

- A client or someone authorized to act on their behalf must contact the department or another appropriate location with a request for benefits. This request can be in the form of a phone call, office visit or a written request by the applicant or another person or agency acting on behalf of the applicant;
- When the online [OHP 7210W](#) application is submitted online, it is time-stamped and a DOR established for the applicant;
- The department may also initiate the application process and establish a DOR for the client;
- Hospitals call the OHP Application Center to establish a date of request (used to be called a “hospital hold”) when an individual is admitted. To find out if there has been a date of request for the applicant, call the OHP Application Center at 800-359-9517.

The application is completed when the person completes and signs the application and provides the necessary information and verification within 45 days from the date of request. The 45-day limit may be extended when circumstances exist that are beyond the control of either the person applying or the department. People may withdraw their application at any time.

- The 45-day limit may be extended when circumstances exist that are beyond the control of either the person applying or the department. People may withdraw their application at any time.
- The 45-day limit must be extended if the 45th day lands on a nonbusiness day such as a furlough day, weekend or holiday.

Example: Mary applies for medical on May 20, 2011. DatePlus calculates the 45th day as July 4, 2011. Since July 4 is a holiday and DHS offices are closed, extend the pend end date (the “45th day”) to July 5.

New applicants

The date of request for new applicants is the day medical care began, if the actual request is made no later than the next working day. If the request is received later than the next working day, the day the request is received by the department is the date of request.

To apply for medical, a person or someone authorized to act on their behalf must either contact a branch office serving the area they live in, an outreach center, including an authorized Federally Qualified Health Center (FQHC) or a Disproportionate-Share Hospital (DSH), or call the toll-free number 800-359-9517, with a request for benefits. A request may be in the form of a phone call, a visit to the office or in writing.

For new applicants, in order to maintain the original date of request, the person’s application form must be received in a branch office no later than 45 calendar days from the date of request. If the 45th day falls on a weekend or holiday, the application must be received the following working day. If the application is not received within 45 days, the actual date the branch office receives the application becomes the new date of request. The 45-day policy does not apply to recertifications.

For Healthy KidsConnect, the date of request will not establish the date medical benefits begin. The 12-month HKC eligibility period begins the first of the month following the date the HKC decision is made.

Once referred to OPHP, HKC subsidy clients will have 45 days to contact DHS or OPHP to enroll in a plan after eligibility has been established. HKC subsidy and HKC ESI reimbursements begin after the client enrolls in a health plan contracted through OPHP.

The date of request for a medical application, which is date stamped on the application form, may also be established by a branch, by the toll-free operator or by a worker at an outreach center. For [OHP 7210W](#) online applicants, a DOR is established when the

[OHP 7210W](#) is successfully submitted by the applicant over the internet and received by the department.

DOR at redeterminations

For redeterminations (including OHP and HKC recertifications), the date of request is the date the application is received by the department, the date the client otherwise establishes a date of request or the department establishes a DOR for the client.

The department establishes a DOR for the client:

- When acting on a reported change;
- When initiating a review, including when the CM system automatically prompts the mailing of either a *Medical Notice: It's time to renew your medical benefits* ([DHS 945](#)) medical pend notice or the [DHS 415F](#) reapplication packet at regularly scheduled redeterminations.

Note: CAF/SSP medical program clients are mailed either the [OHP 7210](#), [DHS 415F](#) packet or [DHS 945](#) medical pend notice at scheduled redeterminations. The [OHP 7210](#) is sent when a child is aging off of medical at age 19 and must reapply as an adult. The [DHS 415](#) packet is sent when the medical end date is aligned with the SNAP end date. The [DHS 945](#) is sent to all other CAF SSP medical program clients at redetermination.

Special HKC Processing. For Healthy KidsConnect families at or over 301 percent, redeterminations will not be made every year by DHS. OPHP will handle these redeterminations.

For HKC subsidy and HKC ESI reimbursement clients turning 19 years old, the Statewide Processing Center (Branch 5503) will redetermine eligibility for ongoing benefits.

Randomly selected OHP Standard Reservation List applicants

Persons randomly selected from the OHP Standard Reservation List can establish a DOR on or after the selection date through 45 days from the date the OHP 7210R is mailed. If the OHP Standard Reservation List Applicant does not establish a DOR within 45 days from the date the OHP 7210R is mailed, the client may request an ADA accommodation. (See Multiple Program Worker Guide MP #13 ([MPWG #13](#)) for more information about ADA accommodations.) If the client does not qualify for an ADA accommodation, treat as a new OHP-OPU applicant.

- The 45 days from the date the OHP 7210R is mailed must be extended if the 45th day lands on a nonbusiness day such as a furlough day, weekend or holiday.

Example: Mary applies for medical on May 20, 2011. DatePlus calculates the 45th day as July 4, 2011. Since July 4 is a holiday and DHS

offices are closed, extend 45-day period after the OHP 7210R mail date to July 5.

☞ SEE [MA E.8](#) FOR MORE INFORMATION ABOUT THE OHP STANDARD RESERVATION LIST PROCESS.

Date of Request: [461-115-0030](#)

When An Application Must Be Filed: [461-115-0050](#)

Authorized Representatives; General: [461-115-0090](#)

Offices Where Clients Apply: [461-115-0150](#)

Application Processing Time Frames; Not Pre-TANF or SNAP: [461-115-0190](#)

OHP-OPU; Effective Dates for the Program: [461-135-1102](#)

Reservation Lists and Eligibility; OHP-OPU: [461-135-1125](#)

Effective Dates; Initial Month Medical Benefits: [461-180-0090](#)

3. **Reviewing for multiple medical programs**

Workers must review for all medical programs when evaluating for initial medical eligibility, when acting on timely reported changes and at regularly scheduled redeterminations:

When reviewing for initial medical eligibility:

- First consider all medical programs except OHP, CEM, CEC and Healthy KidsConnect;
- If not eligible, then evaluate for OHP. For non-CAWEM children under age 19, if not eligible for OHP, evaluate for CEM and CEC;
- If not eligible for any of the above, for non-CAWEM children under age 19, evaluate for Healthy KidsConnect.

4. **Referrals to OPHP**

DHS refers client information to the Office of Private Healthy Partnerships (OPHP) to support Healthy Kids.

- Healthy KidsConnect (HKC) is part of Healthy Kids. HKC cases are referred to OPHP automatically once the HKC coding is added to the CM system. Once referred, OPHP works with the HKC families to issue benefits;
- Some HKC families from 201 percent to 301 percent (KCA) qualify for a subsidy of their employer sponsored insurance (ESI). If ESI is available to a KCA family, but the child is not receiving it yet, send an e-mail to OPHP at [Info, OPHP](#) with the insurance information;

- When KCA families are receiving private major medical but qualify for a waiver of the two-month waiting period, send an e-mail to OPHP at [Info, OPHP](#) with the insurance information;
- When sending an e-mail to [Info, OPHP](#) include:
 - Case number;
 - Case name;
 - Name and phone number of the insurance company, or for employer sponsored insurance, the name and phone number of the employer;
 - The names of child(ren) that are covered by the insurance.

☞ THE CM SYSTEM CODING AND REFERRAL REQUIREMENTS FOR HKC FAMILIES ARE INCLUDED IN THIS CHAPTER, SECTION [E.17](#).

- In addition to HKC families, OPHP also support HK by providing a 100 percent subsidy payment for a child's employer sponsored health insurance in certain circumstances.

When a non-CAWEM Medicaid or CHIP child is not receiving employer sponsored insurance but it is available to them:

- Add the ESP need/resource item with a Continuous end date (ESP C) to the child on the CM case;
- Send an email to [INFO, OPHP](#);
- OPHP and the family will review available health insurance options. If the family chooses to end Medicaid/CHIP coverage, OPHP will notify the worker.

5. Referrals to SPD

Clients that indicate they have disabilities should be referred to SPD, if appropriate, using your local referral process. Do so only after evaluating for all “Plus” Self-Sufficiency medical programs. SPD referrals for applicants who may only be considered for OHP-OPU should be completed immediately, even in cases where the applicant will be pended for OHP-OPU eligibility.

Check with your lead worker or manager for more information about your branch's referral process for OSIPM. CAF Self-Sufficiency and SPD have jointly developed a Worker Guide explaining the process. The [SPD WG-4](#), “Presumptive Medicaid (OSIPM) Decision Procedures” is available at:

<http://www.dhs.state.or.us/spd/tools/program/osip/wg4.htm>.

Clients referred to SPD for an OSIPM eligibility decision should be sent the GSOSIPR “OSIPM Referral” notice available on Notice Writer. Clients denied for Self-Sufficiency medical prior to the referral will also need to be sent the *Notice of Self Sufficiency Medical Program Eligibility Decision* ([DHS 462C](#)). The [DHS 462C](#) is available on the DHS forms Web page and as a two-part Notice Writer notice CM462C1 and CM462C2.

6. Referring SAC Applications to the Children’s Medical Eligibility Unit (CMED)

When a request is made for SAC medical assistance at an OHA/ DHS/AAA office:

- Give the applicant the *Application for Children in Substitute Care* ([DHS 1462](#)) or the *Medical Assistance Application for Children Receiving Adoptive Assistance* ([DHS 1462A](#));

Note: If the need for a SAC medical program eligibility determination is identified after the [DHS 415F](#), [OHP 7210](#) or [SDS 539A](#) has already been completed, do not require the completion of the [DHS 1462](#) or [DHS 1462A](#). CMED can use the [DHS 415F](#), [OHP 7210](#) or [SDS 539A](#) to determine SAC eligibility.

- Fax the completed [DHS 1462](#), [DHS 1462A](#), [DHS 415F](#), [OHP 7210](#) or [SDS 539A](#) application to the CMED Eligibility Specialist at 503-945-7032;
- If you need to contact a CMED Eligibility Specialist, contact via DHS/OHA email system:

Leslee V. Star leslee.v.star@state.or.us
Margaret L. Roberts margaret.l.roberts@state.or.us

☞ SEE [MA B.1](#) FOR MORE INFORMATION ABOUT SAC PROGRAM APPLICATIONS.

7. OMIP/FMIP and eligibility

The Oregon Medical Insurance Pool ([OMIP](#)) and Federal Medical Insurance Pool (FMIP) work together to provide a high-risk health insurance pool for the state. OMIP/FMIP is guided by a citizen board of directors and was established by the Oregon Legislature to cover adults and children who are unable to obtain medical insurance because of health conditions.

[OMIP](#)/FMIP also provides a way to continue insurance coverage for those who exhaust COBRA benefits and have no other options.

[OMIP](#)/FMIP contracts with Regence Blue Cross-Blue Shield as the health insurance provider for [OMIP](#)/FMIP recipients.

Except for OHP-OPU, OHP-CHP and HKC, DHS medical program clients can have [OMIP](#)/FMIP. However, clients may incur an overpayment with [OMIP](#)/FMIP if they receive DHS medical at the same time.

[OMIP](#)/FMIP coverage is not allowed to overlap with OPU, CHIP or HKC as it is *private major medical health insurance*. [OMIP](#)/FMIP clients have a condition that, without treatment, would be life-threatening or would cause permanent loss of function or disability.

- Workers should review the client’s OHP-OPU medical application to determine if they are eligible for a waiver of the six-month waiting period following the receipt of *private major medical health insurance* under the provisions of OAR [461-135-1100](#);
- Workers should review the client’s OHP-CHP, HKC medical application to determine if they are eligible for a waiver of the two-month waiting period following the receipt of *private major medical health insurance* under the provisions of OAR [461-135-1100](#).

☞ SEE OAR [461-135-1100](#) FOR MORE INFORMATION ABOUT SPECIFIC OHP REQUIREMENTS.

To avoid overlap and client overpayment, once determined otherwise eligible for DHS medical, DHS workers should e-mail Sandy Harris with Regence at Sandy.Harris@regence.com to verify the termination date of the *private major medical health insurance*. Include the following information:

- Client name;
- Social Security number;
- If possible, CareAssist or Regence ID Number;
- DOR of DHS medical application;
- “Applicant has been determined eligible for Oregon DHS medical insurance. To avoid an [OMIP](#)/FMIP overpayment and/or overlap of Medicaid with private major medical health insurance, their DHS medical should not begin until their [OMIP](#)/FMIP has ended. Please provide confirmation of the termination date of their [OMIP](#)/FMIP coverage. DHS medical will be started on the day following their termination date.”

Specific Requirements; OHP: [461-135-1100](#)

8. **Redetermination of medical assistance eligibility**

Redetermination process defined

Redetermination is the process used to review eligibility to approve, close or deny the continuation of benefits. This process includes a review of the new or existing application and supporting documentation. It also includes an evaluation of eligibility for all Self-Sufficiency medical programs prior to ending benefits. People must cooperate in the process or their benefits will stop.

☞ SEE [DHS 945](#) REDETERMINATION PROCESS BELOW IN THIS SECTION.

Special CW referral process

When children lose eligibility for foster care, CW sends a referral to the OHP Statewide Processing Center (Branch 5503). Eligibility workers add the children as MAA clients and redetermine their eligibility for ongoing medical. If not eligible for any SSP or SPD OHP Plus medical, the children are converted to CEM for the balance of their 12-month eligibility period.

☞ SEE [MA E.16](#) FOR MORE INFORMATION ABOUT THE CEM PROGRAM.

Frequency of redeterminations

Redetermination is done at assigned intervals, whenever eligibility becomes questionable or when acting on a change that affects current medical eligibility.

- Periodic redeterminations are done every 12 months for the MAA and MAF programs. To ensure that children under age 19 have a 12-month period of eligibility, do not adjust the MAA/MAF redetermination date to match SNAP or other companion cases redetermination dates;

☞ SEE SPECIAL REDETERMINATION PROCESS FOR MAA/TANF COMPANION CASE CLIENTS BELOW IN THIS SECTION.

- Children receiving Continuous Eligibility for Medicaid (CEM) or Continuous Eligibility for CHIP (CEC) are redetermined at the end of their CEM or CEC period;

☞ SEE [MA E](#) FOR MORE INFORMATION ABOUT 12-MONTH CONTINUOUS ELIGIBILITY FOR CHILDREN.

- Periodic redeterminations are done at least every 12 months for BCCM;
- There is no redetermination for EXT;
- OHP redeterminations are based on the OHP certification periods. See OHP Certification Period below;

- HKC subsidy and HKC ESI redeterminations will be made after 12 full months from the eligibility approval date;
- For all SSP medical programs, a redetermination is completed whenever a change has been reported timely that affects current medical eligibility;
- In the MAA, MAF, OPU, OPC, OP6 and CHIP programs, redeterminations may be done early if it is at the time of SNAP recertification. This allows the medical program 12-month end date to match the clients SNAP 12-month certification end date.

The decision to redetermine the medical program case is up to the local branch or district. The local branch or district may choose not to redetermine the medical companion case when establishing a 12-month SNAP certification period.

If the clients are eligible for the same or a higher level of benefits, new MAA, MAF, OPC, OP6 and CHIP 12-month eligibility periods may be established.

In the OPU, OPC, OP6 and CHIP programs, if the redetermination results in ineligibility or if clients do not respond to pend notices, allow the original OPU, OPC, OP6 and CHIP certifications to remain as is.

In the OPU program, if the redetermination results in an increase in monthly premiums, no timely reduction notice is necessary because the redetermination has established a new certification period.

In the MAA and MAF programs, if the new redetermination decision results in ineligibility for continued MAA or MAF benefits, the worker will need to act on the new information to end benefits or to convert to another program. If necessary to close/reduce, send timely notice ([DHS 462A/462R](#)).

Example: Mary and her three children are receiving SNAP benefits. Their SNAP certification will expire September 30. The three children are receiving CHIP and OP6, due to end December 31, 2010. The worker decides to recertify the CHIP/OP6 medical so the CHIP/OP6 medical end date matches the 12-month SNAP certification end date. The worker recertifies SNAP, CHIP and OP6 through September 2011.

Example: Heather and her two children are receiving MAA benefits. Heather reapplies for SNAP. Heather's family is recertified for 12 months for SNAP. The worker determines the family is also still eligible for MAA and matches the MAA end date with the SNAP end date.

