PHE Unwinding for Individuals Receiving LTSS/SPPC benefits

Case Manager Desk Guide

The Case Manager Desk Guide is intended to be used as a tool to assist APD Case Managers during the Public Health Emergency Unwinding Period. This guide does not contain comprehensive eligibility or case management information. It is intended for use by APD Case Managers who have basic familiarity with the eligibility and case management processes. Information should not be pulled from this Guide and provided directly, as written, to Consumers, Community Partners, Assistors, or other entities.

Contents

General Unwinding Information for Case Managers and Consumers 2

Consumer: Potentially Over Resources 5

- Basic Information for Case Managers 5
- Case Manager Tools for Over Resources Scenarios 5
- Additional Information about Resources 5

Consumer: Potentially Over Income 7

- Basic Information for Case Managers 7
- Case Manager Tools for Over Income Scenarios 7
- Additional Information about Income 8

Case Manager: Working with Incapacitated consumers and how to establish an Authorized Representative 9

- Instructions for Adding a Sticky Note: 10

Consumer: Medical Eligibility is Terminated 12

Consumer: Potential Loss of Housing 13

- Basic Information for Case Managers 13
- Case Manager Tools for Loss of Housing scenarios 14

Case Manager: Medicare Information 14

- Medicare Information and Talking Points for Case Managers 14
- Consumer: Medicare Beneficiaries’ Frequently Asked Questions 16

Case Manager: Notice Writing - Updated 19

Case Manager: Restoring Medical When Services Were not Closed Timely- New 24

Case Manager: Restoring Service Benefits if Medical Benefits are Restored- New 24

Note: During the PHE Unwinding, this guide may be updated as appropriate. Please email APD.MedicaidPolicy@odhsoha.oregon.gov with any suggested changes.

Case Manager: ONE Case Manager Alerts, Reports, and Other Tools 25
Case Manager Tools for ONE CM Alerts 26
Uncovered Caseloads 26
Case Manager: Communication with the Eligibility Worker Team 27
Use Existing Tools 27
Additional Informational Resources 28
Case Manager: Manual PMDDT Referral Requests 29
What is PMDDT? 29
Why would Case Managers have to obtain a PMDDT determination? 29
Additional Information about PMDDT 32
Case Manager: Q&A Session Frequently Asked Questions- Updated 32
Questions related to LTSS 32
Questions related to Financial 39

General Unwinding Information for Case Managers and Consumers

When the COVID-19 epidemic began, the federal government established a Public Health Emergency (PHE). During the PHE, states were not allowed to terminate Medicaid coverage. This meant that Medical recipients who experienced changes in circumstances that would normally result in a benefit closure were able to retain Medical coverage.

In late 2022, the federal government passed legislation that would phase out the PHE protections. Effective April 2023, states are required to process an eligibility renewal for all Medical recipients. As cases undergo renewal, PHE protections will no longer apply. In Oregon, these renewals will be spread over a 10-month period, beginning in April 2023. If the individual is found to be ineligible for Medical when the case is renewed, their coverage can end. This process is being referred to as the “Unwinding” process.

The ONE system was configured to ensure that Medical remained open according to federal regulations. The system has also been configured to apply the protections selectively during the Unwinding period. Medical will continue to be protected until the medical case is renewed. This means that routine changes in circumstances will not cause Medical to terminate. Instead, rules that will allow termination will only be activated when the case

enters the medical renewal period. As part of the renewal process, COVID-19 PHE Medical protections will no longer apply.

As part of this Unwinding process, the state is getting ready to send renewal letters to people who are Oregon Health Plan (OHP) members. This is a year-long process so people will get their renewal letters at different times. People will get letters between April 2023 and January 2024.

Case managers may get questions about the unwinding process from consumers.

Talking Points Case Managers can share with Consumers:

- Keep contact information up to date in ONE.
  - We want to make sure you get your letters, so you know what steps to take to keep your coverage. This means you need to make sure we have your current address, phone number, email, or other contact information. You may update your information in the following ways:
    - You may update your contact information in the ONE Applicant portal
    - You may contact the ONE Customer Service Center at 1-800-699-9075 or 711 (TTY)

- When it is time for you to renew your medical coverage:
  - Pay close attention to your mail and open letters you receive from the state.
  - In some cases, you may receive a “case summary” that outlines information that was used by the system to make its eligibility determination. Review this summary and notify the state if information is incorrect and needs to be updated.
  - In some cases, you may need to complete an interview for your renewal. You will get a notice asking you to contact us for an interview. Be sure to schedule your interview and provide us with the most up-to-date information during this interview. The letter you receive will have instructions about how to respond.
  - In some cases, we may ask you to give us more information or proof about what you tell us. If we ask for information, be sure to respond as soon as possible or let us know if you need more time. The letter you receive will have instructions about how to respond.

- If you need help and would like us to talk with someone else about your benefits, you may name an authorized representative to help you. Your authorized representative can be a friend or family member and should be someone who knows about your situation.
    - You may name an authorized representative by contacting the ONE Customer Service Center at 1-800-699-9075 or 711 (TTY), or
    - You may fill out a form and submit the form to your local office. (Authorized Representative and Alternate Payee Form – English, Spanish, other languages at benefits.oregon.gov)

Consumer: Potentially Over Resources

Basic Information for Case Managers

Based on information in the ONE system, we have identified some recipients who appear to be over the resource limit for the program in which they are enrolled.

Basic Eligibility Considerations:

The eligibility rules used to determine resource availability, whether a resource is countable, etc… are complex. Case managers are not expected to evaluate a consumer's resources. The program information provided here is very high level and only intended to give case managers basic information regarding program resource limits.

- MAGI Programs do not have a Resource test
- OSIPM currently has a resource limit of $2000.00
    - Resources are things like bank accounts, certificates of deposit, cars that are not the primary mode of transportation, or properties other than the home in which the consumer lives in.
    - Consumers with countable resources over the program limits may choose to spend or convert resources. However, specific rules guide this process. Case managers are not responsible for navigating these rules.

Case Manager Tools for Over Resources Scenarios

CM Talking Points- Consumer Over Resources- Talking points designed for case managers in conveying information to consumers

Additional Information about Resources

Case managers are not responsible for evaluating the consumer's resources, but they are often the first point of contact when people have questions about their benefits. The reference guides below are designed for eligibility workers, but case managers who want additional context may use these.

- Resources QRG – General information about countable resources, how they are handled, how data is entered into the ONE system, etc.…
- Excess Resources for OSIPM Talking Points – Talking points for Eligibility Workers when working with OHP recipients who have countable resources over the allowable limit.

Consumer: Potentially Over Income

Basic Information for Case Managers

Based on information in the ONE system, we can identify some recipients who appear to have countable income over the allowable limit for the program in which they are enrolled.

Basic Eligibility Considerations:

The eligibility rules used to determine income availability, whether income is countable, etc… are complex. Case managers are not expected to evaluate a consumer's income. The program information provided here is very high level and is only intended to give case managers some basic information regarding program resource limits.

