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MEMORANDUM

To: EES Chiefs and Staff **Date:** November 28,2000

From: Sandra C. Hazlett **RE:** Implementation Instructions for January 2001 KEESM Changes

This memo provides implementation instructions and information for the following January 1, 2001 Kansas Economic and Employment Support Manual changes:

Changes in the Family Medical Programs

Based on recent federal guidance from the Health Care Financing Administration (HCFA) several changes are being implemented in the medical program covering low-income families with children. These changes are a result of requirements found in Section 1931 of the Social Security Act. Section 1931, created as a result of the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), "delinked" medical coverage from receipt of cash assistance.

In addition to the policy and procedural changes described below, a philosophical change is also occurring in these medical programs. HCFA has indicated that states are expected to ensure all eligible families and children obtain and retain coverage under Medicaid. To accomplish this, it is necessary to begin viewing the medical coverage that families on TAF cash assistance receive as a separate program. To facilitate this change, the term Family Medical Coverage is being introduced. The Family Medical category encompasses the Automatic Medical (AM) program associated with TAF, MA-CM, TransMed and Four Month Extended Medical. Although each program continues to have unique, specific eligibility criteria, these programs all provide medical coverage to low-income families with children. In most cases, a separate Family Medical determination will be required for families applying for or terminating from TAF cash assistance.

This HCFA guidance also requires that all families applying for both TAF and medical coverage understand the availability of medical coverage regardless of the TAF cash status. The changes included in KEESM Revision 4 provide for that separate determination and are described below.

I. Separate Determination of Medical Coverage

For families requesting both medical coverage and cash assistance, a separate determination of medical coverage must be completed if TAF is denied. Initially, a determination under the MA-CM program shall be completed for the family. If this determination does not result in eligibility a subsequent determination under any other program(s) that individual family members may qualify for shall be completed.

Because all financial and many nonfinancial eligibility requirements for MA-CM and TAF are equivalent, it is not necessary to complete a separate MA-CM determination if TAF assistance is denied for any of the following reasons:

1. Failure to provide requested information if the information is necessary for a Medicaid determination. For example, MA-CM cannot be determined when a family does not provide income verification.
2. Excess resources
3. Excess income
4. No dependent child in the home
5. Failure to meet residency requirements/living out of state
6. Failure to meet citizenship/alienage requirements, except for SOBRA coverage for emergency services
7. Failure to pursue potential resources (only the individual who refused to cooperate is affected)
8. Failure to provide information about an absent parent or to cooperate with Child Support Enforcement (only the non-pregnant adult caretaker who refused to cooperate is affected)
9. Loss of contact

Although a separate MA-CM determination is not required, a determination under other medical programs must be completed if the categorical requirements of those programs are met for individual members of the family. For example, an MP determination shall be completed for children and pregnant women and an MS determination shall be completed for a person meeting Social Security disability criteria.

It is particularly important to note that a separate determination **MUST** be completed **when TAF is denied because the family did not meet the interview requirement or did not comply with work programs requirements while in TAF applicant status**. The Medicaid program does not require a face to face interview and federal law prohibits the denial or termination of Medicaid coverage because a person does not meet work program requirements while in TAF applicant status. Although Medicaid coverage cannot be denied or terminated for a person in TAF applicant status, Medicaid coverage **(under the Family Medical program)** for non-pregnant adult caretakers shall continue to be terminated when a work related penalty is applied for individuals **after TAF approval**. For example, a separate determination of medical coverage must be done for a family when a caretaker does not comply with Applicant Job Search.

NOTE: Persons eligible for TAF cash continue to be eligible for medical coverage. Therefore, a formal MA-CM determination for those approved for TAF is not necessary.

II. Continuation of Medical Coverage after TAF Closure

Once approved for Medicaid coverage, a person is considered eligible until found to be ineligible. The finding of ineligibility must be due to a reason applicable to Medicaid. Although the TAF and Medicaid programs continue to share common eligibility criteria, because the programs are no longer tied together, a separate evaluation of medical coverage must be conducted when action is being taken on the TAF program. Therefore, medical coverage shall not be automatically terminated when TAF cash assistance terminates. The separate evaluation of coverage shall be done for each individual household member. In order to ensure that coverage does not automatically terminate at this point, an MA-CM program shall be established at the time the TAF program is initially approved to allow coverage to continue while any redetermination is ongoing. Unless determined ineligible for Medicaid for a reason applicable to Medicaid, coverage will continue until the end of the established review period.

