

**OFFICE OF MEDICAID MANAGEMENT  
ADMINISTRATIVE DIRECTIVE**

**TRANSMITTAL:** OMM/ADM 97-2

**TO:** Commissioners of  
Social Services

**DIVISION:** OFFICE OF  
MEDICAID  
MANAGEMENT

**DATE:** December 3, 1997

**SUBJECT:** Medicaid Implications of Welfare Reform

<b>SUGGESTED DISTRIBUTION:</b>	Medicaid Staff Income Maintenance Staff Fair Hearings Staff Staff Development Coordinators
<b>CONTACT PERSON:</b>	Policy: Sharon Burgess at 518-473-5536 New York City Representative - (212) 613-4330 Upstate Systems: Dennis DiMuria at 518-473-5614 Bob Decker at 518-473-6206
<b>ATTACHMENTS:</b>	A - DSS-4571, Alcohol/Substance Abuse Screening Instrument (available on-line) B - Transitional Medical Assistance Fact Sheet (available on-line)

**FILING REFERENCES**

Previous ADMs/INPs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
97 ADM-23			Chapter 436		WMS Coord.
91 ADM-17			of Laws of		Letters of
82 ADM-6			1997;		Sept.30 and
82 ADM-5			PL 104-193		Oct.21,1997
					MBL Trans.
					97-2

**I. BACKGROUND:**

The "Welfare Reform Act of 1997" (Chapter 436 of the Laws of 1997) signed by the Governor in August 1997, defines the new public assistance (PA) programs in New York and their relationship to the Medicaid program. The legislation implements the requirements of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). It also contains provisions specific to New York.

P.L. 104-193 (hereafter "the federal law") eliminated the Aid to Families with Dependent Children (ADC) program and replaced it with a block grant for "Temporary Assistance for Needy Families" (TANF). The federal law does not provide automatic Medicaid eligibility for recipients of TANF cash assistance. Instead, the federal law requires states' Medicaid programs to cover a new eligibility group of low income families. In determining Medicaid eligibility for this new group, states generally must use the income and resource levels and methodology of the ADC program as it existed on July 16, 1996; however, states may change the income and resource levels, within certain limits, and may use a less restrictive methodology for determining countable income and resources.

The Welfare Reform Act of 1997 (WRA) eliminated the State ADC and Home Relief programs, and created new PA Family Assistance and Safety Net programs. Recipients of assistance under the Family Assistance and Safety Net programs are not automatically eligible for Medicaid. However, the WRA also created comparable Medicaid eligibility categories for low income families (consistent with federal law), and for single individuals and childless couples between the ages of 21 and 65 who are not certified blind or disabled.

The federal law also made changes in eligibility for Supplemental Security Income (SSI) recipients and aliens that affect Medicaid for certain individuals. Separate directives will address Medicaid eligibility for aliens and individuals losing SSI.

The federal and State legislation did not change the Medicaid-Only eligibility for individuals who previously were eligible for federally-reimbursed Medicaid. ADC-related and SSI-related Medicaid-Only eligibility groups continue to be available under current budgeting standards and methodology.

The recent approval of New York's application of an 1115 waiver to require the enrollment of Medicaid recipients into managed care plans means that all Medicaid recipients will now receive federally-reimbursed Medicaid. However, the previously existing Medicaid eligibility groups as well as the two new groups must be systemically identified for reporting purposes.

## II. PROGRAM IMPLICATIONS

There are two major Medicaid implications resulting from the federal law and the WRA. The first is the elimination of automatic entitlement to Medicaid for PA recipients. The second is the creation of two new Medicaid eligibility groups that generally parallel the new PA categories of Family Assistance and Safety Net. The new Medicaid eligibility groups are Low Income Families (LIF) and Singles/Childless Couples (S/CC).

There are several differences between the requirements of the new PA programs and those of the new Medicaid eligibility groups. These differences exist because: the federal law requires that the methodology for determining countable income and resources under the LIF Medicaid eligibility group be no more restrictive than that of the former ADC program as it existed on July 16, 1996; and the WRA mandates several requirements specific to each program.

The new laws also make changes to provisions governing Transitional Medical Assistance (TMA), employment requirements, drug and alcohol screening, and the Child Assistance Program (CAP).

The implications of each of these changes are addressed below:

### A. Delinkage of Medicaid from PA

Applicants must indicate on the common application (DSS 2921, "Application for Public Assistance, Medicaid, Food Stamps, and Services") that they are applying for Medicaid. If an individual does not apply for Medicaid, Medicaid eligibility will not be determined. Medicaid may also be terminated separately from PA.

### B. Low Income Families Medicaid Eligibility Group

#### 1. Individuals who may be eligible under LIF

Families with children under age 21, children under age 21 who are not living with caretaker relatives, and pregnant women may be eligible for Medicaid under LIF. This group includes children who receive foster care but who are not eligible under Title IV-E.

