

# On Target October 2012

*A Special Edition that includes a compilation of informative accuracy articles from 2012!*



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### In this issue:

- How to determine a potential UC claim... 1
- Aligning Medical and SNAP Program End-Dates Q&A 2
- SNAP Income Verification at Application and Recertification 3
- Coding Categorical Eligibility... Do we really have to? 3
- When and How to Count Third-Party Payments for SNAP 3
- Presumptive Referral Process 4
- Quality Assurance Panel 4
- Having Reservations about the OHP Reservation List? 5
- How to Count UC Payment Dates 6

### How to determine a potential UC claim...

To be eligible for medical assistance, people must actively pursue assets for which they have a legal right to claim. Many times this means you must evaluate whether or not an individual has a potential claim. When determining if a client has a UC asset to pursue, there are two places to look.

The first is EPC2 (F22 from the WAGE screen):

| Date: 04/06/12 EPC2 - POTENTIAL CLAIM DETERMINATION Time: 09:31 am     |                 |            |                 |            |          |            |           |            |                 |            |
|--|-----------------|------------|-----------------|------------|----------|------------|-----------|------------|-----------------|------------|
| This Does Not Establish a Claim for Unemployment Insurance Page 1 of 1 |                 |            |                 |            |          |            |           |            |                 |            |
| Latest Claim 16/07 for FO 200 VALID                                    |                 |            |                 |            |          |            |           |            |                 |            |
| SSN  | Inc             | Wages?     | N               |            |          |            |           |            |                 |            |
| Last Name  | Other Name      | BYE 13 13  |                 |            |          |            |           |            |                 |            |
| Date of Claim  | Base Yr         | Ext        | limiting        | qtr        |          |            |           |            |                 |            |
| Acct Name/Acct#  | Wages Hrs       | Wages Hrs  | Wages Hrs       | Wages Hrs  |          |            |           |            |                 |            |
| 0893916  | 336.00          | 028        | 504.00          | 042        |          |            |           |            |                 |            |
| 1117736  | 4,471.82        | 514        | 5,781.15        | 665        | 3        | 212        | 48        | 370        | 4,360.89        | 502        |
| <b>Total</b>   | <b>4,807.82</b> | <b>542</b> | <b>6,285.15</b> | <b>707</b> | <b>3</b> | <b>212</b> | <b>48</b> | <b>370</b> | <b>4,360.89</b> | <b>502</b> |
| Base Qtrs  | (1/11)          |            | (2/11)          |            | (3/11)   |            |           |            |                 |            |
| Total Wages  | 18,666.34       |            | Total Hrs       | 999        |          |            |           |            |                 |            |
| 1.5xHWQtr  | 9,427.72        |            | WBA             | 233        | MBA      | 6058       |           |            |                 |            |

The EPC2 screen may show a non-valid claim:

| This Does Not Establish a Claim for Unemployment Insurance Page 1 of 1 |            |           |             |           |        |     |                 |     |     |     |
|--|------------|-----------|-------------|-----------|--------|-----|-----------------|-----|-----|-----|
| Latest Claim 12/11 For FO 200 VALID                                    |            |           |             |           |        |     |                 |     |     |     |
| SSN  | Inc        | Wages?    | N           |           |        |     |                 |     |     |     |
| Last Name  | Other Name | BYE 13 13 |             |           |        |     |                 |     |     |     |
| Date of Claim  | Base Yr    | Ext       | limiting    | qtr       |        |     |                 |     |     |     |
| Acct Name/Acct#  | Wages Hrs  | Wages Hrs | Wages Hrs   | Wages Hrs |        |     |                 |     |     |     |
| Total  | .00        | 000       | .00         | 000       | .00    | 000 | .00             | 000 | .00 | 000 |
| Base Qtrs  | (1/11)     |           | (2/11)      |           | (3/11) |     |                 |     |     |     |
| Total Wages  | .00        |           | Total Hours | 0         |        |     |                 |     |     |     |
| 1.5xHWQtr  |            |           | WBA         | 0         | MBA    | 0   | Non-Valid Claim |     |     |     |

