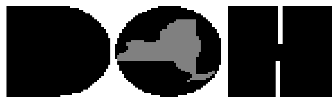

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OFFICE OF MEDICAID MANAGEMENT INFORMATIONAL LETTER

TRANSMITTAL: 98 OMM/INF-02

DIVISION: Office of Medicaid Management

TO: **Commissioners of Social Services**

DATE: July 31, 1998

SUBJECT: Questions and Answers from Medicaid Regional Meetings on Welfare Reform

SUGGESTED DISTRIBUTION:
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ATTACHMENTS:
I: Citizenship/Alien Status Indicator Codes (not available on-line)
II: Medicaid-Only Auto Exemptions (not available on-line)
III: Earned Income Disregard (EID) Code Selection for Budget Types 01, 05, 09 (not available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
OMM/ADM 97-2 97 ADM-24 97 ADM-23 97 ADM-20					98 OMM/LCM 002 SDX Information Sheet 640

The purpose of this Informational Letter is to provide responses to questions asked by local district staff at the Office of Medicaid Management's Fall 1997 Regional Meetings on Medicaid Implications of Welfare Reform and at the Office of Temporary and Disability Assistance's Fall 1997 Regional Meetings. The systems information in this letter reflects Upstate specifications. For New York City, refer to WMS/NYC Software Release Notes 98.1 dated 12/12/97, for systems instructions.

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ALIENS

1. **QUESTION**

Does sponsor deeming apply to pregnant women?

Answer

As a result of the Lewis v.Grinker lawsuit, the requirements of welfare reform regarding alien status do not apply to pregnant women. WMS has been modified to identify pregnant women based on Individual Categorical Codes 15, 36, 42, 43, or 48.

2. **QUESTION**

If an individual was in the country and then left and later re-entered the country, how should the alien status be addressed?

Answer

When an individual applies for Medicaid, the current alien status of the individual must be determined. The fact that an individual left the country for a period of time does not necessarily change his/her status. If the status is still valid, the date the status was originally given would be the determining factor.

3. **QUESTION**

Are persons in a nursing facility on 8/4/97 who are receiving respite care eligible for Medicaid under the "grandfather" provision of State Law?

Answer

Individuals residing in a nursing facility on 8/4/97 for purposes of respite care and in receipt of a Medicaid authorization based on a determination that they were permanently residing in the United States under color of law are included in this provision.

4. **QUESTION**

Is a person covered by the nursing home "grandfather" provision if he/she applies for assistance post 8/4/97 and can be determined eligible retroactive to that date?

Answer

No. The person must have applied for Medicaid prior to 8/4/97, be determined eligible for assistance on 8/4/97 and meet the other conditions of the exception.

5. **QUESTION**

Are individuals who are in the Long Term Home Health Care Program on 8/4/97 included in the nursing home "grandfather" provision?

Answer

No, only people residing in residential health care facilities or residential facilities licensed, operated or funded by OMH or OMRDD are eligible for this exemption.

6. **QUESTION**

What happens when an alien leaves the country and seeks to re-enter and is then requested by his/her Embassy to repay assistance which s/he previously received?

Answer

This does not impact Medicaid eligibility.

7. **QUESTION**

Who makes the determination of medical emergency?

Answer

This policy has not changed. The need for treatment of an emergency medical condition must be certified by a physician.

8. **QUESTION**

Has the policy for continuation of eight months of eligibility for refugees and asylees changed?

Answer

This policy, found in 96 ADM-7, has not changed.

9. **QUESTION**

Does the sponsor need to apply for Medicaid in order to be considered under sponsor deeming?

Answer

The sponsor would not have to apply for Medicaid in order for his/her income or resources to be deemed available to the alien. We are currently awaiting further direction from the Health Care Financing Administration (HCFA) on this issue.

10. **QUESTION**

Is a child born in the United States considered a citizen and eligible for Medicaid for one year if both parents are illegal aliens?

Answer

Yes, the child is a citizen and eligible for Medicaid for one year if the mother received Medicaid while pregnant and the child remains with the mother.

11. **QUESTION**

If a person claims to have been born in Canada and "grandfathered" under his/her parents' naturalization, does the local district need to document citizenship?

Answer

A person claiming citizenship status derived from his/her parents' naturalization would be known to the Immigration and Naturalization Service (INS). The individual should have a document N-560, or N-561, Certificate of Citizenship. If not, he/she should be referred to the INS to obtain this documentation.

12. **QUESTION**

Does the exception for the spouse of a qualified alien who is a veteran or on active military duty continue to apply if the couple is estranged?

Answer

This exception applies to the spouse of a qualified alien who is a veteran of the Armed Forces or who is on active duty in the Armed Forces as long as the couple remains legally married.

13. **QUESTION**

How should alien status be verified?

Answer

The alien must present a document from the Immigration and Naturalization Service which indicates his/her alien status. See the "Documentation Guide for Citizenship and Alien Status" that was distributed at the Regional Meetings, and is attached to this INF.

14. **QUESTION**

How long does sponsor deeming last?

Answer

Sponsor deeming continues until the individual becomes a citizen or can be credited with 40 qualifying quarters of work.

NOTE: Several Regional Meeting sites may have received in their training packet a document entitled "Citizenship/Alien Status Indicator Codes" which was not dated. This version contains incorrect information. The correct version of this document has a revision date of 11/4/97 in the upper right hand corner. A correct version was distributed at each site, and is also attached to this INF as Attachment I. Versions without this date should be destroyed.

AUTOMOBILES (See Attachment II for more information on Medicaid-Only Auto Exemptions.)

1. **QUESTION**

The exemption for a car is now $4650. For Low Income Families (LIF), is the exemption based on $4650 fair market value (FMV) or equity value? Does the same policy apply for Singles/Childless Couples (S/CC)?

Answer

In determining Medicaid eligibility under LIF,the FMV of the car is first compared to $4650. If the FMV of the car is less than $4650, the car is exempt. If the FMV exceeds $4650, the car must be evaluated under the old policy of exempting one automobile if the equity is less than $1500. Any equity in excess of $1500 must be counted against a limit of $3000. If the automobile meets this test, the automobile is exempt. If an excess exists, whichever policy results in a more beneficial decision for the individual is applied.

For S/CC, only the FMV is considered. Any value above $4650 is added to any other available resources. For both LIF and S/CC, any value above allowable limits is entered as a resource code 22, "vehicle".

For both LIF and S/CC, allowing automobiles beyond the limits specified may be permitted pursuant to 18 NYCRR section 352.23(b)(7). For Medicaid, the reasons for allowing exemptions are employment related activities, including child care, or medical need.

NOTE: To determine the value of a car, use the NADA "Trade In" value and adjust for the condition of the vehicle.

2. **QUESTION**

If there is a second vehicle, is it counted as a resource? Is there a distinction if the case consists of a couple?

Answer

For LIF and S/CC, the second vehicle cannot be exempted without justification and should be considered as a countable resource for a single person or a couple. Legal encumbrances can be deducted in establishing the countable value of the second vehicle (FMV - encumbrances = Resource/Equity Value). The $4650 (or $1500) exemption cannot be applied. The second vehicle that the district determines is not exempt pursuant to 18 NYCRR section 352.23(b)(7) should be designated on Medicaid Budgeting Eligibility Logic (MBL) with a resource code of 98, "other". This code is valid for budget types 01, 02, 05, 06, 09 and 10.

3. **QUESTION**

If a person is not working, but is actively looking for work, can the car be considered exempt?

Answer

Yes, for LIF and S/CC, if a person is looking for, and expecting to gain employment in the near future, the car can be exempted. The recipient must provide sufficient documentation to allow the exemption. (See the Answer to Question Number 1.)

4. **QUESTION**

Can a second car be considered exempt based on the need to complete employment-related activities, for child care or medical necessity?

Answer

If there is a medical need or a business or occupational need including employment-related activities, such as training, education and child care needed for employment or employment-related activities, districts may allow an exemption of a second vehicle. Districts may impose a reasonable time limit and/or a limit on the value allowed above the resource standard.