Beginning with all applications processed on or after receipt of this memo, an MA-CM program shall be added and authorized on all cases approved for TAF cash assistance. Because the AM program that is associated with AF will automatically terminate when AF is closed, the use of a secondary program is necessary to ensure Medicaid coverage does not automatically terminate. In these situations coverage will be provided under the MA-CM program. This will allow coverage to continue when TAF cash systematically terminates. Because the MA-CM program will protect children as well as adults, it is no longer necessary to add a separate MP program to cases when TAF is approved solely for the purpose of protecting the children included in the TAF assistance plan. However, it may be necessary to continue to provide medical under the MP program for other children in the household.

If TAF eligibility is terminated for any of the reasons noted in Item I above, MA-CM coverage will also terminate. In addition, closures for failure to return a complete, timely review and terminations for failure to comply with work-related requirements after TAF approval also result in the loss of MA-CM eligibility. In any of these instances, coverage may need to continue for those meeting the continuous eligibility provisions of KEESM 2644 (pregnant women), 2645 (children) and 2646 (newborns) or for certain household members who are not impacted by the change.

The MA-CM program will provide protection from an automatic closure until an evaluation of ongoing medical coverage occurs. Unless a Medicaid appropriate reason is evident that would indicate further action is necessary, no changes need to be made and Medicaid coverage shall continue to be provided from the point of TAF closure through the end of the established review period. Unless specific information is received that indicates eligibility factors are no longer met, ongoing medical shall be provided without a redetermination in the following instances:

1. Failure to provide a complete monthly report form. If eligible, medical coverage will continue to be provided through the end of the review period. Ongoing coverage should be carefully reviewed in consideration of other

eligibility factors. For example, a client fails to return a monthly report form but also calls to tell you she has moved to Missouri would not be eligible for continuing medical. However, a client who just fails to submit a monthly report form would be eligible for continuing medical.

2. Cash fraud disqualification. Penalties applied for any fraud disqualification are not applicable for medical benefits unless the fraud finding is specifically made for Medicaid fraud in a federal court. If otherwise eligible, medical benefits shall continue to be provided throughout the penalty period.

3. Failure to comply with Quality Assurance. Medical benefits shall continue to be provided in instances where cash benefits are terminated due to non-cooperation with Quality Assurance.

Although procedures have been established to protect medical coverage from automatic closure, it is important to note that other than pregnant women and eighteen year olds, the continuous eligibility provisions do not apply to adults. Continuous eligibility only applies to the children in the household. Therefore, it is necessary to react to any other changes, either financial or non-financial that are occurring within the family.

III. Changes in the MA-CM Program

Changes have been made to align Family Medical coverage received under the MA-CM program for both TAF and non-TAF recipients. The review period for non-TAF families has been extended to twelve months and non-TAF families are also required to report changes within ten days and eligibility adjusted accordingly. This change is necessary to ensure the Section 1931 Medicaid program is applied consistently for all individuals receiving coverage.

There continues to be no system support in KAECSES for the necessary financial determination in the MA-CM program. For TAF recipients, the MA-CM eligibility determination has already been completed and only a procedural authorization of the program is necessary. For non-TAF recipients, eligibility shall continue to be determined using the MA-CM Electronic Worksheet. Determinations made following any reported changes shall also be made using the worksheet. The results of this determination (eligibility or ineligibility) are then reflected on KAECSES. In all situations, the worksheet must be printed and retained in the case file as documentation of the eligibility determination.

The MA-CM program is not a spenddown program. Although the MA program is being used to provide this coverage, it is a pass/fail determination. Because the actual eligibility determination is not done on the system, no income should be counted on the system. To avoid the possibility of a resulting spenddown, staff have the option of entering income information on the system. If income is entered, a code of "O" must be entered in the NC/LS field next to each income amount on the UNIN, EAIN and SEEI screens (medical screens only). This

allows the income to be excluded in the MA-CM calculation, which will prevent a spenddown from resulting. KAECSES edits are currently being put in place to ensure that an MA-CM program with a spenddown cannot be authorized. Care must be taken when entering resources on the system to ensure the pass/fail result is appropriate for the MA-CM program, which has a resource limit of $2000. The current MA standards for households of two or more ($3000) are in place in KAECSES.

