

**APD/SSP/CW
Regional Meetings
2013**

Presentations/Updates
Packet 1

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2014: Opening the Oregon Health Plan to more people

Providing health care coverage for low-income Oregonians

What is happening

In January 2014, the Oregon Health Plan (OHP) will be available to more low-income adults. Many of these adults are uninsured and work part-time or in low-wage jobs without access to health insurance.

What it means

More low-income Oregonians will have access to health care coverage, providing them better access to care and more financial stability. Medical debt to providers will be reduced.

1. No more waiting list for the Oregon Health Plan.
2. Income limits are changing. Today the income limit to qualify for the Oregon Health Plan is very low. A person's income must be at or below 100 percent of the Federal Poverty Level (FPL) to qualify. Starting in January, coverage will be available to people who earn up to 138 percent of FPL. That's about \$15,800 a year for a single person or \$32,500 a year for a family of four.

Why this is happening

In 2013, Governor Kitzhaber and the state Legislature approved opening OHP to more low-income Oregonians as allowed under federal health reform. This means that working families will have the high-quality health coverage they need, when they need it, through OHP.

How to apply for OHP or commercial insurance

Cover Oregon is an online marketplace where Oregonians can apply for health coverage. Beginning in October 2013, anyone regardless of income can apply online at www.coveroregon.com. Cover Oregon will include the Oregon Health Plan, Healthy Kids and private insurance plans that begin in January 2014.

Paper applications will be available in multiple languages, and community partners will be available to help people with the application if needed. Help is also available by calling 1-855-CoverOR (1-855-268-3767) or at all Oregon Health Authority and Department of Human Services offices.

Financial assistance paying for private coverage

Based on household size and income, some Oregonians may qualify for no-cost health coverage through the Oregon Health Plan. Others may qualify to get help paying for private health

insurance. A family of four that earns between \$32,499 and \$94,200 a year may qualify to get help paying for private health insurance through Cover Oregon. This includes help paying for insurance premiums and out-of-pocket costs like co-pays and deductibles. Financial help could come in monthly payments or a lump sum when an individual or family files their taxes.

Coordinated care – the Oregon difference

In Oregon we have taken a bi-partisan approach to improve the health care system. Most people on the Oregon Health Plan are served by a local “coordinated care organization.” These organizations bring together all aspects of care: doctors, hospitals, dental care, mental health care and public health.

Coordinated care organizations work for better health, better care and lower costs by focusing on prevention, chronic disease management, earlier interventions, and reduction of waste and inefficiency in the health system.

Improved care

Coordinated care organizations are required to meet quality standards or “metrics” that are posted publicly four times a year. The Oregon Health Authority uses these metrics to assess CCOs on how well they are doing in key areas such as access to care, prevention and health screenings, mental health care, and many other metrics.

Cost containment

Under an innovative agreement with the federal government, Oregon will reduce waste and inefficiency in health care and create a more sustainable system. This will allow us to hold down per capita costs while providing better care.

The number of people expected to qualify

Projections show about 180,000 low-income Oregonians who are currently uninsured could have health coverage through OHP by 2015. Ultimately, 240,000 additional people could be covered through OHP by 2016.

How it will be funded

For the first three years (2014 through 2016), federal funds will pay 100 percent of the costs for people who are eligible under the increased income limit. Federal funding will gradually decline, about two percent a year, to 90 percent in 2020 where it will remain.

Updated 7/8/2013

Oregon Health Plan by Individuals Newly Eligible for Medicaid due to the Affordable Care Act, by County

County	Newly Eligible Enrollees
Baker	1,000
Benton	4,000
Clackamas	16,000
Clatsop	3,000
Columbia	3,000
Coos	5,000
Crook	1,000
Curry	1,000
Deschutes	11,000
Douglas	8,000
Gilliam	60
Grant	300
Harney	400
Hood River	900
Jackson	16,000
Jefferson	2,000
Josephine	7,000
Klamath	5,000
Lake	400
Lane	27,000
Lincoln	3,000
Linn	9,000
Malheur	2,000
Marion	21,000
Morrow	600
Multnomah	53,000
Polk	4,000
Sherman	90
Tillamook	2,000
Umatilla	5,000
Union	1,000
Wallowa	200
Wasco	1,000
Washington	20,000
Wheeler	50
Yamhill	6,000
TOTAL	240,000

This is a projection of the total number of newly eligible adults who would enroll in the Oregon Health Plan by 2016 if Oregon opens OHP to more people as funded and allowed by the Affordable Care Act.

This estimate is based on the number of persons who qualify for Supplemental Nutrition Assistance (SNAP) and are at or below 138% of the Federal Poverty Level, but do not currently have medical coverage through the Oregon Health Plan (OHP). Current enrollees in OHP Standard are not included in these estimates.

Projected Enrollment in the Oregon Health Plan by Individuals Newly Eligible for Medicaid due to the Affordable Care Act, by County

Oregon's Health Insurance Coverage under the Affordable Care Act: Coverage Projections Before and After January 2014

Table 1: Projected Non-Elderly Oregonians Insured under ACA Expansion (Thousands)

Type of Insurance	Calendar Year			
	2013	2014	2015	2016
Non-group Exchange ¹	-	160	210	250
Medicaid newly eligible ³	-	120	180	240
ACA Exchange & Medicaid Coverage	-	280	390	490
Uninsured	550	360	260	170

Note: Both uninsured and previously insured Oregonians will gain coverage through Cover Oregon (the Exchange).

Table 2: Projected Number of Non-Elderly Oregonians Insured by Type (Thousands)

Type of Insurance	Calendar Year			
	2013	2014	2015	2016
Employer-sponsored	1,850	1,850	1,860	1,870
Non-group	220	270	300	330
Non-group Exchange ¹	-	160	210	250
Non-group non-Exchange	220	110	90	80
Medicaid²/CHIP	630	770	840	900
Medicaid ² /CHIP previously eligible	630	650	660	660
Medicaid newly eligible ³	-	120	180	240
Estimated Insured	2,700	2,890	3,000	3,090
Uninsured	550	360	260	170
Total	3,250	3,250	3,260	3,260

Table 3: Projected Percentage of Non-Elderly Oregonians Insured by Type (Thousands)

Type of Insurance	Calendar Year			
	2013	2014	2015	2016
Employer-sponsored	57%	57%	57%	57%
Non-group	7%	8%	9%	10%
Non-group Exchange ¹	-	5%	6%	8%
Non-group non-Exchange	7%	3%	3%	2%
Medicaid²/CHIP	19%	24%	26%	28%
Medicaid ² /CHIP previously eligible	19%	20%	20%	20%
Medicaid newly eligible ³	-	4%	6%	7%
Uninsured	17%	11%	8%	5%

The Oregon Health Authority collaborated with the State Health Access Data Assistance Center (SHADAC) to develop estimates of the potential impact of the Patient Protection and Affordable Care Act (ACA) legislation on the insurance status of Oregonians. The results above are initial estimates produced by SHADAC's Projection Model, using specific assumptions for Oregon, including the decision to participate in the ACA's expansion of Medicaid eligibility to low-income adults and the rate of non-group enrollment expected through Cover Oregon. The assumptions and data were developed jointly by OHA and SHADAC and reflect the best information available. Estimates may change in response to updates to the projection model, changes in assumptions, policy decisions or new information such as more recent demographic or economic data. Amounts and percentages may not add due to rounding.