- MAGI Medical Programs – Various Income standards depending upon the program. See the DHS 5530, linked below. Most adults full under the MAGI Adult category.
- OSIPM:
  - Most programs have monthly countable income standard equal to the SSI Standard ($914.00 for 2023)
  - Individuals receiving Waivered (APD), Independent Choices (ICP), Nursing Facility, or PACE services (PAC) can have countable income up to 300% of the one person SSI Standard ($2742.00 for 2023)
  - Individuals receiving services with countable income over 300% of the SSI standard may establish a qualifying Income Cap Trust and remain eligible for OSIPM.
    - Income cap trusts are established for the benefit of the individual whose income is above 300% of the one-person SSI standard. The trust contains all of the person's income and must be distributed by the Trustee in the order outlined in OAR 461-145-0540(10)(c). The balance remaining in the trust is paid to the state when the person passes away, up to the amount of medical assistance provided on their behalf.

Case Manager Tools for Over Income Scenarios

CM Talking Points: Recipient Over Income – Talking Points designed for Case Managers in conveying information to consumers.

Additional Information about Income

Case managers are not responsible for evaluating the consumer's income, but they are often the first point of contact when people have questions about their benefits. The reference guides below are designed for Eligibility Workers, but case managers who want additional context may use these.

DHS 5530 – Consolidated listing of all program standards and income limits. Please note that this includes all ODHS/OHA programs including Medical, SNAP, TANF, and ERDC.

Income Cap Trusts QRG – General information about Income Cap Trusts.

Income Quick Reference Guide QRG – General information about income data collection in ONE.

Case Manager: Working with Incapacitated consumers and how to establish an Authorized Representative

An annual financial redetermination is required for medical programs requires an interview with the consumer or the authorized representatives. For consumers receiving Long Term Care Services and Supports, the interview can be waived for a consumer who:

- Does not have the cognitive capacity to complete an interview
- Has been assess as either substantial assist or full assist in Self-Preservation, Decision Making or both and
- There is no other appropriate authorized representative to assist the individual

Please see the Who Can Apply QRG for more information. These cases need to be identified as CMs work their caseloads. This includes direct/indirect contacts, initial, annual and change of condition assessments.

As cases are identified, they need to be documented in the ONE system. This will be done using the Sticky Note feature. Any consumers who meet the above criteria will need a sticky note created with the following language:

> *"Consumer name, prime, has been determined as a substantial or full assist in one or more components of cognition as part of a CAPS assessment. They do not have an authorized representative to assist with the medical redetermination process. Please waive the interview requirement for this consumer."*

The local office can make this determination, however, if there are consumers staff are unsure about, please reach out to Central Office for a case staffing. Please use the APD Policy box using a subject line of "Incapacitated Adult AR- Request for Staffing".

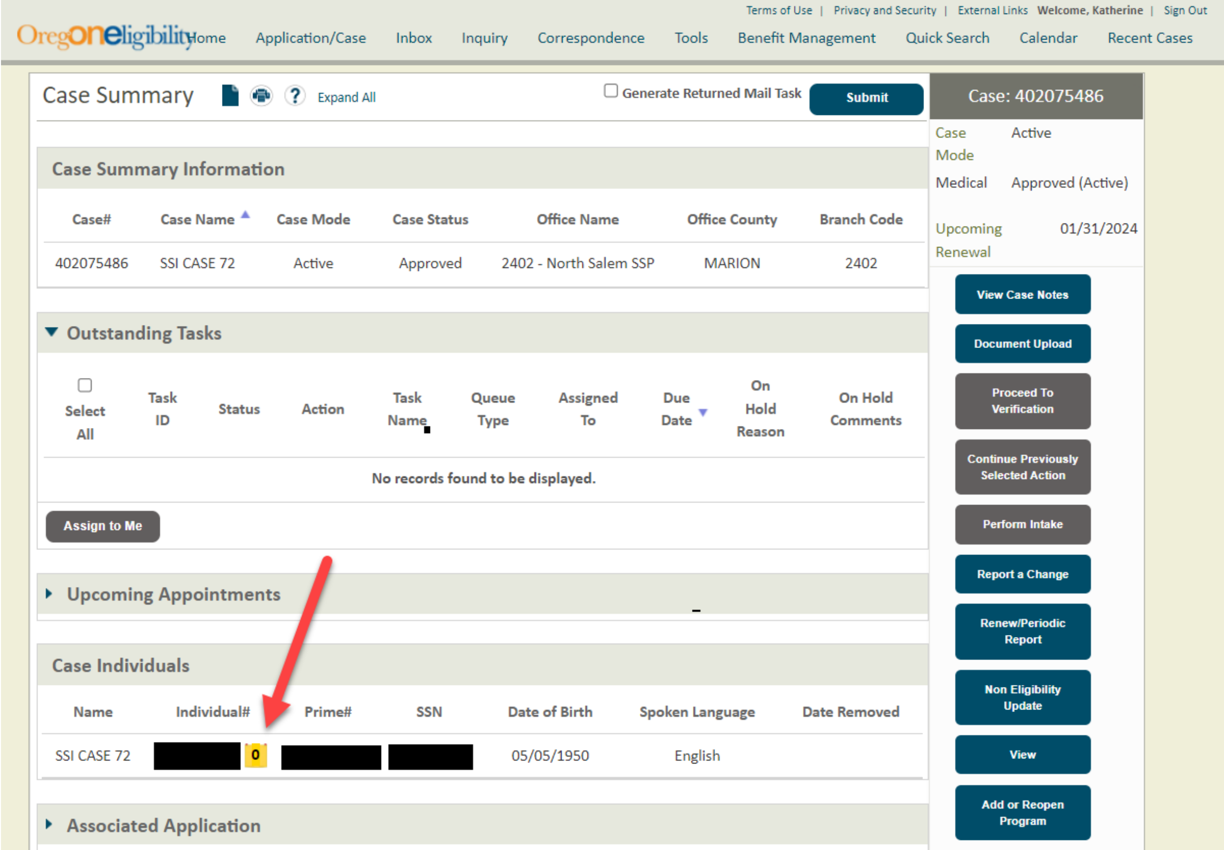
CM need to be checking their ONE alerts to watch for consumers that have been identified as incapacitated to ensure that they remain eligible. Additional reports will be released as the Unwinding continues. These reports will contain data such as consumers who have not completed a review or those who will be losing medical eligibility. These reports will need to be carefully reviewed to ensure that any consumers considered incapacitated are not on these lists. If they are, the CM will need to reach out to an EW via their local office process to let them know the interview should be waived.

An APD Action Request transmittal will provide additional information.

If at any time, a consumer who was previously determined to be incapacitated gets an Authorized Representative, the sticky note will need to be deleted.