Example: Manuel, his wife and child are receiving SNAP, OPU and OPC medical. The SNAP certification is due to expire March 31, 2011. The OPU medical is due to end June 30, 2011. The OPC medical is due to end December 31, 2011. The worker opts to redetermine OPU and OPC medical as part of the SNAP recertification

application. As a result of the new eligibility decisions, the worker determines the family is eligible for SNAP, OPU and OPC. The OPC, OPU and SNAP benefits are recertified for 12 months, through March 2012.

Example: Francisco and his two children apply for SNAP benefits in October 2010. Francisco's children are receiving CHIP through March 2011. The worker determines the family to be over-income for SNAP and the medical income to be over the 201 percent FPL. The worker denies the SNAP benefits and the children remain on the original CHIP certification period through March 2011.

Example: Sierra and her child Sammy are receiving SNAP and MAA benefits. Their SNAP certification is expiring May 31. The MAA benefits are expiring December 31. During the SNAP intake in May the worker determines the child's absent father has moved back into the home and pends for income verification and deprivation information (Sierra did not have this available at the SNAP intake). The pended information is not returned. The worker ends Sierra and Sammy's medical benefits sending a 10-day close notice.

Note: The CM system will close program P2 MAA and MAF cases based on the MAA or MAF need/resource item on CMUP and will send the "CR" close notice. The CM system will close MAA/TANF cases if the only child was an unborn or the only eligible child is turning 19. The CM system also automatically ends MAA for dependent children turning 19, even if there are other dependent children on the case. CM will not close if there is a protected AEN or pregnant woman.

Note: The CM system will close the HKC subsidy and HKC ESI eligibility based on the KCR need/resource end date.

Special redetermination process for MAA/TANF companion case clients

- MAA cases with companion TANF cases will not be mailed the *Medical Notice: It's time to renew your medical benefits* ([DHS 945](#)) form or a [DHS 415F](#) reapplication packet;
- When the MAA redetermination is coming due, the CM system will automatically update the MAA need/resource for another 12 months. This will only happen if there is a companion TANF case;
- If the TANF case closes but there is ongoing MAA eligibility, the CM case will be converted from a program 2 or 82 to a P2 MAA only case;
- When the MAA need/resource end date is updated a notice will be sent to the client letting them know their MAA benefits have been renewed and reminding them to report changes.

DHS 945 redetermination process

Effective December 2010, the [DHS 945](#) pend notice was implemented. The [DHS 945](#) replaces the [DHS 415F](#) redetermination packet for many CAF SSP medical program clients.

- Except for HKC, the [DHS 945](#) medical pend notice establishes a DOR for the 15th of the month prior to the redetermination/certification end date. It is mailed no later than the 20th of the month prior the end date month. For example, if the MAA redetermination is due before July 31, 2011 (MAA 07/11), the [DHS 945](#) establishes a date of request (DOR) for June 15 and is mailed by June 20. The CM system automatically updates the DOR on the UCMS screen and adds a BED code;
- For HKC, the [DHS 945](#) is mailed on the 15th of the 10th month of the certification. For example, if the HKC certification is due to expire July 31, 2011 (KCE 07/11), the [DHS 945](#) establishes a DOR for May 15, 2011, and is mailed by May 20. The CM system automatically updates the DOR on the UCMS screen. It does not add a BED code because BED codes are not allowed on HKC cases;
- The new [DHS 945](#) pend notice will establish a date of request (DOR) for the client's redetermination of eligibility. The CM system case will be automatically updated with the DOR and with a BED need/resource item;
- When a client initiates contact with the department, including submission of a [DHS 945](#), a phone call or voicemail, written notice, etc., treat as a redetermination pend notice:
 - Review the client's application, CM case information, WAGE, ECLM, Work Number and other available information;
 - Consider if the [DHS 945](#) reports any changes that might affect eligibility;
 - Consider if the client needs to submit any additional information. If any outstanding eligibility issues can be resolved by calling the client, please make two attempts to call the client;
 - If necessary send an additional pend notice, using the same 45th day on the [DHS 945](#). Give the client 10 business days to provide the additional information;
 - Narrate as a redetermination, including budget month, income calculation, eligibility decision and so on.
- If the client does not respond to the [DHS 945](#) (does not submit paperwork or verifications, call their worker or make any other contact with the department), the medical case will close at the end of the BED month and the client will be sent a CM system 77B close notice. No followup is required by the worker.

Medical clients excluded from the [DHS 945](#) process:

- SPD medical program cases will not be included in the [DHS 945](#) mailings;
- SSP children turning 19 who need their medical redetermined will continue to be mailed the [OHP 7210](#);
- SSP medical cases that have a companion SNAP case that is expiring the same month or month before the medical case. These cases will receive the [DHS 415F](#).

☞ SEE MEDICAL CHAPTER SECTION [F.8](#) FOR [DHS 945](#) BUDGETING.

There is usually no need for a new application at redetermination/recertification

Clients who are receiving a DHS program (even if the program is not a medical program) do not need to complete a new [OHP 7210](#) or [DHS 415F](#) application when requesting medical.

It does not matter when the application was originally signed, as long as the client is currently receiving DHS program benefits at the time they make the request for medical.

Review the existing [OHP 7210](#) or [DHS 415F](#) and all the information on the original application. Determine what eligibility items need to be verified and send a pend notice.

If there is no current application available in the imaging system or in the file, require a completed application.

Amending the original application

Sometimes an application may need to be amended. If someone has moved into the household and is in the medical filing group, the worker may pend to have the existing application updated by the client. (When a client updates an existing application, the client is amending the application).

- To request the application be amended to include the new filing group member's name, SSN, DOB and other information in the "Tell us about the people in your household" section of the [DHS 415F](#) or question 2 of the [OHP 7210](#). Send copies of the pages of the [DHS 415F](#) or [OHP 7210](#) that need to be amended to the client with a pend notice.

Instead of sending copies of part of the original application, caseworkers may use the *Additional space for other people living with you* ([DHS 415X](#)) or *Additional People* ([OHP 7226](#)) form.

Example: Mary and her three children are receiving SNAP benefits. Mary loses her health insurance and requests medical. The worker may use the [DHS 415F](#) used for the SNAP application to determine eligibility for medical.

Pending for a new application

Instead of sending copies of part of the original application to be amended, the family may be sent a new application.

- When requesting a new application, completion of the application becomes an eligibility requirement. The family must be pended for completion of the new application.

If the client submits a new application packet, a new signature is also required. For example, in a two-parent household, at least one parent needs to sign the reapplication. Do not use the signature on the old application when there has been a break in medical benefits.

Example: Joan and her two children are receiving SNAP and ERDC. Joan reports that her husband John has returned to the household. Joan requests medical for herself, her husband John and their two children. The worker may use the [DHS 415F](#) used for the SNAP eligibility to determine eligibility for medical.

***However**, the worker needs information about John. Instead of amending the existing application, the worker may opt to require a new application and send a pend notice requesting the new application.*

BED coding for periodic redeterminations or when acting on a reported change

For periodic redeterminations or when acting on a reported change that affects medical eligibility in the BCCM, CEC, CEM, EXT, HKC, MAA, MAF, OHP, OSIPM and SAC programs, give the filing group 45 days from the date of request to re-establish their eligibility.

***Note:** Although client's report of a change must be timely in order to be eligible for the 45-days extension, a state agency's report of a change need not be timely.*

If there is not enough time to process the periodic redetermination or act on the reported change, add the BED need/resource item to all but HKC- KCE-coded cases (BED coding is not allowed on HKC- KCE-coded cases). The BED end date should provide enough time to pend and/or send a 10-day notice to close or reduce benefits.

***Note:** Except for HKC KCE cases, clients who receive the [DHS 945](#) will have their CM system case automatically updated with a BED need/resource item.*

If not removed, the CM case will use the BED code to send the 77B 10-day close notice on the 15th of the month. If the 45th day is after the 15th, the BED end date should be the next month.

The Bypass End Date (BED) coding works correctly only when there is a medical end date to bypass. If necessary, change the medical end date to the current month. For

example, if the MAA need/resource end date is 12/10 and the client reports a change requiring MAA redetermination in 07/10, send the pend notice, change the MAA end date to 07/10 and add the BED code.

☞ SEE [MEDICAL ASSISTANCE WG#10](#) FOR MORE INFORMATION ABOUT BED CODING.

If the client is still eligible, but for a reduced benefit package: If the client has turned in enough information to make an eligibility decision and they are no longer eligible for the same level of benefits.

Example: CW notifies you the only eligible child has been removed from the MAA household. Before ending the parent's MAA medical, consider OHP-OPU for the parent. Pend as needed to verify OHP-OPU eligibility. If eligible for OHP-OPU, send a timely continuing notice of reduction, Notice of Decision or Action.

Example: If the client has turned in enough information to make an eligibility decision determine if their HKC income is from 201 percent to 301 percent or is 301 percent or above. Add the BED coding and KCA coding to each child on the CM case. The CM system will automatically refer the children to OPHP. The referral notice includes information about the reduction.

Example: If the client has turned in enough information and the family has income 301 percent and above, the children do not qualify for any DHS medical program assistance. Use the BED coding only if necessary to send the 10-day close notice and the [DHS 462A](#) notice. On a Compute action, end the current benefits and add the KC3 coding to each child on the CM case. The CM system will automatically refer the children to OPHP.

Example: CW notifies you the only eligible child has been removed from the MAA household. Before ending the parent's MAA medical, consider OHP-OPU for the parent. Pend as needed to verify OHP-OPU eligibility. If eligible for OHP-OPU, send a timely continuing notice of reduction, Notice of Decision and Action Taken ([DHS 456](#)), and convert the parent's MAA medical to OHP-OPU medical the first of the month after the timely continuing notice period.

If the client is not eligible for SSP medical anymore, but could be eligible for SPD medical: When a decision has been made that the client is no longer eligible for SSP medical, determine if the client could be eligible for SPD medical. If they could be eligible for SPD medical, complete a referral and if already receiving SSP medical, keep the SSP medical open until SPD has made a decision. Use the BED coding to keep the case open. Do not send a close notice or [DHS 462A](#) until SPD has made a decision.

☞ SEE [MEDICAL ASSISTANCE B.5](#) FOR MORE INFORMATION ABOUT SPD REFERRALS.

If the client's case has to be pended: Once the BED coding has been added to a pended case, if the client does not return the pended, the CM system will automatically send a timely continuing (10-day) close notice; the worker will not need to send a separate close notice. No [DHS 462A](#) is required.

Note: If circumstances or information needed to determine eligibility is expected to be received after the 45-day deadline and the client has no control over the circumstances or information, the 45-day application process may be extended.

☞ SEE [MEDICAL ASSISTANCE WG#10](#) FOR MORE INFORMATION ABOUT BED CODING.

Periodic Redeterminations; Not EA, ERDC, EXT, OHP, REF, REFM, SNAP or TA-DVS: [461-115-0430](#)
Specific Requirements; OHP: [461-135-1100](#)
Reservation Lists and Eligibility; OHP-OPU: [461-135-1125](#)
Acting on Reported Changes; EXT, MAA, MAF, OHP, OSIPM, QMB, SAC: [461-170-0130](#)
Effective dates; Redeterminations of CEC, CEM, EXT, MAA, MAF, OHP, OSIPM, QMB, SAC: [461-180-0085](#)

9. | OHP and HKC certification period

The intent of the OHP and HKC certification period is to give most people a continuous period of medical assistance and to review their eligibility on a periodic basis.

The certification period is the number of months between the person's initial eligibility and when a recertification of eligibility is due, or between one recertification and the next. The certification period is determined as follows:

- For OPC, OP6, OPU and CHP clients, the initial certification consists of the month containing the effective date for starting medical benefits and the following 12 months. For example, if the DOR is 05/15/10 and the client is eligible for OPC, OP6, OPU or CHIP from this date, the certification period would be 05/15/10-05/31/11;
- For HKC children who are eligible for a subsidy (201 percent to 301 percent income), the initial certification period consists of the month containing the OPHP referral date and the following 12 months. Use the KCR need/resource code to indicate the 12th month. Children referred with family income at 301 percent and above are not DHS clients and do not have a certification end date;

☞ SEE [MA E.17](#) FOR HKC CODING REQUIREMENTS.

- For OPC, OP6, OPU, CHP and HKC subsidy (income from 201 percent to 301 percent) recipients, the new certification period is the following 12-month period;

- When a person receiving OHP starts working under a JOBS Plus agreement, extend the certification period to one month beyond the end of the agreement. If the agreement ends early, shorten the period to the original date or the month following the month in which the agreement ends, whichever is later.

How to recertify BEDded cases

If eligible for OHP, any month the client receives benefits because the case had been BEDded counts toward the next OPC, OP6, CHP or OPU certification period.

When recertifying a BEDded case, remove the BED code. Enter a Compute action for the first of the next month. Change the medical case descriptor if necessary and update the OPC, OP6, CHP or OPU need/resource end date. Change the medical start date on CMUP for the recertified client to the first of the next month.

For example, an OPC child's certification is due to end April 30. On April 14, the family reapplies for OHP benefits and the case is BEDded for 06/09. On May 5, the child is determined to be eligible for CHP. Remove the BED code. Compute for June 1, 2009, and enter a CHP need/resource end date of 04/10. Change the child's medical start date to June 1.

Adding/removing persons from an OHP case

When a new person (other than an assumed eligible newborn) wants to be added to an ongoing case, the entire group must establish a new certification period. If the new certification would make the current benefit group ineligible, the original benefit group remains eligible for the remainder of their certification period.

Example: Mary and her two daughters are receiving OHP. Her son John had been living with his father, but has returned to live with Mary and his sisters. John is not receiving any health care coverage, so Mary applies for medical for John on March 15, 2011.

Determine eligibility for Mary, her two daughters and John. If eligible, recertify Mary and her two daughters (giving them a new 12-month certification) and certify John from March 15, 2011, and the following 12 months.

Note: *If John is not eligible for medical, send a denial notice and [DHS 462A](#) notice. Keep Mary and her two daughters on their original certification.*

When a person leaves an OHP benefit group, that person is still eligible through the end of the certification period as long as he or she meets the nonfinancial and specific program requirements. Those remaining in the original benefit group also are still eligible through the end of the certification period if they continue to meet the nonfinancial and specific program requirements. A different case will need to be opened for the person who left the group. If the person is paying premiums as required under the OHP-OPU program, the premium status from the original case will not be updated on the new case.

Information about OHP certifications

A pregnant woman eligible for OHP is not assigned an eligibility period. She is assumed eligible through the last day of the month in which the 60th day following her pregnancy falls. When her assumed eligibility period ends, she needs to reapply to continue to receive benefits even if the certification period for others in the group extends beyond her assumed eligibility period. The computer system uses the DUE need/resource date to determine the period of eligibility. If the pregnancy ends in a month other than the date coded, it is important to change the DUE need/resource date so the person receives the correct period of coverage.

Combining OHP households

When a recipient moves into the household of another recipient, they must be combined into one case if all of the recipients are required to be in the same filing group. When cases are combined, extend the certification period to the latest date for any of the persons in the group.

Affect of reported changes on the certification period

Once a person is determined eligible for OHP, any changes in the filing group's household composition, income or resources, does not affect their eligibility during their current certification period. However, other changes (such as residency, citizenship, and student status) can affect eligibility.

☞ SEE SECTION E ([MA E](#)) OF THIS CHAPTER FOR MORE INFORMATION.

Certification Period; HKC, OHP: [461-115-0530](tel:461-115-0530)
Assumed Eligibility for Medical Programs: [461-135-0010](tel:461-135-0010)

10. | Verification of eligibility

The intent of verification is to ensure that the verbal or written information given by a person is the true information.

People must provide verification of their eligibility when requested. Branch staff may determine what is acceptable verification for specific eligibility requirements and situations. An application may be denied or ongoing benefits ended when acceptable verification is not provided; however, federal policy is clear that ongoing medical clients are “eligible until no longer eligible.” Be sure to list the reason(s) why eligibility needs to be verified on the pend notice. Do not forget to narrate the eligibility factor that needs verification.