¹ Oregon's exchange participation assumption derived from discussions with Cover Oregon. Assumptions include exchange participation rate of 90% of non-group subsidy eligible individuals in 2014 and increased growth in exchange participation for individuals who are not subsidy-eligible through years 2014-2016.

² Includes individuals assumed dual eligible (Medicare & Medicaid) as well as ~70,000 members of the Oregon Health Plan Standard.

³ Excludes Oregon Health Plan Standard. However, Oregon anticipates these members will be classified newly eligible for purposes of enhanced federal match.

Information for Oregon Providers

Overview

In January 2014, more Oregonians will qualify for the Oregon Health Plan as made possible by federal health reform. More people will qualify because the income limit will increase. Today, Oregonians must earn less than 100 percent of the Federal Poverty Level (FPL) to qualify. In January, people earning up to 138 percent of FPL could qualify. That's the same as a single person earning about \$15,800 a year or \$32,500 a year for a family of four.

New enrollment projections

Projections show about 180,000 Oregonians who are currently uninsured could have health coverage through the Oregon Health Plan by 2015, and a total of 240,000 additional people could be covered by 2016. More information about newly eligible adults is available on www.health.oregon.gov, including county-level enrollment projections.

New OHP members and coordinated care organizations

Just like today, new Oregon Health Plan members will enroll in their local coordinated care organization (CCO). If more than one CCO is available, members can choose their CCO.

Oregon Health Plan and Cover Oregon

Oregon's new health care marketplace, Cover Oregon, provides one place for people to shop for health coverage and find out whether they qualify for OHP or a commercial plan. By going to www.coveroregon.com and entering income and household information, individuals and families will know right away what coverage options are available. They will also be able to find out if they qualify for financial help to pay for coverage through Cover Oregon. Cover Oregon enrollment opens in October 2013 and the new health benefits take effect in January 2014.

Reaching out to Oregonians

Cover Oregon and the Oregon Health Authority are working together to help fund grant opportunities for potential community partners such as community-based organizations, local governments and provider clinics.

Community partners awarded funding will work locally to help individuals and families understand their health coverage options, including eligibility for public programs like the Oregon Health Plan and Healthy Kids, and assist with the application and enrollment process. Also, volunteer organizations, including provider clinics, can help anyone coming to their facility. To learn more about outreach and enrollment funding opportunities, as well as volunteer opportunities, please visit www.coveroregon.com.

Last update 07/08/2013

Affordable Care Act – FAQ

- MAGI (Modified Adjusted Gross Income) is an IRS-based form of budgeting which will be used for most OHP clients including parents, pregnant individuals and children. It will NOT be used for current programs such as OSIPM, ERDC, TANF and Medicare Savings Programs (QMB/SMF/SMF) or SNAP.
- New Eligibles – a term for a group of individuals who have not historically had Medicaid eligibility. They are 19-64 with no Medicare and no SSI. They may have SSDI or SSB as long as it is under the MAGI income limit.
- 138% FPL is the gross/countable income limit for MAGI-based Medicaid.
- Roughly 230,000 new Medicaid clients expected in the next 18 months, most of who will be served at Branch 5503 and currently only have SNAP benefits. There will be a process to facilitate their movement into Medicaid.
- Applications for MAGI-based Medicaid will begin to be processed on October 1, 2013. All OHP (OPU/OPC/OP6) programs as well MAA and MAF will use MAGI based eligibility starting 10/1. Eligibility for New Eligibles will start on January 1, 2014.
- Some Division 461 eligibility rules will be going to the 410 Division in October 2013. Primarily those are rules which contain information ONLY on OHP, MAA/MAF and CHIP.
- APD-type programs (OSIPM and QMB) will remain as-is for financial and service eligibility. The rules for these programs/services will stay in Division 461 and 411 respectively for now.
- Detailed workflows, procedures and processes are all being currently worked on and there are very few completed thus far.
- Cover Oregon (The Exchange) will sell health insurance, process tax credits and refer potential Medicaid eligible applicants to 5503.

Modernization

Oregon Benefits Online (Initial Win)



Oregon Benefits Online (Initial Win) In Scope:

Client Portal:

- Client portal and new online application
 - Allows clients to create their own personal accounts, view application information,
 - Allows clients to apply for SNAP benefits
- Ability to attach verification and report a change of circumstances

Worker Portal:

- Worker portal including-
 - Client application data,
 - Caseworker review and basic workflow automation
- Eligibility Determination for: SNAP

Oregon Benefits Online (Initial Win) In Scope

Continued:

Worker Side:

- Ability to cross check rules and policies necessary to support Eligibility Determination programs included in the Oregon Benefits Online (Initial Win) scope.
- Note: With our CMS waiver, SNAP eligible under 138% FPL, a “door-way” will be opened for Medical (Medicaid Expansion). OHA will be notified to open medical. SNAP eligible above 138% FPL will be referred to OHA for tax credits.
- CAP (CAPI and current Online Application) reports will be replaced using a new reporting tool called Business Intelligence Publisher (BIP).
- Data may also be pulled or generated using predefined queries in Siebel; a way to locate one or more records that meet searched criteria
- Retire CAP System (current Online Application and CAPI).
 - CAPI will still be available for historical information needs
- Necessary data sharing with OHP 5503 and Cover Oregon

Oregon Benefits Online (Initial Win) Out of Scope

- Eligibility determination for Long Term Care, TANF and ERDC
- Telephony (technology for telephones)
- Case management and case/service planning
- Scheduling
- Interface with FSMIS
- Replacement of Oregon ACCESS/TRACS

Let's Take A Look At Oregon Benefits Online Initial

Win) – Client Portal (Note: Work in progress – final view will change)

The screenshot displays the Oregon Benefits Online Client Portal interface. At the top, there are two main sections: "Start a New Application" and "Finish Saved Applications". Below these, there are navigation tabs for "Applications", "Change of Circumstances", "Documents", "Appointments", and "Messages". A "Report a change" button is located below the "Applications" tab. At the bottom, there are two buttons: "APPLY TODAY" and "CONTINUE".