Instructions for Adding a Sticky Note:

1. Locate the Sticky Notes on the Case Summary screen. It is in the “Case Individuals” section.



2. Click on the Sticky Note. A new window will open.

3. Add the needed information to the Note Details section and click Submit to save the Sticky Note

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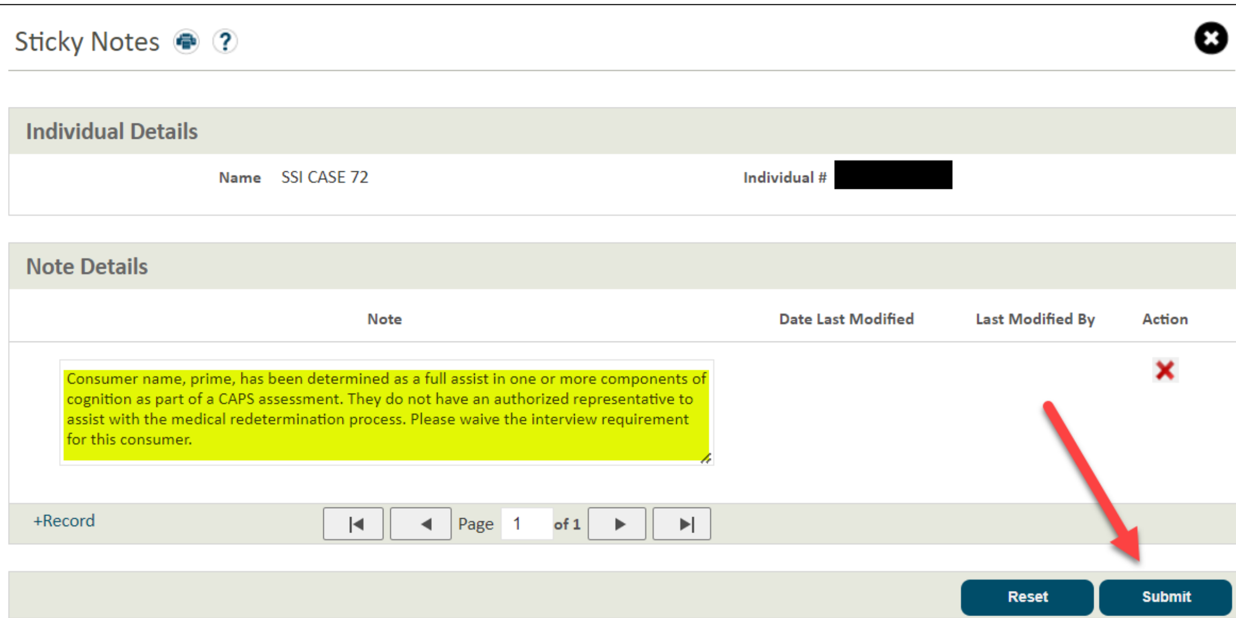
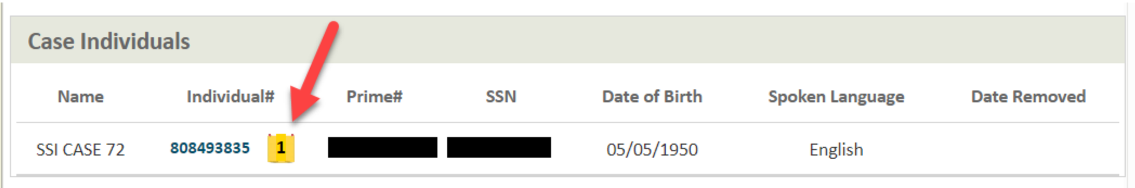


4. If saved correctly, the number on the Sticky Note should increase by 1.



Consumer: Medical Eligibility is Terminated

There are going to be situations in which medical programs will end as part of the Unwinding renewal.

Consumers who are ineligible for OHP Plus Medical (OSIPM, MAGI, or Healthier Oregon), and therefore no longer LTSS eligible, are not eligible for Extended Waiver Eligibility (EWE) or State Plan Personal Care (SPPC).

In these instances, provide the following resources to consumers:

- The Aging and Disability Resource Connection (ADRC) can help individuals find long term care resources in their community.
  - Call 1-855-673-2372 or use the website to search for local resources
- Oregon Project Independence (OPI) may be an option available to individuals losing in-home services. Case managers may refer individuals to their local Area Agency on Aging (AAA).
- Senior Health Insurance Benefits Assistance (SHIBA) can provide support to individuals with Medicare who are losing OHP.
- Housing Assistance – see Loss of Housing
- Local community resources

Note: During the PHE Unwinding, this guide may be updated as appropriate. Please email APD.MedicaidPolicy@odhsoha.oregon.gov with any suggested changes.

Consumer: Potential Loss of Housing

Basic Information for Case Managers

Many APD/AAA consumers currently receive Long Term Services and Supports (LTSS) in Nursing Facilities (NF) or Community Base Care (CBC) settings like Adult Foster Homes (AFH), Assisted Living Facilities (ALF), or Residential Care Facilities (RCF). If the result of the Unwinding renewal is that the consumer is going to lose their OHP Plus Medical, (OSIPM, MAGI, or Healthier Oregon) consumers will no longer receive Medicaid funding for a CBC or NF setting. Case managers will likely be asked to assist with housing options.

- Case managers should review consumers' service needs to ensure they remain service eligible (a new assessment is not required unless requested by the consumer).
  - If the consumer appears service eligible, case managers can look at the Notice Reason in ONE and provide guidance based on the specific situation and reason for medical closure. Please see other sections of this desk guide for information about how to assist consumers who are potentially over income, over resources, etc...
  - If the consumer does not appear service eligible, see resources below.
- Consumers who are financially ineligible for OHP Plus medical (OSIPM, MAGI, or Healthier Oregon), and therefore no longer LTSS eligible, are not eligible for Extended Waiver Eligibility (EWE).
- For consumers who are ineligible for OHP Plus medical, some possibilities include:
  - Staying in the residential setting and pay privately, if possible. The consumer may reapply at any time.
  - Accessing statewide resources:
    - https://www.211info.org/
    - Oregon.gov Rental and Housing Assistance resources
  - Accessing local housing resources
  - Calling Aging and Disability Resource Connection (ADRC) of Oregon, which can help consumers with identifying long term care resources within their community.

Case Manager Tools for Loss of Housing scenarios

CM Talking Points: Recipient Losing Housing - Talking points designed for Case Managers in conveying information to consumers.

Case Manager: Medicare Information

Medicare Information and Talking Points for Case Managers

First, it's important to review a few facts and common myths surrounding Medicare enrollment so you can be better prepared to address questions and concerns:

- Anyone who is eligible to receive Title II Social Security or Railroad Retirement Benefits (RRB) is eligible for premium-free Medicare Part A. That's because the same work history and credits that qualify them for Title II also qualify them for free Part A. Some will be auto-enrolled 24 months after receiving Title II benefits (SSDI) regardless of their age, and some will only qualify to enroll when they turn 65 (e.g., anyone receiving early retirement, survivor, or Disabled Adult Child benefits).

- Anyone receiving SSDI for 24 months OR someone receiving another type of Title II or RRB at least four months before their 65th birthday is auto enrolled in Medicare. They can opt out of Part B, but they can't refuse Part A without losing their Social Security benefits or RRB. Most of the time when someone receiving Social Security Benefits/RRB says they "refused" Medicare, they refused Part B and are actually receiving Part A. This is usually because there's a premium for Part B and Part A is free.

- Anyone not auto enrolled in Medicare must contact the Social Security Administration to sign up. They can do this three months before their 65th birthday and have three months after their birthday, unless they are losing Medicaid, in which case they have 6 months after Medicaid ends.

- We cannot tell someone that they do or don't need to enroll, we can only provide options and information about the potential result. Anyone who is eligible to enroll in

Medicare and losing OHP Plus may want to enroll in Medicare if they have previously opted out because they will otherwise be left with no health coverage. Those who do not qualify for free Part A can be referred to the federal health insurance marketplace if they lose eligibility for OHP Plus. If the question is whether MAGI Adult recipients specifically need to switch to Medicare, we can only say that they won't qualify for MAGI Adult when they turn 65 regardless of their Medicare status, but that doesn't mean they won't qualify for another Medicaid program. There are too many factors involved to address all scenarios, but in general, we encourage everyone eligible to enroll in Medicare to do so. Opting out to maintain OHP Plus eligibility will not have the same result once the unwinding begins, and even though someone no longer qualifies for OHP Plus, they may qualify for a Medicare Savings Program which will help with the cost of Medicare.