Although for federal reporting purposes, deprivation of parental support or care due to continued absence, death, incapacity or unemployment must be recorded, families that do not meet the deprivation criteria are included in the LIF group. The definition of unemployment for deprivation purposes means employment by the principal earner of less than 100 hours per month. The factors previously relevant under the Aid to Dependent Children-Unemployed Parent (ADC-U) program are no longer factors. Completion of the ADC-U checklist (DSS 2502) is no longer required under LIF.

2. Financial eligibility under LIF

The financial standards under LIF provisions generally parallel those of the cash programs; however, no methodology which is more restrictive than the methodology used in the ADC cash program on July 16, 1996, may apply to LIF. Because Medicaid and cash eligibility are delinked, future changes made to the cash program will not automatically trigger changes to the Medicaid program.

a. Initial financial tests:

Financial eligibility under LIF requires that the family's countable income meet certain tests. Three income tests are applied in determining whether a family may be eligible under LIF. These tests are:

- i. comparison of gross income to 185% of the standard of need under the cash program. The test that currently exists under the cash program will continue. If a family's gross income, after certain deductions, exceeds 185% of the cash standard of need, the family will not be eligible under LIF.
- ii. comparison of gross income to the poverty level. If the family's gross income exceeds 100% of the federal poverty level, the family will not be eligible under LIF. For certain special housing situations, the income comparison will parallel calculations used in PA.
- iii. comparison to the cash income standard. As under current procedures, if a family's net income after allowable deductions exceeds the cash standard of need, the family will not be eligible under LIF.

b. New earned income disregard:

If a family's countable income exceeds the LIF standard, the family may not spenddown to the LIF standard. However, eligibility may exist under one of the current medically needy or expanded eligibility (poverty level) programs.

The income disregards used before the WRA continue to apply, except that the disregard of the first \$30 of earned income and 1/3 of the remainder that previously applied to certain PA recipients has been eliminated.

An earned income disregard of 42% will be applied to those families who have earned income and whose net countable income is below the LIF standard. The 42% earned income disregard only applies to families whose eligibility exists before the application of the disregard or who

received PA or Medicaid under LIF in at least one of the previous four months. No time limit is applied to the 42% earned income disregard.

The application of the 42% earned income disregard will be advantageous to recipients of cash assistance and to certain Medicaid recipients whose current countable income exceeds the Medicaid income standard. For cash recipients, net countable income will be reduced. The amount of the cash grant will be increased to compensate for the decrease in countable income. For Medicaid recipients, families who have earned income and whose total countable income exceeds the medically needy income standard may have spenddown eliminated if they meet the financial eligibility tests for LIF.

The earned income disregard will be adjusted annually to reflect changes in the poverty guidelines. The disregard will not apply to families whose total gross income exceeds the poverty guidelines since such families will fail the poverty level test that applies to LIF.

c. Resource eligibility under LIF:

The value of resources allowed to be retained by a family under LIF is \$3000. A family is also able to retain an automobile with fair market value of up to \$4650, and a home which is the primary residence of the family. Individual development accounts established for qualified purposes as described in 97 ADM-23 for PA recipients are disregarded under LIF. These are changes in resources implemented by WRA for PA applicants/recipients (A/Rs) that are also allowed to LIF A/Rs. Additional resource disregards as they existed on July 16, 1996 continue to be allowed.

A family with excess resources is not eligible for Medicaid under LIF. Excess resources can not be offset with incurred medical bills.

3. Differences between PA and LIF eligibility:

- a. PA may include families in Safety Net as well as in Family Assistance. For Medicaid, families with a child under age 21 are always included under LIF rather than under S/CC.
- b. The resource standard for LIF always equals \$3000 while the cash program standard generally equals \$2000. The cash program resource standard equals \$3000 only if the family includes an individual over age 60.
- c. Child care paid by the family and not subject to reimbursement will be allowed as deductions under LIF up to the current standards (up to \$175/month for children over age 2 and up to \$200/month for children less than age 2). The

cash program does not allow a child care disregard since child care is to be provided through Services to PA recipients.

- d. A lump sum payment received by a cash assistance recipient will be considered to meet the household's prospective needs and may render the household ineligible for PA for several months. Current Medicaid provisions require that a lump sum payment generally be considered income in the month received. Any of the lump sum remaining after the month of receipt is considered a resource. These provisions continue for Medicaid and will apply to LIF recipients.
- e. While the cash program may exempt real property that a household is trying to sell for a period of six months, a family may not be conditionally eligible for Medicaid while trying to liquidate excess nonexempt resources.
- f. Children who are temporarily absent from the household are treated differently in Medicaid and PA. Medicaid continues to require that the child be expected to return to the household and does not specify a maximum time of absence. PA considers the child temporarily absent only if the child is expected to return within 45 days. Exceptions to the PA provisions based on good cause are described in 97 ADM-23.

