

# Policy Transmittal Aging and People with Disabilities



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**Number:** APD-PT-24-009

**Issue date:** 5/2/2024

**Topic:** Long Term Care

**Due date:**

**Transmitting (check the box that best applies):**

- New policy   
  Policy change   
  Policy clarification   
  Executive letter  
 Administrative Rule   
  Manual update   
  Other:

**Applies to (check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> All DHS employees                             | <input type="checkbox"/> County Mental Health Directors                       |
| <input checked="" type="checkbox"/> Area Agencies on Aging: Type B     | <input type="checkbox"/> Health Services                                      |
| <input checked="" type="checkbox"/> Aging and People with Disabilities | <input type="checkbox"/> Office of Developmental Disabilities Services (ODDS) |
| <input type="checkbox"/> Self Sufficiency Programs                     | <input type="checkbox"/> ODDS Children’s Intensive In Home Services           |
| <input type="checkbox"/> County DD program managers                    | <input type="checkbox"/> Stabilization and Crisis Unit (SACU)                 |
| <input type="checkbox"/> Support Service Brokerage Directors           | <input type="checkbox"/> Other ( <i>please specify</i> ):                     |
| <input type="checkbox"/> ODDS Children’s Residential Services          |   |
| <input type="checkbox"/> Child Welfare Programs                        |   |

|                               |  |                         |  |
|-------------------------------|--|-------------------------|--|
| <b>Policy/rule title:</b>     | Case Manager Expectations for the ONE System |                         |  |
| <b>Policy/rule number(s):</b> |  | <b>Release number:</b>  |  |
| <b>Effective date:</b>        | Upon Transmittal Release                     | <b>Expiration date:</b> |  |
| <b>References:</b>            |  |                         |  |
| <b>Web address:</b>           |  |                         |  |

**Discussion/interpretation:**

It is important for Case Managers (CMs) to have a full and accurate understanding of how the ONE system and Oregon ACCESS (OA) interact with each other. Staff should have an understanding of the actions and decisions that occur in either system will most likely have an impact on the other.

This transmittal provides information on these interactions, as well as expectations Aging and People with Disabilities (APD) has for CM staff. This information will be later developed into a guide and provided on CM Tools.

Staff who have not done so, or would like a refresher, they can enroll in and take the CM Fundamentals course offered by the APD Medicaid Financial Eligibility Training Unit that provides information on the CM actions needed based on the expectations below. Please use [this link](#) to review this training.

The topics covered in this transmittal includes the following:

[Initial Service Eligibility](#)

[Redetermining Service Eligibility](#)

[CM Assignment](#)

[Approving Service Benefits in OA During Intake Process](#)

[CM Alerts](#)

[Medical Related Payments \(MRPs\)](#)

[Case Notes](#)

[Sticky Notes](#)

[Following Local Processes](#)

[Important Reminders](#)

## CM Expectations for the ONE System

### Initial Service Eligibility

When an individual requests Long Term Services and Supports (LTSS), a 45-day timeframe begins. The start date is the Date of Request (DOR) in ONE and can be found on the Individual Information tab under the Individual Information screen. Both service and financial eligibility must be determined within this timeframe and a decision notice must be provided to the individual.

To meet the 45-day requirement, CMs:

- **Must** complete the service assessment at the same time the financial eligibility is being determined by an Eligibility Worker (EW).
- **Must not** issue any notice regarding service eligibility until financial eligibility has been completed, including waiting for AVS results and any pends to clear.
- **Must not** verbally inform individuals or providers of service or financial eligibility before it has been established.

Not completing service eligibility determinations timely causes a delay in needed service and medical benefits for the individual applying. Informing individuals or providers of eligibility prematurely causes provider payment issues.

If there is a need to extend the 45-day processing timeframe due to service eligibility issues, the CM will need to follow their local process to have an EW extend the SELG Due by Date in ONE to avoid a denial notice being sent to the individual. CMs will

receive the Pending Case alert as notification when the case is pending for an SELG record.

### Redetermining Service Eligibility

If a reassessment determination is not going to be completed timely, causing the individual's benefit to end, or if the individual is no longer eligible for services and there is not enough time to issue a timely notice, staff must have the individual's current benefit in OA extended. Local office management can extend benefits for an additional month through the "Admin Extension" process. Central Office (CO) staff can extend the benefit for more than one month when needed (see link below for this process).