☞ FOR EXAMPLES OF DOCUMENTS USED FOR VERIFICATION, [SEE MULTIPLE PROGRAM WORKER GUIDE #2](#) ON VERIFYING CLIENT INFORMATION.

For all medical assistance programs, verify the following whenever it is reported, changed or as needed for eligibility determination:

- Pregnancy. This must be verified by a medical practitioner, a health department or clinic, or a crisis pregnancy center or other like facilities. Due date verification is not required except when the only child is an unborn child for MAA and MAF or when a CAWEM client is part of the Pre-natal Expansion Program;

☞ FOR MORE INFORMATION ABOUT THE PRE-NATAL EXPANSION PROGRAM, SEE [NC C.3.](#)

- Birth of a child;
- Amount of the premium for cost-effective employer-sponsored health insurance;

Citizenship. Acceptable evidence of citizenship must be provided, but if the client is unable to provide documentation at initial application (and is otherwise eligible for medical), open, code with the CIP N/R, and pend for documentation. If the client does not provide documentation, the CM system will send a close notice and end benefits. The policy applies to all medical program clients, including pregnant women who were opened and then required to provide documentation, but did not do so.

Once a client's medical has been closed for failure to provide citizenship documentation, unless they have good cause, they must provide documentation before they receive benefits again;

☞ SEE [MEDICAL ASSISTANCE D.5](#) FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED.

- Noncitizen status. Handle as we do citizenship documentation. Acceptable evidence of noncitizen status must be provided, but if the client is unable to provide documentation at initial application and declares a noncitizen status that meets the requirements, open, code with the NOP N/R and pend for documentation. If the client does not provide documentation, the CM system will send a close notice and end benefits. The policy applies to all medical program clients, including pregnant women who were opened and then required to provide documentation, but did not do so.

Note: Please note that the NOP/NOE/NOD process applies only to clients who have not provided documentation but who have either 1) declared a status that meets the alien status requirements OR 2) have provided an "A" number that SAVE indicates meets the alien status requirement.

Once a client's medical has been closed for failure to provide citizenship documentation, unless they have good cause, they must provide documentation before they receive benefits again.

Reverify noncitizen documentation at each eligibility determination;

- Income. Verification requirements for income are closely tied with budgeting.

Anticipated income amount

Consider the client's stated anticipated income amount.

- If the client did not provide anticipated amount, call them. It is OK if the statement of anticipated income is from the phone call;
- If the client says they do not know how much they will make, ask questions about their income and jointly determine with the client their countable anticipated income. For example: Explain the income we need is gross, not net. Ask what dates they are paid (as opposed to pay periods) or if their work hours are changing.;
- It sometimes helps to refer to prior income amounts and ask the client if the new anticipated income is likely to be the same. If the client declares their income for subsequent paychecks will change and the change makes sense (pay increase, loss of job, etc.), accept the client's statement and narrate the circumstances. Ultimately the client's anticipation is the last stop in.

***Note:** For OHP, do not annualize, convert or prorate the financial group's income at certification or recertification. Use the OHP countable income available for the budget month. For MAA/MAF/SAC with a new applicant, do not annualize, convert or average the client's income. For ongoing MAA/MAF/SAC clients, average, annualize or convert as necessary so that each month's anticipated income amount is the same.*

Review all available income information

Review all available income information, including pay stubs, Work Number, ECLM, WAGE and the SNAP proof of income verifications. Use any documentation available to verify the income/income source.

- Please note that paycheck stubs do not have priority over other verifications. Do not pend if there is verification available, but it is not a pay stub;
- If payment verification is not available from the budget month, ask for a recent pay stub or other payment verification from the current source of income. Other items that can be used to verify the income source include the WAGE screen, phone call with the employer or letter from the employer, SSA award letter, VA award letter, etc.;
- In the absence of other forms of verification, accept the client's statement and narrate. For example, the client has just started a new job and has not yet been paid. The employer is out of town due to a family emergency and the client is unsure when they will return. The client's statement may be written or oral. Statements the client makes on the application are considered written.

Common sense test

Does the client's stated anticipated income amount make sense?

- There are times when you can see income on our system or verification that has been provided by the employer is different from what the client is reporting;
- If necessary, contact the client and resolve the discrepancy.

For HKC families with income 301 percent or above, do not pend for income verification in order to deny the case.

☞ SEE [MA E.17](#) FOR INFORMATION ABOUT HKC ELIGIBILITY AND SYSTEM CODING REQUIREMENTS

Example 1: The client is paid on the first and 15th of the month. DOR is the seventh. The worker is processing the application on the 10th. For countable income calculations, add actual gross income paid on the first and anticipated gross income for the 15th. To verify the source of income and to validate the client's statement, use a copy of the pay stub from the first, or any verification submitted.

Example 2: Client has a brand new job and has not been paid yet. For the countable income calculation, use anticipated income from the budget month. Do not require any verification for the anticipated income source, accept the client's verbal or written statement

Example 3: New applicant has two part-time jobs and received pay from both jobs in November and December. She is paid every Friday for job #1 and every other Friday for job #2. Her DOR is December 15. Use income already received and anticipated income in December for the countable income calculation. To verify the income source and validate the client's statement, ask for documentation such as a pay stub from each job. If the client says "I can't find a pay stub," accept another form of verification.

Example 4: Client is self-employed and reports \$15,000 from their business in the initial budget month, which is under the \$20,000 business income entity test. The worker needs documentation of the self employment income and can use the completed application, [DHS 943](#), [DHS 859B](#) or similar documentation and available verification such as: bookkeeping records, copies of contract, copies of work agreements and sales receipts. In the absence of other forms of verification, accept the client's statement and narrate.

Note: *Verification of self-employment costs is not required for OHP and MAF unless questionable.*

For all other eligibility requirements – i.e., residence, age, resources – accept the person’s statement unless it is questionable or inconsistent.

Any eligibility requirement may require verification when information is questionable or inconsistent with any of the following:

- Other reported information;
- Other information provided on the application;
- Other information received by the branch office;
- Information reported on previous applications.

EXT. Verify the following eligibility requirements for **EXT**:

- For initial EXT eligibility based on an increase in child support verify that at least one person in the EXT filing group received MAA or MAF for three of the six months preceding the first of the EXT eligibility period;
- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status.

MAA/MAF. Verify the following eligibility requirements for **MAA** and **MAF**:

- Social Security Number or an application for a number;
- Citizenship. Acceptable evidence of citizenship must be provided for some MAA/MAF recipients;
 - ☞ SEE [MEDICAL ASSISTANCE D.5](#) FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED.
- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status;
 - ☞ SEE [SECTION A.1](#) OF THE NONCITIZENS CHAPTER FOR MORE INFORMATION ON VERIFICATION OF ALIEN STATUS.
- American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program;
- Incapacity for deprivation based on incapacity. Other deprivation requirements as needed.

☞ SEE [TANFE](#) IN THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES RELATED PROGRAMS CHAPTER FOR MORE INFORMATION ON DEPRIVATION.

SAC. Verify the following eligibility requirements for **SAC**:

- Social Security number or an application for a number;
- Citizenship. Acceptable evidence of citizenship must be provided for some SAC recipients;

☞ SEE [MEDICAL ASSISTANCE D.5](#) FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED.

- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status;

☞ SEE [SECTION A.1](#) OF THE NONCITIZENS CHAPTER FOR MORE INFORMATION ON VERIFICATION OF ALIEN STATUS.

- American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program;
- Income and resources for children in substitute care;
- Eligibility for adoption assistance for adopted children. The family of a child receiving adoption assistance from another state should have a letter or a copy of the Adoption Assistance Agreement from that state that will confirm the child's eligibility for adoption assistance.

OHP. When people apply for **OHP**, verify the following eligibility requirements for the initial application:

- Social Security Number or an application for a number;

☞ SEE [MEDICAL ASSISTANCE D.5](#) FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED.

- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status;

Note: *If the applicant declares an immigration status that would meet the alien status requirements, does not have verification of their status but is otherwise eligible for full (not CAWEM) medical, open medical and pend for verification of immigration status using the CMNCSPD (Pend Medical; Proof of INS Status) Notice Writer notice. Close medical if the client does not show a good faith effort to provide the requested documentation. CM system coding will be added to support the process. Until it is available, please track the pend period and, if necessary, send a close notice and [DHS 462A](#) and end benefits.*

☞ SEE [SECTION A.1](#) OF THE NONCITIZENS CHAPTER FOR MORE INFORMATION ON VERIFICATION OF ALIEN STATUS.

- American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program;
- Mailing address.

Verify the following when an OHP case is being recertified:

- Citizenship. Acceptable evidence of citizenship must be provided for most OHP recipients as soon as possible after opening benefits. If the client is unable to provide documentation and says they need more time, extend the pend period;

☞ SEE [MEDICAL ASSISTANCE D.5](#) FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED.

- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status;
- Mailing address. A mailing address is required to complete an application. However, there is no length of residency requirement for Medicaid. A person can move within the state, or from out-of-state, and the length of residency cannot be considered in determining eligibility. In verifying a mailing address, workers should be reasonable and not create any barrier to accessing benefits. Medical cards may be sent to any place the person chooses, such as a post office, general delivery or public shelter, or the person may pick up the card at his/her local branch office. This choice is particularly applicable for newly arrived or homeless applicants.

HKC. Verify the following eligibility requirements for HKC:

- Social Security number or an application for a number;
- Citizenship;

☞ SEE [MEDICAL ASSISTANCE D.5](#) FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED.

- Alien status;

☞ SEE [SECTION A.1](#) OF THE NONCITIZENS CHAPTER FOR MORE INFORMATION ON VERIFICATION OF ALIEN STATUS.

- American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program.

11. **Effective dates; initial month medical benefits**

The effective date for starting medical benefits for an eligible client is as follows:

In the OHP-OPU program:

- If an OHP Standard Reservation List Applicant establishes a DOR on or after the random selection date through 45 days after the OHP 7210R mail date, begin benefits on the date of request;
- If an OHP Standard Reservation List Applicant establishes a DOR 45 days before the selection date, begin benefits on the date the applicant was randomly selected.

In the CEC and CEM programs: Begin benefits the first of the month following the month that eligibility for Child Welfare medical, EXT, MAA, MAF, OHP, OHP-CHP, OSIPM or SAC program benefits ends.

In the EXT program:

- If reported timely, start EXT medical the first of the month following the last month of MAA/MAF eligibility. No 10-day notice is required. Because no 10-day notice is required, some TANF/MAA cases will convert to TANF/EXT before the TANF can be closed. An individual can receive TANF and EXT on the same CM case;
- If an MAA/MAF client does not report an increase in income or child support timely, they may still be eligible for EXT. The EXT eligibility would begin the first of the month the household went over income for MAA/MAF.

☞ FOR MORE INFORMATION ABOUT WHEN TO BEGIN EXT BENEFITS, SEE [MA E.3](#).

In the HKC program: The referral to the Office of Private Health Partnerships (OPHP) begins effective the date the referral decision is made. OPHP determines the effective date for enrolling an eligible child in one of the HKC program categories of coverage.

In the MAA, MAF, OHP and SAC programs when converting from HKC subsidy:

- When converting an HKC subsidy client (KCE coding) to MAA, MAF, OHP or SAC begin benefits the first of the month following the month that KCE eligibility ends. Enter a Compute action on the UCMS screen for the first of the next month. Change the medical start date on CMUP to the first of the next month.

In the MAA, MAF, OHP, QMB-DW, REFM and SAC programs when not converting from an HKC (KCE) subsidy:

- Unless converting from an HKC subsidy (see above), if the client meets all eligibility requirements on the date of request, begin medical effective the date of request;

- If the client does not meet all eligibility requirements on the date of request, it is the first day following the date of request that all eligibility requirements are met.

In the OSIPM program: Begin medical for an OSIPM assumed eligible client as follows:

- Effective the first day of the month of the initial SSI payment if the client is age 21 or older;
- Effective the first day of the month prior to the month of the initial SSI payment if the client is under the age of 21.

In the QMB-BAS program: Begin medical the first of the month after the benefit group has been determined to meet all QMB-BAS program eligibility criteria and the department receives the required verification.

In the QMB-SMB and QMB-SMF programs:

- Begin medical the first of the month in which the benefit group meets all program eligibility criteria and the department receives the required verification; or
- The first of the month in which the Low Income Subsidy (LIS) information is received by the Social Security Administration (SSA), if the SMB or SMF program application was generated by the electronic transmission of LIS data from the SSA and the *benefit group* meets all program eligibility criteria.

Retroactive eligibility effective dates

For MAA, MAF, OSIPM and SAC:

- If a benefit group requests and is eligible for retroactive medical benefits, the earliest date they can be eligible is three months before the date of request. For example, if the benefit group requests benefits on July 10, eligibility may begin as early as April 10;
- After the earliest date is established, eligibility is determined on a month-by-month basis. The period starts on the earliest established date and ends on the date the benefit group requests benefits. For example, if the benefit group requests benefits on August 10, the earliest date is May 10. Eligibility is established separately for May 10 through May 31, June 1 through June 30, July 1 through July 31, and August 1 through August 9.

In the QMB-BAS programs:

- If a benefit group currently eligible for QMB-BAS requests and is eligible for retroactive medical benefits under MAA, MAF, OSIPM or SAC, the earliest date they can be eligible is three months before the effective date for QMB-BAS;
- After the earliest date is established, eligibility is determined on a month-by-month basis. The period starts on the earliest established date and ends on the effective

date for QMB-BAS. For example, if the benefit group requests benefits on August 10 and the effective date is September 1, the earliest date the group can be eligible for retroactive medical benefits is June 1. Eligibility is established separately for June 1 through June 30, July 1 through July 31 and August 1 through August 31;

- If a benefit group currently eligible for QMB-DW requests and is eligible for retroactive medical benefits, the earliest date they can be eligible is three months before the effective date of their initial eligibility;
- If a benefit group currently eligible for QMB-SMB requests and is eligible for retroactive payment of Part B Medicare premiums, the earliest date they can be eligible is three months before the effective date of their initial eligibility.

Certification Period; HKC, OHP: [461-115-0530](tel:461-115-0530)
Reservation Lists and Eligibility; OHP-OPU: [461-135-1125](tel:461-135-1125)
Specific Requirements; Retroactive Medical: [461-135-0875](tel:461-135-0875)
Effective Dates; Initial Month Medical Benefits: [461-180-0090](tel:461-180-0090)
Effective Dates; Retroactive Medical Benefits: [461-180-0140](tel:461-180-0140)

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E. Specific Eligibility Requirements

1. Medical Assistance Assumed (MAA)

To be eligible for MAA, a client must be a dependent child or a caretaker relative of a dependent child. However, a dependent child or caretaker relative cannot receive MAA while foster care payments are being made for the child.

There is one exception. If a child in foster care is expected to return within 30 days, the caretaker relative may be eligible for MAA based on the expected return of the child. Confirm the expected return date with CW.

Caretaker relatives can also receive MAA if their only child is an SSI recipient or their child is ineligible for MAA only because citizenship has not been documented yet.

Either parent whose only child is an unborn child can qualify for MAA if the mother's pregnancy has reached the calendar month before the month in which the due date falls.

The father of the unborn child can receive MAA even before the mother's pregnancy has reached the calendar month before the month in which the due date falls if there is another dependent child in the filing group.

Example: Mary is pregnant, due in six months. She is living with Dan, the father of the unborn and her three children from a previous relationship. Dan is the Primary Wage Earner (PWE). He was laid off from his last job and receives a small amount of UC, but the family is still under the MAA income limit. Mary and Dan are not married, but they meet the two-parent deprivation requirements based on unemployment. Even though Mary is not due for six months, everyone qualifies for MAA, including Dan.

A minor parent continues to be eligible for MAA if they lose TANF eligibility because they refuse to live with a parent or adult relative, or if they go over income due to deeming when they are required to **return** to live with a parent. The minor parent must also continue to meet all other TANF requirements.

