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Purchasing and Contract Management	Health Care Delivery Systems and Policy

M E M O R A N D U M

To:	EES Chiefs and Staff; State and Contract HealthWave Clearinghouse Staff, Central Office Staff	**Date:**	5/22/01
From:	Nialson Lee, Administrator, Health Care Delivery Systems and Policy, Health Care Policy-Medical Policy/Medicaid	**Subject:**	Implementation of Centralization of Health Care Programs for Families

Over the past several months, a number of teams have been assigned the task of developing a plan to centralize programs which provide health care coverage for families. The centralization effort has been divided into two phases. Phase I is the centralization of case maintenance and review processing for these programs (which are defined below). Phase II is the centralization of initial eligibility determination for these programs. In addition to developing a plan for transitioning to the new centralized model, a number of changes to eligibility policies were proposed and approved. These policies were designed to help streamline the eligibility determination and maintenance of health care programs for families as well as to help achieve the health care goals of the agency. This letter serves as implementation instructions for Phase I of the centralization effort and for the changes in eligibility policy relating to health care coverage for families effective July 1, 2001. Phase II of the centralization effort will be addressed at a later time.

1. Health Care Programs for Families

The list below defines which programs are discussed in this memo as "health care programs for families." At the end of Phase I of the centralization project, all health care programs for families, with certain exceptions for MA spenddown programs, will be maintained in the HealthWave Clearinghouse. The timeline for transferring these cases to the Clearinghouse is discussed in detail below. The programs that will be maintained by the Clearinghouse are as follows:

A. **MA-CM** (caretaker medical), **TAF medical** (which will be administered on the MA-CM program), **TransMed**, and **Extended Medical**.
B. **All MP programs including all Poverty Level Medicaid, Pregnant Women, and HealthWave programs.**
C. **MA spenddown programs.** (See the "Eligibility Processes" section for a more detailed explanation).
D. **SI programs associated with health care programs for families.** If an SI child or an SI adult lives with a family who is enrolled in health care programs for families, the SI program will be maintained in the Clearinghouse with the health care programs for families. This does not include SI-HCBS programs or cases where the only open program is SI.

All other health care programs will be maintained in the local SRS office. Households whose programs

include both health care programs for families and other assistance programs, including other health care programs not listed above and child care cases, will be split. The health care programs for families will be maintained by the Clearinghouse, and the other assistance programs will be maintained in the local SRS office. For example, a family with a disabled father, a mother, an SI child and two other children apply, requesting medical coverage for all. If eligible, the MA-CM and the SI program for the mother and children will be maintained in the Clearinghouse, but the MS program for the father will be determined and maintained by the local SRS office.

All SOBRA programs, burial programs, and services provided to individuals in current refugee status under any programs will be determined and maintained by the local SRS office. If someone on an open health care program for families dies and the family wishes to seek burial assistance, the family must request burial assistance from the local SRS office. A SOBRA program shall be processed to completion by the local SRS office. If an MP program remains after the SOBRA program is finalized, the MP program shall be sent to the Clearinghouse.

2. Eligibility Processes

A. Processes for new applications

Effective July 1, applications for health care programs for families will be processed in the location they are received, but will be maintained at the Clearinghouse. Applications approved in the local SRS office are to be transferred immediately after approving the program, authorizing through the current system month, and sending a notice to the family that the program is being transferred to the clearinghouse. For example, if a local SRS office receives an application for MP/HealthWave only, that application will be processed by that local office, authorized through the current system month, a transfer notice sent to the family, and the program transferred to the Clearinghouse upon approval. Health care programs for families approved in the field are not to be retained for any period of time before sending them to the Clearinghouse. Any applications that are denied in the local SRS office shall be retained by that office. An application for MA-CM or other health care programs for families received by the Clearinghouse will be processed at the Clearinghouse and retained. An appeal of a denied application shall be handled by the office that denied the application.

In order to accomplish this, all new health care programs for families must be opened on a case number separate from other program involvement. Programs such as food stamps, TAF, MS, HCBS, etc. will be set up on one case number while the MP, MA-CM, MA-WT, MA-EM, or an MA spenddown will be set up on another case number. As mentioned earlier, an SI program where there is also a health care program for families for other family members will be established on the case number that includes the health care programs for families and will be maintained by the Clearinghouse. An MS, HCBS, NF, SOBRA, or burial program will always be established on a separate number and maintained in the field.

