

*Roles and  
Responsibilities  
of Hospitals and  
the Oregon  
Health Authority*

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## About the Hospital Presumptive (Temporary) Medical Process

### The hospital's role

The Hospital Presumptive (Temporary) Medical process allows qualified hospitals to act as eligibility determination sites. These sites will:

- Identify individuals who may be eligible for Medicaid/ CHIP health coverage and could benefit from immediate temporary medical assistance;
- Make immediate temporary eligibility determinations for these individuals;
- Educate individuals about their responsibility to complete the full Cover Oregon/OHA application (7210) for health coverage within required timeframes;
- Provide the 7210; and
- Assist the individual with completing the 7210, or
- Provide information on resources to help individuals complete the application within required timeframes.

### Qualified hospitals

To become an approved eligibility determination site, hospitals must:

- Be enrolled with Oregon Medicaid as a participating provider;
- Notify OHA of their decision to become a Hospital Presumptive (Temporary) Medical eligibility determination site;
- Agree to make determinations consistent with OHA policies and procedures; and
- Meet established quality standards.

Hospitals may not contract the eligibility determination site functions to other entities or use contracted hospital personnel to make eligibility determinations, except in the case of Certified Application Assistants who specifically work with the Qualified Hospital.

### Who can apply for coverage?

Any individual seeking immediate medical coverage may apply. There is no requirement that the individual be admitted to the hospital or be seeking hospital services in order to apply.

### How long does coverage last?

<b>Coverage start date</b>	Midnight of the date the hospital makes the approval decision
<b>Coverage end date</b>	This date depends on submission of the completed 7210. <ul style="list-style-type: none"><li>■ <b>If 7210 is submitted timely</b>, the agency determines MAGI Medicaid/CHIP eligibility, and Presumptive Medical is in effect until the determination is made.</li><li>■ <b>If 7210 is not submitted timely</b>, coverage ends on the last day of the month following the month of the hospital's determination date.</li></ul>

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Only one period of Hospital Presumptive (Temporary) Medical coverage is allowed in any 12-month period, calculated from the last day of the most recent previous period of eligibility.

### What is covered?

Hospital Presumptive (Temporary) Medical covers all services covered under OHP, including dental, vision and mental health.

**Exception:** Pregnant women are covered only for ambulatory prenatal care. Labor and delivery are not covered.

If women who were presumptively eligible when they were pregnant are determined to be Medicaid eligible, based on the timely submission of the 7210, the period including the date of birth and the labor and delivery will often be covered retroactively.

### Can newborns be covered?

A separate hospital presumptive (temporary) medical determination is required to cover newborns.

- Newborns born to women during the hospital presumptive (temporary) period are not considered Assumed Eligible Newborns (AEN).
- If women who were presumptively eligible when pregnant are later determined to be eligible for Medicaid based on the timely submission of a 7210, the newborn's status changes to AEN.

### What eligibility groups are included?

Hospital Presumptive (Temporary) Medical uses the following income guidelines in determining eligibility:

- Parents and Caretaker Relatives (specific \$ limits)
- Pregnant Woman ( through 185% FPL)
- Medicaid Children
  - Under age 1: (through 185% FPL)
  - Age 1 – 18: (through 133% FPL)
- CHIP Children
  - Under age 1: (above 185% through 300% FPL)
  - Age 1-18: (above 133% through 300% FPL)
- Newly Eligible Adults (through 133% FPL)
- Individuals (to age 26) formerly in Foster Care in Oregon (no FPL limit)
- Individuals in the Breast and Cervical Cancer Treatment Program (BCCTP) (through 250% FPL)

**Income guidelines may change yearly.** OHA will email HPM providers with updated income determination guidelines. Please be sure you are using the most recent version. These may also be found at [www.oregon.gov/oha/healthplan/Pages/hpm.aspx](http://www.oregon.gov/oha/healthplan/Pages/hpm.aspx).

## Hospital responsibilities

### What to do before making eligibility determinations

Check MMIS to see if the applicant is currently receiving Medicaid/CHIP. Do not treat the “Admin Exam” benefit package as current Medicaid/CHIP coverage.

If the individual currently receives Medicaid or CHIP, then the individual is **not eligible** for Hospital Presumptive (Temporary) Medical.

### Making eligibility determinations

The hospital is responsible for making **immediate** eligibility determinations that:

- Are initiated using the OHP Hospital Presumptive (Temporary) Medical application (OHP 7260);
- Are based **only** on information provided by the applicant or his/her representative in **Part 1** of the OHP 7260. No additional documentation or verification may be required at the time of the eligibility determination.

