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

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

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 OHP-OPP AEN on the CM case.*

- Selection of a medical, dental and mental health Managed Health Care Plan (MCHP) or Primary Care Case Manager (PCCM) if available, unless they are exempt per DMAP OAR 410-141-0060.

- 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. Be sure to send HIG a DHS 415H with the Kaiser coverage information. Include the information that the coverage does not affect CHIP eligibility.

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 DHS 415H with the Indian Health Service coverage information. Include the information that the coverage does not affect CHIP eligibility.

- 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.

- 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.

- A member of the filing group was a victim of domestic violence.

- The private insurance ended because of job loss.

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 <u>not</u> 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. Reimbursement of Cost-Effective, Employer-Sponsored Health Insurance Premiums (HIPP)

<u>Health Insurance Premium Payment (HIPP)</u>

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. Self-employed people who have group health insurance may also be reimbursed.

The person's health insurance must be a comprehensive plan which includes physician and hospital services. 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 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 X 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.

Remember to consider the number of persons in the benefit group for the program listed above, and not the household group, in determining the HIPP standard. Dental insurance may be reimbursed, but only if the total of the premiums for both the health and dental insurance is cost-effective. If adding the dental insurance premium makes the total premium not cost-effective, only the health insurance premium may be reimbursed.

Example: A filing group consists of a father, mother and two children who receive Medicaid. The two adults receive OHP-OPU and the children receive OHP-OPC. The father has creditable employer-sponsored, group health insurance available at a cost of $245 per month that covers everyone in the filing group.

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).

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)

Except for children covered by Kaiser Child Health Program or Kaiser Transitions Program medical, to be eligible for HKC, a person must be under 19 years of age and must not be covered by private major medical health insurance or by any private major medical health insurance during the preceding two months. The two-month waiting period is waived if –

a) The person has a condition that without treatment would be life-threatening or cause permanent loss of function or disability;

b) The loss of health insurance was due to a change in employment;

c) The person's private health insurance premium was reimbursed under OAR 461-135-0990;

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.

Do not delay HKC eligibility solely because the child is covered by Kaiser Child Health Program or Kaiser Transitions Program medical. Kaiser will end Child Health Program or Transitions Program coverage after the HKC is begun. Be sure to send OPHP a DHS 415H with the Kaiser coverage information.

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

Budgeting for HKC eligibility will follow the same methodologies as those used for CHIP in 461-150-0055.

The countable income standard for HKC is at or above 201 percent of the federal poverty limit.

In order to be eligible for HKC, the child must be a U.S. citizen or meet qualified alien status as provided in OAR 461-120-0125.

Once approved for HKC, the child will be referred to the Office of Private Health Partnership (OPHP). There, the child may be enrolled in one of the following categories:

a) Healthy KidsConnect Employer Sponsored Insurance (ESI);

b) Healthy KidsConnect subsidy; or

c) Healthy KidsConnect full pay.

The eligibility period for HKC is a 12-month period. Once the child is approved as eligible for HKC, they will be referred to OPHP for enrollment. The enrollment period

begins on the date OPHP enrolls the child and may continue through the remainder of the 12-month eligibility period.

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

a) Upon reaching age 19.

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.

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