5. **QUESTION**

Is spenddown of income or resources allowed for the S/CC or LIF?

Answer

No, there is no spenddown of income or resources provision for S/CC or LIF. Families ineligible under LIF will automatically have financial eligibility determined under ADC-related and/or poverty level programs as appropriate.

6. **QUESTION**

Will Public Assistance (PA) apply the "old" policy regarding the vehicle, i.e., the $1500 allowance?

Answer

No. PA has replaced the $1500 equity value policy with $4650 FMV. If under Family Assistance/LIF there are excess resources, the case will be referred to Medicaid for a separate determination. Medicaid must maintain the former $1500 equity value policy as Medicaid cannot be more restrictive under LIF than the ADC policy was on 7/16/96. Medicaid must apply either the $4650 FMV policy or the $1500 equity value policy, whichever is more beneficial to the A/R. For singles and childless couples, only the FMV is considered. (To determine the value a vehicle, see note under answer to question 1.)

7. **QUESTION**

If both members of a childless couple have cars, how are the cars evaluated?

Answer

The FMV of both cars should be obtained. One car may be exempt if it meets the $4650 FMV standard. The equity value of the other must be applied to the resource standard along with any other resources. The district may consider allowing an exemption pursuant to 18 NYCRR section 352.23 (b)(7). The recipient is expected to provide sufficient justification for the district to allow the exemptions(s). (See Questions 2 and 4.)

8. **QUESTION**

Can a pregnant woman be denied due to excess real property or value of an automobile?

Answer

No. There are no resource tests for pregnant women.

$30 AND 1/3 and $30 EARNED INCOME DISREGARDS

1. **QUESTION**

What are the criteria for the $30 and 1/3 and $30 disregard?

Answer

The $30 and 1/3 Earned Income Disregard (EID) applies when using Medically Needy ADC-related budgeting for employed persons who have received Medicaid under a LIF budget in one out of the four preceding months. The $30 and 1/3 disregard may apply when the family has lost LIF eligibility for a reason other than increased earnings, i.e., not eligible for Transitional Medicaid (TMA).

Once an individual has received four consecutive months of $30 and 1/3 and eight months of the $30 disregard, the individual cannot receive the $30 and 1/3 or the $30 disregard again until s/he has not been eligible for Medicaid under a LIF budget as a Medicaid-Only recipient or a Public Assistance recipient for 12 consecutive months. After 12 consecutive months of ineligibility under LIF has elapsed, the $30 and 1/3 criteria could again be applied.

2. **QUESTION**

What happens if the case closes during the period of $30 and 1/3?

Answer

If the case closes during the first four months of $30 and 1/3 and the applicant/recipient (A/R) reapplies within this same four month period, the $30 and 1/3 should be applied. Districts should use EID code of 4.

If the recipient reapplies more than four months after LIF eligibility terminates, the $30 and 1/3 is not applied automatically. The A/R must again be determined eligible for LIF before any of the EID disregards would apply. EID code of 6 will determine whether the A/R is eligible for a disregard. The 45%disregard will apply if eligible as is standard procedure in determining LIF eligibility.

If the case closes before the maximum eight month period of $30 has been received, the $30 disregard clock continues to run even if the case is not an active Medicaid case. (See 85 ADM-33.) If an A/R reapplies within the eight months, s/he would continue to be eligible for the $30 disregard. Use EID code of 5 or 6 depending on whether the case was LIF eligible in 1 of 4 previous months (See Attachment III.)

3. **QUESTION**

Why do we need a code for both $30 and 1/3 and the $30 exemptions?

Answer

Each disregard is time limited; $30 and 1/3 applies for four months and the $30 disregard applies for eight months after the $30 and 1/3 is given.

4. **QUESTION**

Previously, eligible Medicaid families received the $30 and 1/3 and $30 earned income disregards only when they had received Public Assistance benefits in one of the four prior months. 97 ADM-2 indicates that clients may receive $30 and 1/3 and the $30 disregard if they received Medicaid in one of the last four months. Must the family have received PA or Medicaid?

Answer

Families that receive Medicaid under LIF Budgeting, whether or not they are receiving PA, and who have earnings, may be eligible for the $30 and 1/3 or the $30 disregards. The disregard applies when eligibility under LIF is lost, and the family is not eligible for TMA. Medically Needy ADC-related budgeting is used to give $30 and 1/3 and the $30 disregards.

5. **QUESTION**

What if a PA case received $30 and 1/3 within the past year? Does Medicaid have to check the PA budget to see if the individual received the disregard?

Answer

Yes. Since the $30 and 1/3 and the $30 disregard applied in PA until 10/31/97, a family may have received these disregards in PA. The PA case should be reviewed until 10/31/98 to verify whether the $30 and 1/3 and the $30 disregards were received in PA and to verify that the A/R has not been eligible for PA in the past 12 months.

Since the $30 and 1/3 and the $30 disregard can be received only once in a 12 month period, all Medicaid-Only cases must also be reviewed.

FINGER IMAGING

1. **QUESTION**

When will the finger imaging requirements apply to Medicaid?

Answer

The State regulations to implement this provision of the Welfare Reform Act are expected to be promulgated in the near future.

Further instructions will be provided.

DRUG AND ALCOHOL ABUSE

1. **QUESTION**

If an individual is cooperating and the Drug, Alcohol and Abuse (DA&A) screening and assessment is in process, can Medicaid be authorized?

Answer

The general requirements to comply with screening and assessment apply to all Medicaid A/Rs who are singles, childless couples or parents in intact households, who are not pregnant or certified blind or disabled. DA&A processing and eligibility determinations should be completed within the 45 days allowed to determine Medicaid eligibility. As long as the A/R is cooperating in the process, Medicaid processing should continue. Please note that Medicaid requires referral to treatment only when an individual is unable to work as a result of the DA&A assessment. No work requirements are required upon completion of treatment.

2. **QUESTION**

Does the screening checklist need to be completed on-site or could a screening checklist be completed at home for one member of the case and mailed to the local district?

Answer

All adults who are singles, childless couples or parents in intact households and who are not certified blind or disabled, or pregnant must complete the DA&A screening checklist. The checklist may be completed off site as necessary, and returned with any other required documentation.

3. **QUESTION**

If the household is mixed, e.g. the mother is ADC-Related and the father is a Federally Non-Participating (FNP) parent, will the DA&A requirement apply? If the FNP parent does not comply can other individuals in the case be opened?

Answer

Yes, the DA&A requirement would apply to the father in this situation. If he does not comply, he would not be eligible for Medicaid but would be counted in the case. The rest of the family may, if otherwise eligible, receive Medicaid.

4. **QUESTION**

Who pays for the assessment of a new applicant? Who pays for transportation associated with the assessment?

Answer

If the individual is determined Medicaid eligible, Title XIX funding may be available for the assessment and transportation to the assessment. Guidelines for appropriate claiming of these activities are currently under development. These guidelines will be provided to districts in a forthcoming directive.

5. **QUESTION**

Do we think there are enough slots for assessments?

Answer

At initial implementation, every location may not have sufficient capacity to perform assessments in a timely manner. However, if the individual is complying, Medicaid should be authorized once all other eligibility requirements have been met.

6. **QUESTION**

What happens if the applicant refuses to fill out, or sign, the screening instrument?

Answer

The applicant should be denied; Medicaid for other family members is opened if otherwise eligible. (CNS code U71 - Denial-Failure to comply with Alcohol/Substance Abuse).

7. **QUESTION**

Can the screening be made part of the Client Notices System (CNS) recertification package?

Answer

The screening instrument will not be added to the CNS recertification package as the screening is required for a subset of the Medicaid population. Also, the district may choose to require completion only once when no abuse is indicated and may choose to have the screening instrument completed verbally.

8. **QUESTION**

If a person refuses recommended treatment, is this considered refusal to comply?

Answer

If treatment is required as a result of the assessment, the person must comply with these findings. However, if a person initially receives the recommended level of treatment (e.g., inpatient)

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and then leaves, and enters a different level of care (e.g., outpatient), Medicaid can be authorized provided the alternate level of care is determined to be appropriate to the individual's need. Districts may require reassessment to determine if treatment is appropriate.