Consumer: Medicare Beneficiaries' Frequently Asked Questions

Q: I would rather have OHP Plus, why would I enroll in Medicare when I turn 65 if it will disqualify me?

A: **I**f you are receiving MAGI Adult benefits, you won't be eligible when you turn 65 regardless of your Medicare status because there is an age limit. But that doesn't mean you won't qualify for another Medicaid program. There are too many factors involved to address all scenarios, but in general, we encourage everyone eligible to enroll in Medicare to do so. Opting out to maintain OHP Plus eligibility will not have the same result once the unwinding begins, and even if you no longer qualify for OHP Plus, you may qualify for a Medicare Savings Program which will help with the cost of Medicare.

Q: I only have Part A, can I keep my OHP Plus?

A: You cannot stay on MAGI Adult benefits if you have Part A, even if you don't have Part B, but there are other OHP Plus programs you may qualify for as a Medicare recipient.

Q: I only have Part A, can I enroll in a plan on the marketplace?

A: You aren't eligible to enroll on the marketplace because Medicare Part A is considered Minimum Essential Coverage under the Affordable Care Act.

Q: I don't qualify for free Part A, what can I do?

A: If you are not eligible for OHP Plus after the COVID-19 protections are lifted and don't qualify for premium-free Medicare Part A, you can enroll in a health plan on the marketplace; however, there is a Medicaid program that pays for both the Part A and Part B premium called the Qualified Medicare Beneficiary (QMB) program. The income limit is 100% of the Federal Poverty Level, which is $1,235 for one person and $1,664 for a couple in 2023 (it can be larger depending on family size).

Q: What if I opted out of Part B when I was first eligible because I had Medicaid, will I pay a penalty if I sign up now?

A: You have six months after your Medicaid ends to enroll in Part B without a penalty. This is called a Special Enrollment Period. You can also ask an eligibility worker to help you enroll in Part B before your OHP Plus benefits end if you weren't auto enrolled for some reason.

Q: What if I lose OHP Plus but can't afford Part B?

A: You may still qualify for a Medicare Savings Program that can pay the Part B premium. If you qualify for QMB, all of your out-of-pocket Medicare costs will also be paid (premiums, deductibles, co-pays).

Q: What if I don't qualify for anything, including Medicare Savings Programs?

A: You should contact Senior Health Insurance Benefit Assistance (SHIBA) at 1-800-722-4134 for information about your options. You can also contact the Aging and Disability Resource Center (ADRC) at 1-855-673-2372 for information on other resources in your community that can help.

Q: Who can I call for help with enrolling in Medigap or Medicare Advantage Plans?

A: The Senior Health Insurance Benefit Assistance program, or SHIBA, is a good resource for help with Medicare plans if you're losing OHP Plus coverage. If you are going to keep OHP Plus ongoing, you should contact an eligibility worker at your local ODHS or AAA office, or call ONE Customer Service: **800-699-9075 (TTY 711**), 7 a.m. - 6 p.m. Pacific Time, Monday – Friday.

Q: I am over 65 and never enrolled in Medicare, how do I sign up?

A: If you have not applied for Social Security benefits, you need to contact Social Security to sign up for Medicare. Online Medicare enrollment is available at socialsecurity.gov; however, if one-on-one assistance is needed, SHIBA suggests visiting a Social Security field

office in person. You can do this up to three months before your birthday month. If you have questions about eligibility or enrollment in Medicare, call Social Security at 800-772-1213 (toll-free). Always keep a record of the date, time, and name of the service representative, and take careful notes. You may have to call ahead to set up an appointment with Social Security.

Case Manager: Notice Writing - Updated

Notices when individual is Over Income (OVI)

- Individuals receiving OSIPM and LTSS who did not provide verification, or who do not have income cap trust (ICT) by the due date, will receive a notice closing their Medical for being over 300% of SSI. This means they are also no longer eligible for LTSS.
- Individuals receiving MAGI and LTSS who are over income will receive a notice closing their medical. This also means they are also no longer eligible for LTSS.

Notices when individual is Over Resources (OVR)

- Individuals receiving OSIPM and LTSS who did not provide verification or who remain over resources will receive a notice closing their Medical for being over the resource limit. This means they are no longer eligible for LTSS.

State Plan Personal Care (SPPC) note: Individuals who are no longer eligible for OSIPM or MAGI are also no longer eligible for SPPC.

Notices to close medical benefits are auto generated by the ONE system for a specific effective date. Case managers are required to manually issue a notice to close LTSS/SPPC, in alignment with the effective date the medical benefit is closing (see examples below).

Process for manually issuing a notice when the individual is OVI or OVR

- The Sample Decision Notice Guide addresses both over income and over resource situations for closure of LTSS and SPPC (also provided below).
    - Not OSIPM or MAGI eligible
        - Notes:
            - Use SDS 540, not SPAN.
            - A separate notice will be sent from the ONE system for medical denial/closure.
            - Case managers (CMs) should notify an eligibility worker about the service denial/closure when appropriate.
        - Notice rules and reasons:
            - To be eligible for long-term care services or State Plan Personal Care, you must be eligible for either Oregon Supplemental Income

Program-Medical (OSIPM) or a Modified Adjusted Gross Income (MAGI) Medicaid program (also known as Medicaid OHP Plus benefit). You are not eligible for OSIPM or MAGI and will receive a separate notice regarding that decision. Because you are not eligible for OSIPM or MAGI, you are not eligible to receive Medicaid funded long-term care services or State Plan Personal Care. Oregon Administrative Rules 411-015-0015(1)(a); 411-015-0100(1)(b); 411-015-0005(31); 411-034-0030(1)(c); 410-200-0435; 461-001-0030; 461-101-0010(17).

- Effective dates- Updated
    - In-home LTSS and SPPC service closures:
        - The effective date should be the same date as when the medical benefit closing. Example:
            - OSIPM or MAGI is closing effective 8/31/23.
            - LTSS/SPPC closure effective date would be 8/31/23.
            - There is a system edit in place that prevents an authorization from issuing when the pay period that crosses into a month where there is no OHP Plus medical benefit.
            - For example: The in-home plan ends on 9/9/23 and medical is scheduled to close 8/31/23
            - The authorization beginning 8/27/23 will not issue because the medical benefit is ending in the middle of the pay period
            - For that reason, in-home service plans will need to have the final authorization prorated to reflect the partial pay period.
            - To prorate- Divide the number of hours for the period by 14 (round up the answer)
            - Multiply that number by the number of days between the start of the final pay period and the last day of the month

        - Using the example above: If a consumer has 80 hours, divide 80 by 14, which is 6 hours a day. This would be multiplied by 5- the days between 8/27/23 and 8/31/23. The prorated voucher would be for 30 hours for the partial pay period.
        - Clearly narrate the hours in Oregon ACCESS as well as providing timely notice to the consumer and impacted providers.
- LTSS facility (AFH, RCF, ALF, NF) service closures:
    - The effective date is the same date as when the medical benefit is closing. Example:
        - OSIPM or MAGI is closing effective 8/31/23.
        - LTSS/SPPC closure effective date would be 8/31/23.
- Closure of any Medical Related Payments (MRPs) in the ONE system will happen automatically. However, manual notice needs to be sent letting the consumer know that the payment is ending. Send a 540 for the payment with the language from the Sample Decision Notice Guide

Process and notices for individuals receiving SPPC due to PHE keeping their Medical open.