When changes are reported, eligibility may need to be adjusted. This includes changes causing the family to move to TransMed (WT) or 4 month extended medical (EM), which must be provided under an AF program with an appropriate Program Subtype/Individual Medical Subtype. When moving to WT or EM it is necessary to close the MA-CM program because of conflicting medical subtypes. If the change results in financial ineligibility for the household, coverage shall continue to be provided for those continuously eligible under the MA-CM program until the end of the review period. However, coverage may terminate for some caretaker/adults currently covered. When changes result in ineligibility for some household members, this shall be reflected by changing the Participation code on the SEPA screen. For persons still part of the household a code of "DI" shall be used. For persons who have left the household, a code of "OU= is to be used. Examples of these situations are as follows:

Example 1: A non-TAF family consisting of a mother and two children. On 02-05-01 the mother reports she has been approved for Social Security Disability benefits of $800.00/mo. EATSS verifies this. The MA-CM worksheet no longer reflects a budget deficit, indicating the household is no longer financially eligible for MA-CM. Action is taken to terminate the mother's eligibility for MA-CM and her SEPA code is changed to DI beginning 03-01-01. However, the children are continuously eligible, so the MA-CM program remains open to protect coverage for these children. Because the mother meets a categorical requirement for another program (disability) an ex parte review is then completed to determine her eligibility under the MS program.

Example 2: A family consisting of a mother, father and two children receiving only medical coverage under MA-CM since 12-00 report on 03-07-01 that father has taken a new job. The increased earnings are budgeted and a budget deficit no longer results. Because the family has been covered under MA-CM for three out of the past six months, they are TransMed eligible. To convert coverage, the MA-CM program must be closed effective 03-31-01 and an AF program opened effective 04-01, the first month of WT eligibility. The AF application date on APMA is the date of case processing.

Example 3: A monthly reporting TAF family consisting of a mother, her child and her niece fail to submit a monthly reporting form (MRF), resulting in the closure of the TAF case on 04-30-01. The MA-CM case concurrently open protects medical coverage for each person. On 05-15-01 the MRF is received reporting a new job for the mother. When the new income is budgeted, a deficit continues to result. She asks to leave her TAF case closed, because she doesn't want to use any more of her 60 months, but asks for continued medical for herself and her child as well as cash for her niece. Because a client must be given the opportunity to

choose medical only coverage, the TAF program is adjusted to provide a grant for the niece only (shared living). The mother and her child continue to be eligible for MA-CM as the determination for medical coverage includes all three individuals (non-shared living).

Unlike the MP program, MA-CM does not track continuous eligibility through dates even though the Family Continuous Eligibility period is applicable to this population as well. In the vast majority of situations, the review date and continuous eligibility period match, so no additional tracking will be necessary. However, if children or pregnant women exist on the case, an alternate tracking mechanism, such as the use of an alert, must be used to ensure full coverage is provided.

IV. Implementation Procedures

As indicated above, an MA-CM program will be added to all TAF cases in order to ensure a separate determination of medical coverage. An MA-CM program must also be added to all current TAF cases to afford these beneficiaries the same benefit. This conversion process shall also include closing existing MP programs on those cases where MP is open only to protect medical coverage for children and pregnant women.

A list of all current open TAF cases has been provided with this memo (the report titled "Active AF Programs Not WT or EM Sorted by MR Requirement"). A printout for each caseload is included, which indicates which cases also have open MP programs. Households required to monthly report are considered the top priority for this conversion process and are identified on the printout with a "Y" in the MR column. To avoid conflicting medical subtypes it is necessary to first close the MP program and open the MA-CM program the following month. Cases must be monitored carefully to determine if TAF has closed on an unconverted case for failure to return a complete MRF. In these situations an MA-CM program must be added immediately in order to prevent termination of medical coverage. Special instructions on how to accomplish this may be obtained from HelpDesk.

The MA-CM program shall be opened using the current date as the application date with a review through date matching the current TAF program. If newborns, children or pregnant women exist on the case with different CE dates, it will be necessary to track continuous eligibility for those individuals separately.

No mass conversion process is planned for current MA-CM programs. Review periods are not to be extended but if the client remains eligible at the end of the current review period, a twelve month review shall be set at that time. It may be necessary to send some individuals separate instructions outlining the reporting requirements. This can be done by sending the V002, Reporting Changes Requirements. A listing of all current, open MA-CM cases is included for informational purposes only.