People disqualified from TANF only because they have not cooperated with JOBS or substance abuse/mental health requirements are eligible for MAA as long as they continue to meet all other TANF eligibility requirements.

Persons serving a TANF or SNAP intentional program violation (IPV) penalty may still qualify for MAA, even if not pregnant.

2. Medical Assistance to Families (MAF)

When a family or child becomes ineligible for or is denied MAA because of their household composition or income, determine eligibility for MAF medical assistance prior to converting to EXT or other OHP Plus medical program.

Family members may be eligible for MAF when ineligible for MAA under the following situations:

- Situation 1: If a blended (yours/mine/ours) family is ineligible for MAA because of income, resources or other program requirements, eligibility may exist by forming separate filing groups under MAF.

For MAF, a blended family is one in which there is at least one child or unborn in common and the parents are unmarried. To fit in situation 1, there must also be at least one other child in the household from a prior relationship. If the only child is an unborn child in common, it is a situation 2 family (see below);

- Situation 2: A family is over income for MAA because of income from the father of an unborn child. If the father of the unborn child is not married to the mother and there are no other dependent children, the mother and the unborn child form a separate filing group. Deem the father's income to the mother. If the father of the unborn is also the father of another child in the household, consider situation 1.

Do not begin MAF benefits until the calendar month before the month in which the due date falls. For both MAA and MAF, if the only child is an unborn child, there is no eligibility until the month before the calendar month in which the due date falls;

- Situation 3: A family is over income for MAA because of income from an ineligible noncitizen. Eligibility for MAF may exist by deeming the noncitizen's income to the MAF need group.

When deeming the noncitizen's income, deduct the payment standard of the people who do not meet the citizenship or alien status requirements. However, explain to the family that they may choose not to apply for MAF benefits for one or more of their noncitizen children. If the family so chooses, deduct the payment standard for as many noncitizens as are needed to make the balance of the filing group eligible for MAF benefits.

For example, if there is an adult noncitizen and two noncitizen children who do not meet the alien status requirements, but only the adult has income, you may choose to deduct the payment standard for the adult only. The two noncitizen children may receive MAF CWM.

In families with more than one ineligible noncitizen with income, it is possible to remove only one of the ineligible noncitizens from the filing group. For example, in a family with an ineligible noncitizen mother who earns \$350 a month, an ineligible noncitizen father who earns \$400 a month and one citizen child, the

father can be removed and his income deemed, making the mother MAF CWM and the child MAF. Or, if more advantageous to the family, the mother and father can be removed, making the child MAF eligible;

- **Situation 4:** A family is over income for MAA because of income from the spouse of a needy caretaker relative. The spouse with income is removed to form a separate MAF filing group. If the spouse has any dependent children, they must be removed also. Deem the spouse's income to the MAF need group.
- **Situation 5:** A family with self-employment income is over income for MAA. Eligibility for MAF may exist by allowing for actual costs of producing self-employment income.

☞ SEE COUNTING CLIENT ASSETS C ([CA C](#)) FOR MORE INFORMATION.

Filing Group; EXT, MAA, TANF: [461-110-0330](#)

Filing Group; MAF and SAC: [461-110-0340](#)

Specific Requirements; MAA, MAF, and TANF: [461-135-0070](#)

3. Extended Medical Assistance (EXT)

Family members who are eligible for and receiving MAA or MAF may qualify for a period of EXT Medical after their eligibility for MAA/MAF ends.

When an MAA/MAF filing group may be eligible for EXT:

- The filing group must have become ineligible for MAA/MAF because of an increase in the caretaker relative's earnings or because of child support received. Do not require verification of the increased earnings or support;
 - If another change occurs in conjunction with the increase in the caretaker relative's earnings or in child support received, the filing group is not eligible for EXT if the other change, by itself, would have made the filing group ineligible for MAA/MAF.

Example: Anita and her two children, William and Sara, are receiving MAA when Robert, Anita's husband, returns to the household. His earned income puts the family over the income limit for MAA.

*The filing group is **not** eligible for EXT. It was not an increase in the caretaker relative's earnings that caused the filing group to become ineligible for MAA. While Robert is a caretaker relative, it was the earnings that he already had when he joined the filing group that made the filing group ineligible (not an increase in his earnings).*

EXT eligibility period

- If eligibility is a result of increased earnings of the caretaker relative, the eligibility period is for 12 months. Code with the AE2 need/resource item (more on coding below within this section);
 - There is no requirement that the family receive MAA/MAF for three of the six months prior to the beginning of the EXT period. However, to qualify for EXT based on increased earnings of the caretaker relative, the person has to have been eligible for and receiving MAA/MAF;
 - If a filing group meets the eligibility requirements for EXT based on a combination of increased income from the caretaker relative's earnings and child support, even if either increase by itself does not make the filing group ineligible for MAA or MAF, the filing group's eligibility period is based on increased earnings.
- If eligibility is a result of increased income due to child support, the eligibility period is for four months. For EXT based on an increase in child support, the following requirements apply:
 - At least one member of the MAA/MAF filing must have been eligible for and receiving MAA/MAF in three of the six months prior to the beginning of the EXT eligibility period;
 - Do not count months the family received Medicaid in another state towards the three-of-six months requirement;
 - Do not count months on EXT towards the three-of-six months requirement;
 - The three-of-six month requirement does not have to be consecutive months;
 - If MAA/MAF was received for at least one day in a month, the whole month is counted.
- Retroactive MAA/MAF eligibility counts in determining if the filing group meets the three-of-six months requirement for a family that goes over the income limits due to an increase in child support.

☞ SEE [MEDICAL ASSISTANCE E. 6](#) FOR MORE INFORMATION ABOUT DETERMINING ELIGIBILITY FOR RETROACTIVE MEDICAL ASSISTANCE.

Specific EXT requirements

- Persons must have been members of the MAA/MAF benefit group when those benefits ended to be included in the EXT benefit group;

Example: Sally and her son Seth were receiving MAA until Sally received a promotion which put her over the MAA income limit. They are now

receiving EXT. Sally's daughter Joanne joins the household while the family is receiving EXT benefits.

Joanne is included in the EXT filing, financial and need group, but is not included in the EXT benefit group because she was not in the MAA benefit group when those benefits ended.

Example: Allison's MAA medical closed because she did not complete her redetermination. When she reapplied two months later for MAA for herself and her daughter Janie, she was over income for MAA because an increase in child support.

Allison and Janie are not eligible for EXT. They received MAA for three of the previous six months, but she was not receiving MAA when she went over the MAA income limit due to the increase in child support.

- The filing group must include a dependent child. A filing group is no longer eligible for EXT if it does not include a dependent child, but may regain EXT eligibility if it again includes a dependent child;
- Members of a benefit group who become ineligible for EXT may regain eligibility for EXT if they again meet EXT eligibility requirements;

Example: John and his two children became ineligible for EXT because they moved out of state. They moved back to Oregon and again met the eligibility requirements for EXT.

John and his children may be eligible to receive EXT for the remainder of the EXT eligibility period.

Example: Don, Cheri and their daughter Jenny are receiving EXT. Don moved out of the household. Cheri and her daughter continue to receive EXT, but Don loses eligibility.

If Don returns to the household, he may regain EXT eligibility for the remainder of the EXT eligibility period.

EXT CM coding and support

When EXT eligibility is based on increased child support:

- EMS with end date = fourth month;
 - Enter this N/R when converting a CM case to EXT. The end date should be the fourth month of the EXT eligibility period;

- The CM case will automatically close at the end of the fourth month. An advance close notice and application packet will be mailed to the client prior to closure.
- When EXT eligibility is based on increased earned income:
 - AE2 with end date = 12th month;
 - (a) Enter this N/R when initially converting a CM case to EXT. The end date should be the 12th month of the EXT eligibility period. An EXT approval notice will automatically be mailed to the client.

EXT effective date

- If reported timely, start EXT medical the first of the month following the last month of MAA/MAF eligibility. No 10-day notice is required. Because no 10-day notice is required, some TANF/MAA cases will convert to TANF/EXT before the TANF can be closed. An individual can receive TANF and EXT on the same CM case;

Note: *When the family goes over the income due to an increase in child support, make sure the family has met the “three-of-six” months MAA/MAF criteria.*

Example: *Paul and Paula have been receiving MAA for the last six months. On December 30, they report timely that Paul has a new job and they will be over income for MAA in January. Begin EXT medical effective January 1.*

- If an MAA/MAF client does not report an increase in income or child support timely, they may still be eligible for EXT. The EXT eligibility begins the first of the month the household went over income for MAA/MAF.

Reminder: *The budget month used for the EXT determination is the month the client timely reports increased earnings or child support that will make them over the MAA/MAF income limit. If not reported timely, the budget month is the month before the month the client exceeded the MAA/MAF income limit due to increased earnings or child support.*

Assumed Eligibility for Medical Programs: [461-135-0010](#)
Specific Requirements; EXT: [461-135-0095](#)
Eligibility Period; EXT: [461-135-0096](#)
Earned Income; Treatment: [461-145-0130](#)
Dependent Care Costs; Deduction and Coverage: [461-160-0040](#)

4. Medical assistance to children in Substitute or Adoptive Care (SAC)

To be eligible for the SAC program, an individual must be under the age of 21 and:

- Live in substitute care covered by title IV-E of the Social Security Act;
- Live in a foster care or private institutional setting for which a public agency of Oregon is assuming at least partial financial responsibility;
- Live in an intermediate care facility, including an intermediate care facility for people with mental retardation, or a licensed psychiatric hospital;
- Receive independent living subsidy payments from the department to assist the individual to live independently when foster care payments were discontinued;
- Is a child for whom an adoption assistance agreement from another state is in effect, regardless if a payment is being made;
- In a state-subsidized adoptive placement, if an adoption assistance agreement is in effect between a public agency of Oregon and the adoptive parents indicating title IV-E or Medicaid eligibility.

A child in substitute care must meet all TANF nonfinancial and financial eligibility requirements.

Children subject to an adoption assistance agreement described above are assumed eligible for the SAC program.

When a child moves to Oregon from another state where an adoption assistance agreement is in effect between an agency in that state and the adoptive parents, the other state usually sends forms to Oregon's DHS Adoption Assistance Unit indicating the family has moved to Oregon and is eligible for medical assistance. Those forms are forwarded to the Children's Medical Project Team at the Oregon Health Plan branch. The team establishes medical assistance for the child and notifies the family of the coverage.

Instead of sending adoption agreement forms to the DHS Adoption Assistance Unit, a few states send the forms directly to the adoptive parents making them responsible for applying for the child's medical assistance at the local branch office. See [section B.1.](#), *Application for medical assistance*, of this chapter for information on the SAC application process.

Assumed Eligibility for Medical Programs: [461-135-0010](#)
Specific Requirements; SAC: [461-135-0150](#)

5. Citizen/Alien-Waived Emergent Medical (CAWEM) medical assistance

To qualify for CAWEM, a person must meet all the nonfinancial and financial eligibility requirements for another medical assistance program, except the citizen/alien status and Social Security Number requirements.

Exception: There is no CAWEM eligibility under the OHP-CHP category.

You do not need to make a decision about whether the person is in need of immediate medical treatment or in need of childbirth (labor and delivery) services. Medical decisions are determined by the person's medical provider pursuant to the administrative rules of the Office of Medical Assistance Programs. If a medical provider has questions about whether a condition is covered, they should contact DMAP at 800-336-6016.

Medical assistance is authorized under the program (MAA, MAF, OHP and SAC) for which the person would qualify if they met the citizen/alien requirement. CAWEM clients will receive a medical coverage letter when their case opens that says:

“COVERAGE IS LIMITED TO EMERGENCY MEDICAL SERVICES.
LABOR AND DELIVERY SERVICES FOR PREGNANT WOMEN
ARE CONSIDERED AN EMERGENCY.”

A child born to a CAWEM mother is an assumed eligible newborn (AEN). Add the child's medical eligibility to the case using the AEN need/resource code.

Specific Requirements; Citizen/Alien-Waived Emergent Medical (CAWEM): [461-135-1070](tel:461-135-1070)
OHP-OPU; Effective Dates for the Program: [461-135-1102](tel:461-135-1102)

6. Retroactive medical assistance

When people are determined eligible for BCCM, MAA, MAF, OSIPM, QMB-DW, REFEM or SAC, they may be eligible for retroactive medical assistance. People determined eligible for OHP are not eligible for retroactive medical assistance.

Eligible people may qualify for retroactive medical assistance for up to three months preceding their date of request. For example, if the date of request is August 7 and retroactive medical eligibility is established, retroactive eligibility begins May 7.

Eligibility is determined on a month-by-month basis. A person may be eligible in any one or all three of the months.

Except for SSN requirements, cooperation with DCS and JOBS requirements, they must meet all of the program's eligibility requirements for each retroactive month.

People who are eligible for CAWEM because they met all the eligibility requirements (other than alien status) for MAA, MAF or SAC, are eligible for retroactive medical benefits as mentioned above. Clients who are eligible for CAWEM through OHP are not eligible for retroactive medical benefits. This is because there is no eligibility for retroactive medical benefits for OHP except one working day; therefore, people who receive CAWEM through OHP would not be eligible for retroactive benefits.

Example: John and his two children, Paul and Marie, were approved for MAA medical on their date of request, May 13. Marie has unpaid medical

bills from February 16. It is determined that the family met financial and nonfinancial MAA eligibility requirements for each of the three months (February, March, April) prior to the date of request.

Start medical for Marie on February 16, the date the unpaid medical expenses incurred. Use the RM case descriptor to indicate retroactive medical. The rest of the family starts on the date of request.

Example: Same scenario as above, except that the family did not meet MAA financial requirements in March or April (they met all requirements in February).

Start medical on the date of request (May 13). Submit a Request for Retroactive Eligibility ([DHS 148](#)) to HMU for February.

Example: Frank and Mary have a February 15 date of request. They are not eligible in the initial budget month of February, but the worker floats the budget month to March and finds they are eligible for MAA effective March 1. They have a retroactive medical need for January 10 and February 16.

The worker reviews the family's MAA eligibility for January and finds them eligible for MAA on January 10.

Start medical effective March 1. Submit a Request for Retroactive Eligibility ([DHS 148](#)) to HMU for January. There is not retroactive medical eligibility for February.

Specific Requirements; Retroactive Medical: [461-135-0875](tel:461-135-0875)
Effective Dates; Retroactive Medical Benefits: [461-180-0140](tel:461-180-0140)

7. OHP eligibility categories; overview

To qualify for medical assistance under the OHP program, a person cannot:

- Be receiving or deemed to be receiving SSI benefits;
- Be eligible for Medicare, unless the person is a pregnant woman;
- Be receiving Medicaid assistance through another program; or
- Be enrolled in a health insurance plan subsidized by the Family Health Insurance Assistance Program (FHIAP).

OHP includes five categories of people who may qualify for medical assistance. The first category is used to determine eligibility for nonpregnant adults who are 19 years of age and older. Eligibility for pregnant women is always determined using the fourth category.

There are additional categories used to determine eligibility for children. Always determine eligibility for children beginning with the second category, OHP-OPC, before moving on to the other three categories. If the family's income exceeds the OHP-OPC income limit (100 percent), determine if the children might qualify under other categories, such as OHP-OP6, OHP-OPP or OHP-CHP.

Specific Requirements; OHP: [461-135-1100](tel:461-135-1100)

8. **First OHP category: Oregon Health Plan (OHP-OPU Program)**

This category includes uninsured nonpregnant adults who are in a filing group with income under the (OHP-OPU) 100 percent income limit.

To be eligible for OHP-OPU, a person must be 19 years of age or older and must not be pregnant. An OHP-OPU person is referred to as a health plan new/noncategorical (HPN) client.