#### 4. Transitional Medicaid (TMA)

The provision of TMA now applies to the loss of Medicaid under LIF. Receipt of PA is not a factor in determining eligibility for TMA. Families will be eligible for TMA if they lose Medicaid under LIF due to increased income from employment and they received Medicaid under LIF for at least three of the previous six months. TMA is provided only when eligibility is lost under the LIF standards. TMA is not provided when Medicaid eligibility is lost under the medically needy standards that are applied to ADC-related families.

A family losing eligibility for Medicaid under LIF due to earnings who would be fully eligible under the medically needy ADC-related program must be authorized TMA since TMA eligibility is guaranteed for at least six months and may be authorized only upon loss of eligibility under LIF.

#### 5. Child Support Extension

A family will be eligible for the four-month child support extension when it loses eligibility for Medicaid under LIF due to the collection of child or spousal support. The family must have received Medicaid under LIF for at least three of the previous six months. As is currently the case, the extension begins the month following the month of ineligibility due to the support collection. The four-month

extension for child support is not provided to ADC-related medically needy recipients who lose Medicaid due to the collection of child or spousal support.

Families losing eligibility under LIF may be fully eligible under the ADC-related medically needy program. Districts have the option to authorize Medicaid under current processes for periods longer than four months when the family is fully eligible under the medically needy program. Full eligibility must be authorized for at least four months with notation in the case record that full coverage must be authorized for a minimum of four months.

**C. Singles/Childless Couples (S/CC) Medicaid Eligibility Group**

1. Individuals who may be eligible under S/CC

Single individuals and childless couples who are not certified blind or certified disabled and who are between the ages of 21 and 65 may be eligible for Medicaid under S/CC. As is currently the case, those persons who are certified blind or certified disabled, or age 65 or over may be eligible for Medicaid as SSI-related medically needy individuals. Persons under age 21 living alone may be eligible under LIF; they are not included among individuals who may be eligible under S/CC.

2. Financial eligibility under S/CC

Singles and childless couples who are not certified blind or disabled and whose income and resources do not exceed the cash program standard may be eligible for Medicaid under S/CC. The 42% earned income disregard available to families under Family Assistance and under LIF does not apply to S/CC. The \$90 earned income disregard continues to apply. As is currently the case, S/CC applicants/recipients (A/Rs) are not eligible to spenddown to the income standard.

The LIF resource disregard of \$3000 does not apply to S/CC individuals. The resource standard equals \$2000 for S/CC individuals under 60 years of age and \$3000 for those over 60 years of age. Other resources disregarded under PA, including the new PA disregard of a home that is the usual residence and an automobile with fair market value of up to \$4650, generally apply to S/CC individuals.

3. Differences between PA and S/CC eligibility:

- a. Lump sum payments are considered income in the month received for S/CC A/Rs. Any payment that remains in subsequent months is applied to the resource standard.
- b. Conditional Medicaid eligibility is not provided to an individual with excess resources who is trying to sell nonexempt real property.

**D. Child Assistance Program (CAP) Participants**

CAP is a PA employment/self sufficiency initiative to encourage families with children to become employed and to obtain or cooperate in obtaining a child support order, and have paternity established. CAP allows for more liberal income disregards from earned income and requires a one-time resource test at application. Initially, resources may not exceed the applicable cash program standard; there are no subsequent resource tests.

Before passage of the WRA, CAP was approved under a federal waiver for 14 social services districts and included a Medicaid guarantee for CAP participants. The CAP waiver, and the Medicaid guarantee, are expected to expire on November 1, 1997. Under the WRA, any district may apply to participate in CAP. WRA also included provisions to insure that CAP recipients who become ineligible for Medicaid before March 31, 1998 will continue to receive Medicaid through March 31, 1998.

Ongoing Medicaid eligibility for CAP recipients

CAP participants are subject to the same Medicaid eligibility requirements as other families. CAP participants must specify that they are applying for Medicaid. They initially will be financially eligible for Medicaid because they must be financially eligible under the PA, or LIF, standards to participate in CAP. Eligibility must be reevaluated whenever changes in income or resources are reported.

CAP participants who lose Medicaid eligibility due to increased earnings may be eligible for TMA. After TMA eligibility expires, CAP participants may be determined eligible for Medicaid under the medically needy or poverty level programs.

Resources must be evaluated after TMA eligibility expires and whenever Medicaid eligibility is determined under any program that is not a poverty level program. When resources exceed the Medicaid standards, the excess resource provisions described in 91 ADM-17 apply. CAP recipients are not eligible for Medicaid unless they offset excess resources with incurred medical bills.