V. Special Instructions for Cases Closed after October 9, 2000

Because the 1931 Reinstatement Universe was created approximately three months prior to the implementation of the new policies that meet new federal guidance, a special procedure has been created to ensure those persons who lost TAF and Medicaid coverage since this date are fully evaluated for continuing coverage. This process will involve all TAF closures occurring since 10-09-00.

A printout of all TAF closures occurring since 10-09-00 where continued medical eligibility was not provided will be produced in mid-January. These cases must be reviewed, on an ex parte basis, under the new policies to determine if persons who have lost coverage continue to be eligible. If eligible based on the new policies, coverage under the Family Medical program shall be provided beginning with the month coverage was lost.

For example, a case closed 10-31-00 for failure to return a MRF. If there were no other indications of ineligibility those persons whose coverage terminated will have coverage backdated to 11-01-00. For persons not eligible under the new policies based on this review, no additional action is necessary. For example, a case closed 10-31-00 because a family moved out of state. Loss of residency is a valid reason to terminate Medicaid coverage. Therefore, the case shall remain closed and no additional coverage provided at this time.

In most cases the MA-CM program will be used to provide this coverage. However, in instances where MP has continued following the AF termination, conflicting medical subtypes are created when both MP and MA-CM are open. Therefore, the MA program with an individual medical subtype of RB will be used in these instances to provide coverage for these prior months only. When this occurs, it will be necessary to use a participation code of "OU" for the children already covered under MP and all others will be coded "IN" on the MA program. The MA program will be authorized up through the current month. At that point, the MP program would be closed and the CM medical subtype added and the individual medical subtypes changed to "AF".

Because the total number of terminations is expected to be relatively small, this review shall be completed by 02-28-01.

Work Related Requirements Changes

I.

KEESM 3100 Work Related Requirements

Effective October 1, 2000, the designated USDA Food Stamp Employment and Training Program counties are limited to Dickinson, Geary, Riley, and Saline. Some food stamp clients in counties that have discontinued Food Stamp Employment and Training are still erroneously reflecting participation in work programs. A printout listing these clients will be distributed on a quarterly basis beginning in January 2001. EES staff should review these cases and update the coding accordingly.

II.

KEESM 3310.28 Social Security Applicant

A printout of all clients who are currently in the SSA component will be issued at the end of the first full week of December. EES staff should review these cases by the next progress review to determine if there are actual hours of participation related to the SSA application process that need to be recorded on SESP. The KsCares Table will be updated on January 2, 2001 so that hours entered for this component will count toward the TANF Work Participation requirement.

III.

KEESM 3411 Transportation and KEESM 3412 Special Services Allowance

The purpose of the policy changes which extends support services to 12 months for TAF clients who become employed and lose cash eligibility, is to 1) improve TAF clients' employment retention for longer periods of time, 2) reduce time on TAF in between jobs, and 3) help those who are employed advance in their skills, gain experience, and advance their earning power. KAECSES notices related to clients losing TAF cash eligibility due to increased income from employment will be modified to emphasize the availability of the support services while the family is getting established in employment.

Support services will be provided based on an assessment of the client's need for the various types of supports.

Programming changes are being made in KsCares to allow the issuance of transportation payments for up to 12 months following the loss of TAF cash assistance due to the increase in earned income. We anticipate that these programming changes will not be completed by January 2001, but workers should not have any problems making WP payments for transitional clients beginning in January.

This policy change for extending the availability of transportation and special services allowances for 12 months following the loss of cash assistance due to an increase in earned income is effective January 2001 and applies to any TAF client who is in transition (TR) status in January. This means any client with an AF closure date in the period July-December 2000 will be eligible for a total of 12 months of transitional payments. Those clients in TR status in January shall have their transitional period of eligibility extended so that they are eligible for the maximum 12 months. For example, if January is the client's 6th month of transitional eligibility, the period would be extended through July 2001. This client could also be eligible for transportation payments in the period January through July 2001.

A printout listing all TAF clients in TR status will be issued in early December. In a review of KsCares information, it appears that there is also a significant number of clients who have an AF closure date but are still in Open (OP) status on KsCares rather than TR status. As these clients may also be impacted by this policy change, a separate printout of these individuals will be issued to the field early in December. Clients will be listed on the printouts with the oldest AF

closure dates first. EES staff should review these printouts to determine the appropriate action on each case for January.

There may be local issues (e.g., transfer of cases between workers) related to the implementation of this policy change. These local issues should be discussed during the implementation planning of these policies.