If the EPC2 screen shows a non-valid claim then the next step is to look at the ECLM claim list (F5 from ECLM). Do any of the active claims have a future BYE date? If yes, this is a claim from which the client may be able to start claiming benefits. Whether or not they are eligible for benefits from this claim will be determined based upon their job separation.

| BYE   | Base Qtr | FO | ABY | Status      |
|-------|----------|----|-----|-------------|
| 12/11 |          |    |     | VALID CLAIM |
| 23/03 |          |    |     | PURGED      |

Don't forget to determine whether the client has good cause not to pursue a claim. Either way, narrate your decision! For more information on pursuit of assets and determining good cause see FSM Chapter 8, Medical Assistance Programs, D,7, Pursuing Assets

## Aligning Medical and SNAP Program End-Dates Q&A

In the MAA, MAF, OPC, OP6, OPU and CHIP programs, redeterminations may be done early if it is at the time of a SNAP recertification. This allows the medical program 12-month end date to match the client's SNAP 12-month certification end date.

**Question:** *My client's SNAP certification ended on 12/30/11, and they reapplied on 01/03/12. They have ongoing medical benefits. Can I redetermine medical eligibility and align the program end-dates?*

**Answer:** No. In this example the budget month for both programs would be January. The SNAP certification period would be 01/01/12 - 12/31/12 and the new medical eligibility period would be 2/1/12-1/31/13. The resulting program end-dates are not aligned. This is not a scenario when the medical could be redetermined.

Redetermining medical to align with SNAP is only an option at SNAP *recertification*. Since the client's SNAP filing date is after their SNAP certification ended it's no longer considered a recertification.

**Question:** *My client is reapplying for SNAP in the last month of their certification period, and I want to process an early redetermination for medical to align the end-dates. But, their income has gone up enough to increase the premium amount. Should I still do it?*

**Answer:** Yes, even if it increases the client's premium amount, an early redetermination for the sake of end-date alignment is an option. Timely notice of this change is not required.

**Follow-up question:** *I spoke with my client before I processed the redetermination, and they expressed that they're afraid they could not afford an increased premium yet, and it may cause economic hardship. Since I already started the process, do I have to process the redetermination?*

**Answer:** The decision to redetermine the medical program case is up to the worker. The worker may choose not to redetermine the medical companion case when establishing a 12-month SNAP certification. If you've already narrated that you were redetermining the medical benefits, make sure to narrate clearly why it was not completed.

**Question:** *I want to process an early redetermination of medical benefits, but my client has past-due premiums. What should I do?*

**Answer:** When a case is being redetermined to align medical and SNAP eligibility periods and there are past due premiums, take the following steps:

- Pend for payment of past due premiums
- If premiums are not paid by pend due date allow the current medical eligibility period for everyone on the case to remain as is.
- If premiums are paid by pend due date update everyone on the case with a new 12 month eligibility period.

**Note:** *If a client is pended for any information necessary to process a medical redetermination, and does not respond, do not close OPC, OP6, CHP, or OPU medical benefits.*

**Question:** *I am processing an early medical redetermination to align the end-date with SNAP. The household's current income would put the OHP-OPU adults over the income limit. Should I still redetermine benefits?*

**Answer:** No. If the new redetermination decision results in ineligibility, allow the ongoing OPC, OP6, CHIP and OPU certifications to remain as-is.

**Note:** *If the new redetermination decision results in ineligibility for MAA/MAF program recipients, workers will need to act on the new information and convert to the appropriate program or close.*

**Question:** *I am processing an early medical redetermination to align the end-date with SNAP. Based on budget month income, the children would move from the OHP-OPC program to OHP-CHP. Would this be a reduction in benefits?*

**Answer:** No, this is not a reduction in benefits as OPC and CHP are both Plus level benefits. If clients are eligible for the same or a higher level of benefits, new MAA, OPC, OP6, and CHIP 12-month eligibility periods may be established.

