



On Target

September '10 Contributors

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Click here to link to the Family Services Manual



Medical Notices Can Be Confusing!

Medicaid Quality Control conducts case reviews on actions to deny or close medical benefits and one area that is often overlooked in many eligibility decisions is which notice(s) must be sent.

Here are examples of the most frequent notices sent when notifying a client their medical is ending, closing or being reduced along with some examples.

1) **A Basic Decision Notice** is a notice that is mailed no later than the planned date of action on the case.

Example: The agency receives a phone call stating Carla is incarcerated. The agency verifies with the local jail that Carla was admitted on 7/25/10, with no projected release date. The agency ends her medical on 7/31/10 with a Basic Decision notice.

Here are some situations where a worker would send a Basic Decision notice for medical programs:

- When an application for medical is denied or approved (this notice can also be sent by the computer). [461-175-0200](tel:461-175-0200)
- When a client, another adult filing group member or their authorized representative makes a *signed* written request to withdraw their application or end their benefits (457D). [461-175-0340](tel:461-175-0340)
- The client is placed in official custody or a correctional facility. *Note: end medical benefits the end of the calendar month.* [461-175-0230](tel:461-175-0230)
- A client's mail has been returned and their whereabouts are unknown. Send a basic decision notice to close the medical the last day of the month, to their last known address. [461-175-0210](tel:461-175-0210)
- A client has moved out of state and becomes eligible for benefits in another state. [461-175-0210](tel:461-175-0210)

2) **Timely Continuing Benefit Decision Notice** is a notice that must be mailed no later than 10 calendar days before the effective date of the action. *This is the "10-day notice"*

Example: Stan and his son Tony were receiving MAA. Stan reported UC income that placed the family over the MAA income standard. On 7/25/10, the agency redetermines eligibility finding Tony eligible for OPC and Stan eligible for OPU. Since there are not 10 days left in July, the agency must send a timely continuing benefit decision notice in August to reduce Stan's benefits to OPU for the first of the month following notice.

An easy reference for the 10-day guidelines is located in: [Medical Program Worker Guide section 18](#).

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Foster Care and SNAP (SNAP C.4 and CA B.30)

SNAP Policy routinely gets questions about people living in foster care and how to treat them; usually – who has to apply together and what do we count?

There are a couple of basic rules to apply in these situations:

- No one in foster care can apply for SNAP on their own. The foster care provider gets to choose whether to apply for people in their care. This is one of those rare situations that lets us break the purchase and prepare rule.
- It doesn't matter if it's relative or nonrelative, a child or adult. Foster care is foster care.

People in foster care cannot apply on their own because meals are provided as part of their assistance, so they don't have a food need. In most cases, it works best for the household to exclude the person in care. When the foster care charge is left out of the filing group, that means none of their income or the money paid for their care is included in the financial group.

If the care provider does choose to include the person in their care, that means including the person in the financial group. Their income (e.g., SSI, pension, etc.) is countable. Count the payment directly from the foster care program as unearned income for the provider. Do not count the room and board or service payment from the foster care client to their provider: that money is already counted in the SSI, pension, etc. and we don't count it twice.

Example 1: Susan is the foster care provider for Judy (imagine Judy as 6 years old or 60; a niece or unrelated). Susan decides not to apply for SNAP for Judy. Judy is out of the filing, financial, need and benefit groups. Judy's income (SSB survivor's benefits for the child, SSD for the adult) is excluded, as is the payment from the foster care program.

Example 2: Susan is the foster care provider for Judy and wants to apply for SNAP for Judy. Judy is in the filing, financial, need and benefit groups. Judy's income (SSB survivor's benefits for the child, SSD for the adult) counts in full. The payment from the foster care program (CW or SPD) counts as unearned income to Susan.



SNAP Policy Analysts

Self-Sufficiency Systems Changes

Some of you may already know that we re-formed what was known as the TRACS User Group. Our new name: Self-Sufficiency Program Field User Group. We did this because our scope had expanded to include other Mainframe and Web Based applications. We are sponsored by CAF Field Operations and our membership includes field and central office staff as well as partners. Not all districts have representatives, but users can contact any member if they have questions about how to submit a request or to find out what we do. This group represents the needs of SSP systems users across the state.