Outside of the PHE, individuals receiving LTSS, and determined eligible OSIPM due to the 300% SSI rule, would lose both LTSS and OSIPM if they were determined to no longer meet SPL requirements. However, during the PHE, these individuals were instead reduced to SPPC (since Medical was not allowed to be closed). With the PHE Unwinding, the individuals in this category will lose their OSIPM and SPPC benefits unless SPL requirements are now met.

It is critical to discuss the individual's needs and confirm they do not potentially meet SPL.

- If the individual reports no changes that may make them SPL eligible, their SPPC needs to be closed because they are not eligible for OSIPM or MAGI.
    - Use the SDS 540 and the sample decision notice language, OAR, and effective dates provided above.
- If the individual either requests an assessment or there is a possibility the individual could meet SPL, an assessment **MUST** be done before the medical benefit closes. *If the*

assessment cannot be completed before the timely notice deadline to align with the 60-day medical closure period, the case manager must work with the eligibility specialist to override the medical termination to an approval and allow time for the assessment and notice.

- If the individual meets SPL, approve the appropriate benefit in Oregon ACCESS (which updates their SELG record) to ensure ONE is evaluating the correct medical programs.
- If the individual does not meet SPL, the SPAN may be used to **deny** LTSS and **close** SPPC.
  - The effective date for the **denial of LTSS** services for not meeting SPL 1-13 on the SPAN will be the same date the SPAN notice is mailed.

DHS | Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Service Plan and Notice

Branch:	Prime:	DOB:
Case name:		Date of notice: 03/08/2023
Worker name:	Phone number, ext.:	

On **03/31/22** , you were assessed for Medicaid Long Term Services and Supports.

This assessment found you to be: **SPL15.**

Therefore, you are **not eligible for services**

Aging and People with Disabilities (APD) serves individuals who are assessed as Service Priority Level (SPL) 1 through 13 per OAR 411-015-0015. APD is responsible for these programs based on ORS 410.070.

If you disagree with this decision or you do not think your assessment is correct, you may file an appeal by completing and submitting form MSC 443 or by contacting your case manager. Your Assessment Summary is attached as part of this notice. Your hearing rights are also attached to this notice.

This is effective: 3/8/2023

- The effective date for the **closure of SPPC** is the last day of the final pay period in the same month as when the medical benefit is closing.
- SPAN text box for SPPC:
  - Copy/paste this language in the SPPC text box on the SPAN for this situation:

You have been receiving SPPC benefits because your OHP Plus Medicaid benefit package remained open due to Public Health Emergency (PHE) protections. PHE protections have ended, and you have been found ineligible for OHP Plus medical.

You will receive a separate notice about that medical closure. You are no longer eligible for SPPC because you no longer meet the requirements of receiving OHP Plus. This requirement is found in OAR 411-034-0030(1)(c). You may re-apply at any time or if your situation changes. Your SPPC benefits will close effective: [The latest service period end date of the month in which OHP is closing]

- Example effective dates for SPPC closure:

    If OSIPM or MAGI is closing effective 8/31/2023.

    LTSS closure effective date would be 8/26/2023.

Here is why you are not eligible for State Plan Personal Care:

You have been receiving SPPC benefits because your OHP Plus Medicaid benefit package remained open due to Public Health Emergency (PHE) protections. PHE protections have ended and you have been found ineligible for OHP Plus. You will receive a separate notice about that closure. You are no longer eligible for SPPC

Page 2 of 8 DHS 2780N (09/2022)

because you no longer meet the requirements of receiving OHP Plus. This requirement is found in OAR 411-034-0030(1)(c). You may re-apply at any time or if your situation changes.

Your SPPC benefits will close effective **8/26**/2023.

Case Manager: Restoring Medical When Services Were not Closed Timely- New

Case managers (CMs) need to take action to close Long Term Services and Supports (LTSS) when they receive notification that the consumer no longer meets financial eligibility requirements for their OHP Plus benefit package.

It is important to ensure services are closed on the last date of medical coverage, while also meeting timely notice requirements. For example, if medical coverage ends 7/31/23, the CM must close services using an SDS 540 "Notice of Planned Action" that meets timely notice requirements and end services on 7/31/23.

In cases where services are not closed timely, action will need to be taken in the ONE system to restore medical benefits long enough to ensure timely notice requirements for closing services are met, typically one additional month.

The process to restore medical programs for individuals receiving services requires local coordination between the CM and and eligibility worker (EW) and involves work outside of ONE. CMs will need to take the following steps:

- Reach out to an EW following the established local process
- Once medical has been re-established, end the benefit and service plan for the appropriate closure date- see Case Manager: Notice Writing above
- Send the SDS 540 Notice of Planned Action with the coordinating language from the Sample Decision Notice Guide. Ensure a copy of the 540 is sent to EDMS
- Narrate the reason for closure and all actions taken
- Inform the EW that the closure actions have been taken and make sure no additional action is required.

Case Manager: Restoring Service Benefits if Medical Benefits are Restored- New

During the PHE Unwinding, consumers receive an additional two months of protected eligibility, when it has been determined they are no longer financially eligible. For example, a consumer that is determined ineligible financially in August will lose medical October 31st. As stated previously, CMs should send the 540 to close services as soon as they become aware that the consumer is no longer financially eligible.

It is possible that a consumer will take action during the two months of protected eligibility to re-establish their medical benefits, such as providing verification that they are no longer over resources. If this occurs before the closure date of medical, service benefits can be re-established as well.

In cases where a 540 has been sent to close services, a CM needs to do the following:

- Have a conversation with the consumer letting them know they can disregard the 540 and that a new notice will be coming
- Start a new benefit and service plan through the end of service or medical eligibility, whichever is longer
- Send the consumer a 541- Notice of Eligibility and Responsibility
- Narrate all actions in Oregon ACCESS
- Ensure a copy of the 541 is sent to EDMS

Case Manager: ONE Case Manager Alerts, Reports, and Other Tools

Case manager alerts were created in ONE to keep case managers (CMs) informed about the status of a consumer's medical case in the ONE system. These alerts can be viewed on the CM's Homepage in ONE or by using the Case Manager Alert Log in the Tools menu. Consumers who have an active or pending medical case in the ONE system and have an assigned CM in Oregon ACCESS will appear on the CM's homepage. Consumers who do not have an assigned CM, the alert will only appear on the CM Alert Log. There are eight possible alerts.

Updated guidance to eligibility workers (EWs) no longer supports emailing the CM a template when an action is taken on the case. This means the only notification a CM will get on their case will come from the alerts in the ONE system. **It is vitally important that the ONE system is checked regularly, daily if possible, for these alerts, whether in the CM Homepage and/or the CM Alert Log.** This will likely be the only notification a CM receives that a consumer is losing medical eligibility and that action will need to be taken on the service case.

Case Manager Tools for ONE CM Alerts

PHEU Desk Guides – This link is to the main page for all 3 links below

Case Manager Homepage Overview - Brief overview of the ONE Case Manager Homepage

Case Manager Alert Descriptions - Summary of CM Alert Types

Case Manager Steps to Take Before Marking Alerts as Complete – Step by Step guide to Alert Resolution

Additional reports will be available to help identify cases that may lose medical eligibility and consumers who are not following through with actions needed to keep medical open. These will be distributed to supervisors for local office use.