CAP participants who are not eligible for Medicaid must be provided with information about the benefits available through Child Health Plus.

A PA ADM to be issued in the near future will provide additional information about procedures and Medicaid budgeting for CAP recipients.

Medicaid eligibility for CAP recipients until March 31, 1998

CAP participants losing Medicaid eligibility due to increased earnings or child support collection continue to be eligible for Medicaid through TMA and child support extensions. Continued Medicaid eligibility through the application of these extensions



will provide the required Medicaid coverage through March 31, 1998 for most CAP recipients.

If a CAP recipient is found to be ineligible for Medicaid under any program of Medicaid coverage or under the TMA or child support extensions such that Medicaid coverage would end before March 31, 1998, districts must contact the Office of Medicaid Management contact person listed on the first page of this directive to find out how to extend Medicaid coverage.

#### **E. Employment Requirements**

Employment requirements do not apply to any Medicaid applicant or recipient, including those applying for assistance under LIF and S/CC. Sanctions or denials due to failure to comply with employment requirements under PA do not apply to Medicaid applicants or recipients. Medicaid eligibility must be determined for those cases denied PA and continued for those cases sanctioned from PA due to employment requirements, if the individual is otherwise eligible for Medicaid.

#### **F. Alcohol and/or substance abuse screening**

Adult applicants or recipients who are not certified blind or disabled and who are parents in intact households or who are singles or childless couples must comply with screening for alcohol and/or substance abuse. As in PA, screening is to be performed at application and not more frequently than every six months thereafter, unless abuse or dependence is suspected.

When abuse or dependence is indicated, the individual must be referred for a formal assessment by a professional credentialed by the Office of Alcoholism and Substance Abuse Services, as are PA A/Rs. Adults who are not certified blind or disabled and who are singles or childless couples or parents in intact households who fail to comply with screening or assessment are ineligible for Medicaid. Individuals who are referred for treatment and who fail to comply with treatment once that treatment is available are ineligible for Medicaid until they resume a treatment program that is appropriate to their needs. Individuals need not return to residential treatment to regain Medicaid eligibility but treatment must be appropriate to the level of medical need.

### **III. REQUIRED ACTION**

#### **A. Delinkage of Medicaid from PA**

The elimination of automatic entitlement to Medicaid for individuals who apply for PA means that A/Rs must indicate that they are applying for Medicaid to have Medicaid eligibility determined. PA program staff are encouraged to ask applicants whether they need, and would like to apply, for Medicaid when Medicaid has not been recorded on the application. The determination of Medicaid eligibility at the same time as PA

eligibility will afford the applicant the opportunity to receive medical care and will reduce the number of retroactive Medicaid eligibility authorizations for individuals who received PA for the same period.

**B. Low Income Families Medicaid Eligibility Group**

Medicaid eligibility for families, pregnant women and individuals under 21 years of age not living with a caretaker relative must first be determined under LIF budgeting when applications are received in PA or in Medicaid.

**1. LIF Eligibility with a PA Application**

Generally, families eligible for PA will be eligible for Medicaid. Occasionally, families may be denied or closed under PA for reasons that do not apply under LIF or another Medicaid eligibility group. Medicaid eligibility must be determined or continued whenever the reason for closing or denial is not a reason for closing or denial under Medicaid. Following are examples of such instances:

- a. Families denied or closed under PA because they received a lump sum payment, pay child care from earned income, or have resources above \$2000 must have Medicaid eligibility determined separately.
- b. Individuals in families may be denied or sanctioned from cash assistance for failure to comply with employment requirements. Since Medicaid has no employment requirements, Medicaid eligibility must be determined or continued for such cases.
- c. Certain families that include individuals denied or sanctioned from PA for failure to comply with drug or alcohol screening and assessment may continue to include the noncompliant individual for Medicaid purposes. While PA requires that all adults comply with drug/alcohol requirements, Medicaid requires that only A/Rs who are not certified blind or disabled and who are single individuals, childless couples, or parents in households not deprived of parental support comply with drug/alcohol requirements. Adults in other families are not required to comply with drug/alcohol provisions. Refer to **Required Action, Section B** of this directive.
- d. Families that are ineligible for PA because a child is expected to be temporarily absent from the household for more than 45 days without good cause, or because a minor parent is not living in adult supervised housing when required, or not participating in an educational program, must have Medicaid eligibility determined separately.

Families with excess resources may be eligible for PA but will not be eligible for Medicaid while attempting to sell nonexempt real

property. Such applications should be referred to Medicaid to determine whether any family members may be eligible for Medicaid under a medically needy or poverty level program.

Because additional Medicaid budgeting options are available to many families, current procedures to refer cases denied or closed because the family's income exceeds the PA standard will continue as described in 82 ADM-5, Rosenberg.