There are three groups of medical applicants that may be considered for OHP-OPU:

- Clients recertifying for OHP-OPU benefits without a break in assistance, and
- Clients converting from child welfare medical, BCCM, EXT, GAM, MAA, MAF, OHP-OPC, OHP-CHP, OHP-OPP, OSIPM, REFM or SAC to OHP-OPU without a break in assistance;
- Persons randomly selected from the OHP Standard Reservation List. To qualify, the randomly selected person can establish a DOR on or after the random selection date through 45 days from the date the *Oregon Health Plan (OHP) Standard Reservation List – OHP Application* ([OHP 7210R](#)) was mailed.

Note: *Individuals whose names are added to the Standard Reservation List will be sent an Application for Oregon Health Plan and Healthy Kids ([OHP 7210](#)) application with the words “7210P” and “confirmation application” on the label. DHS/AAA offices may receive these [OHP 7210](#) applications. Workers at local branches should date stamp the applications and forward these applications to 5503. The OHP Statewide Processing Center (Branch 5503) will process these applications.*

☞ SEE [WORKER GUIDE #7](#) FOR MORE INFORMATION ABOUT THE OHP STANDARD RESERVATION LIST PROCESS.

“Without a break in assistance” means that the OHP-OPU client requesting recertification established a DOR before their current certification expired.

“Without a break in assistance” also means a client converting from child welfare medical, BCCM, EXT, GAM, MAA, MAF, OHP-CHP, OHP-OPC, OHP-OPP, OSIPM, OYA medical, REFM or SAC applied for medical benefits while still receiving their prior

medical program benefits. It could also mean that their worker re-evaluated the client's medical eligibility because of a reported change or eligibility review.

Example: John is under age 60 and not receiving any medical benefits. He calls his local SSP branch office and says he has just been selected from the OHP Standard Reservation List. The application that was sent out when John signed up for the reservation list has already been denied as he had not yet been selected. The designated branch person adds his DOR to the Reservation List Web site and tells John he will get an application in the mail.

Example: John submits a [DHS 415F](#) application and says he has an emergent need for medical. Following his branch's emergent need process, his OHP-OPU eligibility is pended. The worker updates the pend reasons on the Reservation List Web site.

Example: Later John turns in the pended items. The worker opens his CM system case, adding an LST need/resource item with John's reservation number from the Reservation List Web site. The worker also updates John's reservation on the Reservation List Web site to show John has been approved for OHP-OPU.

Example: Tina is a single adult who is not pregnant, has no children, and has no disabilities. She is currently not receiving benefits under any DHS medical program and was not randomly selected from the OHP Standard Reservation List. She may not be considered for OHP-OPU.

Example: Marvin is a single adult who was selected from the OHP Standard Reservation List on October 15. He was mailed a letter letting him know he had been selected and that he needed to establish a DOR within 45 days of the date the [OHP 7210R](#) was mailed. The [OHP 7210R](#) was mailed October 26. On January 15, Marvin called his local SSP office and asked for medical. He may not be considered for OHP-OPU.

Example: Curt is a single adult who is receiving OHP-OPU. His certification ends on August 31. Curt turns his recertification in timely in August. Since Curt has reapplied timely, he can be considered for OHP-OPU.

Example: Larry is receiving OHP-OPU and his children are receiving OHP-OPC. His certification ends on August 31. He turns in his recertification late on September 1. His family is not eligible for MAA or MAF. Although his children can be considered for OHP, Larry cannot be considered for OHP-OPU.

Example: Barry was selected from the OHP Standard Reservation List on July 15. On July 27, Barry submitted an [OHP 7210](#) application to recertify his children's medical. On the application, he also requested medical for himself. The eligibility worker checked on the Standard Reservation List Web site and found that Barry had been selected July 15. Using the July 27 DOR, the worker determined that Barry is eligible for OHP-OPU benefits and opened Barry's OHP Standard benefits effective July 27.

Example: Mary established a DOR for herself on August 15. The worker checked on the OHP Standard Reservation List and discovered that Mary was selected on July 15 and an [OHP 7210R](#) will be mailed September 10. Using the August 15 DOR and the August budget month, the worker determined Mary was over income for OHP-OPU in August. Mary indicated her income would drop for September, so the worker floated the budget month to September and determined Mary qualified for OHP Standard benefits effective September 1. Since even an initial full-month prorated month doesn't count toward the six month OHP-OPU certification, Mary's certification end date is March 31, 2011.

Note: For OHP-OPU, if the date of request is on or after March 1, 2011, the OHP-OPU certification period begins on the effective date for starting medical benefits (described in OAR [461-180-0090](#)) and includes the following 12 calendar months. See OAR [461-145-0530](#) for details about certification periods.

Example: Frank applies for medical on September 1. The worker checks on the Standard Reservation List Web site and sees that Frank was mailed an [OHP 7210R](#) on July 15. Since it has been more than 45 days since the [OHP 7210R](#) mail date and Frank is not eligible for any SSP or SPD program, the worker denies the application and send a [DHS 462A](#).

Example: Raul calls and establishes a DOR on October 2. Support staff narrates and sends Raul an application. November 2, Raul's application arrives at the branch. The worker sees that Raul has been selected from the list on October 15th. The worker processes Raul's application and finds him eligible for OPU. The worker starts medical on the selection date of Oct 15.

☞ SEE [MEDICAL ASSISTANCE CHAPTER B.3](#) FOR MORE INFORMATION REGARDING THE REQUIREMENT TO REVIEW FOR ALL MEDICAL PROGRAMS.

In addition to other OHP eligibility requirements, an OHP-OPU client:

- Must not be covered by private major medical health insurance. Private major medical health insurance means health insurance coverage that provides medical

care for physician and hospital services, including major illnesses, with a limit of not less than \$10,000 for each covered individual;

☞ SEE [MEDICAL ASSISTANCE CHAPTER D.9](#) FOR MORE INFORMATION REGARDING THE FHIAP REFERRAL PROCESS WHEN HEALTH INSURANCE IS AVAILABLE THROUGH AN EMPLOYER.

- Must not have been covered by private major medical health insurance during the six months preceding the effective date for starting medical benefits. The six-month waiting period is waived if:
 - The person has a condition that without treatment would be life-threatening, or would cause permanent loss of function or disability;

☞ SEE [B.6](#) IN THIS CHAPTER FOR INFORMATION ABOUT OMIP/FMIP AND DHS MEDICAL ELIGIBILITY.

- The person's private health insurance premium was reimbursed under the provisions of OAR [461-135-0990](#);
- The person's private health insurance premium was subsidized through FHIAP; or
- A member of the person's filing group was a victim of domestic violence.

Note: *OPU applicants receiving services through Indian Health Services or who have TPL that the tribe pays for are still eligible for OPU.*

- Some applicants who receive medical benefits through the Veterans' Administration (VA) are not eligible for OHP. VA benefits are considered major medical. There are VA hospitals in Portland and Roseburg. There is also a VA hospital in Walla Walla, used by many Oregon veterans. There are clinics in Eugene, Bandon, Salem, Klamath Falls, Brookings, Bend, White City and Warrenton. If an applicant has access (or has had access in the prior six months) to care through a local VA facility (including the Walla Walla hospital), they are usually not eligible for OHP benefits. If the client says the hospital or clinic is not accessible or says that the Veterans' benefits do not cover their medical needs, then the client may be OPU eligible. If you are not sure, contact a medical policy analyst;
- Must meet the following eligibility requirements:
 - OHP resource limit;
 - OHP budgeting requirements (using only the two-month income average to determine eligibility unless DV);
 - Payment of premiums unless exempt.

Higher education students. When an OHP-OPU person is attending a higher education institution full time, they are not eligible unless they:

- Are in a program serving displaced workers under section 236 of the Trade Act of 1974.
- Meets the income requirements for a Pell grant, which means that either:
 - The student’s Student Aid Report shows an “expected family contribution” less than \$5,274 for the 2010-2011 school year; or
 - The student is eligible for a Pell grant and provides documentation of eligibility from the school’s financial aid office.

Higher education institutions include all public and private universities, colleges and community colleges. Also included are all post-secondary vocational or technical schools that are eligible to accept Pell grants.

ABE, ESL, GED and high school equivalency programs are **not** considered higher education.

Full-time attendance at colleges and universities is enrollment of 12 or more credit hours per term or semester for undergraduates, and nine hours for graduate students. For vocational or technical schools, full-time status is attending classes and other required activities at least 12 hours per week.

A student’s enrollment status continues during school vacation and breaks. It ends when the student graduates, drops out, reduces their hours, is suspended or expelled or does not intend to register for the next school term (excluding summer term).

The Department of Education determines *Pell Grant eligibility* from a student’s financial aid application, titled the *Free Application for Federal Student Aid (FAFSA)*. Eligibility is based on a formula called the Expected Family Contribution (EFC). Each year, Congress sets the ceiling for the EFC. For the 2010/2011 school year, the EFC limit was \$5,274. For the 2011/2012 school year, the EFC limit will remain at the same level at \$5,274. If the student’s EFC figure is less than the limit, the student meets the OHP Pell grant requirement. The student does not have to be actually receiving a Pell grant to meet this OHP requirement.

After financial eligibility is determined, the student is sent an award letter, the *Student Aid Report (SAR)*, which lists the EFC. All higher education students must either provide a copy of their SAR, or for undergraduates, a financial aid award letter from their school to verify they meet the OHP Pell grant requirement.

- If an undergraduate student has an EFC at or below the EFC ceiling, their SAR will state that they are eligible to receive a Pell grant;

- Graduate students cannot receive the Pell grant because it is an undergraduate program. However, all graduate students applying for financial aid complete a FAFSA and receive an SAR that includes their EFC figure.

To verify whether students are displaced workers under the *Trade Act of 1974*:

Step 1 Access ECLM. If the function key “10) TRA” does not appear at the bottom of the screen, the person is not a dislocated worker covered by the Trade Act.

Step 2 If the function key (it will be highlighted) appears at the bottom of the screen, the person is potentially eligible. For these persons, press F10 to access the Trade Act claim screen (ERTC). Look at the column beginning with “Prior SSN,” then go down 10 lines to the “Trng” field. If today’s date is within the beginning and end dates in this field, the person is currently in a program under the Trade Act.

Certification Period; HKC, OHP: [461-115-0530](tel:461-115-0530)

Specific Requirements; OHP: [461-135-1100](tel:461-135-1100)

OHP-OPU; Effective Dates for the Program: [461-135-1102](tel:461-135-1102)

Eligible and Ineligible Students; OHP-OPU: [461-135-1110](tel:461-135-1110)

Reservation Lists and Eligibility; OHP-OPU: [461-135-1125](tel:461-135-1125)

Effective Dates; Initial Month Medical Benefits: [461-180-0090](tel:461-180-0090)

Oregon Health Plan Program premiums. When an OHP-OPU benefit group includes one or more nonexempt persons, a monthly premium is billed to the household. All clients eligible for OHP-OPU, if not exempt, are responsible for payment of premiums. Clients are exempt from paying a premium if they meet one of the following:

- Have OHP countable income at 10 percent or less of the Federal Poverty Level. Clients may become exempt due to income when their OHP is recertified. They may also become exempt within a certification, but only when the benefit group’s OHP income is reduced to 10 percent or less of the FPL when an OHP-OPU client leaves the benefit group or when two OHP certified households are combined during a certification;
- American Indians and Alaska Natives – American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program (HNA Case Descriptor);
- Are CAWEM (CWM Case Descriptor) eligible only.

Note: *To waive OHP past-due premiums at recertification for clients with HPI income at 10 percent or less of the FPL, enter a “WE” in the WAIV field on the UCMS screen. The WE coding only works at recertification and only if the FPL is 10 percent or less of the FPL. Do not adjust or waive premiums during a certification because of income changes.*

Once the amount of the premium is established, the amount does not change during the certification period unless one of the following occurs:

- An OHP-OPU client becomes pregnant;
- A client becomes eligible for OHP-OPU following her assumed eligibility period as a pregnant female;
- An OHP-OPU client becomes eligible for another medical assistance program;
- An OHP-OPU client leaves the benefit group;
- OHP cases are combined during their certification periods.

Note: To adjust premiums when converting from OHP-OPU to an OHP Plus program or when adding an HNA case descriptor, use the MMIS premium panel. Instructions for how to adjust/waive premiums on MMIS are available on the SSP medical tool Web site in the MMIS section.

A premium is considered paid on time when the payment is received by the OHP Billing Office on or before the 20th day of the month for which the premium was billed. The day the payment arrives in the OHP Billing Office's post office box when it is sent via mail, or the day it is submitted via phone or online to the billing office is the date it is received. A premium not paid on time is in arrears. All past due premiums and premiums in arrears for a filing group must be paid before a client can establish a new certification period.

Note: Once determined eligible, OHP-OPU clients cannot be found ineligible for benefits during a certification period for failure to pay past due premiums. Past due premiums only affect eligibility at recertification.

A nonexempt OHP-OPU client can be found ineligible for not paying premiums as follows:

- An OHP-OPU applicant who does not resolve unpaid premiums during the application processing time frame is denied or closed;

Determining eligibility for OHP-OPU applicants with unpaid premiums. When applying or reapplying under the OHP-OPU program, a nonexempt applicant must pay all billed premiums to be eligible. Premiums must be paid before the applicant can be recertified. Include the requirement to pay premiums on the pend notice. If the unpaid premiums are not resolved within the 45 days from the date of request, deny or close OHP-OPU medical assistance for that applicant.

Past arrearage can be canceled if the arrearage was incurred while the person was exempt from the requirement to pay a premium. Clients with OHP countable income of 10 percent or less of the FPL when the premium is calculated at certification, American Indians and Alaska Natives, and clients eligible under the CAWEM program are exempt.

The department will not attempt collection on any arrearage that is over three years old.

Updating the CM case

If exempt from paying premiums, code "WE" in the WAIV field on the UCMS screen.

If the premiums have been paid or adjusted to zero, but the CM case still has a “K” premium status, use the “CD” waiver code to bypass the online edits. If you do not use the WE or the CD coding, the OHP-OPU’s medical will end during overnight processing.

Premium Requirement; OHP-OPU: [461-135-1120](tel:461-135-1120)

The computer determines the amount of the monthly premium by determining the number of persons in the need group, their average monthly income, and the number of nonexempts in the benefit group.

The following table may be used to calculate the premium amount:

OHP PREMIUM by FPL

Number in Need Group	Percentage FPL	Premium Amount Billed for Each Nonexempt OPU Client
	< 10% to 50%	9.00
	50% to 65%	15.00
	65% to 85%	18.00
	85% to 100%	20.00

OHP PREMIUM EXEMPT BY INCOME AMOUNT

Number in Need Group	10% FPL Income Limit (income must be equal to or less than 10% FPL to be premium exempt)
1	\$ 90.75
2	122.58
3	154.42
4	186.25
5	218.08
6	249.92
7	281.75
8	313.58
9	345.42
10	377.25
+1	10% of FPL

Premiums are collected by the Oregon Health Plan Premium Billing Office. OHP premium bills will state where and how to send in payments.

By mail:

OHP Premium Billing Office
PO Box 1120
Baker City, OR 97814

Payments should be made by check, money order or cashier's check or over the phone using Visa, MasterCard or Discover. People who come to a branch office wanting to pay their premiums should be told to send payments to the above address. Their premium notice includes a return envelope. For questions about the billing (whether a payment was received, etc.), call the OHP Billing Office at one of the numbers listed on the billing notice toll-free 888-647-2729, or TTY: 866-203-8931.

9. Second OHP category: Oregon Health Plan for Children (OHP-OPC)

These are persons under the age of 19 in a filing group with income under 100 percent of the income limit. If income is at or above 100 percent, the person may qualify at either the OHP-OP6 (133 percent) or OHP-CHP (201 percent) level. However, assumed eligible newborn children under the age of one who are at or above the OHP-OP6 (133 percent) are to be coded OHP-OPP and not OHP-CHP.

10. Third OHP category: Oregon Health Plan for Children Under Age 6 (OHP-OP6)

These are persons under the age of six in a filing group with income over the OHP-OPC (100 percent) income standard, but below the OHP-OP6 (133 percent) income limit.