An application for health care programs for families only has been developed (see Attachment A). This application is to be given out when families enter the local SRS office or call the Clearinghouse and request an application for medical coverage. If the family is interested in cash assistance, food stamps, child care, or other health care programs not related to family coverage, they shall be given the appropriate form to complete. This may mean that the family will have to complete an application for medical coverage (the short form) and another application for other assistance (the long form). Both applications, if received in the local SRS office, will be processed in the local SRS office. If the family turns in a long form and requests medical coverage, the long form will be used to determine eligibility for health care programs for families

without obtaining a separate application. However, when the family requests an application, if they indicate they want medical assistance, they should be encouraged to complete the short form.

The Clearinghouse may receive some ES 3100 applications in the mail. The Clearinghouse will need to use this form to process health care programs for families, including adult caretaker medical (MA-CM) cases. If the Clearinghouse receives an application where the family has applied for health care programs for families as well as other assistance programs, the Clearinghouse will copy the necessary documents to open the medical programs, register the medical application on a new case number, and send the application and supporting documents to the appropriate local SRS office to process the request for other assistance programs. In this situation, the Clearinghouse will transfer the application to the field immediately to allow for timely processing of the other assistance programs. This process will also be followed if the family has requested medical, either on the new application for health care programs for families or another application such as the ES 3100, for someone who is disabled (currently receiving SSD benefits).

If a family's health care program closes for failure to return review and a review form is returned within 30 days of closure, the review will be processed by the Clearinghouse. If the review is received after the health care program for families has been closed for 30 days or more, it will be treated as a new application and processed where it is received. If it is processed and approved in a local SRS office, it shall be transferred to the Clearinghouse upon approval. If the Clearinghouse receives the review form and other programs are requested, the process described above shall be followed.

B. Process for MA spenddown programs

An MA spenddown program will be processed and retained by the office that received the program application. A spenddown program will not be sent to the Clearinghouse if it is opened in the local SRS office. However, all spenddowns requested for children with special health care needs through the Kansas Department of Health and Environment will all be processed by the Clearinghouse. If the local SRS office receives an application with a sticker attached to it that requests a spenddown be determined for a child with special health care needs, the application shall be sent to the Clearinghouse to complete the initial processing and to maintain the program. See Attachment B for an example of the sticker usually affixed to the back of the application.

C. Process for Open TAF or MA-CM programs transferring to TransMed or Extended Medical

To streamline the eligibility process under the centralized model for health care programs for families, some systems modifications were made which change the way medical coverage is provided to families under the TransMed and Extended Medical programs. Effective July 1, the TransMed and Extended Medical programs will no longer be maintained on the AF/AM program on KAECSES. WT (TransMed) and EM (Extended Medical) program sub-types have been added for the MA program. TransMed will now be administered on the MA-WT program (with participants coded IN instead of WT on SEPA) and Extended Medical will be administered on the MA-EM program. There are two processes to follow to transition a family from TAF or MA-CM to TransMed or Extended Medical.

First, when a family with a TAF and/or an MA-CM program currently open in the local SRS office loses eligibility due to employment or increased child support, the local SRS office is to close the TAF/MA-CM program on the old case number. A new case number with the appropriate MA-WT or MA-EM program will then be registered and opened. The review date will be set allowing for either 12 months of coverage for TransMed or 4 months of coverage for Extended Medical. One option for MA-EM is to set the review

for 12 months, roll it ahead and close it at the end of the fourth month. An MP program shall be opened for the remainder of the children's continuous eligibility period.

Secondly, for a family with an MA-CM program open on a separate case number, change the CM program sub-type to the appropriate WT or EM program sub-type. In order to allow for the appropriate coverage period for TransMed, register a review on RERE (since this is just an administrative action, no review form is required), set a new 12 month review date, exempt the interview, and authorize the program. Follow the same procedure for Extended Medical if the review is due within the next four months. If the review is due more than four months in the future, the worker is to either roll it ahead to the appropriate month and close it at the same time the MA-EM program is started, or track it so that the program can be closed by the appropriate date, allowing for timely and adequate notice. In order to ensure that the children on the Extended Medical program receive 12 months of continuous eligibility, an MP program shall be opened for the remainder of the continuous eligibility period.