9. **QUESTION**

Do we simply accept the recommended treatment level or can we question the recommended level of care?

Answer

Level of care is determined by OASAS Credentialed Alcohol and Substance Abuse Counselors (CASAC) who perform the assessment. These CASACs are either district staff or entities with whom the district has contracted to provide assessment. If the district has a compelling reason to question the recommended level of care, it should be discussed with the CASAC to find a mutually agreeable clinically valid solution.

10. **QUESTION**

Do we need to refer individuals for assessment if there is no chance that the person will be made eligible? Otherwise, the assessment becomes costly and is not necessary if the individual will never be determined eligible.

Answer

Individuals determined to be ineligible for reasons other than compliance with DA&A requirements do not need to be referred for an assessment.

11. **QUESTION**

If a person refuses to complete a screening under PA, can they apply for a separate determination under Medicaid?

Answer

Medicaid has no DA&A requirements for certified disabled or blind adults, pregnant women, individuals under 21 or 65 years of age or over, or adults in families with ADC-related deprivation factors. A PA/Medicaid case that is denied or discontinued for these applicants/recipients should be referred to Medicaid for a separate determination. No referral to Medicaid will be made for singles and childless couples who are aged 21 to 64. No referral to Medicaid will be made for the parents when PA families have no deprivation since the PA case will remain open for the children. Such individuals who reapply for Medicaid must comply with DA&A requirements.

12. **QUESTION**

In Medicaid is there a set durational sanction for refusal to comply with DA&A requirements?

Answer

No, unlike PA, there is no durational sanction for refusal to comply with these requirements. Once the person complies, Medicaid eligibility can be authorized, if the person is otherwise eligible.

13. **QUESTION**

What is the age requirement for S/CC and intact families for DA & A?

Answer

PA considers an individual age 18 and older to be an adult for purposes of DA&A. However, an 18 year old in school or training is not considered to be an adult. For Medicaid, parents in intact households and singles and childless couples who are at least 21 years and under 65 who are not certified blind or disabled or pregnant, as described in answer 11, must comply with DA&A requirements.

14. **QUESTION**

Will the DA&A screening checklist be printed in other languages?

Answer

Printings in Spanish will be available.

15. **QUESTION**

If an individual applies for Medicaid and is already in treatment, how do the screening and assessment rules apply?

Answer

Generally, policies regarding screening and assessment for Medicaid will follow those of PA. If the district has documentation that an individual is in treatment, the individual can be referred for assessment without completion of the screening instrument. The district may require reassessment to determine if the treatment is appropriate. The district may choose to allow treatment to continue and evaluate any additional treatment needs at completion of treatment.

16. **QUESTION**

What if an individual wants to receive treatment?

Answer

Individuals who are not required to be in treatment but who want treatment should be advised they may discuss treatment with the county's OASAS certified professionals or their Medicaid provider.

17. **QUESTION**

Do DA&A screening and assessment requirements apply to the SSI population?

Answer

DA&A screening/assessment requirements do not apply to SSI or SSI-related individuals. They apply only to singles and childless couples and to parents in intact households who are between the ages of 21 and 64 and who are not certified blind or disabled and not pregnant.

18. **QUESTION**

Must we notify A/Rs that they now need to comply with DA&A requirements?

Answer

The Client Booklet describing rights and responsibilities is in the process of being updated to notify affected Medicaid A/Rs of DA&A requirements. Districts are required to implement these provisions consistent with the statutory effective date of November 1, 1997.

MEDICAID COVERAGE CODES

1. **QUESTION**

Are there any changes to Medicaid Coverage Codes as a result of Welfare Reform?

Answer

The major change to Medicaid Coverage Codes is to allow entry of Medicaid Coverage Code 04 (no coverage-ineligible) in a PA case for an individual with an individual status code of 07 (active). This will result in no Medicaid coverage on a PA case and should be used when the individual is not eligible as a result of Alien Status or not applying for Medicaid. Also, MA Coverage Code 04 (no coverage-ineligible) would be used in a PA case when real property is over the resource limit while PA allows up to 6 months to liquidate the property.

Changes in Case Type as a result of Welfare Reform have necessitated a change in Coverage Code for PA eligible parents in intact families. Since the Case Type for these parents has changed from 14 (PG-ADC) to 11 (Family Assistance), Medicaid Coverage Codes must equal 01 (full coverage) or 30 (PCP full coverage) rather than 16 (HR coverage) or 32 (PCP HR coverage). Please refer to 97 ADM-20 and GIS 97 MA/029.

2. **QUESTION**

When changing the Adult Individual Categorical Code from 09 (HR Adult) or 39 (FNP Parent) to 26 (Adult No Deprivation), should the Medicaid coverage code be changed?

Answer

Yes, if the Case Type is 11 (Family Assistance) or 12 (Safety Net, Non-Cash, federally funded) and the Individual Categorical Code is changed to 26 (LIF Adult No Deprivation), the Medicaid Coverage Code must be changed to 01 (Full Coverage), 30 (PCP Full Coverage) or 31 (PCP Coverage Only) as appropriate. Children should remain with an Individual Categorical Code of 09 (LIF Child No Deprivation) with a Medicaid Coverage Code of 16 (HR Coverage).

NOTE: PA must change Individual Categorical Codes: 14 (Essential Person); 30 (HR/FP Parent); and 49 (19-21 year old sanctioned) to appropriate individual categorical codes to ensure the correct one month extension for a separate determination.

Individual Categorical Code 26 is allowed with Medicaid Coverage Codes 16 (HR Coverage) and 32 (PCP/HR Coverage) in PA Case Types 14 (PG-ADC), 16 (Safety Net, Intact Families, Child over 18) or 17 (Safety Net Non Cash). It is also allowed with Medicaid Coverage Codes 16 (HR Coverage), 32 (PCP HR Coverage) and 33 (PCP/HR Guarantee Coverage) in a Medicaid case (Case Type 20).

3. **QUESTION**

Will forced closings continue to be enforced?

Answer

Forced case closings or deletions of individuals as a result of PA entry of 04 coverage (no coverage-ineligible) will not occur if there is already coverage existing on a Medicaid case. No other forced closings or deletion processing have been changed.

4. **QUESTION**

Will Medicaid coverage dates be generated from the PA case?

Answer

Yes, for Transaction Types 02 and 06, Medicaid coverage dates will continue to be generated from the PA Authorization Dates even if the Medicaid Coverage Code is 04 (no coverage-ineligible).

TRANSITIONAL MEDICAL ASSISTANCE (TMA)

1. **QUESTION**

What drives the mailer process for TMA now that eligibility for TMA is based on Medicaid eligibility?

Answer

TMA is based on the loss of Medicaid eligibility. TMA is applied when LIF eligibility is lost due to new employment or increased earnings of the caretaker relative and:

-there is a dependent child living at home, and
-the family has received LIF in three out of the six preceding months prior to losing LIF eligibility.

A new Medicaid undercare reason code, E08, will drive the mailer process for Medicaid-Only cases.

When a worker closes a PA case and enters CNS reason code E31, M92 or M93 on WMS, the Medicaid WMS Reason Code 088 will continue to be generated when appropriate. Reason Code 088 will continue to initiate the mailer process when the PA/Medicaid case is closed.

Since CNS Undercare notices have not yet been implemented, a new manual notice for a Medicaid case has been developed. The new notice was forwarded to districts with the "Dear Medicaid Director" letter of January 5, 1998.

2. **QUESTION**

If the person is TMA eligible, will the system identify the individual as TMA eligible?

Answer

No. TMA can be given only when LIF eligibility is lost AND the individual meets the TMA criteria as described in Question 1 of this section. The ADC-related budget will appear on MBL rather than the previous budget showing eligibility under LIF. The worker must know the TMA criteria and when to apply the policy. There is a WMS edit which prevents entry of RC E08 if the family was not eligible for Medicaid in at least three of the last six months under the Medicaid case number.