**Question:** *My client is reapplying for SNAP in February, 2012. His medical benefits were just redetermined two months ago, and his current program end date is December, 2012. Is it too soon for me to redetermine medical benefits again?*

**Answer:** It's not too soon! You can redetermine medical benefits to align with SNAP when you are recertifying a SNAP case. There is no minimum or maximum requirement regarding the amount of time the client has been in their current eligibility period.

**Question:** *My client reapplied for medical benefits in the last month of her eligibility period. Her SNAP benefits do not expire for another 7 months. Can I just redetermine her medical benefits for a 7 month eligibility period to align with the SNAP end-date?*

**Answer:** No. The decision to align the certification periods is based on the date of the SNAP recertification. When a client is recertifying their SNAP benefits the medical can be redetermined at the same time. The result is a new 12-month period for medical which aligns with the recertified SNAP case. Medical benefits cannot be given less than a 12-month eligibility period when a redetermination is processed.

## SNAP Income Verification at Application and Recertification

Page 3

At initial application and recertification, SNAP clients must verify all income. However, a recurring question is “how much verification and for what time period?” SNAP typically requires a month’s worth of income verification unless the income is changing or an employer or source (for unearned income) verifies the income in another way. To accurately anticipate income, the month’s worth of verification must be recent and reflective. In the past, the rule of thumb has been 30-days prior to the filing date, but it is not a hard and fast rule – you do need a month’s worth of recent, reflective verification to make a determination. Use sound reasoning to see if the verification you receive is enough to accurately anticipate on-going income. For example, client is paid weekly. The client provides two weeks of pay verification prior to the filing date and two weeks of pay verification from after the filing date. This is acceptable and if reflective, should be used to calculate income.

*SNAP Policy Analysts (9/12 edition)*

## Coding Categorical Eligibility... Do we really have to?

Yes, yes we do! Categorical eligibility makes the difference between a denial notice for being over income (or over resources) and getting SNAP benefits for a large percentage of our caseload. Out of 424,834 SNAP cases, only about 4% are **not** categorically eligible. For the other 96% of our cases, being cat el means we can use a higher income standard (185%) and we don’t have to look at resources. Coding categorical eligibility on FSMIS is a critical piece of our work.

The **Cat EI** field on page 1 of FCAS indicates categorical eligibility. FSMIS automatically displays a “Y” in the field when the SNAP case is coded as follows:

- PA in the Categ field;
- \_2, \_4 or D4 in the Prg field;
- GNT or SSI income type; and
- CMS case number and letter for each person on the case.

For all other cases, there is not enough information for FMSIS to determine categorical eligibility so N will display in the **Cat EI** field. Change the N to C to indicate that the eligibility worker has determined it.

Why is this important? Without that little C, cases that are over 130% FPL (the SNAP countable income limit) will be determined ineligible by the computer. This would wrongfully deny benefits, cause an underpayment and be both a targeted and a QC error when reviewed.

And yes, even if the case is under the countable and adjusted income limits, we still must code the computer to show that the case is categorically eligible. See how a simple little C can save you and your clients time and grief?

**PLEASE REMEMBER** you need to check the first page of FSUP to ensure the C is coded before you save the updates. The **Cat EI** field sometimes defaults back to N if you leave page 1 before saving the update (RU or F9). No info systems fix is on the horizon, so it’s up to we the people to get it right. Once the C is coded and saved on the case, it will remain there until you remove it.

*SNAP Policy Analysts (6/12 edition)*

## When and How to Count Third-Party Payments for SNAP

Unearned in-kind income is counted if the money is court-ordered support that should go directly to the client. This is true whether the obligee or the obligor is the one choosing to divert the payment. Count as SUP on the case and allow the appropriate deductions.

Unearned in-kind income is excluded if:

- The payments are voluntary; or
- The payments are supposed to be paid to a third-party.