A TransMed or Extended Medical program currently open on the TAF/AM program is to be transferred to the MA-WT or MA-EM program on a separate case number following the procedure outlined above. This will need to be done according to the transition schedule that is defined later in this memo.

D. Ex parte reviews for MA-CM closures

E. CSE referrals

A CSE medical referral is still required when a family is covered by the MA-CM program. Since the MA-CM program will be maintained on a separate case number, a second CSE referral on the MA-CM case will be required. This may mean a number of CSE referrals being sent for the same family (i.e. TAF, child care, and MA-CM). If a referral is being sent on an MA-CM program and a TAF program is already open, or vice versa, the worker shall note on the narrative line on the CHSE screen that this is a duplicate referral.

A CSE referral is no longer required, however, for TransMed or Extended Medical (see the "July 1 Policy Changes" section below). When an MA-CM program transfers to MA-WT or MA-EM, the CSE referrals shall be removed from the SPRD and CHSE screens. If the remaining open program transitions back to an MA-CM, a new CSE referral will need to be made.

3. Verification for New Application

When transferring health care programs for families **which were recently opened from a new application** from the local SRS office to the Clearinghouse, the following information/verification is to be copied from the field file and mailed to the Clearinghouse:

- The most recent application form used to open the medical program. If only a medical application was received and used to open the program, then the original should be sent to the Clearinghouse. If another application is used to open the case, such as an ES 3100, only the front page, the income page, and the signature page of the application will be copied.
- Verification of alien status.
- Self employment verification.
- Income verification (if the area utilizes an income worksheet, a copy of it should be included).

- Trust fund verification.
- Pregnancy verification.
- Third Party Liability (TPL) information (copies of the front and back of the insurance cards if available. If those copies are not available, include a copy of the insurance section of the application).
- The section of the documentation log that documents the actions taken to open the medical program.
- A copy of the electronic income worksheet for MA-CM programs.

This list does not apply to the transferring of open cases according to the transition timeline. Programs already open being transferred according to the transition timeline do not require copies of verification be sent, as noted below.

4. Case Numbers

The intent of this process is for the local SRS office to have the current and historical electronic and hard copy documentation for all other assistance programs. The Clearinghouse will have the electronic and hard copy documentation of all cases with only health care programs for families under the following procedure:

A. Medical Only

(1) Closed Cases

- The Clearinghouse will keep closed case files where the only program ever associated with the case has been a health care program for families.
- When the Clearinghouse receives a new application for health care programs for families and they inquire on the system to learn that a previous case in the field had only a health care program for families associated with it, the Clearinghouse will request that closed file from the field.
- If the field receives an application for assistance other than medical and the only closed program ever associated with the applicant family is a health care program for families, the other assistance programs will get the new case number and a new case file will be established. The closed health care program for families file will remain in its current location until it is purged or the family re-applies for medical coverage.

(2) Open Cases

- When the Clearinghouse has an open case that has only had a health care program for families ever attached to it, they will continue to keep that case file and number.
- When the field has an open case that has only had a health care program for families ever attached to it, the case file will be sent to the Clearinghouse according to the transition schedule.
- If the field receives an application for other assistance and a case is already open that has only had health care programs for families associated with it, the other assistance programs are to go on a new case number. The Clearinghouse would retain the original case or, if the field currently has it, the case would be sent to the Clearinghouse according to the transition schedule.

B. Combined Cases *(cases that have had both health care programs for families and other assistance*

programs attached at any time)

(1) Closed Cases

- When the Clearinghouse has a case file that has had a combination of health care programs for families and other assistance programs associated with it, the Clearinghouse will copy the documents related to health care programs for families from the case file, create a new case file, CARC the closed record to the appropriate office (this has been tested and is possible) and send the old case file to the last known county of residence of the beneficiary. The Clearinghouse must keep a record indicating they have a medical only case file in storage. If a new application comes in, they will register a new case number and use the medical only case file they have. This process will occur over a six month timeline and will not begin until March 2002.
- When the field office has a case file with a history of both health care programs for families and other assistance programs, they will retain the file. If an application for health care programs for families is received in the future, the office receiving the application will register a new case number and start a new case file. The old case file and case number will be used if the family applies for other assistance programs in the future.