Name	Request Number	Request Type	Request Area	Open Date	Branch Name	Branch Number	Status	Details
Rock, Nelson	1-5672301	Change of Circums...	Change of Income	03/04/2013 23:03...	9999 - EXCEPTION...		Unassigned	got robbed
Rock, Nelson	1-5832932	Change of Circums...	Change of Income	03/06/2013 09:49...			Escalated	Income changed from \$200/month to \$400/m
Rock, Nelson	1-5149121	Change of Circums...	Additional Benefit R...	02/21/2013 15:19...	9999 - EXCEPTION...		Unassigned	Test 02/21/2013
Rock, Nelson	1-5154361	Change of Circums...	Household Changes	02/27/2013 16:45...	9999 - EXCEPTION...		Unassigned	so what do I do here?
Rock, Nelson	1-5672961	Change of Circums...	Address Change	03/04/2013 09:07...			In Progress	Address changed from Portland to 3991 Fairv

This screenshot is of the Client Portal where the client can:

- Apply for SNAP
- Finish a saved application
- Review previously submitted applications
- Report a Change of Circumstance
- View documents attached to applications
- Receive messages from staff

Let's Take A Look At Oregon Benefits Online (Initial Win) – Siebel Worker Portal (Work in progress – final view will change)

The screenshot displays the Siebel Worker Portal interface. At the top, there is a navigation bar with 'Home', 'Calendar', 'Cases', 'Contacts', 'Service', and 'Branch Coverage'. Below this is a 'Case List' section with a table of cases. The first row is highlighted in yellow. To the right of the table is a 'Details from the highlighted case' section with various fields and filters.

New Case Number	Case Type	Case Status	Submitted by Client	First Name	Last Name	Priority	Case Owner	Date Opened	Date Closed	Master Case #	Branch
* 1-2461230	SWAP	Submitted by Client	1234	Tommy	Test	Standard	P1008964	12/14/2012 08:47:25 AM			0903 - LA PINE
1-4971134	Medical	Submitted by Client		Tommy	Dorsey	Standard	SADMIN	2/20/2013 08:10:19 AM		1-4971141	
1-5067194	SWAP	OPA Draft		Sam	Sung	Standard	SADMIN	2/21/2013 04:04:48 PM		1-5148111	
1-5067214	Medical	OPA Draft		Tommy	Dorsey	Standard	SADMIN	2/21/2013 04:04:48 PM		1-5148141	
1-5067967	SWAP	OPA Draft		Rick	Nelson	Standard	SADMIN	2/27/2013 04:48:58 PM		1-5148141	
1-5068027	SWAP	OPA Draft		Rick	Nelson	Standard	SADMIN	2/27/2013 06:51:13 PM		1-5148141	
1-5068087	SWAP	OPA Draft		Rick	Nelson	Standard	SADMIN	2/27/2013 07:09:06 PM		1-5148141	
1-5147177	SWAP	OPA Draft		Tommy	Dorsey	Standard	SADMIN	2/26/2013 04:48:38 PM		1-5147161	
1-5147237	SWAP	OPA Draft		Rick	Nelson	Standard	SADMIN	2/27/2013 11:28:56 AM		1-5148141	
1-5147297	SWAP	OPA Draft		Rick	Nelson	Standard	SADMIN	2/27/2013 11:29:08 AM		1-5148141	

The 'Details from the highlighted case' section includes the following information:

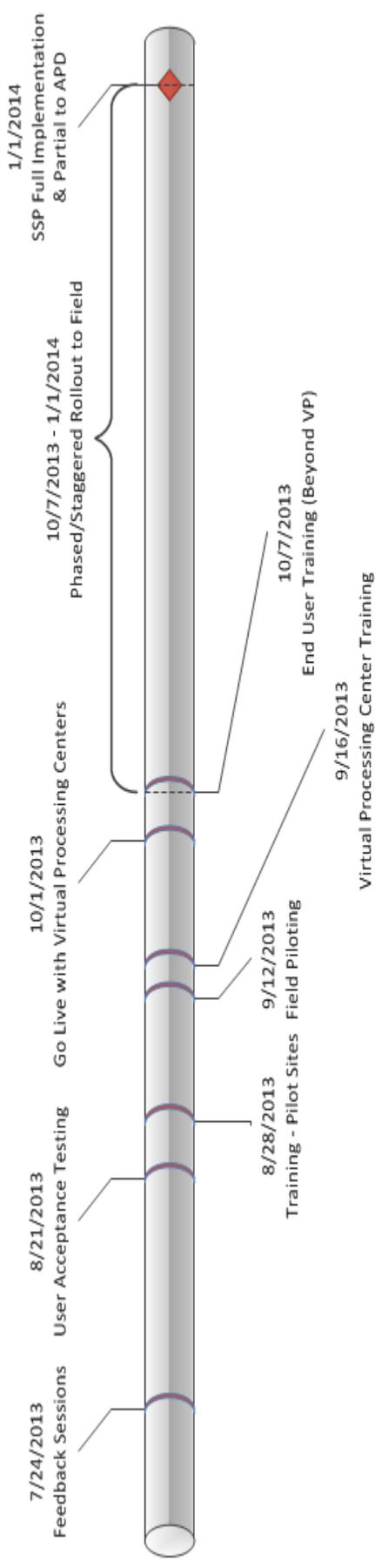
- Case Number: 1-2461230
- Case Type: SWAP
- SSN: [Redacted]
- Priority: Standard
- Master Case #: [Redacted]
- Case Owner: [Redacted]
- Last Name: Test
- First Name: 1234
- Household: Christian Walsh Househ
- Branch: 0903 - LA PINE
- District: 10 - Crook, Deschutes,
- Created By: OR0157487
- Case Status: Submitted by Client
- Date Opened: 12/14/2012 08:47:25 AM
- Date Closed: [Redacted]
- Classification: Unclassified

This screenshot is the Case Tab here you can find:

- A list of all the cases either in your branch or assigned to you
- The case that is highlighted will appear in the bottom applet with more details
- The ability to arrange the columns to your preference



What to expect in the future (with begin dates – end dates not reflected and may overlap)-



User Acceptance Testing:

Feedback Sessions to begin process

Staff testing the Siebel application in the field.

Possible multiple sites used for testing

Issues and feedback will be reported to the project for resolution

Field Piloting:

Pilot staff will be trained

Clients in pilot areas will use the new online applications

Staff will use Siebel to process applications and integrate into business processes

Issues and feedback will be reported to the project for resolution

End User Training:

Virtual PC will support a staggered or phased rollout

Opportunity for all staff to be trained in the Siebel application

Multiple resources for help-Field Liaisons

Change Leaders
Business Transition Analyst



Health Insurance Group (HIG)

Good Cause Coding - 101

There are currently about 27,000 Medicaid recipients that are covered by major medical health insurance they receive from an employer, absent parent, purchase themselves or other source. The state cost avoids (or saves) between \$3.5 and \$5 million dollars each month when a client has another primary payer. Medicaid is almost always the payer of last resort. That's why it's important to timely report other insurance to HIG on the MSC415H so MMIS can be updated. It's also important so clients don't have conflicting information between what they tell their provider and what we have in MMIS. Accurate primary payer information is critical to the state and our Medicaid recipients.

There are times, however, when a client is unable to use their private health insurance due to safety issues or inability to access service. When this occurs a worker has the ability to determine "good cause" so the state does not pursue the insurance. When good cause is determined, workers enter special coding on the case that tells HIG how the insurance should be set up in MMIS.