IE TC Child Care

The new policy criteria should be applied to all requests for child care assistance under the IE TC subtype processed on or after January 1, 2001. The policy changes under this subtype were made to allow more flexibility in authorizing child care for education/training. These changes are intended to support employment retention and advancement for low-income persons.

Basic criteria changes are as follows: client must be employed at least 20 hours per week, education/training must be skill specific and/or create greater earning potential upon completion, and the average of 25 hours per week of past employment criteria has been eliminated. Child care plans may be authorized for persons within the last semester of completing a Bachelor's Degree. Bachelor's Degree specific child care shall only be authorized under this circumstance. All other requests must be for education/training which is skill specific and/or will create greater earning potential upon completion.

Due to continued limited funding available for this service, expenditures must be tracked. Plans will be approved for this service on a first come, first served basis. Areas will no longer be required to monitor a spending allocation for this service. Expenditures will be monitored at the Central Office level. The SAR Child Care and Projected Expenditures Report (M800) will be used to track spending for this service. Once the budgeted amount for this service is obligated and expected to be spent, plans for additional education/training hours should not be authorized. Areas will be notified by Central Office if there is a need to stop authorizing plans for this service.

It is anticipated that minimal case management in processing these requests will be necessary. Persons eligible for this type of child care will not be participating in work programs. The client should be expected to be able to attest to the validity of the education/training in relation to the long range goals of employment retention and advancement. Workers are allowed professional judgment in these situations and should document the rationale for authorization or denial.

ES-3100.4, Application for Health Care Coverage and Food Stamps

This application for benefits, for use by the elderly and persons with disabilities, has been reformatted and several additional questions have been incorporated without increasing the length of the application. Changes have been made to clarify questions currently on the application or to ask for further details. The reasons for making the majority of these changes are self-explanatory. However, the questions added to section G, Transfer Of Property, do require additional explanation.

Questions have been added to this section to determine if an applicant/recipient or spouse has ever consented to a will, a prenuptial agreement or antenuptial agreement. This is

necessary for two reasons. First, if a client has consented to a will for a recently deceased person, it may be viewed as a disclaimer of inheritance per KEESM 5722 and a penalty period may be appropriate. Therefore, it is important that the application request this information. Second, and more importantly, a recent Kansas Supreme Court ruling involving a 1994 Kansas law has established new criteria for determining the type of assets that may be available to a surviving spouse if spousal elective share rights are exercised following the death of a spouse. Although not all medical assistance cases would be impacted, this ruling makes it necessary to evaluate all cases where a community spouse dies first to determine if it is beneficial for the LTC spouse to claim spousal elective share. Although it is necessary for a spouse to consent to a will or establish another legal device (such as a nuptial agreement) to avoid the application of the new standards, not every family will understand the potential impact to the Medicaid program. Especially impacted would be those cases where the deceased spouse had individually owned property or previously transferred property. Because it only allows a widow or widower six months to take a spousal election, it is important to react quickly. Therefore, information regarding such activity is being requested on the application form. Any situations involving such a consent made by the individual and/or his or her spouse shall be referred to EES Central Office for review. Because the client may have given up rights to an asset by consenting to a will, there is an increased possibility of a transfer of property penalty existing in these instances. However, consideration must be made for the additional factors associated with the spousal elective share. Referrals shall continue to be made to the Estate Recovery Unit when a community spouse precedes the medical assistance client in death to determine the course of action to take, as probate litigation may be necessary in some situations in light of these new standards.

Copies of the new application form will be mailed to the area offices for distribution. Previous versions of the form should be destroyed. The 3100.4a has also been modified. The previous addendum has now been replaced with an instructional document outlining the items that need to be provided with the application and general information regarding the program. Copies of the this form will be available through the warehouse as well.

Recap of Printouts

1. **Enclosed with this memo -** List of all current open TAF cases with indicators for cases with open MP programs. Households subject to monthly reporting indicated with a "Y" in the MR column.

2. **Enclosed with this memo -** List of all current open MA-CM programs for informational purposes.

3. **Sent mid-January -** List of all TAF closures occurring since 10-09-00 where continued medical eligibility wasn't provided.

4. **Distributed quarterly beginning in January 2001 -** List of clients in non FS E & T counties reflecting participation in work programs.

5. **Issued at the end of the first full week of December -** List of all clients who are currently in the SSA component.

6. **Issued in early December -** List of all TAF clients in TR status.

7. **Issued in early December -** List of clients with AF closure date but are still in open status on KsCares rather than TR status.

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