Uncovered Caseloads

For offices that have uncovered caseloads, additional action **MUST** be taken by the local office to ensure that these alerts are checked and that consumers who are losing medical eligibility are identified.

The CM Alert Log can be accessed from the Tools menu in ONE. Please follow the link above entitled, "Case Manager Homepage Overview", for directions on how to pull up the CM Alert Log for unassigned cases. These directions can also be followed if a CM will be out for an extended period of time.

Case Manager: Communication with the Eligibility Worker Team

Communication between the Case Manager (CM) and Eligibility Worker (EW) is always important, but it is especially important during the Public Health Emergency Unwinding (PHEU). This communication may be through the ONE system, email, spreadsheet, or other local office procedure.

Use Existing Tools

There are many existing tools to help facilitate communications between staff. It is important to remember all Eligibility Workers may need to be aware of information a Case Manager has received from an individual. Follow local office procedures to forward this information to an eligibility worker in your local office. Eligibility workers across the state, in Store Front Offices (SFOs) and Virtual Eligibility Centers (VECs), may also be working on a case. Therefore, the Case Manager should also document this information in the ONE system by adding a case note.

Remember not all Eligibility Workers have access to Oregon ACCESS. All financial eligibility information must be documented in ONE.

- Case Manager Homepage and Alerts: Eligibility Workers will not typically contact a Case Manager to communicate case information. Case Manager Alerts were created to automate important notifications to the CM about financial eligibility. Reviewing the Case Manager Homepage and case information in ONE regularly, daily if possible, is especially important during the PHEU. For more information about these alerts the Case Manager: ONE Case Manager Alerts, Reports, and Other Tools section earlier in this guide.
- Case Notes: Case Notes are a historical record of case information that impacts financial eligibility. They are part of the case record and cannot be deleted. A Case Manager can add a Case Note in ONE to document actions they have taken related to eligibility. An example is when information received from an individual is relayed to the eligibility team using spreadsheets, emails, or verbally. When documenting in the Case Notes, provide as much detail as necessary. For example, "Individual provided CM with Income Cap Trust document and bank statement. Documented on local eligibility spreadsheet that documents were turned in. Gave documents to support staff to upload to the ECF in ONE."
- Sticky Notes: Sticky Notes are informal notes about an individual. They can be edited and deleted. These notes can be seen by anyone looking at a case and are very quick to

reference since they aren't part of a long list of notes. An example is information relating to the capacity or cognitive ability of an individual to complete financial eligibility requirements or to note information about money management. Specific eligibility information should not be entered into Sticky Notes.

- Electronic Case File (ECF): All financial eligibility documents must be uploaded to the ECF in ONE. If an individual gives you a document related to financial eligibility, follow your local process to have that document uploaded to the ECF in ONE and add a Case Note to ONE explaining this. An example is when an individual gives you a banking document to bring back to the office showing details of how they have spent their resources.
- Other Local Processes: Follow all local processes to communicate information or request action needed on a case.

Additional Informational Resources

Below are some resources that can be referenced to facilitate communication between case managers and eligibility staff.

- Case Notes QRG- Reviews How to Add a Case Note
- Document/Information Received in Person ETOP
- Internal Communication to Eligibility Worker ETOP

Case Manager: Manual PMDDT Referral Requests

What is PMDDT?

To qualify for OSIPM Medical benefits, a consumer must meet OSIPM "basis of need." OSIPM benefits are only available to individuals in at least one of the following categories:

- Individuals age 65 or over
- Individuals with a disabling condition that meets the Social Security Administration (SSA) disability standards
- Individuals with vision loss that meets the SSA blindness standards

If a consumer meets one of the criteria listed above, then the OSIPM "basis of need" requirement is satisfied.

When SSA has made a finding of disability or blindness, the consumer meets the basis of need requirements for OSIPM. However, if no SSA determination has been made, Oregon can make a "presumptive" determination by applying SSA disability and blindness rules and make its own disability/blindness decision. This is called a Presumptive Medicaid Disability Determination. The ODHS team that makes these determinations is called the Presumptive Medicaid Disability Determination Team, or PMDDT.

Why would Case Managers have to obtain a PMDDT determination?

Most of the time, case managers will not have to initiate a referral to PMDDT for a disability or blindness determination. Most PMDDT referrals are made from the ONE system. When ONE is evaluating medical eligibility and identifies that a PMDDT determination is required the system will initiate the PMDDT referral process. However, if the consumer is found eligible for a medical program for which disability or blindness status is not required, the ONE system will not generate the PMDDT referral. For example, a disability/blindness determination is not required for MAGI benefits. Therefore, when a consumer is determined eligible for MAGI benefits in ONE, the system will not initiate the PMDDT referral process.

In ONE, if an applicant is eligible for a MAGI program, OSIPM is not evaluated. However, there are some common situations in which LTSS service needs require an OSIPM determination. Because ONE will not evaluate for OSIPM when MAGI medical has been established, and a disability/blindness determination may be required for the OSIPM evaluation, case managers may need to manually initiate a PMDDT referrals. The most common scenarios:

- The consumer needs Extended Waiver Eligibility (EWE) benefits, which are only available to OSIPM recipients
- The consumer would like to receive services through the Independent Choices Program (ICP), which is only available to OSIPM recipients.

As described above, a consumer must meet the OSIPM "basis of need" requirements to be eligible for OSIPM. In addition, the consumer must meet other financial and non-financial eligibility requirements. There are program income and resource limitations, residency requirements, immigration status requirements, etc. The OSIPM eligibility rules are complex, and a finding of disability or blindness is only part of the overall determination. Therefore, before pursuing a manual PMDDT determination, it is always a good idea to coordinate with an Eligibility Worker to ensure that the consumer will otherwise meet OSIPM program requirements before the PMDDT referral is made. If it looks as though the consumer would otherwise be PMDDT eligible, a manual PMDDT referral to determine disability or blindness may be required.

The following documents are needed to process PMDDT referrals outside of the ONE system:

- SDS 620
- SDS 708
- MSC 3010 – Release of Information (ROI) for every medical provider, hospital and clinic, that has evaluated or treated the person for the disability in the last 2 years, for ODHS-Aging and People with Disabilities (APD) and the Social Security Administration.

  If all 4 lines on the 3010 are not initialed and the form is not signed with a "wet signature" many providers will not provide records and they will not accept electronic signatures. Missing signatures/initials will delay the PMDDT decision.

There are several ways you can send a referral to PMDDT.

- The preferred and most efficient way to send completed referrals to PMDDT is to scan the documents and securely e-mail them to PMDDT.Referrals@odhsoha.oregon.gov along with an explanation as to why it is being done manually and who should be notified of the PMDDT decision. These emails are checked daily.
- If you do not have the capability to scan the documents, send them by fax to 503-390-1460 or mail them to PMDDT at 3420 Cherry Ave NE, Ste. 140 Salem, OR 97303.

If you need to **expedite** a referral, the individual's case manager must include the following along with the forms listed above:

- Two years of medical and/or mental health records
- SDS 0620A form (Activities of Daily Living (ADL))
- SDS 626 form (Work History)

Local offices are no longer authorized to field approve and to open OSIPM without coordination with PMDDT

The local office, usually a lead or manager, alerts PMDDT that there is a possible condition that meets the criteria on the SDS 620A. PMDDT policy analyst or manager then reviews the submitted evidence to decide if we can start the OSIPM presumptively. PMDDT continues to develop the case and makes a final decision once all the evidence has been gathered.