Examples of reasons why we would not pursue private health insurance are:

1. Domestic violence. When TPL is pursued, the insurance carrier will send an EOB (explanation of benefits) to the policyholder. If the policyholder is the abuser, it could place the client in a dangerous situation because the abuser knows where they live and what services they received.
2. Providers are not available where the client lives. A good example of this is Kaiser Permanente. They provide coverage in a limited area of the state. If a child is covered by Kaiser and is sent to a residential facility in Eastern Oregon, they would not be able to access basic services. What is important about determining good cause for lack of access is to be sure that good cause really exists. If a client is claiming no access to providers, workers can contact the insurance company to see if a client has access where they live.
3. When a child is covered by their biological parent's insurance and are in the process of being adopted.

When good cause is determined, workers update the PHI field on CMUP or in OR ACCESS. The information is then transferred to the Recipient Base Information panel in MMIS. It's important to know that the PHI field is **informational only**. It has no functionality except to inform the user that good does or does not exist. That means the information in the good cause field does not talk directly to any other functions in MMIS.

So how does it work?

The worker's role is to code the PHI field with one of the codes below that most closely matches the client's situation regarding third party insurance.

- Enter "0" when there is no TPL
- Enter "1" when there is TPL and it is ok to pursue
- Enter "2" when the mother is the policyholder and there is a safety concern with her.
- Enter "3" when the father is the policyholder and there is a safety concern with him.
- Enter "4" when there is a single policy and mother and father both are policyholders and there is a safety concern with both of them.
- Enter "5" when there are multiple insurance carriers and there are safety concerns with both parents/policyholders
- Enter "6" when the client has TPL provided by someone other than a parent and there are safety concerns.(for example a grandparent or step parent)
- Enter "7" when the client has active TPL but, for other good cause reason, the TPL should not be pursued. (such as an adoption or can't access the insurance).

When HIG receives a request for good cause they check to see if the information received on the good cause request matches what is coded on the case. When the information does not match they may contact the worker for additional information or may update the case coding.

Important information about Good Cause

- The most accurate way to see if good cause has been added to the TPL is by looking in the TPL panel in MMIS. Not on the Recipient base information panel or on the case. There are too many inconsistencies. MMIS is the most reliable.
- When on the TPL panel, be sure to click the drop down menu to see the most current good cause status. Sometimes the most current is not what appears first.
- If the field has been coded with a 1 - 7, a 415H still needs to be sent to HIG. Even when there is good cause, HIG still has to add the TPL to MMIS.
- Clients with good cause coding (2 - 7) cannot be enrolled in a managed health care plan because they still have active TPL. They access their medical benefits on fee for service.
- The 2 - 7 coding is for safety and access to care situations only and cannot be used for billing convenience or to resolve co-pay issues.
- Adding 1 - 7 coding does not prevent auto enrollment. Only an active exemption will prevent auto enrollment

If you are uncertain about how to apply good cause coding or if you have questions about third party insurance, please contact HIG.

Email: tpr.referrals@state.or.us

Phone: 503 378-6233

Fax: 503 373-0358

Payment of Private Health Insurance Premiums

Overview

Oregon Health Plan (OHP) clients may also have individual (private) or employer-sponsored insurance, also known as Third Party Liability (TPL). The State (Medicaid) is the payer of last resort, so the client's TPL normally becomes the primary payer.

The State has two programs that may be able to reimburse OHP clients for the amount they pay for third party insurance. These programs assist the State in providing cost-effective health care.

- HIPP - Health Insurance Premium Payment program – Reimburses eligible policyholder's for the amount they pay for their employer-sponsored health insurance. Payments usually go directly to the policyholder.
- PHI - Private Health Insurance program - Covers insurance premium costs for eligible household members with health care costs estimated (if covered by DMAP) to be higher than the cost of paying the premium. Payments usually go to the insurance carrier instead of the policyholder (although there can be exceptions).

Both HIPP and PHI do **not** pay premiums for:

- Non-SSI institutionalized and waived clients whose income deduction is used for payment of health insurance.
- Vision, dental, long-term care or other stand-alone policies.
- Clients covered by Medicare Part A and/or Part B.

Health Insurance Group

The Health Insurance Group's (HIG) Premium Reimbursement Coordinators, located within the Office of Payment Accuracy and Recovery (OPAR), determine eligibility for both HIPP and PHI. Determining eligibility includes collecting documents from clients, reviewing for cost effectiveness, data entry in MMIS to issue payments and all other administration related to the program. Contact a Reimbursement Coordinator by calling 503 378-6233 or by e-mail at ReimbursementsHIPP (in Outlook) or reimbursements.hipp@state.or.us (outside of Outlook). Documents can be faxed to 503 378-0358.

Managed care plans

Clients that are determined eligible for the HIPP or PHI program cannot enroll into a medical managed care plan. The client's private or employer-sponsored health insurance becomes the primary payer. DMAP pays for any Medicaid services that are not covered by the third party insurance on a fee-for-service basis.

In the event a client is already enrolled in a managed health care plan at the time third party insurance is reported to HIG, the client will be disenrolled from that plan on the last day of the month it is reported.

HIPP - Health Insurance Premium Payment

Program requirements

The HIPP program provides premium reimbursement for eligible Medicaid clients covered by employer-sponsored group health insurance.

Effective January 1, 2012, the policyholder does **not** have to be in the **same household**. It is possible to reimburse eligible absent parents, grandparents or others who are paying for the health insurance premiums. However, the State does not reimburse for third party insurance premiums if the policyholder has been court ordered to provide it.

As a condition of Medicaid eligibility, employed individuals with CEM, EXT, GAM, MAA, MAF and OHP (except OHP-CHP and OHP-OPU) **must** enroll in their employer-sponsored group health insurance if it is cost-effective. Self-employed individuals who opt to purchase group health insurance may also apply for HIPP. See Oregon Administrative Rule *461-155-0360*.

To qualify for HIPP, the employer-sponsored health insurance must be:

- A comprehensive major medical policy that includes inpatient and outpatient hospital, physician, lab, x-ray and full pharmacy benefits; and,
- (Note: Insurance policies that cover a specific conditions or diseases such as a cancer-only policy or only have a prescription discount card are not eligible.)
- Determined cost-effective based on the [Medical Savings Chart \(MSC\)](#); and,
- Meet HIPP requirements in OAR 410-120-1960.

Note: The State does not reimburse the employer's share of the premium cost.

HIPP eligibility

The HIG coordinator that receives a [MSC415H](#) (Notification of Other Health Insurance) uses the following steps to determine if the employer-sponsored insurance is cost effective:

- Determine if the Medicaid client has EXT, GAM, MAA, MAF, OSIPM or OHP (excluding OHP-CHP, OHP-OPU and CWM/CWX).
- Verify the insurance is a major medical policy and enter TPL information into MMIS.
- Contact the client for more information if they pay all or part of their premium.
- Confirm with the employer the premium amount and how often it is paid (for example, \$75.00 is taken out of employee's pay every week).
- Compare each eligible client by PERC code to the amount allowed for that PERC code on the [Medical Savings Chart](#). Each person's allowed amount is added to the allowed amount for all others eligible on the case (in some instances HIG may include people on separate cases). For example, a child may be on their own D4 case but living in the same household with other family members who are on a separate case.