*Example 1* – A family member or absent parent chooses to pay the client’s rent directly to the landlord. This is done as a favor or a voluntary agreement; no court order. Exclude the payment and do not allow the Shel deduction.

*Example 2* – The absent parent has a court-order to pay the mortgage to the bank directly. This is excluded and the client is not given a Shel deduction.

Earned in-kind income is always excluded. The most common example is an on-site manager whose rent is part of his compensation for work. Do not count the value of the rent as EML and do not allow the Shel deduction. SNAP policy does *not* consider whether the value of rent is included in taxable income.

*SNAP Policy Analysts (9/12 edition)*

## Presumptive Referral Process

Self-Sufficiency eligibility workers must complete the presumptive referral process (PMDDT) when a client reports a disability that prevents them from working and will last at least 12 months or is terminal or they are requesting benefits under Employed Persons with Disabilities. Prior to making a PMDDT referral, the worker must evaluate for all other medical programs. At redetermination, the client must be kept open at the same benefit level until a presumptive determination is approved or denied.

Referrals should only be completed when a client is not otherwise eligible for **Plus** benefits (REFM, SAC, MAA, MAF, EXT, OPC, OP6 or CHIP).

The PMDDT referral process includes screening the client to determine whether or not they meet all OSIPM financial and nonfinancial criteria (if the client requests Waivered Services or if the client is applying for the Employed Persons with Disabilities (EPD) Program, skip this step). To assist in determining whether or not a referral should be made, staff can refer to the PMDDT Referral Flow Chart: <http://www.dhs.state.or.us/spd/tools/program/osip/flowchart.pdf>.

If appropriate, a referral is made to the Disability Services office according to local process. The *Referral for Seniors and People with Disabilities (SPD) Medical Eligibility Decision* (DHS 0709) form can be used.

- If a referral is made for a client who has an open medical case, the worker will code the case with a “PMP” case descriptor to identify that this medical case has a PMDDT referral. If necessary, add a BED need/resource date to the case to keep the clients benefits at the current level while the PMDDT referral is being processed.
- If approved for presumptive medical, PMDDT will inform the local Aged and People with Disabilities (APD) office who will, in turn, inform the SSP worker.
- If there is an open CM case, the worker will transfer the case online to the requesting APD branch.
- If denied, PMDDT will inform the local APD office who will, in turn, inform the SSP worker. The SSP worker will replace the “PMP” case descriptor with a “PMD” case descriptor.

For clients who do not have any open medical benefits, send the *462C Notice of Self-Sufficiency Medical Program Eligibility Decision* to the client after making the referral.

**Example 1:** Mary and her only child Tim are receiving MAA benefits. Mary reports her child Tim has moved in with his father. Mary reports she has a disability which prevents her from working. The eligibility worker determines Mary is eligible for a PMDDT referral and follows the local process to send the referral to the local APD office. The eligibility worker also codes the MAA case with a BED need/resource date of 03/12 (three months from the current date) and adds a PMP case/descriptor.

**Example 2:** Chavez is receiving OHP-OPU benefits which are ending 01/12. Chavez calls his worker to request that his medical benefits continue. The eligibility worker determines Chavez is no longer eligible for OHP-OPU but Chavez has indicated he has a disability and the worker determines he is eligible for a PMDDT referral. The eligibility worker follows the local process to send the referral to the local APD office, updates the BED need/resource date to 03/12 and add a PMP case/descriptor.

*SSP Medical Policy Analysts (1/12 edition)*

## Quality Assurance Panel

On the last Monday of each month, the Quality Control (QC) unit conducts a statewide video conference (QA Panel meeting) to review the errors they have identified. The concept of the meeting is for staff in branch offices, QC, SSPAT, policy staff, training staff, and all connected parties, to meet and talk about what caused the error and how to prevent it in the future.