The worker making the manual PMDDT referral must enter a case note in ONE that includes the following:

- ➢ Explain that a PMDDT manual referral was made (include submission date)
- ➢ The reason for the PMDDT manual referral. Example: The individual is requesting to enroll in the Independent Choices Program which is incompatible with MAGI (their current medical program); therefore, they need a disability determination outside of ONE for OSIPM.
- ➢ What documents were sent.
- ➢ Who should be notified on the PMDDT decision.

PMDDT will enter a case note in ONE when the case filed is approved and has a final decision. PMDDT will usually notify the designated person on the manual PMDDT referral request – usually the case manager or a local office lead/manager. If PMDDT determines that the consumer meets OSIPM disability or blindness criteria, then the case manager may coordinate with an eligibility worker to change the ONE MAGI approval to an OSIPM approval.

Additional Information about PMDDT

The following tools were created primarily for eligibility workers. However, case managers interested in additional information PMDDT may find these resources helpful.

PMDDT & SFPSS Referrals QRG – information on ONE supported PMDDT processes

Case Manager: Q&A Session Frequently Asked Questions- Updated

Questions related to LTSS

Q. If a person is receiving EWE and notice is received that the consumer will be losing medical, does EWE continue until the medical closes or until their EWE certification ends?

A. A consumer cannot have EWE if they do not meet financial eligibility. If a consumer's medical is closing because of financial eligibility, the EWE benefit would end either when their medical program closes or EWE eligibility ends, whichever is sooner. As a reminder, EWE cannot be offered to a consumer losing services if they are closing because of financial eligibility. EWE is only for consumers that are assessed SPL 14-18 **and** that remain financially eligible.

Q. After mail has been sent and we verified the mailing address is correct, and someone communicates they haven't received anything, and it's been a week or longer....(enough time to get mail) should we request that notice be resent, or just tell them to contact eligibility workers, or the VEC, or what do you suggest in order to keep the process moving and not cause even more delays for not receiving mail? (This is not referring to returned mail).

A. The CM should look at the Correspondence module in ONE to help identify what the mailing was. We do not recommend sending the mailing again as that would take too long. Please

Note: During the PHE Unwinding, this guide may be updated as appropriate. Please email APD.MedicaidPolicy@odhsoha.oregon.gov with any suggested changes.

verify that the address on file is correct and if not, reach out to an EW using your established local process to get the address updated. An appointment may be necessary for an EW to go in-depth with the consumer about what is needed.

Q. Where is the link for the over resources list? Will a new copy of the lists be sent each month?

A. There is not a link to the OVI/OVR lists provided to local offices. Those were sent out to the DMs for distribution to local staff. Updated versions of the lists may be sent out as information is changed or new data is received.

Q. I LOVE that the guide is pinned to the top of the CM Tools page. Will it stay there for the duration?

A. The link to the guide will stay at the top of the CM Tools page. It will always show the date of the latest version. Additionally, any updates to the guide will be made in red.

Q. Will that take into account PACE's 45-day closure time and not 30 days like everyone else?

A. An alert in the ONE system will be created when a consumer loses medical eligibility. This notification should be received with more than ample time to complete needed closure actions. It is up to the CM to be aware of, and take action, within each program's timely requirements.

Q. For facility residents - if they are over resources, will they be given a spend down option?

A. Any individual that has a resource amount that exceeds our limits and are no longer going to be eligible for LTSS, part of the eligibility workers' conversations is there are options for the consumer (see above talking points for these conversations). They can do a spend-down, they could go off of services and private pay the facility until those resources are below the limit and then reapply. They can potentially spend the money on whatever they may need for their own personal needs (not give it away) and, if they get that done before their renewal date comes due and they meet the eligibility criteria at that point, then they are eligible. Another option that they could pursue that is available to them is they could reach out to the Estate Administrations Unit, find out how much they could pay towards that claim and pay that amount as well. If that brings them below the limit, then they certainly would be eligible. We do not want to provide them definitive options saying, "this is what you must do," or, "these are the only options you have." We can only say, "these are potential options for you. It's your

choice how you want to proceed with spending your money." Additionally, we do not want to tell consumers "You must spend XX amount of money to be eligible."

Q. What about when a consumer is no longer SPL eligible and the medical is dependent on their service need? Are we still reviewing for SPPC until their next medical renewal?

A. At the time of their annual recertification, if a consumer is receiving the OHP Plus package, they are entitled to, and should receive any service program they are eligible for, including SPPC. A CM should have a conversation with the consumer that their continued eligibility is dependent on their financial eligibility for medical programs. If the consumer chooses not to take the program, a 457D can be completed waiving their rights to SPPC benefits.

Q. Will notices in different languages be sent out timely? Would PHEU affect the new translation process/workload?

A. Closure notices sent from ONE have already been translated and additional translation should not be needed. If there's anything specifically that you would normally be translating and sending out separately (i.e., notices your office created), then you would have to do that separately if it's not a document that we already have available. There is that new process utilizing Workfront and they are aware that the increased workload is coming.

Q. If we close because they didn't do the interview. Do they have a time frame in which they can apply and get back on service benefits?

A. If a consumer loses financial eligibility, they retain PHE protections for 2 additional months. For example, if they are determined in June to lose financial eligibility, they will keep their medical program for July and August. If a consumer becomes financially eligible within the 2 months and services have not yet closed, we can look at re-establishing service benefits without a reassessment. Provided the consumer's assessment is still valid and there has not been a change in condition, CMs can withdraw the closure notice and continue service benefits through the remaining time of the assessment period.

Q. When completing the tasks for those clients that are OVI or OVR, should case managers refer the information they find from the client to eligibility? Or is it more just for client's to be aware of upcoming steps?

A. Every office should communicate with their eligibility teams and work on developing their own flow and what that would look like. It may vary from office to office. It is recommended

and encouraged that if a CM gets information that can be shared with an eligibility worker, they should do so, but it doesn't mean that the consumer may not have to reshare that with the eligibility worker again or provide additional documentation. The conversation with the consumer and a CM should be at a higher level and more informational to then get them to have that more in-depth conversation with an eligibility worker and not wait until the last minute or ignore meetings or ignore requests for information. Consumers that have PHE protection (a COVID-19 indicator on their case) keep protection when changes are reported. Consumers should be encouraged to report changes so the most up-to-date information is on the case.

Q. With the new expanded MAGI, are those folks able to access SPPC? We have been told that they are unable to access LTC but have not been given an answer on SPPC.

A. The Bridge Program (referred to as expanded MAGI or EXADLT) is not eligible for SPPC because it is not the equivalent of OHP Plus. A consumer must have OHP Plus to be eligible for SPPC.

Q. Are eligibility workers going to be having conversations with the consumer about their benefits closing if they're not eligible for financial/medical or will the service case managers be responsible for direct contact regard these closures outside of simply sending the service closure notice?