(2) Open Cases

- When the Clearinghouse has an open case due for review with a history of both health care programs for families and other assistance programs, they will close the current medical case, copy the essential medical information from the file and start a new file, register a new case number, CARC the closed case and send the old case file to the county of residence of the beneficiary.
- When the field has an open case with a history of both health care programs for families and other assistance programs with a current open health care program for families, according to the transition schedule below, the field will close the medical program on the old number, register a new case number for the medical program, open the health care program for families on the new case number <u>making sure to enter the same review date that was used on the old case number</u>, complete the transfer checklist, and CARC the case to the Clearinghouse. No paper file shall be sent. The program should be sitting in the current system month and authorized prior to sending it to the Clearinghouse.
- When the field has an open case with a history of both health care programs for families and other assistance programs but currently only has another assistance program open, the field will retain this case file. If a new application for health care programs for families is received, a new case number will be obtained and a new case file will be started for the health care program for families.

C. Other Assistance Programs Only

(1) Closed Cases

- The Clearinghouse should not have any closed files where there is a history of only other assistance programs. If they do have any of these cases, the case files shall be sent back to the last known county of residence upon discovery.
- If the field has a closed case that has only had other assistance programs associated with it, the field will retain this file. A new application for health care programs for families requires

obtaining a new case number and a new case file started.

(2) Open Cases

- The Clearinghouse should not have any open cases that have a history of other assistance programs only. If they do have any of these cases, the case files should be sent back to the last known county of residence upon discovery.
- If the field has an open case that has only had a history of other assistance programs, the field should retain the case. A new application for health care programs for families would require obtaining a new case number and starting a new case file.

After the transition has begun, some cases with only health care programs for families registered will close. It may be necessary for the local SRS office or the Clearinghouse to register a new application on a case number already existing if that case number was a medical only case number. It will be important when registering new applications to make sure that a case number used only for health care programs for families is not already in existence before registering a new case number. This can best be discerned by viewing the different case numbers associated with the PI on the CLPR screen and noting a case number that has only had health care programs for families attached to it. <u>If the only other programs attached to the case number were never in open status and never had benefits paid (denials), the case number shall be deemed not to have had any other program involvement.</u>

<u>5. Sharing of Information</u>

Often, families will have two cases, one maintained in the local office and one maintained in the Clearinghouse. Information may be reported to one entity that will also need to be reported to the other entity. For instance, a family which has an MA-CM case maintained in the Clearinghouse may call and report a change of address to the Clearinghouse. This may also have implications for their food stamps, child care, or other programs maintained in the local SRS office. In order to accommodate the reporting of information to the appropriate entities, the following procedure has been developed:

A. An electronic form has been developed (Attachment C) which will be used to report <u>a change of address, a family or individual moving out of state, a TAF case opening, a TAF case closing, a CSE non-coop on a TAF household, and/or the death of a recipient/beneficiary only.</u> No other changes will need to be reported or shared between the Clearinghouse and the local SRS offices.
   - Electronic mailboxes will be set up in the Clearinghouse and in each SRS county office. Information meeting the above criteria that needs to be shared between the Clearinghouse and the local offices will be sent via e-mail to the appropriate mailbox.
   - Each office will designate staff who will check the e-mail and route the change report to the appropriate worker who will take appropriate action based on what is being reported.
   - A list of e-mail addresses will be sent in the near future.

B. For changes other than those listed above, staff will need to direct families reporting changes to report the changes to the other entity using the following statement:
   - For the Clearinghouse, the statement should be, “If you have other SRS programs, you are required to report these changes to your local SRS office.”
   - For the local SRS office, “If you have health care coverage, you are required to report these changes to the HealthWave office. The number to call to report these changes is 1-800-792-4884 and the call is toll free.”

6. Transition Timeline for Cases Currently Open

There are two types of open health care programs for families that will be transferred to the Clearinghouse. The first type is a health care program for families with no other current program involvement, such as food stamps, child care or TAF associated with it. This type of health care program for families will primarily be MP only, but may also include an MA spenddown, MA-CM, TransMed or Extended Medical.

The second type is a health care program for families with other program involvement associated with it. These two types will have different procedures for the transition. Overall, the transition should begin in the middle of July 2001 and be complete by July 2002. It is important that the following time lines be strictly followed so that the transfer of medical programs to the Clearinghouse goes smoothly, and we ensure that eligible families do not lose medical coverage in the process.