3. **QUESTION**

TMA guarantees six months of eligibility. If the individual marries during the six month period, or the father of one of the children in the TMA household returns home, do the wages of the new spouse/father apply? Is the unearned income of the new spouse counted?

Answer

The new spouse's/father's income is not counted for the initial six months because Medicaid is guaranteed to the individuals originally included in the case. If the father applies for Medicaid, the family's income and resources are counted in determining his eligibility.

After the initial six months, the spouse/father and his/her earned income would be added to the rest of the household's earned income to determine TMA eligibility.

4. **QUESTION**

Can new individuals be added to the case during the TMA guarantee period?

Answer

Yes, they can, but only if they are in the household and the family would be eligible (categorically and financially) under LIF in the current month. However, if the individuals originally included in the case are ineligible under LIF budgeting with the new individual's earned income added, then the new individual and his/her income should not be added in until after the 6 month guarantee period. This does not include individuals who are not related by blood, marriage or adoption to children in the household since they would not be included in a LIF household.

5. **QUESTION**

When a person fails LIF and is entitled to TMA, must a new budget without a "T" in the Expanded Eligibility Code (EEC) field on MBL be done?

Answer

The budget that shows ineligibility for LIF does not include a "T" in the EEC field. No additional budget needs to be done at initial TMA authorization.

The EEC code of "T" is used when the worker has received the third and sixth month mailers from the recipient. The "T" generates a MBL budget which compares earned income to 185% of the federal poverty level to determine TMA eligibility for months seven through twelve.

6. **QUESTION**

What Individual Categorical Codes should be used for Transitional Medicaid?

Answer

The LIF Individual Categorical Codes (01-09, 13, 15, 26 or 48) should be used.

7. **QUESTION**

How does the local district track the receipt of the mailer?

Answer

The mailer system on WMS, selection 24 from the main menu, allows the worker to record all actions relating to the TMA mailer.

8. **QUESTION**
What budget should be stored for TMA?

Answer

For the first six months, the initial budget which caused the individual to fail LIF should be stored (the ADC-related budget). The worker should make a note on the budget output kept in the case record that the person is receiving six months of guaranteed TMA. For the second six months, the "T" budget should be stored.

9. **QUESTION**

Could a family be fully eligible under Medicaid-Only but receive TMA first?

Answer

Yes, if ineligible for LIF, the Medicaid level will be asterisked to indicate that the family failed the LIF budget. The worker should determine if the family meets the TMA criteria and authorize the case accordingly. At the conclusion of the TMA period, the case will become due for recertification. Eligibility should be evaluated under all appropriate Medicaid categories.

10. **QUESTION**

Can a person receive TMA based on the retroactive period?

Answer

TMA must be prospective, but the retroactive period should be evaluated to determine if:

- Medicaid coverage is requested for bills in the retroactive period;

  and

- the person is determined to have been fully eligible under LIF for the retroactive period.

If they meet the above criteria, retroactive months can be used in the three out of six months test for qualifying for TMA.

11. **QUESTION**

Does this mean that we in Medicaid are transitioning our own cases?

Answer

Yes. Since PA and Medicaid are no longer linked, TMA is driven from ineligibility for LIF regardless of whether the A/R is a PA or Medicaid recipient.

12. **QUESTION**

Do all the requirements/tests under TMA continue?

Answer

Yes, except that eligibility for TMA is driven from loss of eligibility for Medicaid under LIF regardless of whether the A/R is a PA or Medicaid recipient.

13. **QUESTION**

If a person on PA requests their PA and Medicaid cases to be closed due to increased earnings, must TMA be provided?

Answer

The worker should inform the A/R about TMA. However, if the A/R does not want TMA, then both PA and Medicaid cases should be closed.

14. **QUESTION**

After the TMA extension (12 months) are the individuals automatically entitled to the 45% earned income disregard?

Answer

No. The 45% Earned Income disregard is a LIF disregard. Once a person's TMA has ended, a new budget must be calculated. Please note that TMA began when LIF eligibility ended. If the income has not changed, the recipient will not be eligible under LIF budgeting.

If the family's income has decreased, eligibility must be evaluated as for any applicant who has not received LIF in one of the last four months, i.e., use EID 6. Eligibility will be evaluated under LIF, ADC-related, and poverty level programs as appropriate.

15. **QUESTION**

If a TMA case has a decrease in earnings during the second six months and the case would be eligible under LIF, should Medicaid be authorized under LIF or be continued under the TMA extension?

Answer

TMA should continue because in most situations (especially those with fluctuating earnings) TMA will allow for longer periods of Medicaid coverage.

16. **QUESTION**

If a case has been extended under TMA since September (based on loss of the $30 and 1/3 or $30 earned income disregards that applied under ADC), do we need to rebudget these cases?

Answer

No. Any extensions which began and were not completed prior to November 1, 1997, should continue until the end of the extension.

17. **QUESTION**

Will a closing drive TMA on a Medicaid-Only case?

Answer

No. When LIF eligibility no longer exists due to increased earnings, the Medicaid case will not be closed. Rather, the worker must authorize TMA. When a recipient fails LIF due to new or increased earnings, an ADC budget will be displayed. The Medicaid worker must enter CNS undercare reason code E08 to start the mailer process when the worker has determined that TMA eligibility exists. (See Question 1 in this section.)

18. **QUESTION**

Can you count the Child Care expenditure as a deduction and allow for TMA?

Answer

Child care paid by an applicant/recipient is a deduction under LIF and TMA budgeting. If a recipient fails the LIF budget, a six month guarantee of TMA does not require any further changes to the budget until the TMA budget must be done when the mailers are received in months three and six.

19. **QUESTION**

If a person was on PA but refused Medicaid, then lost PA eligibility due to increased earnings, is the person eligible for TMA?

Answer

No. The person must have been receiving Medicaid under LIF in three of the six preceding months.

20. **QUESTION**

If a person has increased earnings which were unreported while on PA, should TMA be authorized while PA is investigating fraud, and if TMA can be authorized, when should it start?

Answer

If there is no proof that fraud exists, TMA should not be pended while potential fraud is being investigated. If the A/R is convicted of fraud, the county should: (1) delete the individual who committed fraud from the TMA case; (2) redetermine ongoing Medicaid and TMA eligibility for the other family members; and (3) attempt to recover Medicaid incorrectly paid.

If otherwise eligible, TMA should be authorized prospectively, beginning with: (1) the month following learning of the increased earnings; or (2) the month following the transaction date if the closing date is in the month following the transaction date due to the 10 day notice requirement. For example, if the transaction date is April 5 and the closing date is May 10, then TMA begins May 1.

NOTE: TMA can be rejected or terminated in situations where it is documented that the client was never actually eligible for LIF in at least 3 of the last 6 months when counting all income, including unreported income.

21. **QUESTION**

Does TMA cross county lines?

Answer

Yes. When the family moves, they must go to the local social services office where they moved and tell the worker they were on TMA in their former county of residence. The new county should request documentation from the previous county and provide assistance (TMA) as appropriate.

22. **QUESTION**

If a case was recertified prior to 11/1/98 and as a result was not

rebudgeted using LIF methodology, how should this case be handled at recertification?

Answer

The case should be reviewed for possible LIF eligibility from 11/1/98 forward. If the case was LIF eligible in any month, then a an EID code 1 should be used at recertification. The case also gains potential eligibility for TMA.

23. **QUESTION**

If it is necessary to make an undercare transaction to a TMA case, should Codes 088, 089, E08 or Y78 be re-entered to continue the TMA case?

Answer

No, Codes 088, 089, E08 and Y78 should not be re-entered, because WMS will create a new mailer cycle based on the new authorization-from-date.

24. **QUESTION**

When a pregnant minor living at home who is eligible under LIF recertifies at the end of the post partum 60 day extension and her parents' income must now be counted in determining her eligibility, is she eligible to receive TMA?

Answer

As long as the teen is working and counting her parents' income makes her ineligible under LIF, then she can receive TMA.

If the teen is not working and becomes ineligible due to parental income, the teen is not entitled to TMA.

CHILD ASSISTANCE PROGRAM (CAP)

1. **QUESTION**

Do CAP cases receive TMA?