**Always use the most current OHP 7260 application available at [www.oregon.gov/OHA/healthplan/pages/hpm.aspx](http://www.oregon.gov/OHA/healthplan/pages/hpm.aspx).**

### Completing the OHP 7260

Regardless of the eligibility decision, the hospital is responsible for ensuring completion of the OHP 7260.

<b>Part 1</b>	<p><b>REQUIRED INFORMATION:</b> Only the following information is absolutely necessary to complete in Part 1 (applicant attestation only; no documents required)</p> <ul style="list-style-type: none"><li>■ Applicant’s full legal name</li><li>■ Family size</li><li>■ Household’s gross monthly income</li><li>■ Oregon resident? (Yes/No)</li><li>■ U.S. citizen, U.S. national or qualified non-citizen? (Yes/No)</li><li>■ Previous period of Hospital Presumptive Medical Assistance? (Yes/No) If Yes, when?</li></ul>
	<p>The following information is <b>not required</b> to make an eligibility determination, but should also be completed if readily available:</p> <ul style="list-style-type: none"><li>■ Other medical coverage? (<b>NOTE:</b> precludes HPM for <i>CHIP</i> and <i>BCCTP</i>)</li><li>■ Pregnant? (Yes/No) If yes, pregnancy due date</li><li>■ In Foster Care at age 18?</li><li>■ Eligible for or receiving SSI benefits?</li><li>■ Receiving Medicare benefits? (<b>NOTE:</b> precludes HPM coverage for <i>new adults</i>)</li></ul>

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<b>Part 2</b>	Record eligibility determination. If approved, mark the appropriate eligibility group
<b>Part 3</b>	Applicant information including Social Security number, address, alternate format or language needs. This information is necessary in order to properly identify the individual in OHA information systems and thus, to ensure appropriate coverage for the individual and proper payment for hospitals and other providers.
<b>Part 4</b>	Signatures

### Notifying the applicant

At the time of the presumptive determination, the hospital gives the individual immediate written notice of whether s/he is approved, or denied, coverage under this program.

Notification requirements	For approvals	For denials
Copy of the completed Application (OHP 7260) – Complete Parts 1, 2, 3 and 4 for all applicants	X	X
Approval Notice (OHP 3263A)	X	
Denial Notice (OHP 3263B)		X
Full Cover Oregon/OHA (OHA 7210) application packet	X – Mark “Hospital Presumptive” at top of page 1	X – Do not mark “Hospital Presumptive”
Help completing the 7210, or information on resources to help the individual complete and submit the 7210	X	X
Explanation that the individual must complete and submit the 7210 as soon as possible (no later than the temporary coverage end date listed on the Approval Notice)	X	
Explanation that the denial is based on applicant statements and a simplified process which may not have the same outcome as the formal eligibility determination.)		X

### Notifying OHP Customer Service (Branch 5503)

Within 5 working days of each eligibility determination (approval or denial), the hospital is responsible for submitting the following to OHP Customer Service in a single fax:

- A copy of the completed Approval Notice (OHP 3263A) or Denial Notice (OHP 3263B) issued to the individual, and
- A copy of the individual’s completed OHP 7260.

**FAX the required documents to OHP Customer Service at 503-373-7493 marked “Attention Hospital Presumptive Team.”**

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All determination forms (the 7260 and either the 3263A or 3263B) for each individual applicant must be faxed together. **Do not include completed 7210s with these forms.**

### Verifying MMIS enrollment

Hospitals should check MMIS within a week of submitting the required forms to OHA to confirm if individuals determined presumptively eligible are entered in the State system.

If the MMIS enrollment is not complete, the hospitals should contact the OHP Customer Service Hospital Presumptive Medical (HPM) Team at 1-800-699-9075 or by email.

- **Anselma Ullua-Avalos:** Extension 84315, or email [anselma.ulloa-avalos@state.or.us](mailto:anselma.ulloa-avalos@state.or.us)
- **Ellen Rust:** Extension 84340, or email [ellen.rust@state.or.us](mailto:ellen.rust@state.or.us)

### Submitting completed 7210s to OHP Customer Service

**Do not include the 7210 application with the initial MMIS enrollment request to OHP Customer Service.** Fax completed 7210 applications for presumptively eligible individuals to the HPM Team at 503-373-7493 clearly marked “Hospital Presumptive”.

If an individual has applied and has not received an update on the status of their 7210 application, hospitals may contact the OHP Customer Service HPM Team to identify the application and ensure the application processing is expedited.