For both types of cases, copies of verification mention in section three of this memo does not apply. The only time hard copy documents need to be sent to the Clearinghouse is if the case has never had any other program involvement associated with it. In this instance, the entire case file will be sent. For all other cases, the Clearinghouse will begin to build a new file when the program is due for review. The Clearinghouse may request copies on a case-by-case basis of alien or pregnancy verification from the field file.

A. Open Health Care Programs for Families with No Other Current Program Involvement

The local SRS offices are to begin sending cases to the Clearinghouse starting the middle of July, with the first round to be CARC'd no later than August 16 so that review labels can be printed and sent to the appropriate location. If any cases are not CARC'd by the appropriate date, it is the responsibility of the local office to complete those reviews and, if approved, send them to the Clearinghouse. Please refer to the "Case Numbers" section of this memo to determine if a case file must be sent, and to see if a new case number needs to be registered prior to CARCing and sending, depending on previous program involvement on the old case number. **A case file will only need to be sent if it is a medical only case with no history of other program involvement.**

The Clearinghouse will send the medical review forms and process these reviews. Except for medical only cases with no history of other program involvement, the Clearinghouse will be responsible for starting a new case file.

Health care programs for families with no other current program involvement will transferred according to their review dates, with two months being sent at a time. CARCing and sending the case must occur by 5:00 pm the first business day following the 15th of the month in order for review labels to be sent to the appropriate location. The local SRS office will be responsible for processing any reviews that are not transferred according to the timeline below.

- Between 7/15 and 8/16/01– CARC and send programs due for review in 10/01 and 11/01.
- Between 8/16 and 9/15/01–CARC and send programs due for review in 12/01 to 1/02.
- Between 9/15 to 10/16/01–CARC and send programs due for review in 2/02 to 3/02.
- Between 10/16 to 11/16/01–CARC and send programs due for review in 4/02 and 5/02.
- Between 11/15 to 12/16/01–CARC and send programs due for review in 6/02 and 7/02.
- Between 12/15 and 1/16/02–CARC and send programs due for review in 8/02 and 9/02.

B. Health Care Programs for Families with Other Program Involvement

Transferring a health care program for families with other program involvement to the Clearinghouse will require some additional action be taken both by the local SRS office and by the Clearinghouse. In accordance with the timeline below, the local SRS offices will identify those medical programs that are to be transferred to the Clearinghouse. The procedure for the local office to transfer the medical programs is to close the health care programs for families on the existing case, register a new case number and open the same medical program with the same family members coded IN, making sure to set the review date to the same date as on the old case number. CARC the new case to the Clearinghouse. **In these instances, no case file will be sent to the Clearinghouse.**

Prior to these programs being CARC'd, the transfer checklist shall be completed by the local SRS office to ensure that the appropriate programs have been sent and that they are set up correctly. After the checklist has been completed and any issues dealt with as a result of the checklist, the checklist shall be sent to the Clearinghouse.

The Clearinghouse will begin to build a new case file when the medical review comes due and is returned. There may, however, be instances when the Clearinghouse will require some verification that is present in the field file such as alien verification or pregnancy verification. The Clearinghouse may request this information on a case-by-case basis in order to avoid having to obtain the verification again. If the Clearinghouse requests this verification, the local office is to send copies.

These health care programs for families will be sent to the Clearinghouse prior to the medical review coming due and only the other assistance programs will remain open in the local SRS office on the old case number. As the reviews come due for the other assistance programs on the old case numbers, the field will send review forms for those programs only. Since the ES 3100 will not be revised immediately, it will be necessary during the transition period to black out that part of the review form where individuals can request medical. This will prevent a request for medical coming to the local SRS office when the review will be completed by the Clearinghouse. The medical section of the review form shall only be blacked out for reviews when **all** medical programs on that case will be reviewed at the Clearinghouse. If there are any medical programs remaining open on the case in the local office, such as an MS program, the medical section of the review form shall not be blacked out. The medical portion of the ES 3100 shall not be blacked out for any other reason than for the health care programs for families reviews which come due during this transition to the Clearinghouse.