Answer

Yes, CAP participants may be eligible for TMA if they meet the standard TMA requirements. (See OMM/ADM 97-2 and 97 ADM-24.)

2. **QUESTION**

If a CAP/TMA eligible case has a decrease in earnings and the case would be eligible under LIF, should the TMA extension continue?

Answer

Yes, TMA should continue regardless of eligibility under one of the budgeting methodologies because in most situations (especially those with fluctuating earnings) TMA will allow for a longer period of Medicaid coverage.

3. **QUESTION**

What is the amount which can be allowed for the child care deduction?

Answer

A child care deduction will be allowed only when the family has out of pocket child care expenses. The child care deduction continues to be $175 (age two or over) or $200 (under age two). If the family is eligible under LIF without deducting child care, no further calculation is necessary. If there is an excess income amount which is less than the allowed child care deduction, a budget with the child care deduction for the child care expenses as they were actually paid by the family should be done on MBL. MBL allows entry of child care as a deduction under LIF.

4. **QUESTION**

If the budgeting is done for CAP and the person is eligible for Medicaid with a spenddown, does the county need to wait to apply the spenddown until April, 1998 (after the guarantee)?

Answer

Districts were advised in OMM/ADM 97-2 that if a CAP recipient was found to be ineligible for Medicaid or Medicaid extensions such that Medicaid coverage would have ended before March 31, 1998, then they should have contacted the Office of Medicaid Management (OMM) to find out how to extend Medicaid coverage (97 ADM-24). Districts should continue to contact OMM should such circumstances arise. CAP workers will do TMA and authorizations for Medicaid under LIF budgeting. When a spenddown exists, the case should be referred to Medicaid staff or a CAP worker trained on Medicaid.

5. **QUESTION**

Are CAP recipients required to pass the 185% of the gross income test and 100% of the federal poverty level test?

Answer

These tests apply to all applicants under LIF budgeting. They do not apply to Medicaid eligibility under ADC-related or poverty level programs.

6. **QUESTION**

   If unearned income makes a CAP recipient ineligible, will TMA apply?

   Answer

   TMA applies when **earned** income causes ineligibility under LIF. However, the family might be eligible for the four month child support extension or the $30 and 1/3 or $30 earned income disregards and must be evaluated under these provisions.

MBL/EID/BUDGETING PROCESS (Attachment III, Earned Income Disregard (EID) Code Selection for Budget Types 01, 05 and 09, reflects answers to many of the questions in this section.)

1. **QUESTION**

   The MBL screens include values F and N under Earned Income in the "T" field. What do these values represent?

   Answer

   An "F" in this field provides for the $90 earned income disregard. Each employed individual is entitled to one $90 disregard. The entry of an "N" (No deductions) will prevent the $90 disregard from being deducted on the budget. Code N is a required entry in the "T" field for one of two incomes when one person has two separate incomes budgeted since only one $90 disregard applies per employed person.

2. **QUESTION**

   Can a third line of Earned Income be added to the MBL screen?

   Answer

   Currently MBL can only accommodate two occurrences of earned income. However, if one individual has two incomes the gross amounts can be added together and entered in one of the two income fields. An increase in the number of Earned Income entries has been added to the list of items which we have identified as potential changes for any redesign effort.

3. **QUESTION**

   In the future, could printing and distribution of individual budgets as a result of Mass Rebudgeting be considered?

Answer

Due to the scope of Mass Rebudgeting, the printing of budgets is not feasible. However, when CNS is able to produce MRB notices, income information will appear on the notice.

4. **QUESTION**

For the determination of TMA, will MBL know if the A/R was eligible in three of the past six months?

Answer

No. There is no connection between MBL and WMS. WMS will perform the 3 out 6 month test on a particular case number when the worker inputs undercare reason code E08. (See Attachment III of the WMS/CNS coordinator letter dated November 18, 1997.) However, the worker must determine if the A/R was receiving Medicaid through LIF budgeting in three of the six preceding months. Receiving MA through LIF budgeting can be a combination of Medicaid-Only and Medicaid received simultaneously with PA.

5. **QUESTION**

Can the resource screen handle 7 digits?

Answer

The resource screen can still only accommodate six digits. This request will be considered as part of the anticipated MBL redesign.

6. **QUESTION**

Is an Age Indicator (AI) on the MBL input screen required for all cases?

Answer

The Age Indicator is only required for S/CC cases (BT 02, 06, and 10) when resources are entered on the budget. The AI is needed since this category of individuals has two resource levels distinguished by age. If no resources are entered on the budget, an entry in the AI is not required.

7. **QUESTION**

Are cars always entered on the budget?

Answer

No, cars are not entered as a resource if they are exempt or when not exempted and there is no excess value (i.e., value doesn't exceed appropriate exemption standard).

8. **QUESTION**

Will the system automatically determine eligibility under the various categories (LIF, ADC, poverty levels, etc.)?

Answer

The system will do the necessary work to determine the most favorable category of eligibility. If the worker makes entries in the appropriate fields, MBL output will asterisk the PA standard if LIF eligible or the Medicaid level if eligible under ADC-related budgeting or present the Expanded Eligibility Screen when appropriate.

9. **QUESTION**

If a family does not want to apply for a child with income, how must budgeting be done?

Answer

Mehler budgeting (the option of an applicant/recipient to exclude children with income or resources) is not allowed under LIF budgeting or poverty level budgeting, but is allowed when doing an ADC-related budget using medically needy standards. Since the worker must explain budget options to help the A/R decide if it would be more advantageous to the rest of the family if they did not apply for a child(ren) with income, the Medicaid worker should:

- First do the LIF budget with the entire family and all their income included in the budget if the family has provided information about the child's income/resources. MBL will perform the calculations and indicate whether the family is eligible under the PA standard or Medicaid level.

- If they fail the LIF budget and have a spenddown under the medically needy budget, the A/R may decide to exclude a child with income. In such a situation or when the family has not provided information about the child's income or resources,

  -Do the budget again using EID 6 if there is earned income without the child and without the child's income/resources.

  -If eligible under the medically needy standard, authorize Medicaid for the applying household members. Use the individual categorical codes for ADC-related medically needy families and keep a copy of the budget in the case record.

-If budget shows eligibility under LIF, note on the budget (which should be kept in the case record) that the family is not categorically eligible for LIF (since LIF does not allow Mehler budgeting). Use ADC-Related medically needy individual categorical codes to authorize Medicaid for the applying household members.

Note: If only a parent is applying, LIF budgeting may be used. However, if a parent is applying with some but not all of the children, then use Mehler budgeting and the Medically Needy ADC-related standards.

10. **QUESTION**

If child care is being paid in full by the local department of social services (LDSS), is child care deducted in the Medicaid budget?

Answer

No, only the costs actually paid by the A/R can be deducted.

11. **QUESTION**

If a family fails LIF, does the Medicaid-Only ADC-Related budget compare income to the Medicaid or the PA Level whichever is higher?

Answer

ADC-related budgeting will continue to compare income to the higher of the Medicaid or PA level whether the family fails LIF for either income or resources. However, if the family fails LIF due to excess resources, the family is ineligible for LIF. Eligibility calculated in MBL will reflect ADC-related budgeting.

12. **QUESTION**

How does the worker know if the person fails the 100% poverty level in LIF budgeting?

Answer

The worker will not now know which LIF test is failed when MBL moves to ADC-related budgeting. Addition of this feature will be considered as part of the anticipated MBL redesign.

13. **QUESTION**

Why is the EID code of 1 used for one person and the EID code of 6 used for the other?

Answer

Different EID codes may be used if both wage earners had not been on LIF in one of the previous four months. The EID code of 6 is only used for A/Rs who have not received LIF in one out of the four previous months. The EID code 1 is used when LIF was received in one of the four previous months.

For EID code 6, MBL:

a. performs the 185% of PA standard of need test;
b. performs the 100% federal poverty level test (1996 levels until June 1998);
c. compares net income to PA standard of need (allowing the $90 earned income disregard and child care deduction); and
d. if all tests are passed, MBL will then allow the 45% earned income disregard.