Deprivation of parental support must be recorded for families applying for Medicaid. Although PA under Family Assistance may be provided to families regardless of deprivation due to continued absence, incapacity, death or unemployment of a parent, deprivation must be recorded for Medicaid purposes. Documentation of unemployment requires that the principal wage earner, as stated by the applicant, be employed less than 100 hours per month. No prior work history is required to document unemployment. The ADC-U checklist is no longer required.

## 2. LIF Eligibility under Medicaid-Only Applications

### a. Financial Eligibility

Families who apply for Medicaid will have eligibility evaluated under several Medicaid budgeting standards. Medicaid eligibility will be systemically evaluated in a three step process as follows:

- i. LIF eligibility will be evaluated by using the financial tests described under **Program Implications, B.2**, of this directive.
- ii. If not eligible under LIF, the family's eligibility will be evaluated under the medically needy ADC-related program. Medically needy budgeting allows for the deduction of health insurance paid by the family that is not allowed under LIF. It continues to allow the deduction of the \$30 and 1/3 earned income disregard when the family received Medicaid under LIF in at least one of the past four months and the worker enters the appropriate disregard. It also allows the family the option to delete children who have income from the application, as described in 82 ADM-6, Mehler/Vailes. Families meeting deprivation criteria may also become eligible by offsetting any excess income or resources with medical bills.
- iii. If families are not fully eligible under medically needy budgeting, eligibility for pregnant women and appropriate children will be evaluated under the expanded eligibility (poverty level) programs.

### b. Two parent households without deprivation

The parents in two parent families that are not deprived of

parental support or care are able to receive LIF budgeting, including the 42% disregard of income, as long as they meet all other LIF financial tests. When such households are not eligible under LIF, the family's eligibility is determined under the medically needy standards, except that the parents are not able to achieve eligibility by meeting any excess income or resources with medical bills. Districts are no longer required to document ineligibility at the PA standard since the automated budgeting process incorporates this test.

The costs of providing Medicaid to parents in two parent households not deprived of parental support when family income is between the PA standard and the medically needy standard previously had been reimbursed at 75% State share and 25% local share. Approval of the 1115 waiver by the Health Care Financing Administration now allows 50% federal reimbursement. Under the federally approved 1115 waiver effective October 1, 1997, costs for Medicaid for these parents now reflect a 50% federal share, a 37.5% State share, and a 12.5% local share.

c. Pregnant women and/or children applying on Medicaid/WIC application (DSS 2921P)

The one page Medicaid/WIC application used when only pregnant women or children born on or after October 1, 1983 apply for assistance contains no resource information. Current procedures will continue in determining eligibility for such applications. Financial eligibility will be correctly determined systemically.

**C. Singles/Childless Couples (S/CC) Medicaid Eligibility Group**

Medicaid eligibility for single individuals or childless couples who are not certified blind or disabled may exist when applications are received in PA or Medicaid.

1. S/CC Eligibility with a PA Application

Previously, singles or childless couples who were not certified blind or disabled and were between the ages of 21 and 65 needed to be financially eligible for PA to be eligible for Medicaid. Generally, that policy continues. However, now Medicaid must be requested for Medicaid to be authorized to individuals eligible for PA.

S/CC A/Rs may occasionally be denied PA for reasons that do not apply to Medicaid. In these situations, Medicaid eligibility must be determined separately. Two of the most common reasons are listed below. For additional reasons, refer to 97 ADM-23.

- a. S/CC A/Rs denied or closed under PA because they received a lump sum payment must have Medicaid eligibility determined separately. Medicaid considers such payments to be income in the month received and applies any remainder to resources in

subsequent months.

- b. S/CC A/Rs denied or sanctioned from PA for failure to comply with employment requirements must have Medicaid eligibility determined or continued. Medicaid has no employment requirements.

S/CC A/Rs may be eligible for PA but will not be eligible for Medicaid while attempting to sell excess nonexempt real property. A separate Medicaid eligibility determination is not needed in such cases.

2. S/CC Eligibility under Medicaid-Only Applications

S/CC A/Rs must meet the PA income and resource standards to be eligible for Medicaid. The employment requirements in PA do not apply to Medicaid. Individuals between the ages of 21 and 65 who are not certified blind or disabled will be eligible for Medicaid only if they are financially eligible for PA.

**D. Drug and Alcohol Screening Requirements**

Singles, childless couples and parents in families without a deprivation who are not certified blind or disabled must comply with certain drug and alcohol screening, assessment and treatment requirements.

1. Applicants

a. Screening

As in PA, single persons, childless couples or parents in families without a deprivation, who are not certified blind or disabled, must answer the questions on the DSS-4571, Alcohol/Substance Abuse Screening Instrument (Attachment A). A copy of the completed screening instrument must be retained in the case file. When two or more "yes" responses are received, the individual must be referred for an assessment. If the worker has reason to suspect alcohol or substance abuse through observation of the individual's behavior, the individual must be referred for an assessment. If fewer than two "yes" responses are received, the Medicaid determination process continues; there is no need for an assessment.