If the premium payment exceeds the combined allowed amount on the MSC, HIG will check to see if anyone in the benefit group qualifies for the PHI program.

If *OAR 410-120-1960* and the above requirements are met, HIG authorizes and enters the HIPP reimbursement payment into MMIS.

Reimbursements are paid by check through MMIS. Reimbursements are **no longer** made through the Electronic Benefits Transfer (EBT) process (also known as ReliaCard), or by workers using the 437 Special Cash Pay process.

HIG re-determines eligibility at least annually and more frequently, if needed.

Examples:

- Mom's employer provides insurance for her, Dad and two children. Only the children are eligible for Medicaid. Mom has \$435.00 deducted from her check each month for her portion of the insurance. The children have PERC codes of H2 and HB. The combined insurance allowance on the [Medical Savings Chart](#) is \$687.00 (\$448.00 for HB and \$239.00 for H2). The cost of their insurance is cost effective because the premium amount is below the allowable amount.
- Dad does not live in the household and is not covered by Medicaid, but he provides insurance through his employer for his disabled son who lives in a group home. The son's PERC is D4. The cost of the insurance is \$537.00 per month. The allowance on the [Medical Savings Chart](#) is \$1141.00. The cost of their insurance is cost-effective because the premium amount is below the allowable amount.
- Client has a private policy that they purchased. The premium is \$430 per month. The client has cancer. The allowable amount on the [Medical Savings Chart](#) for his XE PERC code is \$249.00. Because the client has an illness that is covered on the [Special Conditions Chart](#), we can make an additional allowance of \$231.00 in our calculation ($\$249.00 + \$231.00 = \$480$). The combined amount is greater than the \$430.00 cost of the premium that makes it cost effective for reimbursement under the PHI program.

PHI - Private Health Insurance

Program requirements

In special situations, DMAP may pay health insurance (third party) premiums even if the premium is greater than what is allowed on the Medical Savings Chart (MSC). This may occur when the third-party insurance cost is less than the estimated cost of DMAP paying fee-for-service for their medical care.

Individual **and** employer-sponsored insurance may qualify for the PHI program. Payments for PHI generally go directly to the insurance carrier however payments may be paid directly to the policyholder or their representative. PHI **may or may not cover everyone** in the benefit group and the reimbursement may be a pro-rated portion of the premium.

PHI eligibility determination

The HIG coordinator follows these steps to determine if PHI is cost effective:

- Determine if the Medicaid client has EXT, GAM, MAA, MAF, OSIPM or OHP (excluding OHP-CHP, OHP-OPU and CWM/CWX).
- Verify the insurance is a major medical policy and enter TPL information into MMIS.
- Determine if anyone in the household covered by the third party insurance has a specific medical condition listed on the [Special Conditions Chart](#) (SCC). The listed conditions are associated with higher utilization costs.
- Confirm with the client or insurance company the amount of insurance premiums and how often they are paid.

If anyone covered by Medicaid and third party insurance has a medical condition covered on the MSC, add the amount for the eligible persons' PERC code on the MSC to the amount allowed on the SCC and determine if the insurance premium is equal to or less than the combined allowed amounts.

If the third party insurance is determined cost-effective and all requirements in OAR-410-120-1960 are met, HIG authorizes and enters the PHI reimbursement payment into MMIS.

PHI eligibility is re-determined at least annually and more frequently, if needed.

How to refer clients for HIPP or PHI

You will typically use the client's completed [MSC415H](#) to refer them for HIPP or PHI eligibility review. E-mail the form to [ReimbursementsHIPP](#) (in Outlook) or reimbursements.hipp@state.or.us (outside of Outlook) or fax to 503-373-0358. For questions, call a HIG Premium Reimbursement Coordinator at 503-378-6233.

Examples of when to refer a client for the HIPP or PHI program are:

- Client indicates they pay for all or part of a third party insurance on Section 5 of the MSC415H or Extra Form E (part of the 7210 application). Workers may submit either the MSC415H or Extra Form E.
- Client reports they have COBRA insurance.
- Paycheck stubs show that health insurance is deducted from a paycheck but the client has not submitted a MSC415H. In this case, workers should "pend" the application in lieu of a completed MSC415H. Upon receipt of the completed form, send referral to HIG.
- Client is employed by a company that offers group health insurance, even if the client has opted out. HIG will contact the client or employer to find out if the insurance is cost effective.
- Client is working and indicates they have a private, individual health insurance plan.
Note: Client may purchase health insurance directly from the insurance carrier and it will not show on their paycheck stub.

For instructions on how to complete the [MSC415H](#), go to [OPAR-AR-11-001](#).

Reference

Hearings

Insurance premium reimbursements are not a medical benefit and therefore are not subject to hearings. See OAR 410-120-1960.

Questions?

Client or worker questions related to HIPP or PHI should be directed to a Premium Reimbursement Coordinator at 503 378-6233 or e-mail at [Reimbursements_HIPP](#) (in Outlook) or reimbursements.hipp@state.or.us (outside of Outlook). Documents can be faxed to 503 378-0358.

Client questions regarding third party insurance and Medicaid eligibility should be referred to their local OHP branch worker.

Forms

MSC415H: <https://apps.state.or.us//Forms/Served/de0415h.pdf>

Other resources

[Medical Savings Chart](#) & [Special Conditions Chart](#)

Applicable OARs:

DMAP		DHS/OHA		
410-120-1960	461-120-0330	461-120-0350	461-135-1100	461-170-0035
410-120-0345	461-120-0345	461-135-0990	461-155-0360	461-180-0097

DMAP - Medical Savings Chart (MSC)

The Medical Savings Chart is used to determine eligibility for the Health Insurance Premium Payment (HIPP) and Private Health Insurance (PHI) programs.

Effective January 1, 2012, Health Insurance Group, Office of Payment Accuracy and Recovery

Eligibility group	PERC Code	Cost-effective premium amount (employee cost)
CEM	HD, HE, HF, HG	\$147
OHP-OPC	H1, H2, H3, H4, OHP-OPC	\$239
OHP-OP6	HB, HA	\$448
OHP-OPP	L2, L6, L8, HC	\$705
EXT	XE	\$249
MAA/MAF	2, 82	\$386
SAC	C5	\$1785
OSIP-AB	3, B3	\$495
OSIP-AD	4, D4	\$1141
OSIPM-OAA	1, A1	\$180
Foster Children-SCFR	19	\$237
GA	5, GA	\$163

DMAP - Special Conditions Chart add-on list

The Special Conditions Chart (SCC) is used to determine eligibility for the Health Insurance Premium Payment (HIPP) or Private Health Insurance (PHI) programs when premium amounts exceed the Medical Savings Chart and a recipient has one of the conditions listed below.