For EID Code 1, MBL:

a. performs the 185% test;
b. performs the 100% FPL test;
c. if all tests are passed, allows the 45% Earned Income Disregard.

Under EID code 1, MBL does not compare net income to the PA standard of need before giving the 45% because the worker has determined that the recipient is currently eligible under LIF or received LIF in one of the past four months. MBL automatically gives the 45% EID to LIF eligible A/Rs who pass the 185% and 100% FPL tests.

14. **QUESTION**

What EID Code should be used at recertification?

Answer

The worker will need to know whether the wage earner has been eligible under LIF previously when rebudgeting at recertification. If the wage earner has received Medicaid under ADC-related or poverty level programs until recertification, EID Code 6 must be used.

If the family is eligible under LIF until recertification, EID Code 1 must be used. If the family has received LIF in at least one of the past four months and is now ineligible for LIF and has not received the $30 and 1/3 or $30 disregards within the past 12 months, EID Codes 4 or 5 may be used.

15. **QUESTION**

Will PA be entering the EID codes?

Answer

PA budgeting parallels MBL budgeting for EID codes 1 and 6 only. The remaining EID codes do not reflect PA budgeting. PA will no longer use $30 and 1/3 or $30 as disregards. Also, PA has no programs parallel to Medicaid's ADC-related medically needy or poverty level programs to require the use of these codes.

16. **QUESTION**

Can MBL be programmed to blink when a worker leaves an EID code of "6" in the budget at recertification?

Answer

No. This change will not be included with the Welfare Reform system changes because if LIF was not received in one of the four previous months, code 6 should be used again.

17. **QUESTION**

Can MBL give workers a message on the output screen when an undercare case with earnings fails LIF and should be considered for TMA?

Answer

No. A message would need to be on all cases (undercare) where an ADC-related budget is displayed. Many of these cases will not have been eligible under LIF before.

18. **QUESTION**

If there is no earned income in the budget, is it still necessary to enter the EID code (budget is changing due to child support)?

Answer

No. Entry of an EID code is required only when a family has earned income.

19. **QUESTION**

Since PA budgeting requires entry of a shelter amount, must we document shelter amount to do a LIF budget?

Answer

Shelter amount must be documented, however, a statement from the A/R may be accepted as documentation of shelter for LIF eligibility. If a statement of shelter expenses is not provided then the shelter amount should be entered as zero.

20. **QUESTION**

If a family applies and wants retroactive coverage for past bills, will the family be eligible for the 45% earned income disregard if their LIF eligibility is confirmed for the retroactive period?

Answer

Yes. If eligibility is authorized under LIF for the retroactive period (and the period is on or after 11/1/97), the 45% EID will apply to the subsequent months.

21. **QUESTION**

Are gross earnings used for the Federal Poverty Level test in LIF budgeting?

Answer

Yes. The sum of gross earned and unearned income is compared to the Federal Poverty Level.

22. **QUESTION**

When will a deduction for health insurance be allowed?

Answer

Health care premiums will not be allowed as a deduction under LIF budgeting, but if cost effective, Medicaid can pay the premiums including premiums for single and childless couples.

NOTE: Health care premiums should still be entered on MBL. For all budgets except 02, MBL will not deduct premiums for LIF budgets, but will allow the deduction for ADC-related budgets.

23. **QUESTION**

When completing a LIF budget, we will need to know the amount of the shelter expense and fuel type. We will be asking for a landlord statement to show the amount of the rent. Will the landlord statement be sufficient for verification of the fuel type, or do we need verification from the fuel company?

Answer

Districts have the option to accept a statement from the client regarding reasonable shelter and fuel expenses under a LIF budget since entry of these expenses are necessary only under LIF budgeting. Districts should verify fuel and shelter expenses with additional documentation when the statement appears unrealistic given the case circumstances.

DEFINITION OF CHILDHOOD DISABILITY

1. **QUESTION**

Does the "deemed" disability status for children who lose SSI due to the change in the disability criteria end when the child reaches age 18?

Answer

Yes. The childhood definition of disability ends when a child reaches age 18.

2. **QUESTION**

When the list of children who have lost SSI eligibility due to a change in disability criteria is made available to local districts (via BICS and hard copy), will the system automatically set the SSI Status Code to "5"?

Answer

The system will not automatically set the SSI Status Code to 5. This should be done as a result of the worker's review of the case.

3. **QUESTION**

Do SSI benefit levels for children vary?

Answer

The SSI benefit levels vary depending on the living arrangement of the child. If the child is living with his or her parent, the SSI benefit level is the "living with others" amount (Federal Benefit Rate plus State supplement found on the SSI Benefit Levels Chart, DSS-3715EL Rev. 10/97).

4. **QUESTION**

What happens if a disabled child loses SSI for financial reasons and his or her parents are on SSI? How should the child be budgeted?

Answer

The parents would be invisible in the Medicaid budget process. The child would be budgeted as an SSI-related household of one.

5. **QUESTION**

What categorical code should be used for children who have a deemed disability status?

Answer

The individual categorical code will depend on the budget under which the child is found eligible. If the child is eligible under an SSI-related budget using SSI income/resource levels, the categorical code should be 12 (Disabled).

6. **QUESTION**

Why does the SSI Status Code "5" need to be entered if the child is not eligible under an SSI-related budget?

Answer

Pending further information from the Health Care Financing Administration (HCFA) regarding the on-going nature of a child's disability status, local districts are requested to use the "5" code for identification purposes. If the child is eligible for any category (including eligible with a spenddown) the SSI Status Code "5" should be entered. If the child is ineligible under all categories, the SSI Status Code does not have to be entered.

7. **QUESTION**

Local districts are currently using the SSI Status Code "5" to identify Disabled Adult Child (DAC) cases. The use of the same "5" Code for children who have a deemed disability status will not allow for the distinction of these two types of cases.

Answer

The DAC cases will look different on MBL with an EEC Code "E" (Disabled Adult Child DAC)) and an Unearned Income Source Code "47" (Social Security Benefit - DAC).

8. **QUESTION**

Will the parents' income information be available on the tape of children who have lost SSI? Do we need to contact the parents?

Answer

Additional information regarding parental income/resources will probably be required.

As part of the Medicaid eligibility redetermination process, parents may be contacted.

9. **QUESTION**

If a child is receiving Public Assistance benefits, should PA be coding these cases with an SSI Status Code of "5" as well?

Answer

Yes, this is the only method of identification.

10. **QUESTION**

When should a local district look at an SSI-related budget for a child?

Answer

For initial eligibility redeterminations (following the loss of SSI) and at recertification, local districts should do a LIF/ADC-related and SSI-related budget. The net income and resources from the SSI-related budget must be compared to the SSI income and resource level. If the child is not fully eligible under the SSI-related budget, a review of eligibility under the LIF/ADC-related budget should be made. (See 98 OMM/LCM-002 for further information.)

MEDICAID/SSI COVERAGE

1. **QUESTION**

Currently, New York's processing of State Data Exchange (SDX) transactions does not generate the correct Medicaid effective date for Supplemental Security Income (SSI) applications filed on or after August 22, 1996. Will this be changed?

Answer

Effective January 10, 1998 via the Automated SDX/WMS Interface (Upstate) and Auto SDX (NYC), the Medicaid effective "FROM" date equals the actual month of SSI eligibility. Attachment I to SDX Information Sheet, #640, dated December 24, 1997, contains further information.

2. **QUESTION**

Since the "Dear SSI Beneficiary" letter issued by the State indicates that SSI recipients may be eligible for payment of unpaid medical bills for up to three months prior to the month of SSI application, is the letter going to be changed to reflect the correct three month retroactive period?

Answer

The effective date of an SSI application, as defined in federal law, is the later of the first day of the month following the date

the application is filed or the first day of the month following the date the individual first becomes eligible. For example, an application filed April 2 (the month of SSI application) will not be effective until May 1. The "Dear SSI Beneficiary" letter refers to the "month of application" rather than the "effective" date of an SSI application. Therefore, it is not necessary to make any revisions to the "Dear SSI Beneficiary" letter.