If the individual refuses to answer the questions on the screening instrument, the individual is ineligible for Medicaid. The individual and the individual's income and resources will continue to be considered in determining the eligibility of any remaining family members.

b. Assessment

As in PA, an assessment is required when two or more positive responses are received to the questions on the screening instrument, or when the worker has reason to suspect abuse of

drugs or alcohol. The assessment must be performed by an alcohol and substance abuse professional credentialed by the Office of Alcoholism and Substance Abuse Services (OASAS) and may include drug testing. The district may choose to use a counselor at the district or may use a contractor. A copy of the completed screening instrument must be forwarded to the person conducting the assessment.

The assessment must determine whether the individual is abusing alcohol and/or drugs. If abuse is found, the assessment must determine whether the individual is able to work. As in PA, if the individual is not able to work, the individual must be referred to and comply with treatment.

c. Treatment

If the results of the assessment indicate that treatment is required, the individual must comply. Treatment must be received from a professional credentialed by OASAS. If the district is advised that the individual has failed to comply with available treatment, the individual is ineligible for Medicaid.

If the individual leaves a treatment program but returns to another appropriate treatment program, the individual may again receive Medicaid, if otherwise eligible.

d. Monitoring of compliance and Medicaid authorization

After an applicant is found financially and otherwise eligible, Medicaid can be authorized for an individual referred for assessment or treatment. If the district receives information that the individual has not complied with completion of the assessment or with treatment, the individual is not eligible for Medicaid.

2. Recipients

a. Screening

A drug/alcohol screening must be completed once for each recipient. It may be required more frequently but not more frequently than once every six months, unless the district has reason to believe that the individual is abusing or dependent on alcohol or drugs. If no abuse or dependence is indicated, the district is not required to repeat completion of screenings at recertification.

b. Assessment and treatment

As indicated for applicants, two or more positive responses to the screening instrument require referral for an assessment by a professional credentialed by OASAS. Procedures for assessment and treatment continue as for applicants.

3. Other Drug/Alcohol Evaluation Administrative Issues

Additional procedural information, programmatic clarification, and instructions regarding funding for costs incurred to implement the drug/alcohol screening and assessment requirements, will be provided in a subsequent directive.

**E. Implementation Procedures**

1. Undercare

The delinkage of Medicaid from PA and the new budgeting methodology described for low income families generally will not affect the Medicaid eligibility of families currently receiving PA or of most families receiving Medicaid-Only. As is described in **Section IV., Systems Implications** of this directive, rebudgeting to determine eligibility for PA families will now include a 42% earned income disregard. Many of those now eligible will receive additional cash grants.

For Medicaid-Only families, rebudgeting to include the 42% earned income disregard could change eligibility for some families whose gross income is below 100% of the federal poverty level but above the Medicaid income level. For those families, spenddown will be eliminated. When mass rebudgeting is performed, affected cases will be included in the reports of cases changed in mass rebudgeting that must be reviewed for appropriate action.

A manual notice to address instances in which LIF budgeting results in the elimination of spenddown will be included in an upcoming WMS Coordinator Letter. This notice must be sent to affected recipients. If the recipient has incurred/paid medical bills during the months of November or December, the recipient may bring the bills to the district to receive credit/reimbursement.

For single individuals and childless couples, the budgeting of income remains unchanged. As noted in this directive, the resource allowances have increased.

Individuals denied or closed in PA solely due to work rules shall, if otherwise eligible, receive Medicaid. Such cases must be referred to Medicaid to have eligibility reevaluated.

Drug and alcohol screening must be completed for singles and childless couples and parents in families without a deprivation who are not certified blind or disabled at next recertification.

2. Applications

The budgeting procedures for LIF will be reflected in eligibility determinations performed after mass rebudgeting as described in Section IV.

**IV. SYSTEMS IMPLICATIONS**

Upstate

Numerous systems revisions have been implemented to support Welfare Reform changes and future reporting requirements. Further details on the items listed below can be found in the WMS Coordinator Letters of September 30, 1997, October 21, 1997, and one to be issued in early November 1997, and MBL Transmittal 97-2.