Specific Requirements; OHP: [461-135-1100](tel:461-135-1100)

11. Fourth OHP category: Oregon Health Plan for Pregnant Females Under 185 Percent and Their Newborn Children Under One Year of Age (OHP-OPP)

This category includes pregnant females in a filing group with income below the 185 percent income limit and their assumed eligible newborn children at or above the OHP-OP6 (133 percent) income limit.

Specific Requirements; OHP: [461-135-1100](tel:461-135-1100)

12. **Fifth OHP category: Oregon Health Plan for Children (OHP-CHP)**

These are persons who may qualify for medical assistance under the Children's Health Insurance Program (CHIP). The CHIP program is not a Medicaid Title XIX program, but is provided through another federal program, title XXI, which was a provision of the federal Balanced Budget Act of 1997. They are under the age of 19 who are not eligible under the OHP-OPC, OHP-OP6 or OHP-OPP categories. The financial group's income must be over the OHP-OPC (100 percent) income limit for children ages 6 through 18 or over the OHP-OP6 (133 percent) income limit for children under age 6 or over the OHP-OPP (185 percent) income limit but below the OHP-CHP (201 percent) income limit.

OHP-CHP persons must meet all the following requirements:

- Must provide or apply for an SSN;
- Verification of Citizenship or alien status requirements;
- Must not be pregnant with income less than 185 percent (code OHP-OPP if pregnant and less than 185 percent of the FPL);
- Pregnant children (under age 19) with income from 185 percent to 201 percent of the FPL may receive CHIP. Do not forget to add the new CDU (CHIP DUE) need/resource item, unborn child and father of the unborn to the CHIP child's CM case;

Note: *Eligibility for pregnant CHIP women is limited. If the pregnant CHIP woman loses CHIP eligibility at redetermination (turning age 19 or at the end of the CHIP 12 month certification), convert to Continuous Eligibility for CHIP pregnant children.*

☞ SEE [SECTION 16](#) BELOW FOR MORE INFORMATION ABOUT CONTINUED ELIGIBILITY FOR CHIP PREGNANT CHILDREN.

Note: *Children born to pregnant CHIP women are assumed eligible for Medicaid for one year. Code the child as an MAA AEN on the CM case.*

- With a few exceptions listed below, the child must not be covered by private major medical health insurance. Private major medical health insurance means health insurance coverage that provides medical care for physician and hospital services, including major illnesses, with a limit of not less than \$10,000 for each covered individual;
- Do not delay CHIP eligibility solely because the child is covered by Kaiser Child Health Program or Kaiser Transitions Program medical. Kaiser will end their medical after the CHIP medical eligibility is opened;

Note: *Effective March 26, 2010, the OHP Statewide Processing Center (Branch 5503) will process SSP applications for children in Kaiser Permanente's Child Health Program or Transitions Program. Fax the application to 5503 at 503-373-7493.*

A cover letter was developed to support the process. Be sure to include the “Attention” cover letter when faxing the application. The cover letter will be posted to the [SSP medical Web site](#) the week of March 29.

- Do not delay CHIP eligibility solely because the child is receiving services through Indian Health Services or has major medical paid for by the tribe. Be sure to send HIG a *Medical Resources* ([DHS 415H](#)) form with the Indian Health Service coverage information. Include the information that the coverage does not affect CHIP eligibility;
- For children who are eligible for CHIP and have been covered by private major medical health insurance, verify the TPL has ended before opening CHIP benefits. To verify the TPL has ended, the worker can call the employer or the insurance provider. If more information about the insurance provider is needed, i.e., phone number or policy number, workers can request a copy of the insurance card or have the client complete the [DHS 415H](#) form;
- Unless covered by Kaiser Child Health Program, Kaiser Transitions Program, Indian Health Services or tribal paid health coverage, the child must not have been covered by any private major medical health insurance in the past two months. The two-month waiting period is waived if any of the following are true:
 - The person has a condition that without treatment would be life-threatening or cause permanent loss of function or disability (accept the client’s statement);
 - The loss of health insurance was due to a change in employment (includes children whose COBRA coverage has ended or whose parents choose to end COBRA coverage.);
 - The person’s private health insurance premium was reimbursed by a HIP payment;
 - The person’s private health insurance premium was reimbursed under the policy for Reimbursement of Cost-Effective Employer-Sponsored Health Insurance.
 - The person’s private health insurance premium was subsidized by FHIAP or by the Office of Private Health Partnerships (OPHP);
 - A member of the filing group was a victim of domestic violence.

Specific Requirements; OHP: [461-135-1100](#)

Note: *Remember the parents of CHIP children should never be forced to apply for, accept, and maintain other health insurance coverage as this is not an eligibility requirement in the CHIP program like it is in Medicaid.*

When a person is in a hospital and becomes ineligible for OHP because they no longer meet the age requirement for their category, they can continue to be eligible for OHP until the end of the month in which they are discharged from the hospital.

13. Third-Party Insurance (TPI), Health Insurance Premium Payments (HIPP) and Private Health Insurance (PHI) reimbursements

Third-Party Insurance (TPI) – Other private or employer-sponsored insurance

When a client is identified as having private or employer sponsored health insurance, it must be added to MMIS because Medicaid, in most cases, is the payer of last resort. Other insurance policies are also known as third-party resources, third-party liability (TPL) and health care coverage (HCC).

The Health Insurance Group (HIG) verifies third-party insurance policies and then updates MMIS. Effective September 2009, HIG also:

- Adds a TPL exemption to MMIS so clients with TPL are not auto-enrolled into a managed health care plan (FCHP or PCO). HIG does not add exemptions for dental or mental health plans.

Note: TPL exemptions only prevent auto-enrollment. They do not prevent manual enrollment. Before enrolling, workers should check MMIS to be sure clients are not already enrolled, have an active exemption or have active TPL.

If the client is already enrolled in an FCHP or PCO, HIG disenrolls the client from the plan effective the last day of the month.

DHS 415H – Medical Resources form

Clients are required to report to the department when members of their household who are receiving or applying for Medicaid have other insurance. This is done by completing a *Medical Resources* form ([DHS 415H](#)). Once completed by the client or a worker, the [DHS 415H](#) is sent to the Health Insurance Group (HIG). HIG verifies the insurance with the insurance carrier and updates the TPL file in MMIS. The [DHS 415H](#) should be sent to HIG for new insurance and when existing insurance ends or changes.

DHS 156 – Request for Rush Verification of Third Party Insurance form

If a client is having an emergency and is unable to get prescriptions or other medical services due to inaccurate TPL information in MMIS, a worker can request “Rush” processing by e-mailing the [DHS 156](#) form to HIG at [Referrals, TPR](#). In most cases rush requests are done the same day they are received.

Health Insurance Premium Payment (HIPP)

When a person living in the household has employer-sponsored group health insurance that covers a household member who is eligible for a medical assistance program (except CEC, OHP-CHP and OHP-OPU), the amount of the health insurance premium payment (HIPP) paid by the person (not the employer's share of the cost), may be reimbursed by the department if it is cost-effective for the state. Self-employed people who have group health insurance may also be reimbursed if determined cost-effective.

To qualify, the person's health insurance must be a major medical plan which includes physician and hospital services, doctor visits, lab and x-ray and pharmacy. Examples of major medical plans are: a Health Maintenance Organization (HMO); a Preferred Physicians Care Organization (PCO); a Point of Sale Plan (POS); or an Indemnity Health Insurance Plan. Examples of what would **not** be a major medical plan are: Medicare supplements, accident or replacement policies.

The amount of the premium paid by the household must be cost effective using the following steps:

- Determine the number of people in the household group who are in the benefit group of any of the following programs: CEM, EXT, GAM, MAA, MAF, OHP (except CEC, OHP-CHP and OHP-OPU), OSIPM and SAC;
- Based on the number of benefit group members determined above, the maximum cost-effective premium is determined from the following table:

HIPP Premium Standard	
CEM/EXT/GAM/MAA/MAF/OHP-OPC, OHP-OP6, OHP-OPP/SAC	
# in Benefit Group covered by insurance	Cost-effective premium amount (Employee cost)
1	\$ 82
2	\$164
3	\$246
4	\$328
5	\$410
6	\$492
7	\$574
8	\$656
9+	\$738

The insurance is cost-effective if the employee's share (the premium the employee pays) is equal to or less than the amount determined from the table.

When determining the employee's share of the employer-sponsored group health insurance premium amount, averaging the payments may be necessary if the premium amounts are not deducted monthly.

Example: A client is paid every other Friday and \$66.50 is deducted from his/her check for employer-sponsored group health insurance premiums. Multiply $\$66.50 \times 2.15$ to determine the monthly employer-sponsored group health insurance premium amount. In this example, the monthly employer-sponsored group health insurance premium is \$133.00.

To determine the correct allowed amount, remember to consider the number of persons in the benefit group and not the household group. Dental insurance may be piggybacked with the medical and reimbursed, but only if the total of the combined premiums for both the health and dental insurance fall under the allowed amount on the HIP Standard Chart. If combining both the medical and dental exceeds the allowed amount, only the health insurance premium may be reimbursed (assuming it falls below the standard). You cannot reimburse solely for a dental, vision or long-term care insurance policy.

Example: A filing group consists of a father, mother and two children. The two adults are not eligible for OHP Standard because they are covered by the father's employer-sponsored health insurance. The children receive OHP-OPC. The cost of the father's insurance is \$245 per month and all four of them are covered on the policy.

Step 1: Determine the number of people in the benefit group who receive EXT, GAM, MAA, MAF, OHP-OPC, OHP-OP6, OHP-OPP, OSIPM and SAC that are covered by the employer-sponsored group health insurance. In this example, the number is two (the two children who receive OHP-OPC).

Step 2: Use the premium table to determine the maximum cost-effective premium for the number determined in Step 1. In this example, the maximum cost-effective premium amount is \$164 (the amount is based on two people in the benefit group).

Step 3: If the maximum cost-effective amount is more than the employer-sponsored group health insurance premium amount, the filing group is eligible for HIPP reimbursement. In this example, the employer-sponsored group health insurance premium cost of \$245 is more than the \$164 maximum cost-effective amount for two. Therefore, the filing group would not qualify for HIPP reimbursement.

In this example, the employer-sponsored group health insurance policy/premium covers all members of the benefit group, but because only two members of the benefit group are receiving Medicaid, we cannot use the four-person maximum to determine if the employer-sponsored group health insurance is cost effective.

Note: *You cannot pro-rate for HIPP. In this example, you **cannot** divide the \$245.00 cost by the number of people in the benefit group to come up with a per-person amount. You must count the entire amount of the premium and only the two people covered by Medicaid.*

In special situations, DMAP's PHI program may pay the cost of health insurance premiums if an individual with high-cost medical expenses does not qualify for the HIPP program. For more information about the PHI program:

☞ SEE PAYMENT OF PRIVATE HEALTH INSURANCE PREMIUMS BELOW.

For new cases, the HIPP reimbursement starts on the date of request (the first month may be prorated) or, if no one is eligible on that date, the reimbursement starts on the date of initial medical assistance eligibility.

For ongoing cases, the HIPP reimbursement starts on the first day of the month the insurance is effective, or the first of the month in which the person requests reimbursement, whichever is the latest.

People must report within 10 days any change in health care coverage or the amount of their premiums.

People who receive medical assistance (except OHP-CHP and OHP-OPU) must apply for, accept and maintain employer-sponsored cost-effective group health insurance if it is available to them. If the insurance is available at a later date or open enrollment period, they must tell us when it will become effective.

If a person does not cooperate and does not have good cause, they are not eligible for medical assistance unless they are pregnant. There is no ineligibility for people who are pregnant. Only the individual who can legally assign rights and obtain the insurance is assessed the penalty for failure to meet this requirement and loses medical eligibility. The other individuals in the group, such as other adults or the children, continue to receive Medicaid. See [Section D](#) for good cause criteria. When an ineligible person agrees to cooperate by enrolling in their insurance plan at the earliest opportunity, they are eligible for medical assistance.

Payment of Private Health Insurance (PHI)

In special situations, DMAP may pay for insurance premiums even if the premium is greater than what is allowed on the HIPP Standard Chart. This may occur when the cost for an individual's health services is less than the estimated cost of paying for those services on a fee-for-service (FFS) basis. The Health Insurance Group (HIG) administers the PHI program and determines program eligibility. HIG may request medical documentation or copies of Explanation of Benefits (EOBs) before PHI can be approved. Payments for PHI generally go directly to the insurance carrier; however, in some cases, payments may be paid directly to the policyholder. The health insurance may be a private individual family policy or employer-sponsored insurance. The PHI program is for physical health policies only. The department does not reimburse for dental, vision or other types of policies under the PHI program.

HIG determines if the PHI premium payment is cost effective by:

- Reviewing the client’s past claims and payments from state medical programs and/or private insurance carriers;
- Estimating the current and probable future health status of the client based on existing medical conditions or documentation;
- Evaluating the extent/limit of coverage available to the client under any health insurance

DMAP does not pay PHI premium payments for:

- Non-SSI institutionalized and waived clients whose income deduction is used for payment of health insurance premiums;
- Clients eligible for HIP;
- Vision, dental or long-term-care policies.

Refer potential PHI clients to HIG if the client is ineligible for HIPP because the client’s share of the premium exceeds the allowed amount on the HIPP Standard Chart, or their insurance is not an employer-sponsored insurance plan, **and** the client has a medical condition that may make it cost effective for the state to pay the premium.

To make a PHI referral complete Sections 1 through 4 on the *Request for Health Insurance Premium Payment (HIPP) or Private Health Insurance (PHI) Premium Payment* ([DHS 3073](#)) form and fax it to HIG at 503-373-0358. You must include a copy of the *Medical Resources* ([DHS 415H](#)) form.

Other documentation may be required such as the *Authorization for Use & Disclosure of Information* ([DHS 2099](#)), medical records, doctor letters or chart notes. If any of these are already available, they should be faxed along with the [DHS 3073](#). It is not necessary to request these before making the referral, but if they are already available, sending them with the referral can shorten processing time.

Caseworkers and clients are notified if the client has been approved or denied by mail after the PHI eligibility determination has been made. HIG review PHI cases annually, or as needed to redetermine eligibility for the program

☞ SEE [DMAP WORKER GUIDE # 7](#) FOR MORE INFORMATION.

Client’s Rights and Responsibilities: [410-120-1855](#)

Payment of Private Insurance Premiums: [410-120-1960](#)

Medical Assignment: [461-120-0315](#)

Requirement to Pursue Assets: [461-120-0330](#)

Clients Req. to Obtain Health Care Coverage and Cash Med. Support; CEM, EXT, GAM, MAA, MAF, OHP (except OHP-CHP), OSIPM, SAC: [461-120-0345](#)

Clients Excused for *Good Cause* from Compliance with OARs [461-120-0340](#) and [0345: 461-120-0350](#)

Client-Specific Requirements; Reimbursement of Cost-Effective, Employer-Sponsored Health Insurance Premiums: [461-135-0990](#)

Changes That Must be Reported: [461-170-0011](#)

Effective Dates; OHP Premium: [461-180-0097](#)

Personal Injury Claim: [461-195-0303](#)

14. Using Express Lane Eligibility (ELE) for children in the OHP-OPC and OHP-CHP programs

The CHIP Reauthorization Act of 2009 provided the option for states to implement Express Lane Eligibility (ELE) for Medicaid and CHIP. ELE allows states to borrow some eligibility findings from other agencies approved by the department as Express Lane Agencies (ELA), such as WIC and SNAP, and to use those agencies' findings to determine medical eligibility for children.

Effective August 2010, DHS will be implementing SNAP ELE. Because the Center for Medicaid Services (CMS) will not permit branch offices that already determine eligibility for both SNAP and medical programs to make ELE determinations based on SNAP income, **SNAP ELA findings will be used only at the Statewide Processing Center.**

SNAP income calculations will be used to determine eligibility for the OPC and CHP programs for children in filing groups where no one is receiving medical assistance. Cases are placed in OPC or CHP as follows:

- Children with SNAP income below 163 percent of the federal poverty level (FPL) are placed in the OPC program;
- Children with SNAP income at or above 163 percent FPL are placed in the CHIP program.