3. **QUESTION**

Can the individual present an unpaid bill as well as paid bills and have coverage backdated as a result?

Answer

Yes. For the retroactive period, unpaid bills can be presented for payment and paid bills can be presented for reimbursement, if the A/R is otherwise eligible. Medicaid coverage can be backdated for up to four months (three months for the retroactive period if otherwise eligible, plus one month "gap month"). Once system modifications have been made to generate the correct Medicaid effective date, coverage can be backdated for a maximum three month period if otherwise eligible. Paid bills should be reviewed for possible reimbursement.

4. **QUESTION**

If individuals have excess income in the gap month are they fully eligible for Medicaid?

Answer

This situation should not occur. An individual should meet all eligibility factors in the month immediately preceding the Medicaid effective date that is currently being system driven.

5. **QUESTION**

In cases where retroactive SSI benefits are paid, is Safety Net (case types 16 & 17) interim assistance recouped?

Answer

Yes. Additionally, for purposes of determining whether a retroactive lump sum payment is to be paid in installments rather than in one lump sum, any interim assistance is deducted first.

INDIVIDUAL CATEGORICAL CODES

1. **QUESTION**

There are a number of new Individual Categorical Codes as a result of Welfare Reform. Are there edits which will control the entry of the Individual Categorical Codes?

Answer

Individual Categorical Codes are used in a number of situations as well as across Case Types. As a result, there are very few edits in place to control the entry of the Individual Categorical Codes. Workers should refer to the chart provided during Regional Meetings or contained in the November CNS Coordinator letter. Limited editing may be requested to indicate a mismatch (using a combination of LIF & Medicaid-Only codes) as a system enhancement.

2. **QUESTION**

Why are Individual Categorical Codes important?

Answer

Individual Categorical Codes are used for editing a variety of aspects in the processing of a case. Additionally, the entry of codes is used to ensure proper claiming of Federal and State participation in the payment of a medical claim for the individual. The CNS processing of separate determinations and notices has been revised and is now based on the Individual Categorical code rather than the Case Type associated with the individual. In addition, Categorical Codes are used for reporting by category and program evaluation.

3. **QUESTION**

When should Individual Categorical Code 39 be used?

Answer

Individual Categorical Code 39 is used for parents in intact households (FNP expanded parents) when determining ADC-related eligibility. This Categorical Code should be used even if parents are ineligible under an ADC-related budget.

4. **QUESTION**

Can edits be put in place between WMS and MBL to ensure the correct Individual Categorical Code is used?

Answer

Currently, there is no ability to cross edit between the two systems.

5. **QUESTION**

Will there be a mass systemic conversion of categorical codes?

Answer

No, there will be no mass conversion of categorical codes for cases. The system cannot assign the appropriate categorical code. These codes will need to be addressed the next time the case is handled.

6. **QUESTION**

There will not be a mass conversion of all the individual categorical codes for cases on file when the Welfare Reform systems changes are implemented. When Individual Categorical Codes are used to create proper CNS notices for Medicaid extensions of PA cases, is it necessary to change Individual Categorical Codes when closing or denying the case?

Answer

When closing a PA case, the Individual Categorical Code **must** be changed to reflect the new Individual Categorical Code resulting from the Welfare Reform changes and which are effective 12/15/97. When denying a PA application, the appropriate Individual Categorical Code must be entered.

7. **QUESTION**

Due to the differences in the PA and Medicaid definition of a minor child, is it possible that PA assigned Individual Categorical Codes differ from Medicaid assigned categorical codes?

Answer

No. PA treats minors who are 18 years old and not in school, and 19 and older as adults. PA will identify these minors using the Medicaid definition of a minor child (under 21 years of age with or without a deprivation factor). The Individual Categorical Codes are 01 through 09 (i.e., 09 could be a child with no deprivation living in or out of home with no specified relatives, i.e., parents).

However, if a minor parent is living outside the parental home, with his/her own child, then use categorical codes for adults based on the circumstances of the child in the home. For instance, when the minor parents of a child are living on their own, there may be no deprivation. The minor parent's individual categorical codes will equal 26 under LIF and 39 under ADC-related eligibility.

8. **QUESTION**

Do we need to use Individual Categorical Code 36 for Presumptive Eligibility for Pregnant Women?

Answer

Yes.

9. **QUESTION**

Why can't the Individual Categorical Codes 01-09 be used for ADC-related budgets?

Answer

Individual Categorical Codes 01-09 will be used to identify children who are found eligible under LIF budgeting in either PA or Medicaid. For reporting purposes, it is necessary to make a distinction between children eligible under LIF from those eligible under ADC-related budgeting. Since Individual Categorical Codes 01-09 are used in PA, the decision was made to use categorical codes 01-09 for LIF budgeting in Medicaid.

WORK RULES

1. **QUESTION**

If a work rules sanction crosses the November 1st effective date, does the sanction apply?

Answer

No. However, if a previous sanction resulted in Medicaid ineligibility, it will be necessary for the individual to reapply for Medicaid. If the person applies separately for Medicaid, there are no work rules. The Medicaid eligibility should be determined without regard to the sanction or to work rules. If the individual does not apply separately for Medicaid, the Medicaid case remains closed.

2. **QUESTION**

Must a current PA recipient apply for a Medicaid redetermination when PA closes due to noncompliance with work rules?

Answer

If the recipient initially applied for Medicaid, it is not necessary to reapply because loss of PA will not generate a Medicaid closing. A separate determination must automatically be made unless the Medicaid case can be closed for the same reason as the PA case.

3. **QUESTION**

Is an education sanction for TA considered the same as an employment sanction?

Answer

Yes, therefore, an education sanction has no impact on Medicaid eligibility. (See 97 ADM-23, page 16.)

MISCELLANEOUS

1. **QUESTION**

If there is increased child support, is there a four month guarantee even if the child support was established earlier than the current reason for closing the case?

Answer

No. There must be increased child support in the month in which eligibility is lost and the family must have received Medicaid under LIF for at least three of the previous six months. If these criteria are met, then the four month period is a guarantee of eligibility.

2. **QUESTION**

Can health insurance premiums, when determined cost effective, be paid directly to the carrier rather than reimburse the A/R?

Answer

Yes. Districts can choose to pay insurance premiums directly to the carrier, or to the employee, or to the recipient.

3. **QUESTION**

Must the ADC-U checklist be used for Medicaid?

Answer

No. The ADC-U checklist is no longer used for Medicaid.

4. **QUESTION**

We no longer need to do an ADC-U checklist to prove ADC-U categorical eligibility. When the clients are not working and have never worked, can the intact family be ADC-U eligible?

Answer

No. An individual must have worked at some time in the past in order to be identified as a principal wage earner.

5. **QUESTION**

When you have a family active on LIF and one of the children starts to receive child support income which makes the family ineligible under LIF, can we still Mehler that child out of the LIF budget and then give the child a four month Medicaid extension or does the entire family come off of LIF and be given the four month extension?

Answer

The entire family would get the four month extension if they were eligible under LIF for three out of the past six months. After the four month extension, the family must be budgeted under ADC-related budgeting methodology. The child can be deleted from the case and remaining family members authorized as ADC-related individuals.

6. **QUESTION**

If individuals are eligible for LIF, will they always be in receipt of Family Assistance?

Answer

No, a person may choose not to receive a cash grant but may choose to receive Medicaid-Only.

7. **QUESTION**

Is there a required recertification following the four month extension for child support?

Answer

As in the past, districts must redetermine Medicaid eligibility prior to the end of the extension. However, a full recertification is not necessary.

8. **QUESTION**

Does a minor child who needs Medicaid-Only need a separate Medicaid case from his/her family on PA/Medicaid?

Answer

Generally, a separate Medicaid case must be opened for children not included in a Public Assistance/Medicaid case. However, WMS continues to allow the authorization of Medicaid on an active PA case in certain instances.

For example, infants under age 1 not in receipt of cash but eligible for Medicaid during the 1 year guarantee period (use individual categorical code 41); and non CAP children in a CAP household (use individual categorical code 40) may be authorized Medicaid-Only on a PA case.