1. The delinkage of PA from Medicaid means that the system must recognize instances where individuals who are eligible for cash are not eligible for Medicaid. This will be accomplished by supporting a Recipient Medicaid Coverage Code of 04 (No Coverage) for an active cash recipient. For further details regarding MA Coverage Date and code edits, refer to the WMS Coordinator Letter of September 30, 1997.
2. For proper reporting and Medicaid claiming, the definition of certain Individual Categorical Codes has been changed and new codes have been added. Since a majority of the former ADC cases will now be Family Assistance (FA) cases, the current ADC-Related Individual Categorical Codes (01-08, 13) will be redefined to be used for MA, Family Assistance, and Safety Net cases. Even though deprivation is no longer considered for cash eligibility, it still must be recorded for Medicaid claiming and reporting. The following are the new definitions for Individual Categorical Codes which existed before Welfare Reform:

- 01- FA/SN/LIF Child-Death of a Parent (Deprivation)
- 02- FA/SN/LIF Child-Incapacity Parent (Deprivation)
- 03- FA/SN/LIF Child-Imprisonment Parent (Deprivation)
- 04- FA/SN/LIF Child-Military Service Parent (Deprivation)
- 05- FA/SN/LIF Child-Divorce, Annulment, or Legally Separated Parent (Deprivation)
- 06- FA/SN/LIF Child-Abandonment/Desertion by Parent (Deprivation)
- 07- FA/SN/LIF Child-Removed by Court
- 08- FA/SN/LIF Child-Unemployed Principal Wage Earner (Deprivation)
- 09- FA/LIF/SN/SCC Child (No Deprivation) and Singles/Childless Couple
- 13- FA/LIF/SN Dependent Relative
- 15- FA/LIF/SN Pregnant Woman (without deprivation)
- 39- FNP Parent (Case Type 20 Only)

New Individual Categorical Codes have been added. These include:

- For ADC Related Budgets: 21-ADC-Related Adult (Deprivation)
- MA Only (Case Type 20) 22-ADC-Related Child (Deprivation)
- 25-ADC-Related Child (No Deprivation)
- 42-ADC-Related Pregnant Woman (MA Level)
- 43-Pregnant Woman - (expanded levels)



TANF & MA Cases

26-FA/SN/LIF Adult Intact Family (No  
Deprivation)

48-FA/SN/LIF Pregnant Woman (Deprivation)

For further details on the proper entry of these Individual Categorical Codes, please refer to the November 1997 WMS Coordinator Letter.

3. Welfare Reform legislation requires that Transitional Medical Assistance (TMA) now be generated from the termination of Medicaid eligibility, not cash assistance. This means that TMA processing must now be supported for Medicaid cases as well as PA cases with Medicaid coverage. In order to support this change, a new Undercare Maintenance Reason Code of **EO8**, for Case Type 20 only, should be entered when six months of TMA coverage is to be provided. This will begin the TMA mailer process.
4. MBL changes will include the addition of the Earned Income Disregard (42%), and other calculation changes as detailed previously. These changes will be detailed in MBL transmittal 97-2 to be issued in mid-November 1997.

#### New York City

New York City Systems Implications will follow under separate cover.

#### **V. NOTICES IMPLICATIONS**

Effective November 1, 1997, all existing and new manual notices will reflect the changes necessitated by the WRA. Existing closing and denial notices issued through the Client Notice System (CNS), will reflect these changes as of November 1 as well. Notices issued by PA will reflect the Medicaid changes required by the WRA.

#### Existing Medicaid-Only Notices

Existing manual notice DSS-3623, "Notice of Intent to Discontinue/Change Medical Assistance", must be used to accommodate the new generation of TMA and child/spousal support extensions on Medicaid-Only cases. Pen and ink changes must be made to the DSS-3623 to notify the recipient of eligibility under TMA or for the four-month extension due to receipt of child/spousal support. A Transitional Medical Assistance Fact Sheet that explains the TMA extension is included as Attachment B and must be reproduced locally and sent when TMA is authorized. Workers must check the first "Change" box and the "Other" box. Workers must strike the phrase " (non financial) change in circumstances" and write in one of the following messages:

- TMA

Medical Assistance coverage will continue under Transitional Medical Assistance. (See attached Transitional Medical Assistance Fact Sheet)

- Child Support Extension

Medical Assistance will continue until     (date)     due to receipt of increased child/spousal support payments.

Effective with the mass rebudgeting migration, CNS notices for closings and denials will reflect the new Welfare Reform terminology and the change in the resource level from \$1,000 to \$2,000 and \$3,000 for SCC and \$3,000 for LIF budgeting.

New Medicaid-Only Notices

Several new notices are required as a result of Welfare Reform.

For TMA, a new manual notice to be generated from a Medicaid case is now required. This notice is under development and will be forwarded to districts upon completion. Until the new notice is provided, districts must use the DSS-3623 as described above.

CNS denial and closing notices to reflect the new alcohol and substance abuse requirements are available. Denial/Closing Reason Code U71 -Failure to Comply with Drug and Alcohol Requirements, must be used to generate appropriate language.

A copy of the MBL budget must accompany the DSS-3623. For TMA cases, the Transitional Medical Assistance Fact Sheet (Attachment B), must be sent with the appropriate notice.