***Note:** If the parents also request medical, the worker will use the ELA findings to determine whether the child is OPC or CHP and open medical in the appropriate program. The worker will then pend for information needed for MAA/MAF. If the parents return the pended information and are eligible for MAA/MAF, MAA/MAF will be opened for the family. If the parents do not respond to the pend or are not eligible for MAA/MAF, staff will leave the children on OPC or CHP based on ELE.*

A new case descriptor, *Express Lane SNAP* (ELS) has been created to identify the children found eligible based on an ELA determination.

Using ELE, verification requirements are reduced or eliminated. The following eligibility factors must still be verified:

- Citizenship (open with CIP coding if needed);
- Health Insurance information for children eligible for OPC.

***Reminder:** Children covered by private major medical health insurance are ineligible for CHIP. When the child is found to have SNAP income at or above 163 percent of the FPL but the child has other health insurance, they cannot be enrolled in CHIP. Prior to denying or closing medical for the child, the eligibility worker will need to determine medical eligibility based on current Medicaid or CHIP policy.*

There are reduced verification requirements for:

- Absent parent information;
- Identity (a parent’s signature on a SNAP application is sufficient for children under age 16).

There are no verification requirements for the SNAP program findings of:

- Income;
- Filing group size;
- SSN;
- Residency.

The following eligibility factors must still be verified:

- Citizenship;
- Health insurance information for children eligible for OPC.

Definitions for Chapter 461: [461-001-0000](#)

Specific Requirements; OHP: [461-135-1100](#)

Eligibility and Budgeting; OHP: [461-150-0055](#)

Poverty Related Income Standards; Not OSIP, OSIPM, QMB, TANF: [461-155-0180](#)

Income Standard; OHP, REFM: [461-155-0225](#)

Use of Income; OHP, HKC: [461-160-0700](#)

15. **Breast and Cervical Cancer Medical (BCCM)**

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) amended Title XIX (Medicaid) of the Social Security Act to give the option of providing Medicaid eligibility to uninsured women who are screened by the Centers for Disease Control and Prevention’s National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of treatment for breast or cervical cancer, including precancerous conditions.

No income or resource limits exist for the BCCM program.

To be eligible for the BCCM program, a woman must:

- Have been screened by the [Oregon Breast and Cervical Cancer Program](#), which is coordinated by the DHS Health Services and paid for by NBCCEDP, and is in need of treatment for breast or cervical cancer, or precancerous conditions;
- Be under the age of 65. (The BCC Screening Program, coordinated by DHS Health Services, has its own eligibility criteria for screening services which includes a requirement that the woman be at least 40 years old.);

- Be uninsured. She must not have creditable coverage for the needed treatment of breast or cervical cancer, or precancerous conditions, by health insurance;
- Creditable coverage includes:
 - Individual or group health insurance;
 - Medicare;
 - Medicaid;
 - Armed forces insurance;
 - Family Health Insurance Assistance Program (FHIAP);
 - Oregon Medical Insurance Pool (OMIP).
- Not be eligible under any of the mandatory Medicaid programs (MAA, MAF, Medicaid for pregnant women and children or OSIPM).

The [Oregon Breast and Cervical Cancer Program](#) of DHS Health Services provides grants to local county health departments and tribes throughout the state to administer screening and diagnostic services. Local program staff provide case management services.

Because a woman must be screened by the [Oregon Breast and Cervical Cancer Program](#) and found to need treatment to be eligible for BCCM, the application process is initiated by an Oregon Breast and Cervical Cancer Program Coordinator who assists the woman in completing a BCCM application form upon receiving a diagnosis of cancer or precancerous condition. The coordinator submits the BCCM application form to the Statewide Processing Center to establish eligibility. If it appears the woman could be eligible for a mandatory Medicaid program, the coordinator will assist the woman in requesting an *Application for Oregon Health Plan and Healthy Kids* ([OHP 7210](#)) from the application center. The [OHP 7210](#) will be marked “BCP” on the label. If a woman submits the [OHP 7210](#) to a branch office, it is to be forwarded to the Statewide Processing Center.

A woman found eligible for the BCCM program will have her case coded as program P2 with a BCP case descriptor. If the woman is later determined to be eligible under any of the mandatory Medicaid programs, her case will be coded with that program coding and with a BCS case descriptor.

A woman who loses eligibility for another medical program, but has her case coded with the BCS case descriptor, is still eligible for the BCCM program as long as she still needs treatment and continues to meet all other eligibility requirements for the program.

A woman is no longer eligible for the BCCM program when:

- Her course of treatment has been completed;

- She reaches age 65;
- She becomes covered for treatment of breast or cervical cancer by credible health insurance;
- She is no longer a resident of Oregon.

For information regarding the screening and diagnostic services of the [Oregon Breast and Cervical Cancer Program](#), contact the local county health department or call DHS Health Services at 503-731-4273. Information about the program can also be found on the program's Web page at <http://egov.oregon.gov/DHS/ph/bcc/index.shtml>.

16. Twelve-month continuous eligibility for non-CAWEM children

Effective October 2009, non-CAWEM children under age 19 who lose eligibility for EXT, CW medical, MAA, MAF, OHP, OSIPM or SAC medical may qualify for medical under the Continuous Eligibility for Medicaid (CEM).

CEM eligibility overview

Begin continuous eligibility for Medicaid (CEM) when the child:

- Was eligible for and receiving EXT, CW medical, MAA, MAF, OHP or OSIPM, but lost eligibility for the program before the child was able to receive Medicaid for 12 full months from their most recent eligibility decision (either the initial eligibility decision or from the most recent redetermination).

To qualify for CEM, the child must also:

- Be under age 19;
- Meet the alien status requirement for medical.

Note: Effective October 2009, LPR children (under age 19) meet the alien status requirement and qualify for full Medicaid and CHIP benefits without having to wait for five years.

LPR children turning age 19 may no longer qualify for full medical program benefits. When a child is turning age 19, determine if the 19-year-old's LPR status began less than five years ago. If it began less than five years earlier, consider eligibility for CAWEM benefits.

☞ SEE THE [WORKER GUIDE NC-1](#) FOR MORE INFORMATION ABOUT IMMIGRATION STATUS REQUIREMENTS FOR MEDICAL.

CEM benefits end when:

- They have received Medicaid for 12 straight months since their most recent eligibility decision (either the initial eligibility decision or from the most recent redetermination);
- The child moves out of state;
- The child turns age 19;
- The family voluntarily requests the medical be closed.

Procedures and examples

When a child is determined no longer eligible for EXT, MAA, MAF, OHP, OSIPM and SAC, review for all medical programs as per the usual ‘due process’ procedure.

☞ SEE [MA.B](#) FOR MORE INFORMATION ABOUT THE REDETERMINATION PROCESS AND ACTING ON REPORTED CHANGES.

If found ineligible for EXT, MAA, MAF, OISPM, OHP, QMB and SAC medical programs, consider if the child is a U.S. citizen or meets the Medicaid/CHIP alien status.

- If the child is a U.S. citizen or meets the Medicaid/CHIP immigration status, convert to CEM for the remainder of the 12 months. Enter the CEM (Continuous Eligibility for Medicaid) need/resource item and case descriptor. For the CEM end date, use the end of the 12-month period (counting from either the initial eligibility decision or from the most recent redetermination);

Example 1: Regina is receiving OP6; her certification is due to end November 30, 20XX. On June 10, Regina turns six years of age. A redetermination is initiated, and Regina’s household now has income over 201 percent of the FPL. The worker determines Regina is only eligible for Continuous Eligibility for Medicaid (CEM). The worker codes Regina with the CEM case descriptor and need/resource for 11/20XX.

Example 2: Seth is receiving MAA. His LPR status date is January 2008. His MAA redetermination need/resource end date is January 31, 20XX.

On October 2, Seth’s mother reports that her husband has returned home and that he earns about \$3,000 a month. Acting on the reported change, the worker determines that the family is not eligible for EXT, MAA, MAF, OHP, OSIPM or SAC and ends medical for the mother (sending a 10-day close notice and Notice of Medical Assistance Program Eligibility Decision ([DHS 462A](#))). The worker reviews Seth’s eligibility and finds Seth is eligible only for Continuous Eligibility for Medicaid (CEM). The worker enters

the CEM case descriptor and CEM need/resource item for 01/20XX.

Example 3: Mark and his two children are receiving MAA. No one meets the disability criteria for OSIPM presumptive. Mark reports an increase in child support that makes the family ineligible for MAA. The worker converts the family to EXT for August 1, 2009, through November 30, 2009.

In November, the worker redetermines medical eligibility for the family and learns that Mark has a new job with health insurance. No one in the family is eligible for MAA, MAF, OHP (or OSIPM or SAC). The children are converted to CEM. The worker enters the CEM case descriptor and CEM need/resource item on each CEM eligible child. The CEM need/resource end date is July/2010 (12 months from when the EXT began).

Example 4: Maria and her two children, Consuela and Antonio live with Antonio's father. Maria and Antonio's father are not married. They are over income for two-parent MAA, so Maria and Consuela receive MAF CAWEM (redetermination due April 30, 20XX), while Antonio receives OPC CAWEM (certified through March 31, 20XX).

Maria reports March 5 that she won her UC hearing and her UC has just begun. The UC amount exceeds the MAF income limit. The worker reviews eligibility for MAF and OPC and determines that the family is over income for MAA, MAF, OHP and ineligible for OSIPM. The worker realizes that neither child is eligible for CEM because they do not meet the alien status requirement. The worker sends a 10-day close notice and Notice of Medical Assistance Program Eligibility Decision ([DHS 462A](#)) and ends MAF and OPC effective March 31.

Procedures for CEM children turning age 19:

CEM: Children turning age 19 are no longer eligible for Continuous Eligibility for Medicaid (CEM) unless pregnant. If pregnant, the CEM child will receive benefits through the end of the second month following the DUE date.

CEM children who are not pregnant will be sent advance and final medical close notices automatically by the CM system. The CM system will end their benefits at the end of the month following their 19th birthday.

CEM children will be mailed advance and final close notices and a reapplication packet. If there is a date of request (DOR) established before the CEM ends, add a BED code. Review for medical program eligibility and convert to a new program or end medical benefits with a 10-day close notice and [DHS 462A](#).

CEC eligibility overview**Begin Continuous Eligibility for CHIP (CEC) when the child:**

- Is pregnant;
- Is eligible for and receiving CHIP; but
- Loses eligibility for CHIP for a reason other than private major medical insurance.

The CHIP pregnant woman who loses her eligibility for a reason other than private major medical insurance should be reviewed for possible OPP or another Medicaid program first. If the only program the CHIP pregnant woman is eligible for is CEC, convert from CHIP to CEC.

CEC benefits end when:

- Pregnancy ends;
- They move out of state;
- They request to close medical; or
- Private major medical insurance begins.

A pregnant child receiving CHIP with household income from 185 percent up to 201 percent will have a new need/resource code; CDU. The need/resource date will be the month the pregnancy is due to end. This is different from a child who is pregnant with household income below up to 185 percent FPL: that child will be coded OPP.

If the CDU date (CHIP Due date) is on or before the 15th of the month, the CEC end date is the same month as the CDU end date.

If the CDU date is after the 15th of the month, the CEC end date will be the next month to allow for 10-day notice.

When notified the baby has been born to a woman coded CEC, add the BED coding to the mother and initiate a redetermination of eligibility.

Example 1: Bailey is age 17, receiving CHIP, and pregnant with a CDU (due) date of 3/23/10. Her CHIP certification end date is November 2009. At recertification, the family's income is over the CHIP income limit. The worker converts Bailey to CEC with a need/resource of March 2010. Bailey's CEC will end at the end of March 2010 unless she initiates a redetermination and is eligible for medical at that time.

Example 2: Amanda is age 18, pregnant and due December 2009. She is coded with a CDU for December 2009. Her CHIP benefits began in

August 2009; she is coded CHP with a redetermination date of July 2010. Her baby is born in December. Because this child is still age 18 when the baby is born, she continues as CHP with a redetermination date of July 2010. However, Amanda turns age 19 in February 2010. Because she is no longer pregnant, and is now 19 years of age, her benefits will end. She must be considered for other medical programs prior to closing or reducing benefits.

Example 3: Shelby, an 18-year-old child is pregnant with a due date of February 23, 2010. She is currently receiving CHIP and scheduled for a redetermination in June 2010. In December 2009, she turns age 19. Because she is 19, she is no longer eligible for CHIP. The worker determines the only program she is eligible for is CEC. The worker changes her program to CEC (with a CDU date of 2/2010). However, because the due date is past the 15th of the month, the CEC date is the following month, or 3/2010, to allow time for notice. When the baby is born, her CEC benefits will end. She may be eligible for another medical program at that time.

Example 4: Tara is 18 years old and receiving CHIP with household income from 185 percent up to 201 percent of the FPL, and with a redetermination date of December 2009. In August 2009, she brings in proof of pregnancy; she is not due until March 2010. She is coded CHP with a redetermination date of 12/2009 and also CDU with a due date of 3/2010. At her December redetermination, it is determined her household income is now above 201 percent FPL. The worker codes her CEC of March 2010, and CDU for March 2010.

Example 5: Bethany, an 18-year-old who is pregnant with a due date of March 2010, is receiving CHIP and scheduled for redetermination in June 2010. Bethany receives major medical health insurance through an absent parent in December 2009. She is no longer eligible for CHIP, and is not eligible for CEC due to the major medical health insurance. The worker closes her benefits December 2009 after sending a timely closure benefit notice [DHS 462A](#).

Special 5503 OP6 procedure:

The OHP Statewide Processing Center (Branch 5503) currently receives a monthly report of children turning age 6. Staff from 5503 will review the report and redetermine eligibility for each OP6's filing group. The procedure will remain, but be expanded to include Continuous Eligibility for Medicaid.

Example: Chad is a U.S. citizen. He is certified to receive OP6 through June 30 of next year. Chad turns age 6 in February. In January, the OHP Statewide Processing Center (5503) receives a report of OP6 children turning age 6. 5503 staff review Chad's eligibility to

determine if he qualifies for any other DHS medical program. If not eligible for any other DHS medical program, 5503 will convert Chad to Continuous Eligibility for Medicaid (CEM) by adding the CEM case descriptor and need/resource item. The CEM end date will be 06/XX (the original OP6 certification end date).

Special 5503 MAA/MAF/OPP procedure:

The OHP Statewide Processing Center (Branch 5503) will work a monthly report of pregnant children under age 19 whose MAA/MAF eligibility is ending because there are no dependent children on the case. The report will also list OPP children whose medical is ending.

Example: Felicia is age 16 and receiving OPP. The DUE date on her CM case is 08/09. In 07/09, 5503 will redetermine eligibility for Felicia's medical filing group.

17. Specific requirements; Healthy KidsConnect (HKC)

Overview

HKC provides health insurance to families through the Office of Private Health Partnerships (OPHP). OPHP provides health insurance through HKC insurance carriers or by helping the family pay for employer sponsored insurance (ESI).

- Families with income from 201 percent of the Federal Poverty Level (FPL) up to 301 percent FPL qualify for a subsidy payment from OPHP to help them pay for the cost of the insurance. The subsidy is used to help pay the insurance premium necessary to enroll the child with an HKC insurance carrier or to help pay the ESI premium;
- Families with income from 301 percent FPL and above may choose to enroll their children with an HKC insurance carrier, but must pay for the entire premium amount.

Even though families with income from 301 percent FPL and above do not qualify for any DHS medical program, DHS is responsible for determining the family can be referred to OPHP.

HKC families are automatically referred to OPHP when the HKC (KCA/KC3) coding is entered on the family's CM system case.

After being determined eligible for HKC and the HKC coding is entered on the family's CM system case, an automated referral is made to OPHP. OPHP works with the family to enroll the child in one of the following categories:

- (A) Healthy KidsConnect Employer Sponsored Insurance (ESI) subsidy for families with income 201 percent to 301 percent FPL;
- (B) Healthy KidsConnect subsidy for families with income 201 percent to 301 percent FPL; or
- (C) Healthy KidsConnect full pay for families with income 301 percent and above.