Although to a worker, this may feel intimidating; those who have attended have provided feedback quite to the contrary. Workers and others attending walk away with a better understanding of what may have caused the errors, how to prevent them in the future, and the efforts QC makes to avoid citing errors to begin with. And- no one *ever* gets yelled at or singled out in any way. In fact, we need your help and perspective- increasing accuracy is a statewide effort!

QC staff strives to make the meeting as informal as possible, and policy staff is available as a resource and to provide clarification as needed. It is our goal for the meeting and discussions to be meaningful for those attending.

Even if you don't have an error, we encourage you to attend the QA panels. It's a great way to find out what is happening around the state, clear up misinformation, learn about why we have reviews and connect with your fellow workers around the state.

If you would like to attend, first talk to your manager, then contact one of the Quality Control managers, Susan Beckett or Lisa Barger-Fox, to access copies of the cases to be discussed and locations for the video conference. Local staff is invited to attend at our new location, at 3541 Fairview Industrial Drive in Salem. Hope to see you at a QA panel meeting soon!

## Having Reservations about the OHP Reservation List?

Well, here are some pointers to help you determine if a person has been selected from the Standard Reservation List (SRL), what constitutes a date of request (DOR) and what date to start eligibility.

How do I know if a person has been selected from the SRL? When you visit the SRL website and click on the “Reservationwide info” tab, you will enter the client’s reservation showing their reservation number. This field tells you the Random Selection Date, the 7210R Mailed Date, the Deadline Date and if the reservation has been Deactivated and why.

The Deactivation reason tells you a couple of things and does not always mean the client has been selected. You have to look at the *reason* for the deactivation. If a Reservation has been deactivated because the client has a current active Medicaid case you will see “Active Med Case”; this is good! The agency has already determined eligibility.

If you see “Application Mailed”, it means just that, an application has been mailed and we are just waiting for the client to contact the agency to establish a date of request (DOR) within 45 days of the Mailed Date (by contacting the Department orally, in writing or by submitting an application).

If you see any of the following reasons for deactivation; “Withdrawn”, “Closing List”, “Moved/Return Mail”, “Duplicate” and “Other”, the client HAS NOT been selected and cannot establish OPU eligibility through the reservation list. They must have a Selection Date *and* establish a DOR.

So, what date does the agency use to start OPU if the client meets all eligibility requirements? For the majority of cases, the start date for OPU will be the date the client contacts the agency within 45 days of the date the 7210R was mailed.

However, if the client has established a DOR within 45 days of their SRL selection date, (*even if the application was denied- see example below*) the *Selection Date* is the date to begin medical if you find them eligible. Remember to check the SRL *before* you deny an applicant to see if they have been selected.

Here are a few examples:

- John is currently in pending status through PMDDT. He is then selected from the SRL on 12/15/10. His OPU eligibility can begin on 12/15/10 as he was pending a PMDDT determination when he was selected.
- Mary establishes a DOR of 9/25/10 and her application is pending for income and resource verification. She was selected from the SRL on 10/20/10. On 11/2/10, Mary submits her income and resource verification. The earliest Mary’s OPU can begin is 10/20/10- the date she was selected.
- Billy was randomly selected on 12/15/10 and established a DOR of 1/10/11 by calling and inquiring about his medical. Since the 1/10/11 DOR is after the random selection date, but earlier than 45 days after the 7210R mail date, the earliest Billy’s OHP medical can begin is 1/10/11
- Jim submits an application for medical with a DOR of 1/1/12. On 1/13/12, his application is denied for “program closed to new eligibles”. On 1/30/12, Jim is selected from the SRL and mailed an application that he returns on 2/6/12. The agency reviews the case narratives and the worker notes Jim’s DOR of 1/1/12 was recently denied. The agency can review Jim’s eligibility based on the 1/1/12 DOR, and if eligible, open medical on the selection date (as it was within 45 days of the 1/1/12 DOR).