Combined PA/MA Notices

Although PA and Medicaid are delinked, the automated CNS will continue to include both the PA and Medicaid decision in the closing or denial notice when appropriate. The automated system will continue to generate a Medicaid case, if the reason for closing the PA case does not apply to Medicaid.

When Medicaid coverage code 04 (no Medicaid) is used on a PA-Only case, the initial manual opening notice should address the reason Medicaid is not being provided. An additional box will be added to the Notice of Decision, DSS-4013, to reflect that the individual did not apply for Medicaid. This box must be checked when the applicant has not applied for Medicaid. Until the notice is revised, districts must use the DSS-4013, check the "Other" box, and write in the following language in the Medicaid section of the notice:

"not applying for Medical Assistance. You did not indicate on the application that you wanted to apply for Medical Assistance."

For coverage code 04 cases that are due for PA recertification or other actions, subsequent manual notices as well as CNS closing and denial notices need not make further reference to Medicaid and no referral to the Medicaid Unit is required.

For combined PA/MA cases, pen and ink changes must be made to manual notices DSS-4014 and DSS-4015 to notify the recipient of eligibility under TMA or the four-month extension due to increased child/spousal support. Please note that the four-month child support extension must be provided only when the individual is not otherwise eligible for Medicaid for a minimum of four months as described in Section II, B.5 of this directive.

Workers must check the first box of the Medicaid section of the notice indicating continued Medicaid coverage. Workers must write in the TMA or child support extension message that is used for Medicaid-Only cases.

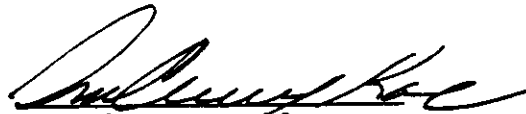
A copy of the ABEL budget must accompany the DSS-4014 and DSS-4015. For TMA cases, the Transitional Medical Assistance Fact Sheet (Attachment B), must be sent with the appropriate notice.

Mass Rebudgeting

A forthcoming MBL transmittal will address mass rebudgeting notices.

**VI. EFFECTIVE DATE**

This directive is effective upon receipt, retroactive to November 1, 1997.



Ann Clemency Kohler  
Director  
Office of Medicaid Management

Attachment A

CASE NAME	CASE NUMBER	CLIENT NAME
OFFICE/UNIT NUMBER	WORKER NAME/NUMBER	CIN NUMBER
CLIENT REFERRED FOR ALCOHOL/SUBSTANCE ABUSE ASSESSMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		

ALCOHOL/SUBSTANCE ABUSE SCREENING INSTRUMENT

1. In the last 12 months, have you ever felt you ought to cut down on your drinking or drug use?       Yes       No
2. In the last 12 months, have people annoyed you by criticizing your drinking or drug use?       Yes       No
3. In the last 12 months, have you ever felt bad or guilty about your drinking or drug use?       Yes       No
4. In the last 12 months, have you ever felt the need for an "eye opener", or awakened wanting a drink or another drug?       Yes       No
5. In the last 12 months, have you ever been hospitalized because of alcohol or drug use?  
 [Examples: 1. Having been in an accident while drunk or high; 2. Having a severe psychiatric problem like a suicide attempt after or during alcohol or drug use; 3. Having an alcohol or drug overdose.]       Yes       No
6. In the last 12 months, have you ever lost a job or failed to complete school or a training program due to alcohol or drug use?       Yes       No
7. In the last 12 months, have you lost housing (been evicted or became homeless) due to alcohol or drug use?       Yes       No
8. In the last 12 months, have you ever tried unsuccessfully to stop or greatly reduce your amount of drinking or drug use?       Yes       No
9. In the last 12 months, have you ever been in alcohol/substance abuse treatment?       Yes       No

CLIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Attachment B

TRANSITIONAL MEDICAL ASSISTANCE FACT SHEET

Your Medical Assistance coverage will continue under Transitional Medical Assistance for 6 months as long as you are a caretaker relative of a dependent child under age 21 who is living with you.

This is because your income is over the Low Income Family income limit due to increased earnings, new employment or loss of earned income disregards.

You may be eligible to receive Transitional Medical Assistance for up to 6 more months after the first 6 months of your extended Medical Assistance has ended if:

- o your earned income remains below certain levels; and
- o you remain employed; and
- o a dependent child under age 21 continues to live with you.

If you want Transitional Medical Assistance to continue for the full 12 months, you must complete the information on the reports we send you every 3 months. You must return the reports, along with copies of your paystubs, to us by the due date which will be shown on the first page of the report. You will receive your first report within 4 months. Remember to save your paystubs so that you can send copies to us with the reports.

It is important that you return these reports to us because the information you give in the reports will be used to determine your eligibility for the additional 6 months of Transitional Medical Assistance coverage.