Health care programs for families with other current program involvement will be transferred to the Clearinghouse based on the review dates, with one month being sent at a time. CARCing and sending the case must occur by 5:00 pm the first business day following the 15th of the month in order for review labels to be sent to the appropriate location. The local SRS office will be responsible for processing any reviews that are not transferred according to the timeline below. The schedule to transfer these cases is as follows:

- Between 7/15 and 8/16/01– CARC and send programs due for review in 10/01.
- Between 8/15 and 9/16/01– CARC and send programs due for review in 11/01.
- Between 9/15 and 10/16/01– CARC and send programs due for review in 12/01.
- Between 10/15 and 11/16/01– CARC and send programs due for review in 1/02.
- Between 11/15 and 12/16/01– CARC and send programs due for review in 02/02.
- Between 12/15 and 1/16/02– CARC and send programs due for review in 03/02.
- Between 1/15 and 2/16/02– CARC and send programs due for review in 04/02.
- Between 2/15 and 3/16/02– CARC and send programs due for review in 05/02.
- Between 3/15 and 4/16/02– CARC and send programs due for review in 06/02.
- Between 4/15 and 5/16/02– CARC and send programs due for review in 07/02.
- Between 5/15 and 6/16/02– CARC and send programs due for review in 08/02.
- Between 6/15 and 7/16/02– CARC and send programs due for review in 09/02.

A printout is being developed which will identify, by unit, which cases are due for review and when they should be sent to the Clearinghouse. This printout should be in each county office by the 15th of each month beginning with July. The transfer checklist used in the past when transferring cases from the field to the Clearinghouse has been updated and shall be used beginning July 1, 2001. (Attachment D)

Any reviews for health care programs for families located in SRS offices that are due prior to 10/01 shall be completed by the local SRS office.

C. Transferring from TAF or MA-CM to TransMed or Extended Medical

Since the review date is re-set when a case transfers to TransMed or Extended Medical, the above schedule may exclude families who lose TAF or MA-CM eligibility during this six-month transition phase due to employment or increased child support. If during the transition period a family whose TAF or MA-CM program is still maintained in the local SRS office moves from TAF or MA-CM to TransMed or Extended Medical , the local SRS office shall establish the TransMed or Extended Medical eligibility on the MA-WT or MA-EM program following the procedure outlined in the "Eligibility Processes" section earlier in this memo. The MA-WT or MA-EM program shall be sent to the Clearinghouse once it is opened on a new case number.

7. July 1 Policy Changes

A. **Elimination of penalties for failure to meet work requirements**. Effective July 1, no penalties will be applied on a health care program for families when an adult TAF recipient fails to meet work requirements. Penalties already established prior to July 1 will continue in place. However, if the agency receives a request from the family to begin medical coverage for July 1 or after, the penalized individual(s) should be given coverage as long as all other eligibility requirements are met, even if the adults are under a minimum penalty period for the TAF program. If an MA-CM program remains open for the children at the time the request is made, no new application to add the parents is necessary. If the MA-CM program has been closed for more than 30 days, a new application is required. This policy relates to medical programs only and does not affect penalties for the TAF cash or food stamp programs.

B. **Elimination of resource tests for health care programs for families.** Effective with any application processed on or after July 1, resources (excluding trust funds) will no longer be considered in determining eligibility for health care programs for families. Resources are still required for other assistance programs, including health care programs not related to family

coverage. If there are two case numbers open for the family, one for health care coverage for families and one for other assistance programs, and resources are listed on one case number, the resources will automatically appear on the other case number as well. For the health care for families case number, the resource screens (LIRE, OTAP, and VEHI) should not be accessed. If a worker does NEXT through these screens, the worker administering the health care for families case must not change any resource information on the health care case number as this may affect a family's eligibility for other assistance programs on the other case number. The worker administering the health care program for families does not need to obtain resource information from the family or add any information to the resource screens. The one exception to this rule is if there is a trust fund available to the family which must be listed on the LIRE screen for MA programs only. Trust funds are exempt as a resource for the MP program.

It is not necessary to pass through the resource determination (MARD) screen to authorize the MA program, but if the worker administering the health care program for families passes through the MARD screen and there are resources listed on the resource screens in excess of $3,000, a warning will display that says the family does not pass the resource test. The program can still and should be authorized on the income determination (MAID) screen. If the family has a trust fund listed on the LIRE screen in excess of $3,000, MARD will again say that the family is not eligible due to excess resources, but the system will still allow the program to be authorized. The worker must enter a denial code and deny the MA program for excess resources in this situation.