Back in January some of you may have noticed that a new icon was added to the SSP Staff Tools page. It is a suggestion box for system improvements. The box was placed there in hopes that a few of you would notice and send in your suggestions to improve TRACS, Mainframe, and Web based applications. We called this our "soft" opening. Some of you did notice and we had a few ideas come to the group for review. We have developed an objective process for evaluating suggestions and are now ready to handle additional suggestions. We know that staff and our partners have lots of good ideas to make practice better with system improvements. With this announcement, we are hoping that many of you will submit your suggestions.

So, how do you submit a suggestion? When you have a suggestion to help improve the efficiencies of TRACS, Mainframe and Web based applications, go to the staff tools page at http://www.dhs.state.or.us/caf/ss_stafftools.htm and click on the shiny yellow suggestion box in the middle of the page. Instructions will guide you through the process of submitting a suggestion. Additional information about the SSP Field User Group is also available. Currently, there is a list of members and a copy of our Charter. Future additions will include our meeting minutes. If you don't have a suggestion now – please take a couple of minutes to go to the website and check us out – you may get inspired!



Greg Chandler, Program Manager D11

HNA

For applicants or recipients who provide verification of tribal heritage, add the HNA coding on CMUP, regardless of the medical program.

- HNA clients may choose whether they wish to be exempted from managed care enrollment.
- The HNA coding affects provider billing. Some providers may not be paid the correct amount without the HNA coding on the case.
- HNA coding is very important for HKC subsidy clients (income from 201% FPL to 301%FPL) who are referred to the Office of Private Health Partnerships (OPHP). HNA children are not required to pay premiums when referred to OPHP as KCA.

It's also important to know that Tribal Clinics or Indian Health Services can now fax requests to add HNA coding and send HNA verification to the OHP Statewide Processing Center (branch 5503). Branch 5503 adds the HNA case descriptor to the CM case, narrates in TRACS and faxes notification to the worker. However, branch 5503 does not exempt the HNA client from managed care.

CHIP/HKC 2-Month Un-insurance Requirement

It's common knowledge that kids cannot have CHIP or HKC with current Third Party Liability (TPL) or Employer Sponsored Insurance (ESI). However, there are cases where the family has applied because their circumstances are changing, and they will need Healthy Kids medical.

Children can have other insurance with MAA, MAF, EXT, OSIPM, OPC or OP6. The other insurance is considered the first payee, and the state medical is the second payee.

However, before denying a child with income at or above CHIP levels because they have TPL or ESI, is there anything that tells you there was an anticipated change that motivated the family to apply, or that they may meet one of the reasons to waive the 2-month un-insurance period? If you don't see anything, proceed with the denial.

If you do see a change in circumstances that may make them eligible for CHIP or HKC, contact the applicant to learn more. We may be able to coordinate the closure of the other insurance with the start date of CHIP or an HKC referral can be made because the child will meet one of the reasons to waive the 2-month un-insurance period.

For example, the family may have reduced hours at work and can no longer afford the Employer Sponsored Insurance (ESI). In this example, the child may be eligible for CHIP because the change in employment is one of the reasons why we can waive the un-insurance period. The worker should contact the family and determine if the family is planning on ending the other insurance. If that is the case, the worker can coordinate the closure of the ESI with the start date of CHIP.

There will be times when eligibility staff will make a referral to OPHP for children who currently have TPL but who meet one of the reasons to waive the 2 month un-insurance period and the family is hoping to move the child to HKC. OPHP will coordinate the closure of the other insurance with the start date of HKC when the family is planning on ending the other insurance and meets one of the reasons we can waive the un-insurance period.

Child Support Sanctions

Per rule, when a parent of a Medicaid recipient refuses to cooperate with child support to establish paternity, the parent who refuses to cooperate is sanctioned *at the request of the Division of Child Support*. Once a child support worker contacts a medical eligibility worker to request a sanction, review to ensure the client can be sanctioned.