When a benefit expires:

- The medical benefit in ONE may close, sending a closure notice to the individual, which may cause confusion.
- Payment delays to providers
- Additional workload for:
  - CMs- calls from the individual, actions to restore the case and actions to correct provider payment issues.
  - EWs- actions to restore the case and calls or appointments with the individual.
  - Support Staff- phone calls with the individual, scheduling appointments with EW/CM staff.
  - Hearings- additional hearing requests generated because of the loss of medical benefits.

To request an Admin Extension, please follow the process in transmittal [APD IM 23-062 New Way to Submit Tier Three Admin Service Plan Extensions](#)

### CM Assignment

When a CM is assigned a case in OA, they must check the "ONE CM" box on the Case Overview screen. This sends the CM information to the ONE system.

| Role    | Name       | ONE CM                              |
|---------|------------|-------------------------------------|
| Service | [Redacted] | <input checked="" type="checkbox"/> |

The CM must also check ONE to make sure they are showing as the assigned CM on

the Case Summary screen, whether they are initial (intake) or ongoing (service). If the CM does not show on the case in ONE, they will not receive the CM Alerts for changes to the case.

| Assigned Worker Information |          |              |             |           |
|-----------------------------|----------|--------------|-------------|-----------|
| Individual Name             | Person # | User Type    | Worker Name | Worker OR |
|                             |          | Case Manager |             |           |

### Approving Service Benefits in OA During Intake Process

Do not create a benefit line in OA until the individual has been determined financially and service eligible. Creating the benefit line prior to eligibility being completed causes provider payment issues, requirements to complete unnecessary Direct/Indirect calls and forced eligibility in ONE because individuals were incorrectly told they were eligible.

Once an individual is financially eligible, CMs must create and approve a benefit line and service plan right away. If the individual is unsure of where they want to receive services, a benefit should still be created following these steps:

- Create and approve a benefit plan with In-Home as the setting (see Note below)
- Create an Hours segment and Service plan with a TBD provider (it does not have to be in approved status)
- Use Oregon Administrative Rule (OAR) [461-180-0040](#) to determine the appropriate start date for services.

This allows the individual to begin receiving medical benefits (if applicable) and start receiving Waivered Case Management Services (i.e., Direct and Indirect Contacts). A facility plan should not be opened with TBD providers.

Approving the benefit line in OA sends an SELG record to the Mainframe and ONE in real-time. ONE runs eligibility if possible, or a task is created for an EW. When an individual is initially applying for LTSS, this SELG record is vitally important to completing the financial eligibility process.

Without an approved SELG benefit, ONE will deny the appropriate TOAs (medical, service or both). If the case is denied for not having service eligibility and it was in error, please follow your local process to work with an EW to correct the case.

\*Note: When the ONE case is approved using an in-home benefit, ONE will treat the individual as an in-home service consumer for the purposes of calculating liability. If the benefit line is later modified to Residential or NF, ONE will calculate a liability. Adverse action logic will apply as ONE will see the addition of liability as adverse to the

individual. The liability will not be reflected in ONE until the appropriate adverse action timeframe has been applied:

- If the change is made before the 15<sup>th</sup> of the month, the liability will be effective for the next month.
- If the change is made after the 15<sup>th</sup> of the month, the liability will not be effective until the month after next.

ONE does not calculate liability until the individual is service and financially eligible. However, it is important that CMs explain to individuals interested in facility placement that they will have to pay towards their cost of care, including Room and Board. This conversation should be narrated in OA as well as on the case notes in ONE.

### **CM Alerts**

The Homepage and CM Alert Log were created so CMs would be notified of changes impacting service eligibility on their caseload. CMs can find informational guides about the Homepage and CM Alerts including what actions the CM needs to take for specific alerts on this page: [ONE Resources for CMs](#)

It is an expectation that CMs regularly check their alerts in ONE. The recommendation is at least weekly. It is vital that these are acted on timely. Failure to do so creates additional workload for staff, creates delays in benefits to the individual, payments to providers and in due process for hearings. Once you have taken all actions on an alert, you must mark it as complete.

### **Medical Related Payments (MRPs)**

CMs have rights to create MRPs in ONE. Some MRPs can automatically approve and send payments while others are sent for approval by a supervisor, manager, or CO.

CMs must be aware of available Long-Term Care (LTC) MRPs and determining eligibility for them. It is also a CM's responsibility to create the MRP and to submit the request as well as sending the appropriate notice. When a MRP is created, a Case Note in ONE must be entered (see Case Notes below) and a narration should be entered in OA as well. [Program Payments and Supports QRG](#)

### **Case Notes**

Case Notes are the formal record of what has occurred on a case. There are a few circumstances where a CM must add a Case Note in ONE.

