DHS Oregon Department of Human Services

Children, Adults and Families

Information Memorandum Transmittal

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Authorized Signature

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Topic: Medical Benefits

Subject: CAF SSP Medical Program Q & A

Applies to (check all that apply):

- ☐ All DHS employees
- ☐ Area Agencies on Aging
- ☒ Children, Adults and Families
- ☐ County DD Program Managers
- ☐ County Mental Health Directors
- ☐ Health Services
- ☐ Seniors and People with Disabilities
- ☐ Other (please specify):

Message: CAF SSP medical program analysts and trainers have compiled a list of frequently asked questions, and our responses.

Ending Client Benefits:

Q: Mom and child were on MAA. Child welfare requested I end the child's medical assistance as they had removed the child from mom's household. Because there is no other child in the household, do I close the case immediately?
A: No. End benefits for the child per child welfare's request (it is okay to end the child's benefits on any date as the child is going to be receiving medical assistance through child welfare, and no notice is required). It is okay to leave mom on an MAA case without a child while you review for other medical.

Pend for information needed to determine mom's eligibility for other programs, including OHP Standard. If mom owes past due premiums, pend for payment of those premiums also. You have 45 days from the date you were notified of the change to complete the application process. If mom is eligible for OHP Standard, send a reduction notice and make OHP Standard effective on the first of the month following the timely reduction notice. If mom is not eligible, end benefits at the end of the month in which you were able to send a timely closure notice.

Q: Is it true that clients who have medical assistance closed when they are incarcerated can have their benefits restored once they are released?
A: Pregnant women who have medical assistance closed at the time they become incarcerated and who are released during their period of protected eligibility should

have their benefits restored.

Premiums:

Q: I've heard that premium disqualifications are going away for OHP Standard clients. Has this already occurred?
A: No, it hasn't been implemented to date. Senate Bill 782 passed in August 2005, requiring changes around our premium policy. However, the changes are contingent on federal approval and we are still waiting. Once we get CMS approval, we will be able to implement the new policy within a few months. The changes will include elimination of premiums for clients below 10% of the FPL, and there will not be disqualifications for late or non-payment of premiums for OHP Standard clients during their certification period.

Q: Does this mean my client's who have not paid premiums will not be held responsible for payment of the premiums they are billed for?
A: No. Client's who are billed for premiums are required to bring their premium status to current at reapplication unless they are exempt at the time they reapply because their income is then below 10% FPL.

Application Process:

Q: I have a case where 2 adults are reapplying for medical assistance, but only one of the adults signed the application. Do I need to pend for the second signature? They both signed the previous application, and we have a rule that states they didn't have to submit a new application if they establish a date of request, as we can use the previous application and update with current information.
A: Yes, the current "who must sign the application" rule trumps the "when an application must be completed" rule in this scenario. They didn't need to submit an application, but because they did submit a reapplication, both adults must sign it.

Q: When a woman is no longer pregnant and her medical assistance is ending after the 2 months protected eligibility, can she be considered for the OHP Standard program?
A: Yes. When she reapplies at the end of her protected eligibility, she can be considered for all other medical assistance, including the OHP Standard program. If she meets all the financial and non-financial eligibility requirements, she can be transitioned in to the OHP Standard program.

Q: There is a question, "Does anyone have a condition that is life threatening or disabling if not treated?" on the medical application. Is the purpose of this question to flag eligibility staff that the client should be referred for a disability decision?
A: No. That question lets eligibility staff know the client has a health issue that may allow them to waive the six month period of uninsurance that would otherwise make them ineligible for some medical programs.

Q: I'm reviewing a family for MAA, but the dad (PWE) had a recent job quit. I am going to pend the client for verification he applied with UC. Can benefits be opened on this case while I wait for the answer?
A: No. There is no deprivation if the client is not eligible for UC unless there is good cause. Narrate in TRACS why you made your decision.

Q: Is the $10,000 self-employment business cap a prorated amount of the total gross income if the incorporated business has multiple owners?
A: No. When an applicant's business is incorporated, we consider the entire gross income of the business, even if there are several partners. For example, a father and his 2 sons are partners in a corporation that grosses $15,000 every month, and one of the sons is applying for medical assistance. As the $15,000 is above the $10,000 cap, we would deny the son's application.

Q: Do I need a signature on the 859B self-employment form when the client is self-employed and completes it?
A: Yes.

Miscellaneous:

Q: When do I transfer a CM system case; when the client tells me they will be moving, or after they have moved?
A: After they have moved. When a client's CM system case is moved to a new county, the system ends the managed health care plan in the previous county. If the client has not moved at the time the address is changed on CM system, it could create challenges in access to care.

If you have any questions about this information, contact:

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