A. Yes, absolutely. Eligibility workers are, and should be, having these conversations around their financial eligibility but the conversations are limited to financial eligibility. Eligibility workers are having that conversation about OHP closing or reducing but eligibility workers across the state don't really understand the nuances of how that eligibility is affecting LTC and that's when the case manager comes in to offer that additional support, do a CA/PS if needed, and explain how financial eligibility affects their LTC services. That's really the CM's expertise so, it's a two-pronged approach. Developing that relationship with your eligibility team and developing those processes with them is going to be important to support consumers through that transition.

Q. We were given a list of consumers at risk of losing medical and services, will this list be updated as we move through the unwinding process?

A. We do not anticipate that a new list will need to be issued, unless new data is found that wasn't provided originally. This highlights the need to check ONE alerts regularly, daily, if

possible, rather than rely solely on the list. There will be consumers not on the list that have alerts appear that may affect their benefits.

Q. Do consumers keep their PHE protections if they've requested an early assessment and it is determined that they actually require less assistance than previously?

A. PHE protections are specific to medical benefits. So, if someone requests an early assessment, the CM assesses them, and determines that they have less service needs, then the CM needs to act upon that new assessment and reduce their services. This has been in place since late 2020 when we got direction from the federal government that services could be reduced. Even if it is determined that they are no longer eligible for services (not even SPPC), they will not lose their medical benefits until that redetermination process has been completed.

Q. ONE will send the closure notice for medical programs. Will we be required to give 10-day notice for services, or can we send our closure notices without 10-day notice?

A. Notice must be given for closure of services. We cannot close services without timely notice. With the PHEU, medical has additional protection of two months. So, let's say that their medical redetermination is due July 31, and an eligibility worker determines in July that the consumer is no longer financially eligible, that consumer will retain medical eligibility for August and September. The case manager will get an alert in July that that consumer is no longer financially eligible as of the end of September and the CM can send notice as early as July that services are closing because that closure date is set. With this in mind, there should be ample time to give timely notice of benefit closures.

Q. I am wondering about the number of hearings we will get. I am concerned about consumers' services staying open during the hearing.

A. To clarify, just because someone files a hearing, it doesn't automatically mean that they get to keep their benefits open. They have to request to keep their benefits open. So, that would be COB (Continuation of Benefits) or APP (Aid Paid Pending) on MSC0443 which is the form that you would help them continue with to file a hearing. There is a section on the MSC0443 that explains COB or APP. The consumer needs to understand that, by requesting that, if they lose, that full amount from the time they should've had services closed until the time the hearing occurs and a decision is made by the ALJ (Administrative Law Judge) goes toward their estate claim and they're responsible for that amount. All consumers need to be made aware of

this if they are filing for a hearing because some consumers will opt to not use the COB or APP because of this stipulation. We fully anticipate that there will be an increase in hearings. The hearing unit and policy team have been getting prepared for that and you should as well. Hearings have been significantly reduced in the last couple of years and we will see a large increase at first before likely seeing the number of hearings reduce to pre-pandemic numbers.

Q. If a client is incapacitated but has a payee would their payee be the auth rep and complete that interview?

A. A consumer having a payee does not mean that the person can complete a financial interview. During the financial redetermination process, the only person that can complete an interview besides the consumer, or an adult on the case, is the authorized representative that has a completed DHS 231. If the consumer is incapacitated and cannot sign a 231, then they cannot have an authorized representative. This is because the department is not able to appoint an authorized representative for an incapacitated adult. If they have a rep payee, we can gather information from them, but they cannot be treated as an authorized representative.

Q. Our CMs are concerned with the workload increase that could be caused by these conversations with the SPPC consumers closing and offering those new assessments when they have a significant workload already with ongoing assessments and intakes. Also, does the client going to Hearing and the Dept. being upheld to close Title XIX affect this process at all?

A. The process outlined in the CM Desk Guide was discussed heavily with both the hearings and policy units. The process isn't intended for a CM to offer an assessment to every consumer that is losing SPPC. The process is asking for a conversation with the consumer about their needs, specifically the four ADLs that determine eligibility and identify if they may or may not be eligible. If their response indicates they do not have needs in those areas and won't meet Title XIX requirements, the CM can take action and close the case. If their reported needs indicate that they may be eligible for Title XIX, an assessment needs to be completed. If the consumer states they want an assessment, we need to honor that request. If this process is not followed and the CM does not have a conversation with the consumer, the consumer can request a hearing. If the Administrative Law Judge (ALJ) finds that the conversation with the consumer didn't occur and they were not given an opportunity to request an assessment, the ALJ will remand it back to the local office, an assessment will have to be completed, and

medical benefits will need to be reopened. It is a much greater workload that just having a conversation with the consumer up-front.

Q. If a case no longer has PHE protections, indicating that they have already had a medical renewal, on the 15th of the month, if no SELG is found on a case for the following month, will the system re-run and end the service TOA pre-emptively for the following month? My question arises because completing CAPS, putting on service plans can be difficult to do by the 15th of the month.

A. The ONE system is designed to check each month for an SELG record for the following month. This occurs on the 15th of the month. If the medical benefit is dependent on the consumer's continued service eligibility, the system will terminate if the SELG record is ending and there is not a new record showing ongoing service eligibility. This is typically the LTCSERV TOA. Once the system receives a new SELG record, ONE reruns eligibility and authorizes the benefit if it can. If it can't, it creates a task for an eligibility worker to go in an authorize benefits to prevent any gaps.

If an assessment cannot be completed before the 15th of the month, admin extensions may be requested to extend one month through the end of the following month and approved by someone with Tier 2 rights. The expectation remains that the assessment should be completed before the end of the current month. The extension is only to maintain a current SELG record for ONE to check against, not for additional time to complete the assessment.

Q. Prior to ONE, the case manager would work with consumer and family on spenddown process, EAU, etc. to avoid closing someone. Are the Eligibility Workers educated on how to do this and who to contact?

A. This is part of the reason that the lists were provided and the CM Desk Guide were created. There is a two-prong approach in supporting LTC consumers. The Desk Guide provides some top-level information on these topics for CMs to talk to their consumers about, but, ultimately, the more detailed parts of those conversations will occur with an Eligibility Worker. They will cover the process, next steps and what the consumer needs to complete in terms of their financial redetermination. The conversations should not be telling a consumer what to do, rather explaining what things can impact their eligibility. Do not tell a consumer how to spend their money. This includes telling them to repay Medicaid-provided services. That can be provided as an option, but it is not their only option. Do not give financial or legal advice.

However, a CM can coach people on how to avoid a potential DQ if they choose to spend-down.

Q. Shouldn't we use the 4105 to inform the HCW of ending of payment authorizations to prevent them from claiming hours beyond the authorized date? Is there a way for the ONE system to do this automatically? If not, could this be considered for the future? (Probably a big ask.)

A. Best practice is to communicate the information to the HCW using the 4105. This form should always be used to inform the HCW of changes. ONE is not tied to services, so it cannot automatically send any service-related forms. Changes in Oregon ACCESS are not quick and take time, but it is something we can investigate for the future.

Questions related to Financial

Q. How are Disqualified Transfers (DQs) assessed during the PHE being handled as we unwind?

A. If the DQ was for a new consumer, it was served before services were started. If the DQ was found after the consumer started on services, the ONE system followed DQ logic for the calculation/start date, but no action was taken during the PHE and that protection continues through their financial redetermination and protection period. Once that expires, if there is any remaining DQ to serve, then it is applied at that time. In other words, if there is a remaining balance on the DQ at the time of renewal, the individual will start serving it then.