Effective January 1, 2012, Health Insurance Group, Office of Payment Accuracy and Recovery

CCS2 Code	Description	Average paid per-client, per-month
019	Pancreatic disease – excluding diabetes	\$396
002	Cancer	\$231
009	Blood disorder (sickle cell, hemophilia	\$213
001	TB, HIV/AIDS, Hepatitis A, B or C	\$173
018	Liver Disease	\$157
015	Cardiovascular disorders	\$137
023	Childbirth (if neonatal delivery cost PMPM is \$268)	\$105
012	CNS disorder-Multiple sclerosis, Epilepsy, Cerebral Palsey, Plegia (Quad, Para, Mono), Paralysis, Parkinsons, Huntingtons	\$65
027	Spina bifida	\$65
010	Mental Health disorders (Autism, DD)	\$61
016	Chronic lung disease, COPD	\$65
011	Alcohol & Chemical dependence disorders	\$54
021	Renal disorders (kidney disease)	\$50
005	Diabetes	\$40



- **HB2216**
 - Reauthorizes nursing facility provider tax through June 2020.
 - Provides incentives to reduce nursing facility capacity by 1,500 beds

- **SB21**
 - Directs APD to develop a plan to improve and modernize LTC system.
 - Reports due Feb 2014 and Feb 2015.

- **Legislatively Adopted Budget Summary**
 - Reduce nursing facility caseload by 800 individuals (428 biennial average).

 - Implements workload model for delivery staff, with significant increase in staffing.

 - Develop special capacity to meet the needs of seniors in Oregon State Hospital.

 - Develop special capacity to meet the needs of hard-to-divert/transition nursing facility residents.

 - Reinstigate Money Follows the Person (Oregon Community Choices Program)

 - Implement innovation fund designed to fund pilot projects that will increase quality and/or reduce costs in LTC.

 - Replacement of Oregon ACCESS with modern case management system.

**Department of Human Services
2013 Legislative End of Session Report**

July 22, 2013

EXECUTIVE SUMMARY:

From a DHS perspective, the 2013 Legislative Session proved to be a balanced mixture of budget and policy debates. It also focused on discussions regarding accountability of agencies and their use of public funds.

Although the economy showed some improvements and the legislature had more funds after the May forecast than anticipated at the beginning of the Legislative session, there was still a conversation of sustainability for programs and services as the session progressed. For the most part, policy matters had increased focus on major issues such as PERS that were not directly connected to DHS programs. That said, policy matters directly related to DHS were discussed and legislation that impacts DHS was passed.

The Legislature and state agencies seem to be adapting well to the annual sessions. There appeared to be more conversation from the legislators about taking major policy changes a bit slower and a willingness to use multiple sessions to accomplish some major policy decisions. Likewise, some of the budget conversations seem to suggest thinking beyond a two-year investment and plan for a long-term, sustainable outcome. Conversations regarding both revenue and budget reductions seemed to drive much of the policy communication.

This Legislative session also provided Oregon with more than a dozen new legislators. These “freshmen” legislators jointed with the senior legislators to create a fast-paced session that saw more than 2,000 bills introduced within the first three days of opening the 2013 legislative session. This session offered a Democratic majority House, Democratic majority Senate and a Democratic Governor (last session, we had a Split House, Democratic Senate and Democratic Governor). Monday, July 8, 2013 marked Sine die with more than 900 bills still alive to the end.

For your review, the DHS Legislative Team, DHS Budget staff and DHS Program staff compiled a brief overview of bills that passed this session which impact DHS. In addition, we reference some bills that did not pass but would have had an impact on DHS if passed; they may appear at some time in a future legislative session. This session, we tried to group the bills by “themes” rather than by “bill number,” to provide you with an easier read. We also have the themes grouped into program areas, again, hoping this will help you as you review the work from this Legislative session.

DHS INTRODUCED BILLS

AGING & PEOPLE WITH DISABILITIES SPONSORED BILLS

HB 2056—AMENDED INTO HB 2216 AND PASSED

HB 2056 extended the current long term care facility assessment for six more years until July 1, 2020, and all exemptions to the assessment—with the exception of the Oregon Veterans' Home—are eliminated. **HB 2056** also outlines a strategy for helping providers reach a goal of reducing Oregon's long term care bed capacity by 1,500 beds by the end of 2015.

Background: In 2003, the Legislature passed a bill requiring long term care facilities to pay a self-assessment to the state. The assessment is used to leverage matching federal funds, which in turn allow an increase in reimbursement rates paid back to the facilities. Under current law, the assessment is set to expire on June 30, 2014; however **HB 2056** extended the assessment through July 1, 2020. To give some perspective, it's estimated that the assessment will now collect \$127.7 million for the 2015-17 biennium. It will bring in \$218 million in leveraged federal funds.

HB 2056 also sets a goal of reducing Oregon's long term care bed capacity by 1,500 beds by December 31, 2015. The bill establishes procedures and a financial incentive for providers to purchase the bed capacity from another long term care facility. If the 1,500 bed reduction target is not met, DHS will start adjusting nursing facility reimbursement rates downward in 2016.

Notes: In the Ways & Means Subcommittee on Human Services, **HB 2056** was amended into **HB 2216**. **HB 2216** contains the hospital assessment and the long term care facility assessment, as well as the 1,500 bed reduction goal. It passed the Legislature toward the end of session. **HB 2216** is *effective October 8, 2013*.

SB 21—PASSED

SB 21 requires DHS to convene a committee in order to develop a plan for improving and strengthening the long term care system. The plan must cover several elements, including strategies supporting independence, care setting choice, and culturally responsive services. DHS will also gather related data on the long term care system and system cost drivers. Along with agency staff, committee membership will include community partners, consumers, seniors and people with disabilities, and legislators. DHS will provide an update to the Legislature in 2014 and a final report must be presented to the Legislature no later than February 1, 2015. *Effective July 1, 2013*.

Background: Oregon is a national leader in providing home and community-based long term care services for older adults and people with disabilities. However, with the expansion of the aging population and the need for assistance increasing, Oregon's system cannot meet the demand with the current level of resources. Through SB 21 DHS asked to convene a public planning process with legislative oversight, to develop an improved and secure long term care system. The goal isn't to change what's working well, but instead to think about strategies such as better serving the non-Medicaid eligible population, increased service equity, and stonger in-home supports.

CHILD WELFARE SPONSORED BILL

HB 2053—PASSED

HB 2053 will make it possible for Oregon tribes or DHS to run criminal background checks on prospective and existing foster parents and others who live in their homes. DHS received advice from legal counsel that the statute was not clear in this area. This legislation clarifies law and provides assurance that criminal background checks can be conducted by either the Tribes or DHS for foster home certification. *Effective May 9, 2013*

Background: Prior to this bill, Tribes did not have a clear and consistent way to accomplish required criminal background checks on prospective foster parents and other persons who live in the homes of prospective foster parents. This legislation clarifies law and provides assurance that criminal background checks can be conducted by either the Tribes or DHS for foster home certification. Also, the criminal background checks are required by the federal code that governs the Title IV-E funds that are critical for maintaining and supporting the foster care programs. Federal law requires states to conduct criminal background checks for all adults in a potential foster home before placing a foster child in that home. Without this criminal background check, states are not allowed to use federal funds for placement of children in that foster home.