9. **QUESTION**

How do you determine LIF eligibility for pregnant women and children applying on the one-page application (DSS 2921P)?

Answer

As indicated in OMM/ADM 97-2, the one page Medicaid/WIC application is used when only pregnant women or children born on or after October 1, 1983 apply for assistance contains no resource information. As a clarification, such cases should be processed using the LIF income budgeting methodology. If income is below the LIF standard, the case should be treated as a LIF case with appropriate coding.

10. **QUESTION**

If workers are only taking applications, why train them on the effect of the 45% earned income disregard when it has no impact on Medicaid eligibility?

Answer

The 45% earned income disregard is part of the LIF budgeting methodology and does affect the category under which Medicaid may be received. The earned income disregard needs to be calculated with the earnings the individual has at that time. At recertification, the worker may enter increased earnings. Once eligible under LIF, the A/R may become eligible for TMA or the child support extension.

11. **QUESTION**

Are the local shares different between the LIF and Medicaid-Only ADC-related groups?

Answer

No, the shares are 50% Federal/25% State/25% Local for both.

12. **QUESTION**

If the funding shares remain the same as in the past, what is the advantage to Medicaid-Only ADC-related?

Answer

While there is no difference in local shares or federal reimbursement, there are potential advantages to the A/R. For example, spenddown is not allowed under LIF, but is allowed under Medicaid-Only ADC-related. Similarly, the Medicaid income and resource levels used in Medicaid-Only ADC-related are higher, while the lower PA income and resource standards are used in LIF budgeting/eligibility.

13. **QUESTION**

If a child is deleted from the PA case, must there be a separate referral to Medicaid? How should the Medicaid determination be done, as a part of PA case or separate case?

Answer

Medicaid eligibility for a child whose PA/Medicaid is closed in PA must have Medicaid eligibility redetermined. Continue to follow current local procedures.

14. **QUESTION**

If an individual is guaranteed Medicaid for four months due to child support and the authorization is shortened to reflect the four months, do changes need to be made to the managed care codes?

Answer

Usual procedures apply when an authorization period is shortened. No special coding is necessary when the child support extension is applied.

15. **QUESTION**

Under the PA transfer of assets rule which applies to S/CC A/Rs, what services is an S/CC A/R ineligible to receive?

Answer

An S/CC A/R is ineligible for all care and services, not just for nursing home services.

16. **QUESTION**

If a hospital calls regarding a bill and the client had not previously requested Medicaid through the PA case, should the worker just put up coverage?

Answer

No, the PA recipient must apply for Medicaid. PA and Medicaid are delinked. If he/she did not originally apply for Medicaid, eligibility for Medicaid must be established. The recipient may apply for Medicaid by re-signing and redating the original application and checking the Medicaid box. Medicaid can be authorized for the three months prior to that date if the A/R is otherwise eligible.

17. **QUESTION**

The federal Welfare Reform bill provides for a 10 year ineligibility period for SSI benefits for persons convicted of misrepresenting their identity or place of residence in order to receive benefits simultaneously in two or more states. Does this provision apply to the Medicaid program?

Answer

The 10 year ineligibility period does not apply to Medicaid. If, however, an individual is found to have been a resident of another state, the district may pursue a recovery of Medicaid paid on his/her behalf.

18. **QUESTION**

Do the funds in a "dedicated account" for children under the age of 18 continue to be excluded for Medicaid when the child's SSI cash benefits are discontinued?

Answer

Recently issued information from the Social Security Administration advised that funds in a dedicated account are excluded for 12 months following the month SSI cash benefits are discontinued. Therefore, for purposes of determining Medicaid eligibility, such funds are to be excluded from resources for 12 months following the month SSI cash benefits are discontinued. In addition, any interest earned by these funds is excluded as income for this 12-month period, as long as no other funds are commingled with the dedicated account funds.

Note: A dedicated account is an account in a financial institution to receive and maintain SSI past-due benefits which are required or allowed to be paid into such an account. There are also restrictions on the use of the funds in a dedicated account.

PUBLIC ASSISTANCE REGIONAL MEETING QUESTIONS

1. **QUESTION**

If a client does not apply for Medicaid when the case is opened in PA and later changes his/her mind, does there have to be a new application at that time?

Answer

The Medicaid box on the PA application can be checked, initialed, and the application re-signed and dated. Medicaid can be authorized for the 3 months prior to that date, if otherwise eligible.

2. **QUESTION**

Local doctors are requesting an extra $10 for completing an employability physical. Should the county be paying this? Is it Medicaid reimbursable?

Answer

If the doctor has been paid by Medicaid or through local administrative funds for performing the exam, no additional fee should be necessary to obtain the results of the exam.

3. **QUESTION**

Regarding a determination of eligibility for ADC-U for Medicaid claiming and reporting purposes only, does the principal wage earner parent have to be unemployed at least 30 days?

Answer

No. The principal wage earner must either be unemployed or employed less than 100 hours per month.

4. **QUESTION**

For Medicaid eligibility, when will the $30 & 1/3 earned income disregard be used?

Answer

See the $30 and 1/3 Earned Income Disregard Section of this letter.

5. **QUESTION**

What is the status of Medicaid when IPV sanctions are implemented under Family Assistance (FA) and Safety Net Assistance (SNA)?

Answer

IPV sanctions implemented under Family Assistance and Safety Net Assistance will continue for Single/Childless Couples or parents in intact households.

6. **QUESTION**

Is cooperation with DA&A screening, assessment and treatment requirements also required for Medicaid?

Answer

See the DA&A Section of this letter.

7. **QUESTION**

Are cars included in the Medicaid resource tests?

Answer

Yes. See the Automobile Section of this letter.

8. **QUESTION**

Is cooperation with child support enforcement still a requirement for Medicaid-Only cases?

Answer

Yes. Medicaid A/Rs continue to be required to comply with child support requirements. Pregnant women are not required to comply until the end of the 60 day postpartum period.

9. **QUESTION**

Regarding MA eligibility, what if an individual was notified about an employment sanction and requested a fair hearing so that the PA and MA sanction could not start until a hearing decision in favor of the agency? If the original notice was before the change to the state law and the hearing decision came down after the change, will the individual be sanctioned for MA or not?

Answer

As of November 1, 1997, Medicaid has no employment requirements. No employment sanction can be imposed on a Medicaid recipient after October 31, 1997. However, the Medicaid sanction may be upheld for the portion of the sanction prior to November 1, 1997.

10. **QUESTION**

If a client declines Medicaid, can we give 04 coverage? Example: Mom applies for PA for a child that is covered on his father's health insurance policy and does not want Medicaid for the child.

Answer

Yes.

11. **QUESTION**

Under the old rules, when a deprivation factor ceased to exist for ADC, a three month extension was granted to maintain the category of assistance temporarily. Under the new FA rules this is no longer necessary. However, what is supposed to be done with MA as deprivation is still a factor.

Answer

When PA updates the case to reflect the absence of deprivation, the individual categorical codes reflecting the new status may be entered. For Medicaid, current procedures continue to apply.

12. **QUESTION**

Does Medicaid have any plans to implement employment requirements for their program?

Answer

The law currently specifies that there are no employment requirements for MA recipients. This policy must continue unless a legislative change occurs.

Ann Clemency Kohler
Deputy Commissioner
Office of Medicaid Management

GLOSSARY

1. ADC-related - Aid To Dependent Children - related
2. CAP - Child Assistance Program
3. CNS - Client Notice System
4. DA&A - Drug/Alcohol and Abuse
5. EID - Earned Income Disregard
6. FA - Family Assistance
7. FNP Parent - Federally Non Participating Parent
8. IPV - Intentional Program Violation
9. LIF - Low Income Families
10. MBL - Medicaid Eligibility Budgeting Logic
11. OASAS - Office of Alcohol and Substance Abuse Services
12. S/CC - Singles and Childless Couples
13. SNA - Safety Net Assistance
14. TMA - Transitional Medicaid
15. WMS - Welfare Management System