C. **12 months of continuous eligibility for minor pregnant women (Title XIX only).** Effective July 1, minor pregnant women approved for Title XIX under any health care program for families will have 12 months of continuous eligibility. Initially establishing the continuous eligibility date will follow the same guidelines as for non-pregnant minors on the MP program. If the child is not pregnant at the time of application but later reports she is pregnant, a 12 month continuous eligibility period will have already been established, and the minor pregnant woman will be due for review during her pregnancy. If the minor pregnant woman cooperates with her review requirement and is still pregnant at the time of review, her review shall be approved and she shall be granted another 12 months of continuous eligibility.

If the minor pregnant woman is eligible under the MP program, the worker will add the PP code for the two month post partum period when the baby's birth is reported and roll the program into the third month following the month of birth. The worker will then remove the PP code on SEPA, authorize the program, and override the medical sub-type on MERE to N4. This process is needed to ensure the sub-type does not automatically switch to another sub-type when the program rolls into the next month. The system will automatically copy details into future months through the end of the continuous eligibility period. If the work is being done in a past month, the worker will need to ensure that the current system month reflects the N4 medical sub-type or the system will not copy the details forward. After CARCing the case to the clearinghouse, check MEBH to ensure that the medical sub-type is N4.

For minor pregnant women eligible under a medical program other than MP, the continuous eligibility date must be tracked manually. The worker must ensure the minor pregnant woman is afforded continuous eligibility for 12 months according to the guidelines listed above.

For purposes of this policy, a minor is someone who is 18 years old or younger. If the pregnant woman turns 19 years old in the middle of a review or continuous eligibility period, she only has

continuous eligibility through the two month post partum period. Minor mothers whose post partum period ends June 30, 2001 shall not be granted the 12 months of continuous eligibility. If the post partum period ends on July 1 or after, the minor mother shall be granted 12 months of continuous eligibility.

D. **Change in loss of contact procedures.** Effective July 1, any continuously eligible individual whose mail returns or whose whereabouts are unknown will not lose eligibility for loss of contact. **This relates to the health care programs for families only and only to those individuals who are continuously eligible.** If the case in question is an MA-CM case, the worker shall try to make contact with the family. If after several attempts, the family cannot be contacted, the parents shall be coded OU on SEPA. Since the children are continuously eligible, they shall keep their medical coverage until the time of the next review. If the health care program is for children only (MP or HealthWave), no action shall be taken until the next review. If the whereabouts of the individual or family are subsequently learned (i.e. through the forwarding address provided on returned mail), appropriate action should be taken at that time. For example, if mail returns for a family whose children are on HealthWave, no action shall be taken at that time. If it is later reported and verified that this family moved out of state, ADDR shall be updated and the case shall be closed, allowing for timely and adequate notice. If the case were an MA-CM case and several attempts had been made to verify the whereabouts of the family with no success, the parents would be removed from the case and given proper notice that their coverage had ended, but the children would remain on the open MA-CM case until the end of the continuous eligibility period.

E. **Elimination of HIPPS referrals for health care programs for families.** Effective July 1, it is no longer required to send a HIPPS referral. Since individuals eligible for health care programs for families are part of the managed care population, a HIPPS questionnaire will be included with the managed care enrollment packet and the family will be required to complete it and send it to the HIPPS unit. In instances where SRS or contract staff are aware of a family with a child with high medical expenses and/or an employer who offers low cost family coverage, it is still encouraged to send a referral to the HIPPS unit.

F. **CSE referrals for TransMed and Extended Medical.** Effective July 1, 2001 CSE referrals are no longer required for TransMed and Extended Medical programs. CSE referrals are still required for MA-CM. When an MA-CM program transitions to MA-WT or MA-EM, the children shall be removed from the CHSE screen and coded "ND" on SPRD. For TransMed and Extended Medical programs that are currently open, the referral shall be removed at the time of review or when the case is moved from the AF/AM program to the MA-WT or MA-EM program. A new referral will be required if the program moves back to MA-CM.

8. Follow Up

Through the transition process, there may be a need for clarification of appropriate procedures. Health Care Policy–Medical Policy/Medicaid will issue Q & A documents on an as-needed basis to address questions. As questions arise, please send them to Darin Bodenhamer at dxxdb@srskansas.org .