Being selected from the SRL “opens the door” to OPU eligibility; however, the client must meet other eligibility factors including; a \$2000.00 OPU resource limit, current premiums, pursuit of assets and must not have had private or employer sponsored major medical in the previous six months (unless it can be waived, per [461-135-1100](#)).

Links:

[http://www.dhs.state.or.us/caf/caf\\_ss\\_medical/srl-field-user-guide.pdf](http://www.dhs.state.or.us/caf/caf_ss_medical/srl-field-user-guide.pdf)

[http://www.dhs.state.or.us/caf/caf\\_ss\\_medical/srl-training-material.pdf](http://www.dhs.state.or.us/caf/caf_ss_medical/srl-training-material.pdf)

OAR(s): [461-135-1125](#) and [461-135-1102](#)

## How to Count UC Payment Dates

*Wouldn't it be wonderful if information stayed the same, at least for a while?*

*Well, in April we published an article on counting UC payment dates when there is a potential 5<sup>th</sup> payment in a month. Literally within days of that article, a minor but important change was made to our UC help screens. The change is that ReliaCard Deposit payments are posted two working days after the last activity date. The updated text of that article is shown below.*

Confused about how to count UC payments when there is a potential 5<sup>th</sup> payment in a month? Turns out, you're not alone. This issue came up several times this month based on reviews of January eligibility decisions.

The best way to know for sure what day of the week the client physically receives their UC payments is, of course, to ask the client. (Also, don't forget to check what the client wrote on the application.) The Medical Policy unit strongly encourages direct contact with the client because the actual day the client has access to the funds may vary particularly if they get paid by check.

So here are some basics about UC. Clients can be paid three ways: by "Reliacard," by direct deposit or by check. The Reliacard is a U.S. Bank Visa card used by OED to issue UC payments.

ECLM, EPAY (F13 from ECLM) and the individual payment screens all show the method of payment for UC:

RD = ReliaCard

ED = Electronic Deposit

P (with no other descriptor) = Check

Pretty easy so far? Lets talk about dates. Four dates come up in regard to UC: Processed date, Entered Date, Last Activity Date and Reconciliation Date.

**Processed Date:** This is a term best dropped from any UC discussion because it isn't a date on any UC screen and it could mean different things to different people.

**Entered Date:** Clients are normally required to check in with OED by phone or computer each week. They normally do this on Sunday or Monday so they can get their check as soon as possible. The "entered date" is generated on the Monday night run unless Monday is a holiday or the client did not check in timely.

**Last Activity Date:** This is the last day of the week the check was processed to pay. This is normally the same as the "Entered Date." THIS is the date you count from to estimate when the client receives access to their funds. You must go into the individual payment screen to see the last activity date.

**Reconciliation Date:** For RD and ED, the reconciliation date may be the same as the entered date and the last activity date; but, for checks it will be considerably later. The check is reconciled by OED once it has cleared the bank and been returned to OED. You must go into the individual payment screen to see the reconciliation date.

So when does the client get their money?

RD – Payments are posted to the claimants' account **two** working days after the Last Activity date.

ED - Funds are normally in the client's bank account **two** days after the Last Activity date.

P (check payment) – Checks are mailed the day after the Last Activity date (Normally allow 3 days for mailing).

In summary, most UC clients are paid through the ReliaCard or Direct Deposit but some are paid by check. The "Last Activity" date is the date you want to work from in estimating whether a fifth payment was received in the budget month.

Quality Assurance (6/12 edition)

```

Date: 04/30/12                PAYMENT DISPLAY                Time: 04:23 pm
-----
P&M          * Last Activity *
              04/20/12
              Last Activity Date
The last day the week processed to pay.
Date format is: MM/DD/YY.
When the week is paid:
1. Benefit checks are mailed the next work day.
2. Electronic Deposit payments are
   posted to claimants' accounts two
   working days later.
3. ReliaCard Deposit payments are
   posted to claimants' accounts two
   working days later.
F3)Exit
-----
5) Clm Sum          13) Pay List          NM/LF          IVR Hist
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```