Action Taken- A CM must add a Case Note any time they take an action in ONE. The Case Note should include what was done and why. Here are a few examples:

Example #1- A MRP was created for R&B-

Case Note: Individual Name moved into Facility Name on XX/XX/XX and the first

month R&B payment was made to the facility for \$XXX.XX.

Example #2- An individual is evaluated for a potential Disqualifying Transfer of Assets (DQ) and their service eligibility determination.

Case Note: Individual Name completed an assessment on XX/XX/XX with CM Name. The assessment resulted in SPL XX and the individual is/is not eligible for Title XIX services.

Document received- CMs may receive financial documentation from individuals on their caseloads. CMs should accept any documentation the individual provides. All financial documents received by a CM must be brought back to the local office and date stamped. The CM should create a case note, stating:

- What document(s) were received,
- Who they were received from,
- The date they were received, and
- Who they were given to in the local office (Title not employee name).

For more information on case notes, CMs can review the [Case Notes QRG](#).

## **Sticky Notes**

Sticky Notes are a feature in ONE meant for communication between staff with important information on a case. All staff roles in ONE can create and view Sticky Notes. They are located on the Case Summary screen and are next to the individual's name. There is not specific guidance for what information should go into a Sticky Note outside of the Incapacitated Adults process, which you can find in [APD 23-010 Incapacitated Adults and the Public Health Emergency Unwinding](#) (PHEU). While the transmittal is related to the PHEU, the guidance specific to Sticky Notes is ongoing and should be followed.

Information added to Sticky Notes can be for topics ranging from an individual or workers safety, an individual's communication preference or specific supports needed by an individual. Here are some examples:

- An individual on your caseload is hard of hearing and that staff calling them need to speak loudly.
- The individual does not answer phone calls from numbers they don't recognize, requiring a call to the spouse's number instead.

An EW may add a Sticky Note with important information or concerns they may have on the case that cannot be noted elsewhere. Sticky Notes are not a permanent part of the individual's record and can be updated or deleted at any time.

## **Following Local Processes**

There are situations when communication is needed between CMs, EWs and SS. For

example, an individual on their caseload has moved into a facility or has passed away.

Each local office must have a process that provides direction on how CMs, EWs and SS communicate information. The process must include how CMs should handle financial information or documents given to them, who is responsible for uploading them into ONE and ensuring a task is created to be worked by an EW. These processes must be written in a way that makes sure work is done by the appropriate role and does not add undue workload to other roles.

### **Important Reminders**

ONE, OA, Mainframe and MMIS all communicate together. If the systems are not in sync, there will be issues with the individual's benefits and provider payments.

Before setting up the benefit line in OA, check ONE for the medical/service TOA to ensure you are choosing the correct benefit. Review [Service Categories and Types of Assistance](#) QRG for additional information.

When ONE determines financial eligibility, it does so on a three-month window. It is important to look at the TOAs for all three months when creating the benefit lines to ensure they match.

These types of changes are common and cause the most provider payment issues.

- Financial eligibility updated and the TOA changed. This can occur retroactively. For example, eligibility is run in February 2024, which caused the TOA to change back to December 2023. The benefit line in OA may need to be updated.
- Financial eligibility updated and the effective date changed, however, the TOA remains the same. This can also occur retroactively. The benefit line in OA may need to be updated, but more likely the payment system (POC, 512) needs updated.
- The benefit line in OA is ended, changed, or invalidated. The information is sent to the Mainframe and ONE, and eligibility re-runs, which caused a TOA change, effective date change or closure.

The benefit line in OA should only be updated in specific circumstances:

- Change in type of service setting (in-home to CBC or to NF)
- Dates have ended and a new plan is needed (new assessment or extension)

When making an update to the benefit line in OA because of a change in ONE, it is important to follow up with the other payment systems to ensure that they are updated as well. This includes touching the 512 or updating the POC.

HCW changes or moving from the same facility type to another does not require a new benefit line. This can be done with an update to the service plan, which does not send an update to the Mainframe or ONE.

**Field/stakeholder review:**  Yes  No

**If yes, reviewed by:** OPS Review

**Filing instructions:**

*If you have any questions about this policy, contact:*

|  |      |
|--|------|
| Contact(s): APD Medicaid Policy              |      |
| Phone:                                       | Fax: |
| Email: APD.MedicaidPolicy@odhsoha.oregon.gov |      |