Note: HKC families who do not pass the business \$20,000 business entity income test should be referred to OPHP as nonsubsidy (KC3) HKC clients.

HKC eligibility

To be eligible for HKC, a person must be under 19 years of age and must meet the alien status requirement. There is no CAWEM coverage under HKC.

Income treatment and availability of income requirements used for determining HKC eligibility are the same as used for CHIP.

Budgeting for HKC eligibility follows the same methodologies as those used for CHIP in OAR [461-150-0055](#).

- Determine eligibility using budget month income, including the \$20,000 business entity income test for principals of a business;
- If not eligible using the budget month, the budget month can be floated.

Note: Float the budget month if the family indicates their income is decreasing and they could qualify for OHP Plus or a higher subsidy level using the new budget month.

The countable income standard for HKC is at or above 201 percent of the federal poverty limit. Families eligible for HKC with income 201 percent to 301 percent (KCS) are DHS medical program clients. They qualify for a subsidy paid for with title XXI funds. (Title XXI is also used to fund the CHIP program.)

Families eligible for HKC with income 301 percent and above (KC3 coding) or who do not pass the \$20,000 business entity income test are not DHS clients, but are referred to OPHP anyway. Some families with income 301 percent and above choose to work with OPHP. They choose to enroll with an HKC insurance carrier and pay the full insurance premium.

In order to be eligible for HKC, the child must be a U.S. citizen or meet qualified alien status.

- If a child does not have citizenship documentation but is otherwise eligible for HKC at 201 percent to 301 percent of the FPL, add the KCA coding to the CM case. Also add the CIP coding and send a CMCITPD or other pend notice to the family. Transfer the case to 5503 and mail/shuttle/UPS the application to 5503 using the HKC cover sheet;

- Once the citizenship documentation has been provided. Update the child's Person Alias/Update citizenship fields, remove (or have 5503 remove) the CIP/CIE coding and narrate;
- If it has been determined the family's income is 301 percent FPL and above, add the KC3 coding to the CM case but do not add the CIP coding or pend the family for citizenship documentation for the child. (I.e., do not pend when you are going to deny the medical application anyway);
- If the family's self-employment business does not pass the \$20,000 business entity income test, code as KC3 with HPK of \$9999. The \$9999 HPK income amount is used as a way for OPHP to identify families who do not meet the \$20,000 business entity income test. A new case descriptor will be added to the CM system soon that will replace the \$9999 identifier. (Notification will be sent via transmittal when the new case descriptor is ready.)

☞ MORE INFORMATION ABOUT HKC CASE CODING IS BELOW IN THIS SAME SECTION.

The eligibility period for HKC is a 12-month period. Once the child is approved as eligible for HKC, the CM system refers the case to OPHP for a subsidized enrollment with an HKC insurance carrier or for an ESI subsidy payment.

To be eligible for HKC, the child must not currently be covered by private major medical health insurance or by any private major medical health insurance during the preceding two months.

Note: *The Kaiser Child Health and Kaiser Transitions insurance programs are not considered private major medical. Neither program affects HKC (or CHIP) eligibility.*

After the private major medical has ended, there is a two-month waiting period before the child can be enrolled by OPHP into HKC. However, if the child qualifies for a waiver of the two-month waiting period, OPHP will ensure the private major medical has ended. Do not delay referring families to OPHP if they are otherwise eligible for HKC and qualify for a waiver of the two-month waiting period.

The two-month waiting period after the private major medical has ended is waived if:

- a) The person has a condition that without treatment would be life-threatening or cause permanent loss of function or disability (accept the client's statement);
- b) The loss of health insurance was due to a change in employment (includes children whose COBRA coverage has ended or whose parents choose to end COBRA coverage);
- c) The person's private health insurance premium was reimbursed by a HIP payment;

- d) The person’s private health insurance premium was subsidized by FHIAP or by the Office of Private Health Partnerships (OPHP);
- e) A member of the person’s filing group was a victim of domestic violence.

If an HKC child is receiving private major medical and qualifies for a waiver of the two-month waiting period:

- Code the KCA or KC3 HKC referral on the CM system;
- Send an e-mail to OPHP at “[Info, OPHP](#)” in GroupWise with the case number, case name, name of the insurance company, phone number of the insurance company or employer offering the insurance, names of child(ren) covered by the insurance. A [DHS 415H](#) is not required for HKC. The e-mail replaces the [DHS 415H](#);
- OPHP will work with the family and the insurance carriers so that the private health insurance will be closed before the HKC benefits are issued.

☞ SEE [B.4](#) IN THIS CHAPTER FOR MORE INFORMATION ABOUT THE E-MAIL REFERRAL TO OPHP.

Example: John and Mary are applying for medical for their daughter Maria. Maria has a health condition that without treatment could be disabling. John and Mary have been paying for private TPL for Maria but can no longer afford the premiums. The family’s income is 252 percent of the federal poverty level (FPL) and Maria could qualify for HKC after her insurance ends.

Since Maria has a health condition that qualifies her for a waiver of the two-month uninsurance requirement, add the KCA coding to Maria on the family’s CM case. Send an e-mail to [Info, OPHP](#) letting OPHP know that Maria qualifies for a waiver of the two-month wait. List the case number, case name, Maria’s name and the name of the insurance company (and the insurance company’s phone number, if known). A [DHS 415H](#) is not required.

Example: Sara is applying for medical for her daughter Heather. Sara lost her job, and has been paying for Heather’s insurance through COBRA. The family’s income is 205 percent FPL and Sara cannot afford to keep paying the COBRA health insurance premium.

COBRA coverage is due to a change in employment and qualifies Heather for a waiver of the two-month waiting period. Refer to OPHP by adding the KCA coding to the CM case. Send an e-mail to OPHP letting them know that Heather qualifies for a waiver of the two-month wait. Include the case number, case name and list Heather as the person qualifying for the two-month waiver. Include the name of the

health insurance company and phone number (if known). A [DHS 415H](#) is not required.

Example: Jennifer is applying for medical for her son Franklin and daughter Louise. Louise is included on her absent father's insurance, but Franklin has a different father and does not receive any insurance. Jennifer just separated from Louise's father because of domestic violence. Jennifer explains that Louise's father has been very upset about having to pay for Louise's insurance and continues to threaten Jennifer.

Jennifer no longer wants to use the insurance for Louise and wants to receive medical benefits for both Franklin and Louise. The family's income is at 220 percent FPL.

The two-month wait can be waived because of the domestic violence. Send an e-mail to OPHP letting them know Louise qualifies for a waiver of the two-month wait. Include the case number, case name and Louise's name. Include the name of the health insurance company and phone number (if known). A [DHS 415H](#) is not required.

A child found eligible for HKC becomes ineligible if any of the following occur:

- a) Upon reaching age 19: *Children aging off of HKC at age 19 are not treated as new applicants for OHP Standard. They do not need to be randomly selected from the reservation list to qualify for OHP Standards as long as they establish a date of request before their HKC ends. If eligible, they may transition into OHP Standard effective the first of the month after the 10-day notice of reduction period.*
- b) When the child becomes covered by private major medical (see OAR [461-135-1100](#) for a definition of private major medical) and the insurance is not under contract to OPHP.
- c) Upon becoming a resident of another state.
- d) When the family does not pay their share of the HKC insurance premium.
- e) When OPHP determines the child no longer qualifies for enrollment through OPHP.
- f) When the department determines the child does not meet the requirements for eligibility, including, but not limited to, failure to re-enroll before the end of the eligibility period.

After determining eligibility

After making the eligibility decision, HKC cases must be transferred to Branch 5503:

- Please transfer the KC3, KCA or KCE CM system case to the OHP Statewide Processing Center (Branch 5503) online;
- Shuttle, UPS or mail a copy of the application to 2850 NE Broadway, Salem OR 97303. Be sure to use the HKC cover sheet. The cover sheet is available on the [SSP medical tools Web site](#).

When to e-mail OPHP

- For HKC families with income from 201 percent of the federal poverty level (FPL) to 301 percent FPL, determine if the child is eligible for a KCA referral to OPHP. After coding the KCA/KCR referral on the CM system, send an e-mail to [INFO, OPHP](#) in the following situations:
 - When the KCA child is not receiving private major medical but it is available;
 - When the child who is otherwise eligible to be referred as a KCA child is receiving private major medical but qualifies for a waiver of the two-month waiting period.

When sending e-mails to [INFO, OPHP](#) about Health Insurance, be sure to include the following information:

- Case number;
- Case name;
- Name and phone number of the insurance company, or, for employer sponsored insurance, the name and phone number of the employer;
- The names of child(ren) that are or could be covered by the insurance.

***Note:** The [Info, OPHP](#) e-mail process replaces the [DHS 415H](#) process for HKC clients. The [DHS 415H](#) is no longer faxed to OPHP. The [DHS 415H](#) is still completed and sent to HIG for Medicaid clients.*

Reporting changes

KCA and KCE families must report the following changes:

- A change in availability of employer-sponsored health insurance;
- A change in health care coverage;
- A change in mailing address or residence;
- A change in name;
- A change in pregnancy status of any member of the filing group.

Redeterminations

Redetermine eligibility whenever an HKC subsidy (KCA or KCE coding) family reports a pregnancy, when the certification period is due to expire, when a KCA/KCE child turns age 19, when the family requests a new child be added to the KCA/KCE benefit group or whenever there is a change reported that affects eligibility.

Adding a child to a KCA/KCE benefit group: When a KCA or KCE family requests a child be added to the benefit group, redetermine eligibility for everyone in the family. Review each child for CEC, CEM, EXT, MAA, MAF, OHP and OSIPM eligibility. If not eligible for an OHP Plus program, consider KCA.

- If as a result of the new redetermination to add the child, the new filing group's countable HKC income increases so that the subsidy would be reduced, add the child to the original HKC certification period using the original HPK income amount. The new benefit group remains eligible at the same subsidy level for the remainder of the original certification period;
- If as a result of the new HKC redetermination to add the child, the HKC filing group's countable HKC income decreases so that the subsidy would be increased, add the child and establish a new 12-month certification period for every child in the benefit group based on the new HPK income amount.

Converting from HKC subsidy (KCA or KCE coding) to another program: When a KCA or KCE family is found eligible for another DHS medical program, convert the children to the other program effective the first of the next month. Convert the adults to the program effective the DOR.

☞ SEE [MA B.9](#) FOR MORE INFORMATION ABOUT MEDICAL PROGRAM EFFECTIVE DATES.

Special Branch 5503 procedures

Branch 5503:

- Works a report of KCA/KCE children turning age 19;
- Processes changes reported by the HKC subsidy client (KCA or KCE coding) to OPHP. For example, when OPHP is notified that someone had moved in or out of a KCA household or there is an address, phone number or other CM system update is needed;
- Redetermines eligibility for all HKC subsidy clients with cases in Branch 5503.

HKC CM system coding

Overview

For more information about the HKC CM system coding requirements, see the [SSP medical program Web site](#).

For all HKC referred children, regardless of the income or circumstances, do not use the “VP” or “CP” CM case status to determine if the child is receiving medical benefits. HKC referrals in “VP” or “CP” status do not mean the child is receiving any kind of medical.

If the child has been referred to OPHP for HKC, the child will have a KCA or KC3 case descriptor.

- KCA children are eligible for DHS medical program benefits. Their family’s income is 201 percent to 301 percent. Once OPHP enrolls the child with an insurance carrier or begins making ESI premium subsidy payments, the KCA case descriptor will automatically be updated to KCE (HKC enrolled) and a medical start date added or updated;
- KC3 children are not eligible for DHS medical program benefits. They may purchase health insurance, but must pay the full premium amount. DHS benefits must be ended when completing the referral to OPHP. The CM case will remain in “VP” status through the KC3 referral end date. KC3 children include children who are not eligible for DHS medical program benefits because the financial group did not pass the business entity \$20,000 income test.

KCA (201 percent to 301 percent HKC referrals)

HKC clients eligible at the KCA level are DHS clients. Do not send them a denial or closure notice when converting to HKC.

- Enter the number in the need group (including unborns) in the #OHP field on the UCMS screen;
- Use the HPK income need/resource to list income amounts (instead of the HPI need/resource).

Use a KCA case descriptor and need/resource item to identify each child who is HKC eligible with income 201 percent to 301 percent.

- Once the KCA coding is added, the CM system will automatically refer the KCA child to OPHP. The CM case will display in VP status until the KC3 referral is closed. OPHP has 45 days from the date of the referral to work with the family and issue a subsidy payment;

Note: *KCA children referred to OPHP may not have a medical start date on CMUP. The only time a KCA child will have a medical start date on CMUP is if the child*

is already receiving medical benefits through another program before the referral is made.

- For the KCA need/resource end date, use the month in which the 10-day notice period ends after the 45-day period;

Example: A decision to refer to OPHP is made on April 15, 2010. Count 45 days from April 15 and add time for a 10-day notice. In this example the KCA end date is 06/10.

- If the KCA referred child is already receiving OHP Plus benefits, add the BED code as needed to keep the benefits open until OPHP issues HKC benefits. Match the BED end date to the KCA end date.

Use a KCR need/resource to identify each KCA referred child.

- The KCR end date is 12 months from the referral date.

Example: The decision is made April 15, 2010, to refer a KCA child to OPHP. The KCR end date is 04/2011.

Note: *KCA-referred children are eligible for a DHS medical program. Do not send them a denial notice. Also, the CM system will automatically send a referral notice. If the child is BED coded, the computer will add the reduction information to the referral notice. No 10-day notice of reduction is required.*

Employer Sponsored Insurance coding:

If the family has employer sponsored insurance available for the KCA child but the child is not receiving the insurance:

- Add an ESP need/resource item with a continuous date (ESP C) for each child with the available coverage. (Consider the insurance available even if it is not the employer's open enrollment period).

KC3 (301 percent and above HKC referrals):

- Enter the number in the need group (including unborns) in the #OHP field on the UCMS screen;
- Use the HPK income need/resource to list income amounts (instead of the HPI need/resource). If the family is eligible for KC3 because the family is self-employed and the business entity income is \$20,000 or higher, enter nines (9999) as the HPK income amount.

Use a KC3 case descriptor and need/resource item to identify each child who is HKC eligible with income 301 percent and above.

HKC children with family income at or above 301 percent are not DHS medical program clients. Families with children receiving DHS medical program benefits must be sent the CMCNSUB closure notice and a [DHS 462A](#) notice. Families with children who are not currently receiving DHS medical program benefits must be sent a CMDNSUB denial notice and a [DHS 462A](#) notice.

- Use a KC3 case descriptor and need/resource item for each child needing referral at 301 percent or above;
- For the KC3 need/resource end date, use the month after the referral was made. The CM case will display in VP status until the KC3 referral is closed;
- If the children are currently receiving DHS medical benefits, enter a COMPUTE action and end benefits the end of the month after the 10-day notice (and [DHS 462A](#)) is sent. You might need to wait until after the CM system compute deadline before adding the KC3 referral.

Note: *KC3-referred clients are not eligible for any DHS medical program. Do not forget to send them a closure or denial notice with the [DHS 462A](#) notice. No notice is required for the KC3-referred children. The CM system will automatically send a referral notice.*

Filing Group; HKC, OHP: [461-110-0400](#)
Periodic Redeterminations; Not EA, ERDC, EXT, OHP, REF, REFM, SNAP or TA-DVS: [461-115-0430](#)
Certification Period; HKC, OHP: [461-115-0530](#)
Required Verification; BCCM, EXT, HKC, MAA, MAF, OHP, SAC: [461-115-0705](#)
Specific Requirements; OHP: [461-135-1100](#)
Specific Requirements; Healthy KidsConnect (HKC): [461-135-1101](#)
Income Standard; HKC, OHP, REFM: [461-155-0225](#)
Concurrent and Duplicate Program Benefits: [461-165-0030](#)
Changes That Must be Reported: [461-170-0011](#)
Notice Situations; General Information: [461-175-0200](#)
Effective Dates: Initial Month Medical Benefits: [461-180-0090](#)

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