- To sanction, the child in question must be in the household.
- A pregnant woman cannot be sanctioned until after her protected eligibility period ends.
- Consider if the client has good cause not to cooperate with DCS requirements.
- Parents of CHIP and HKC clients are not required to cooperate with DCS. We cannot sanction parents for failure to cooperate with DCS requirements when the child receives CHIP or HKC.
- A timely closure notice such as the CMRMDCS NoticeWriter notice must be sent to the adult whose medical benefits will be sanctioned.
- The sanction ends when the Division of Child Support informs the eligibility worker the adult has now cooperated.



OHP Standard Reservation List

Just a reminder; individuals who are randomly selected from the OHP Standard Reservation List and then are denied because they don't meet eligibility can request to be put back on the reservation list again. There is no limitation to the number of times an individual can request to be put back on the reservation list after their reservation number has been deactivated.



August 2010

Targeted SNAP Reviews

100% Accuracy Honor Roll

0310 Canby SPD	1717 Grants Pass DSO	3003 Hermiston SSP
0313 Milwaukie SPD	1911 Woodburn ADS	3102 Enterprise SSP
1201 John Day SSP	2011 Eugene LCOG ADS	3111 LaGrande SPD
1211 John Day SPD	2019 Cottage Grove AAA	3112 Enterprise SPD
1311 Burns SPD	2711 Dallas ADS	3417 Beaverton SPD
1404 Refugee Branch	2911 Tillamook ADS	3617 McMinnville ADS

90% or Better

96.67 Lebanon SSP	2202	93.33 Warrenton ADS	0411	92.00 Medford SSO	1513
96.30 The Dalles SSP	3301	93.33 St. Helens SSP	0501	92.00 Medford DSO	1517
96.00 Redmond SPD	0914	93.33 St. Helens SPD	0511	92.00 Hillsboro SPD	3411
96.00 Roseburg SSP	1011	93.33 Gateway Center	1102	91.67 Klamath Falls SPD	1811
96.00 Toledo ADS	2111	93.33 D8 Processing Center	1503	91.67 Portland West ADS	2518
96.00 North Salem ADS	2411	93.33 Albany SSP	2201	91.30 Springfield SSP	1101
96.00 South Salem ADS	2412	93.33 Ontario SPD	2311	90.70 McKenzie Center	2001
95.83 LaGrande SSP	3101	93.33 Pendleton SPD	3011	90.00 LaPine SSP	0903
95.83 E Multnomah ADS	3518	93.33 Hermiston SPD	3013	90.00 Prineville SSP	1601
95.00 St John's SSP	2601	93.33 Florence ADS	3211	90.00 Warm Springs SSP	1603
95.00 Florence SSP	3201	93.33 The Dalles SPD	3311	90.00 Cave Junction SSP	1702
94.12 Bend SPD	0911	93.33 Tigard SPD	3415	90.00 Woodburn SSP	1901
93.55 Hillsboro SSP	3402	93.18 D4 Processing Center	2203	90.00 Albany ADS	2211
93.33 Baker City SPD	0111	93.02 Oregon City SSP	0302	90.00 Dallas SSP	2701
93.33 Estacada SPD	0314	92.86 Corvallis SSP	0201	90.00 Pendleton SSP	3001
93.33 Astoria SSP	0401	92.86 West Eugene SSP	2002	90.00 Milton-Freewater SSP	3004
		92.00 Portland SE ADS	1418		

TRACS Tip

I continue to see Service Desk tickets related to the CM case number on plans in TRACS. Generally, the problem is discovered when workers try to issue a JOBS payment or JCCB.

TRACS and JAS do not update case numbers when a client moves from one case to another and have an open plan in TRACS. When a client moves from one TANF case to another (like teen parents who move from parents' case to own case) workers need to end the old plan and open a new plan: *JAS/TRACS do not update CM number, so JASR and the JCCB will not reflect the correct case information without this update.*

- Workers need to end the old plan and begin a new one in order to pick up the new case number.
- For JOBS child care needs that are within the date range of the older plan, contact the Direct Pay Unit at 1-800-699-9074 for the months needed.