DEVELOPMENTAL DISABILITIES SPONSORED BILL

SB 22—PASSED

SB 22 updates several statues related to Developmental Disabilities because they are outdated and in need of revision. Over the last two decades there have been significant changes in the service system for people with intellectual and other developmental disabilities (I/DD). The cumulative effect of these changes is that many current statutes need to be updated. **SB 22** is a “clean up” bill that makes those adjustments. *Effective April 11, 2013.*

Background: We have closed all public and private institutions—the last two institutions, Fairview Training Center and Eastern Oregon Training Center, closed in 2000 and 2009 respectively. Our system now relies totally on community-based services. Oregon is one of only a few states in the country that can make that claim. Additionally, in the last 12 years we have instituted an array of cost-effective, in-home services but our statutes have not kept up with all these change. In response, **SB 22** does several things:

- a) Eliminates references to institutions that no longer exist (Fairview Training Center and Eastern Oregon Training Center),
- b) Updates language (e.g. mental retardation to intellectual disability),
- c) Adjusts for some current practices that changed as a result of eliminating institutions (e.g. civil commitment process, service eligibility determination that in current statute reference certain institutional requirements),
- d) Clarifies the authority of DHS to certify, license, and contract for programs for people with I/DD, and
- e) Updates the rights statement for people receiving services.

SELF SUFFICIENCY SPONSORED BILL

HB 2055—AMENDED INTO HB 2322 AND PASSED

HB 2055 continues the current suspensions to TANF. A program redesign in 2007 produced positive results for clients. However, in order to balance the budget in 2009 several reductions and suspensions were implemented. Those suspensions would have expired this year requiring additional resources, but **HB 2055** extends the suspensions until 2015.

Background: The Governor's Recommended Budget continued the TANF reductions and suspensions into the 2013-15 biennium. **HB 2055** is intended to align with the Governor's decision by providing the statutory language needed to make that happen. The bill was heard in committee together with HB 3440, which was a bill that would have required DHS to provide aid to prevent families from qualifying for TANF. Both bills were sent to Ways and Means for funding discussions. However, the Legislature only passed **HB 2055**, meaning that the currently reduced TANF program will continue into the next biennium.

Notes: Ultimately, the legislature decided to take the substance of **HB 2055** and place it in the end-of-session program change bill. You will find **HB 2055** amended into **HB 2322**.

Important Change

Medical transportation reimbursement

Starting July 1, 2013, reimbursement for medical travel will come from your local transportation brokerage, instead of your Department of Human Services (DHS) branch office.

This means you will need to ask your local transportation brokerage to approve and repay you for any health-related travel expenses covered by your Oregon Health Plan (OHP) benefits.

What you should do

Please contact your transportation brokerage before July to find out what you need to do for future medical travel needs. For example, any forms you may need.

Until July 1, you will still get approval and reimbursement from your DHS branch office for meals, lodging and mileage needed to travel to your health care visits.

Local transportation brokerages

A list of transportation brokerages in each county is available in this letter. Please use the brokerage that serves the county you live in.

What if I already have approved travel costs for after July 1?

If your local DHS branch office has already approved travel costs for a trip you are taking after July 1, they will still pay for it. Starting July 1, please work with your brokerage for future travel approval.

Questions?

- Please call OHP Client Services: 1-800-273-0557
- Call your worker if you need this letter in another language or format, such as (but not limited to) large print, Braille, audio recordings, Web-based communications and other electronic formats.
- TTY: Dial 711

Transportation Brokerages

Use the brokerage in your county to ask for approval and receive reimbursement for your medical transportation costs.

Counties served	Brokerage
Benton Linn Lincoln	Cascades West Ride Line Cascades West Council of Governments Phone: 541-924-8738 Toll-free: 866-724-2975
Baker* Jefferson* Crook* Malheur* Deschutes* Union* Grant* Wallowa*	Cascades East Ride Center Central Oregon Intergovernmental Council Phone: 541-385-8680 Toll-free: 866-385-8680
Lane	RideSource Call Center Lane Transit District Phone: 541-682-5566 Toll-free: 877-800-9899
Gilliam Umatilla Hood River Wasco Morrow Wheeler Sherman	Transportation Network Mid-Columbia Council of Governments Phone: 541-298-5345 Toll-free: 877-875-4657
Coos Josephine Curry Klamath Douglas Lake Jackson	TransLink Rogue Valley Transit District Phone: 541-842-2060 Toll-free: 888-518-8160
Marion* Polk* Yamhill*	TripLink Salem Area Mass Transit District Phone: 503-315-5544 Toll-free: 888-315-5544
Clatsop Columbia Tillamook	Northwest Ride Center Sunset Empire Transit District Phone: 503-861-7433 Toll-free: 866-811-1001
Clackamas* Multnomah* Washington*	Transportation Services Tri-Met Phone: 503-802-8700 Toll-free: 800-889-8726

**Note: The brokerage in these counties will not be providing client reimbursement on July 1, 2013. They may delay until January 1, 2014.*

For TTY/Relay Service, dial 711.

**Transportation Brokerages
(Ambulance authorizations)**

Counties served	Brokerage and contact information
Benton Linn Lincoln	<p>Cascades West Ride Line (fee-for-service only) – Cascades West Council of Governments</p> <p style="text-align: center;">Phone: 541-924-8738 Toll-free: 866-724-2975</p> <p><i>Note: Contact InterCommunity Health Network CCO for authorization for enrolled members.</i></p>
Baker Crook Deschutes Grant Harney	<p style="text-align: center;">Jefferson Malheur Union Wallowa</p> <p>Cascades East Ride Center – Central Oregon Intergovernmental Council</p> <p style="text-align: center;">Phone: 541-385-8680 Toll-free: 866-385-8680</p>
Lane	<p>RideSource Call Center – Lane Transit District</p> <p style="text-align: center;">Phone: 541-682-5566 Toll-free: 877-800-9899</p>
Gilliam Hood River Morrow Sherman	<p style="text-align: center;">Umatilla Wasco Wheeler</p> <p>Transportation Network – Mid-Columbia Council of Governments</p> <p style="text-align: center;">Phone: 541-298-5345 Toll-free: 877-875-4657</p>
Coos Curry Douglas Jackson	<p style="text-align: center;">Josephine Klamath Lake</p> <p>TransLink – Rogue Valley Transit District</p> <p style="text-align: center;">Phone: 541-842-2060 Toll-free: 888-518-8160</p>
Marion Polk Yamhill	<p>TripLink – Salem Area Mass Transit District</p> <p style="text-align: center;">Phone: 503-315-5544 Toll-free: 888-315-5544</p>
Clatsop Columbia Tillamook	<p>Northwest Ride Center – Sunset Empire Transit District</p> <p style="text-align: center;">Phone: 503-861-7433 Toll-free: 866-811-1001</p>
<p>The brokerage below will not be providing ambulance authorization beginning 7/1/13; they may delay until 1/1/14.</p>	
Clackamas Multnomah Washington	<p>Transportation Services – Tri-Met</p> <p style="text-align: center;">Phone: 503-802-8700 Toll-free: 800-889-8726</p> <p><i>Note: Contact DHS branch offices until further notice.</i></p>

For TTY/Relay Service, dial 711.

