DHS Oregon Department of Human Services

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Information Memorandum Transmittal

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Authorized Signature

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Topic: Medical Benefits

Subject: Revisions of DHS 415H (Medical Resources)

Applies to (check all that apply):

- ☐ All DHS employees
- ☒ Area Agencies on Aging
- ☐ Children, Adults and Families
- ☐ County DD Program Managers
- ☐ County Mental Health Directors
- ☐ Health Services
- ☒ Seniors and People with Disabilities
- ☒ Other (please specify): CAF SSP transmittal group

Message: The *Medical Resources* form (DHS 415H) was revised and is now available online in English, Spanish, Russian, Vietnamese and Somali.

The DHS 415H now includes sections for all types of medical coverage, including pharmacy, dental, vision, and long-term care. The form was revised by a committee of SSP, SPD, and OPAR staff. It was previously sent for full SSP field review, but implementation was delayed to add language about using the client's SSN.

Clients must pursue available assets

Since third party insurance is an asset, clients must pursue this resource to be eligible for medical assistance.

Cooperation in pursuing health care coverage includes, but is not limited to, applying for, accepting, and maintaining all available cost-effective health care coverage, and identifying and providing information to the department for obtaining health care benefits.

Verification of medical coverage is a **pendable** item. Pend the client for a completed DHS 415H and/**or** copies of all medical cards. At redetermination, verify that there are no changes to their medical coverage. If there are changes to the medical coverage, pend the client for completion of the DHS 415H.

Clients who have third-party insurance need to fully complete the DHS 415H and **return the form to their eligibility worker** for review. Prior to faxing to HIG, the eligibility worker needs to complete the "comments" section of the DHS 415H.

If the client has a medical card(s) from their third-party insurance carrier(s), get a copy of the front and back of each pertinent card and complete the top section of the DHS 415H by including program, branch, case number, worker ID, and case name. No need to fill in all the names of the clients with private insurance if you have copies of all the medical cards. Complete the "comments" section at the end of the form if there are safety concerns for the client or if there is good cause in using the private insurance. Fax copies of the medical card(s) along with the DHS 415H to HIG.

Note: The eligibility worker is responsible for determining HIP reimbursement eligibility prior to faxing the form to HIG.

Complete a DHS 415H and fax to HIG when:

- There is third-party insurance when the client initially applies;
- There are changes in the client's insurance coverage;
- Client's insurance coverage ends; or
- The client indicates there is a safety concern or the client is not able to access the insurance coverage in their area. This allows HIG to code the client's case appropriately.

HIP eligibility

Most Medicaid clients must apply for, accept, and maintain employer-sponsored, cost-effective group health insurance if it is available to them. Clients must also report within ten days any change in health care coverage or the amount of their premiums.

- OHP-CHP is not Medicaid. OHP-CHP clients are not affected by the HIP requirements.
- Pregnant women and OHP-OPU clients are not required to pursue employer-sponsored health insurance.
- Only the individual who can legally assign rights and obtain the insurance is required to cooperate.

To be included under HIP, the insurance must include basic/major medical benefits. It must also be "cost-effective." Employer-sponsored insurance is considered cost-effective if the premium is less than the HIP standard. To determine if the premium is cost-effective, count only those in the EXT/MAA/MAF/OPC/OP6/OPP/OSIPM/SAC benefit group and compare against the HIP standard.

If a client who is required to cooperate does not:

- For all but OHP, remove the client from the need group. For OHP, remove from the benefit group only.
- 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 children, continue to receive Medicaid. When the client agrees to cooperate by enrolling in their insurance plan at the earliest opportunity, they may be eligible for medical assistance.

For example: *Meri and her three children are receiving MAA medical. Meri does not sign up for cost-effective health insurance available from her employer. Meri is required to pursue cost-effective, employer-sponsored health insurance. She is no longer eligible for Medicaid and her Medicaid must end. The number in the MAA need group (#prg on UCMS) changes from four to three.*

NOTE: If the HIP need/resource code is added to Meri's case with the month her employer-sponsored insurance is available, the CM system will automatically send the close notice and end benefits. See the HIP coding reminder section below for more information.

For example: *Mark receives OHP-OPU and his two children receive OHP-OPC. Mark does not sign up for his employer's insurance. Since Mark is an OHP-OPU recipient, he is not required to sign up for employer-sponsored health insurance and there is no penalty.*

For example: *Joshua's son Nick receives OHP-OPC. Joshua does not receive DHS medical benefits. Joshua refuses to signup for cost-effective, employer-sponsored medical for his son. There is no penalty to apply to the case because Joshua is not receiving OHP benefits.*

For example: *Mary is separated from her husband, John. John has insurance available through his employer, but refuses to cover Mary and their children on his insurance. Since Mary cannot sign up for the insurance, only John, we do not penalize Mary because John did not sign up for the coverage. (However, unless she has good cause for non-cooperation with DCS, Mary is required to cooperate with DCS.)*

HIP coding reminder

If the employer-sponsored health insurance is available at a later date, such as an open enrollment period or after new employee trial service, the client must notify us

when it will become effective. For private health insurance that will be available to the client at a later date:

- Determine if the health insurance will meet the HIP eligibility criteria.
- If it will be cost-effective, add the HIP need/resource item to the CM system case, but do not enter an amount. Instead, enter the date of the enrollment period.
- The CM system will send a notice to the client the month before the HIP date that says, “You must sign up and give us proof. If you do not, you may lose your medical benefits. If you cannot get health insurance, call your worker.”
- If the HIP coding is not removed, the CM system will automatically send a close notice, end the client’s coverage and add the RTE (refused to enroll) case descriptor.

HIP effective dates

To add the HIP payment to the CM system case, add the HIP need/resource code, a C continuous date, and the amount of the payment.

- For new cases, the HIP reimbursement starts on the date of request (the first month is prorated) or, if no one is eligible on that date, the reimbursement starts on the date of initial medical assistance eligibility.
- If the HIP payment is authorized after the CM system case has already been opened, the initial prorated payment must be done using the special pay process.
- For ongoing cases, the HIP 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.

Questions?

The *Family Services Manual* Medical Chapter E.13 provides more HIP information, including how to average HIP payment amounts and additional examples.

For SSP, send an e-mail to SSP-Policy, Medical or contact Carol Berg at 503-945-6072, Joyce Clarkson at 503-945-6106 or Michelle Mack at 503-947-5129.

If you have any questions about this information, contact:

Contact(s):	see above		
Phone:		**Fax:**	
E-mail:			