For example: When Bob and his family come in to apply for TANF, you see an old open plan for Bob and begin adding new JOBS activities. STOP!

- Old plans need to be closed at earliest possible date and a new plan started when client is a new applicant.
- If there is a new case number or branch, or if the children in the household have changed, you will not be able to issue a correct JCCB.

If you need assistance, please contact the DHS Service Desk at 503-945-5623.

Leslie Potter, Business Analyst





August 2010 Targeted Medical Reviews 100% Accuracy Honor Roll

0401 Astoria SSP	1404 Refugee Branch	2203 D4 Processing Center
0702 Integrated Srvs SSP	1502 Ashland SSP	2404 Santiam Center
0903 LaPine SSP	1505 Rogue Family Center	2601 St. John's SSP
1102 Gateway Center	1702 Cave Junction SSP	2803 NE Processing Center
1103 Willamette SSP	1802 Lakeview SSP	3004 Milton-Freewater SSP
1201 John Day SSP	2002 West Eugene SSP	3101 LaGrande SSP
1202 Condon SSP	2003 Cottage Grove SSP	3102 Enterprise SSP
1301 Burns SSP	2201 Albandy SSP	3201 Florence SSP
	2202 Lebanon SSP	3401 Beaverton SSP

90% or Better

96.55 Springfield SSP	1101	93.33 Maywood	3501	90.00 New Market Theater	1402
94.87 Metro Processing Ctr	1403	93.10 SE Portland SSP	1401	90.00 Teen Parent SSP	1406
94.74 McKenzie Center	2001	91.67 NE Processing Ctr	2803	90.00 D8 Processing Center	1503
94.12 Oregon City SSP	0302	91.43 North Salem SSP	2402	90.00 Prineville SSP	1601
94.12 N Clackamas SSP	0303	90.00 Baker City SSP	0101	90.00 Grants Pass SSP	1701
93.33 St. Helens SSP	0501	90.00 Corvallis SSP	0201	90.00 Woodburn SSP	1901
93.33 Ontario SSP	2301	90.00 Coos Bay SSP	0601	90.00 Pendleton SSP	3001
93.33 Keizer SSP	2405	90.00 Alberta SSP	0701	90.00 Gresham SSP	3502
93.33 Dallas SSP	2701	90.00 S Umpqua Center	1002	90.00 McMinnville SSP	3601

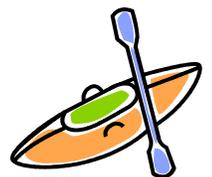
Medical Notices Can Be Confusing, continued from page 1

Here are some situations where the agency would send a Timely Continuing Benefit Decision notice for medical programs:

- Benefits are reduced or closed. [461-175-0200](tel:461-175-0200)
- Benefits are reduced or closed but, the child is referred to the Office of Private Health Partnerships (OPHP) for the Healthy KidsConnect full buy-in program (those clients in the 301% and above and/or KC3 category). [461-175-0200](tel:461-175-0200)
- The client reports they have moved out of state and they are not eligible for benefits in the other state. [461-175-0340](tel:461-175-0340)
- A client is receiving a Health Insurance Payment (HIP) reimbursement and the cost of the Employer Sponsored Insurance goes up making the client ineligible for the HIP reimbursement. [461-175-0200](tel:461-175-0200)
- The client reports a change that reduces or closes their medical eligibility. [461-175-0200](tel:461-175-0200)

One last reminder, there are differences in how a client requests a “voluntary withdrawal” of medical benefits that effects eligibility and can be tricky.

- If a client makes an *oral* request to end or reduce benefits, a *timely continuing benefit decision notice* is sent. [461-175-0340](tel:461-175-0340)
- If the client makes a *signed, written* request to withdraw, end, or reduce benefits, a *basic decision notice* is sent. [461-175-0340](tel:461-175-0340)



Sending the appropriate notice provides clients with information about how denials or closures affect their cases, provides hearing rights and is good customer service.