Office of Program Integrity

The Office of Program Integrity (OPI) includes the Quality Control Unit and Quality Assurance Unit. OPI supports DHS and OHA programs in ensuring compliance with state and federal laws and rules; and to assist with improving program accuracy through high quality and timely accuracy review services, information sharing and collaboration with program design and delivery. For more information, visit our website: <https://inside.dhsoha.state.or.us/dhs/opi.html>.

Quality Control Unit (QCU)

QCU assists programs with ensuring compliance with federal quality control review requirements, and provides valuable program effectiveness feedback to field offices and state and federal agencies. The work of this unit often leads to the establishment of best practices for accuracy and effectiveness of select programs.

Quality Assurance Unit (QA)

QA promotes accurate, consistent and effective program delivery through statewide targeted review processes, presentation of error trends training and publication of accuracy related information and best practices. Reviews are conducted at approximately 73 SSP branches, 47 APD and AAA branches and the OHA OHP Processing Center (branch 5503). Reviews are completed at local offices by a team of reviewers to promote coaching at the individual worker level and effective communication with local leadership.

Contact Us: Email: Unit.Quality-Control@state.or.us

Susan Beckett, Manager
503 373-7961

Susan.m.beckett@dhs.state.or.us

Jeff Reilly, Lead Worker
503 373-7970

Jeffrey.p.reilly@dhsoha.state.or.us

2013 Quality Control Medical Error Trends

Reviews of Active MAA, MAF, EXT, OPC, OP6, OPP and OPU Medical Determinations Statewide (Oct 2012 – March 2013 Sample Months):

- 290 Total Active cases reviewed
- 602 Total Active beneficiaries were reviewed and of those;
 - 40 persons determined ineligible (6.7%)
 - 39 persons in incorrect program (6.5%)
 - 20 persons with incorrect effective date (3.3%)

Top Three Ineligibility Error Causes and Preventative Tips

Over income

12 errors

- Excluded income counted - review counting client assets to determine which income is countable

- Agency converted income - For OHP, income is not converted, pro-rated or annualized

Non-Pursuit of UC

11 errors

- Access the EPC2 screen through WAGE to determine if potential UC claim exists
- Review criteria for establishing good cause for non-pursuit of UC and narrate if you are applying good cause

Not selected from the SRL

5 errors

- Review SRL to determine if the client has been selected
- See SRL field user guide: http://www.dhs.state.or.us/caf/caf_ss_medical/srl-field-user-guide.pdf

Top Three Incorrect Program Errors

No review for other program eligibility

21 errors

- Review MAA criteria when determining eligibility
- Agency reduced to OPU from OSIPM and the client requested medical before the reduction; the agency did not review basis of need for OSIPM

Due Process (notice)

11 errors

- When reducing/converting from Plus program benefit to Standard benefits; review for other plus program eligibility, include a valid reason for the reduction on the notice and send timely notice

Reviews of Negative MAA, MAF, EXT, OPC, OP6, OPP and OPU Actions Statewide (Oct 2012 – March 2013 Sample Months):

- 290 Total Negative action cases were reviewed
- 596 Total beneficiaries were reviewed and of those; QC determined 139 beneficiaries were incorrectly denied or terminated (23.3%).

Top Three Invalid Denial / Termination Causes and Preventative Tips

Notices:

59 errors

- **No Notice Sent (24 errors)**
 - A decision notice is required to be sent to the benefit group describing the action taken to reduce or close benefits.
- **Incomplete/Invalid notice (15 errors)**
 - A notice must contain the reason for the closure or denial.
 - A notice must contain the correct effective date for the change.
- **Timely notice sent but not sent timely (12 errors)**
 - Allow the 10 day notice period when reducing medical.
- **Incorrect notice (7 errors)**
 - Send a denial notice when denying an initial request for medical.
 - Send a closure notice when closing ongoing medical.

Misapplied policy:

57 errors

- **Didn't allow 45 days (24 errors)**
 - Review application processing timeframes and allow the client the appropriate time to respond to a request for verification.
- **Closed OHP mid-certification (11 errors)**
 - Changes in the OHP filing group's household composition, income or resources, does not affect eligibility during their certification period.
 - For *new* OPC, OP6, and OPU clients, the *initial* certification period is the month containing the effective date for starting medical benefits and the following 12 months. The certification period for these *ongoing* cases is twelve months.
- **Agency didn't redetermine eligibility (5 errors)**
 - Review all available medical programs prior to ending or reducing medical.
- **Mid-month closure (5 errors)**
 - End medical on the last day of the month allowing for 10 day notice.
- **Back dated closure effective date (4 errors)**
 - The effective date for ending OHP medical is the last day of the month allowing for 10 day notice, unless the client qualifies for a Plus program benefit they are not already receiving.
- **Incorrect conversion date (4 errors)**
 - The effective date for converting from OHP plus to OHP plus is the first day of the following month.
 - The effective date for converting from OSIPM to OHP Standard is the first day of the following month allowing notice period.

Acting on reported changes:

14 errors

- CM Closure for no SSN, client provided (**7 errors**)
- DOR established prior to closure, No BED coding added (**4 errors**)
 - Add BED coding when pending at redetermination
- Client provided pending items prior to closure action (**3 errors**)

SNAP QC ERROR TRENDS
Reviews of Negative SNAP Determinations
Statewide Findings
FFY 2013 (Oct – Feb 2013)

Total negative action cases reviewed: 332 Cases in error: 70
Negative Error rate: 21.08%

FFY 2013 National Negative Error rate: 24.34% (through Feb 2013)

Top Error Causes and Analysis

- 1. Notices: 33 errors (47.14% of error causes)**
 - 17 cases - Notice sent to an incorrect address
 - 9 cases - Failed to send a notice of adverse action (1 denial, 7 closures)
 - 7 cases - Notice was invalid for other reasons

- 2. Invalid Suspensions: 33 errors (47.14% of error causes)**
 - 24 cases - Did not process the Interim Change report timely
 - 6 cases - Case was not coded as NED as required
 - 2 case - Failure to convert to TBA when required
 - 1 case - Failure to update the RPT EXP field

- 3. Improper Denial: 4 errors (5.71% of error causes)**
 - 4 cases - Denial action was processed late

- 4. Invalid Denial: 2 errors (2.86% of error causes)**
 - 2 cases - Invalid denial because applicant was under 22 living with a parent

** Some cases had more than one error cause.*