### Recordkeeping requirements

The hospital is responsible for maintaining the following records for three years from the last date of billing for services associated with Hospital Presumptive Medical determinations:

Description	Retain on file:
Eligibility determinations completed	Completed 7260's
Approval Notices issued	Completed 3260A's
Denial Notices issued	Completed 3260B's
Record of applicants given, prior to leaving the hospital, 7210s, with information on the requirement to complete the 7210 and instructions on how to get help completing the application	As determined by Hospital and approved by OHA
Record of applicants given, prior to leaving the hospital, 7210s, and also given help completing the 7210	As determined by Hospital and approved by OHA

## OHA responsibilities

### Processing Hospital Presumptive (Temporary) Medical approvals

Upon receipt of approved eligibility determinations, staff at OHP Customer Service will:

- Confirm hospital is a qualified hospital;
- Confirm individual reflects no Medicaid/CHIP eligibility on MMIS;

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- Confirm individual has not received Hospital Presumptive (Temporary) Medical eligibility within the past 12 months;
- Enter applicants in the system;
- Start eligibility effective the date shown at the top of the Approval Notice; and
- Ensure eligible individual is not auto-enrolled in a Coordinated Care Organization (CCO), other physical health managed care organization (MCO or FCHP) or dental plan for the presumptive period. This means the individual will receive all health care services (physical, dental, mental health) on a fee-for-service (open card) basis.

## Processing OHP 7210s

Upon receipt of a completed OHP 7210, staff at OHP Customer Service will:

- Complete the determination of ongoing eligibility under the appropriate program, and
- If found eligible for Medicaid/CHIP, ensure that the individual is enrolled in a CCO or other physical health managed care entity (MCO or FCHP), as appropriate.

## Ending Hospital Presumptive (Temporary) Medical coverage

Staff at OHP Customer Service will ensure coverage ends for all approved individuals as follows:

- **For individuals who submitted a 7210 timely**, temporary eligibility ends the date the formal determination of Medicaid/CHIP eligibility (or ineligibility) is made.
- **For individuals who did not submit a 7210 or who submitted a 7210 untimely**, temporary eligibility ends at the end of the month following the month of the hospital Presumptive Medical determination.

When Hospital Presumptive (Temporary) Medical coverage ends, individuals do not receive a notice of their coverage ending. The approval notice they receive in the hospital serves as their notice that this benefit is temporary and will end within two months of the approval date.

## Recordkeeping requirements

OHA maintains records of the following:

- Number of individuals, statewide and by hospital, who:
  - Submitted a 7210 within the required timeframes.
  - Were ultimately determined eligible for Medicaid/CHIP.
  - Were ultimately determined ineligible for Medicaid/CHIP.
- All claims and payments related to approvals for:
  - Individuals ultimately eligible for Medicaid/CHIP, and
  - Individuals ultimately ineligible for Medicaid/CHIP.

## Applicant's responsibilities

### When applying:

Provide true and accurate information for OHP 7260.

### If approved for hospital presumptive coverage:

If interested in pursuing ongoing eligibility, submit completed 7210 prior to the end of the month following the month of hospital's determination.

### If denied for hospital presumptive coverage:

Option to complete 7210 for full eligibility determination.

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## Standards and criteria

The hospital must target the following OHA standards for all individuals approved for Hospital Presumptive (Temporary) Medical benefits. Standards and criteria will be refined over time.

Proposed quality standard	Criteria
1. <b>90 percent</b> of all approved applicants (specify if a. or b.)	a. Are given a 7210 and information on resources for assistance with the application process, or b. Are given a 7210 and provided assistance with completing the 7210.
2. <b>90 percent of the time</b>	The hospital's determination that applicants do not have current Medicaid/CHIP is correct.
3. <b>90 percent of the time</b> ( <i>once hospitals are able to perform this function</i> )	The hospitals' determination that applicants did not receive temporary coverage within the past 12 months is correct.
4. <b>75 percent</b> of all approved applicants	Submit a 7210 within the prescribed timeframes.
5. <b>75 percent</b> of all approved applicants who submit a full application	Are found eligible for Medicaid/CHIP benefits.

## Sanctions and loss of qualification

As the Hospital Presumptive (Temporary) Medical program progresses and standards and criteria are refined, OHA proposes to enforce the standards as follows:

If the prescribed standards are not met for a period of one calendar quarter, OHA will establish with the hospital a written Plan of Correction (POC) that describes:

- Targets and timelines for improvement;
- Steps to be taken in order to comply with the performance standards;
- How additional staff training would be conducted, if needed;

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- The estimated time it would take to achieve the expected performance standards, which would be no greater than three months; and
- How outcomes would be measured.

OHA may impose additional correction periods, as appropriate.

If targets are not met after a sufficient period for improvement, as determined in discussions between OHA and the hospital, OHA may disqualify a hospital from making eligibility determinations under this program.