TANF/Medicaid State Review
South Carolina Final Report

I. Description of the Review Process

Introduction

Federal Government representatives conducted an on-site review of certain aspects of South Carolina's Medicaid program during the week of November 1-5, 1999. The review team consisted of four Regional Office staff: Jessie Spillers and Linda Lattimore of the Health Care Financing Administration (HCFA), Rosalind Rogers of the Office of Civil Rights (OCR), and Bill Battle of the Administration on Children and Families (ACF). This report contains information gathered through reviews of the State's documents, policies and procedures as specified below, case reviews and discussions with State Medicaid representatives, consumer advocates and other relevant parties identified. As such, this report is limited to the information gathered from these sources regarding South Carolina's Medicaid program as of November 1-5, 1999 with respect to the areas addressed. Subsequent to the review, the State and local advocacy groups also were given the opportunity to comment on the review team's findings. While this report generally describes the State's program at the time of the review, it also may reflect the State's and advocates' comment in whole or in part, as well as information that updates the findings to reflect actions the State has taken since the review. A copy of the full comments from the State is appended to this report.

In March 1999, HCFA, along with ACF, released to States a guidebook entitled, "Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World." The guidebook is part of our effort to work with States to ensure that people moving off cash assistance and working families who may not realize they are eligible for assistance, receive Medicaid benefits when eligible. The guidebook makes clear that States have options and flexibility available to conduct their program. In fact, States have more options now than ever before to provide health insurance to low-income families, including the ability under Section 1931 of the Social Security Act (the Act) to make more families eligible for Medicaid, and the option to eliminate the "100 hour rule" to expand Medicaid eligibility to working, two-parent families. The guidebook also makes clear that States have responsibilities under the law. States must furnish a Medicaid application upon request and may not impose a waiting period on the Medicaid application. States must also process Medicaid applications without delay and can not end coverage until all categories of eligibility are explored.

Following issuance of the guidebook, HCFA, along with other agencies within the Department of Health and Human Services (DHHS), conducted site visits and reviewed certain aspects of each State's eligibility and enrollment policies and processes, including

those related to transitional Medicaid. Our objective for this assessment is to help South Carolina and other States ensure that welfare and Medicaid eligibility and enrollment procedures are effectively coordinated, comply with Federal requirements, and ensure that low-income families and children are enrolled and remain enrolled in Medicaid when eligible. HCFA is also using this review process to identify successful models of enrollment and outreach that we could share with other States.

State and Local Offices

The South Carolina Department of Health and Human Services (DHHS) is designated as the Single State Medicaid Agency and provides Medicaid and Partners for Healthy Children, the State Children's Health Insurance Program (SCHIP), health benefits for low-income individuals, families and children. The Department of Social Services (DSS) administers the TANF program and, through a contractual agreement with the DHHS, administers the Medicaid application and enrollment process, including transitional Medicaid and redeterminations. The two agencies meet monthly to discuss policy, eligibility issues, and information systems. Staff frequently contact each other on an informal basis.

The review team followed the schedule detailed below:

November 1, 1999 (afternoon)	Ms. Beth Hutto S.C. Appleseed Legal Justice Center
November 2, 1999 (morning)	Entrance Conference and State Staff interviews, State Medicaid Office, Columbia, South Carolina

Department of Health and Human Services

Dr. Samuel Griswold	Medicaid Director
Lillian "Bunny" Jones	Deputy Director - Health Services
Roger Posten	Deputy Director - Operations
Darlynn Thomas	Bureau of Health Services
Barbara Longshore	Division of Eligibility
Sally Brown	Division of Eligibility

Department of Social Services

Wilbert Lewis	Deputy Director - Policy & Oversight
Donald Graves	Director - Medicaid Field Operations
Pam Parnell-Hopkins	Medicaid Quality Assurance
Linda Martin	Program Reform and Research
Gwen Kuhns	Family Independence (TANF)

Alyce Player	Family Independence
Rudy Long	Medical Support
Garnell Cauley	Medical Support
Miriam Bickley	Systems
November 2, 1999 (afternoon)	Spartanburg County DSS
County Director Directors of the Medicaid and TANF Medicaid and TANF Caseworkers	All staff were present only part of the visit. units.
November 3, 1999 (morning)	Orangeburg County DSS
County Director Directors of the Medicaid and TANF Medicaid and TANF Caseworkers	All staff were present only part of the visit. units.
November 3, 1999 (afternoon)	Kershaw County DSS
County Director Directors of the Medicaid and TANF Medicaid and TANF Caseworkers	All staff were present only part of the visit. units.
November 4, 1999	Case records from the three counties were reviewed at the State Medicaid Office in Columbia.
November 5, 1999	Exit interview, State Medicaid Office, Columbia
State participants:	Same as at entrance conference

Before the visits, the review team decided to conduct as much of the survey as possible with all four members present. However, the team split into two groups to simultaneously interview Spartanburg, Orangeburg and Kershaw county staff on November 2-3.

Background on the Review Process

In order to get background information; the review team first met with Ms. Beth Hutto of the Appleseed Legal Justice Center advocacy group. Ms. Hutto confirmed that there are not many advocacy groups in the Columbia area. Details of the interview are contained in Section III.

Before conducting the Medicaid/TANF assessment, Federal staff provided the State, in a September 10, 1999 letter, with a comprehensive list of documentation and case sample requirements. These requirements were specified in the September 1999 review procedures guide supplied by Central Office. Upon receipt of this listing, State and Federal staffs worked together, to identify the case sample requirements so that systems staff could begin the process of segregating data. Universe identification was completed and the subsample selections were pulled within short timeframes, facilitated largely by the diligent efforts of the State. Counties were selected for on-site review, then subsamples were randomly selected from State universe case data for calendar years 1997 and 1998 of TANF and Medicaid active cases, denials, and terminations listed by county and case number (excluding aged, blind and disabled cases). Sub-sample selections from the §4913 eligible group were also accomplished.

To thoroughly assess State eligibility and enrollment processes, the review team selected three diverse counties in close proximity to Columbia, the State capital, for review: Spartanburg, a large populated county; Orangeburg, a medium populated county; and Kershaw, a small rural county.

We asked that the cases be ready for us to take with us to Columbia to do the review at the State offices.

In order to review Section 4913 policy and practice, we asked the State to acquire a listing of 1997 and 1998 SSI terminations from the local Social Security Administration office. We selected thirty cases for review, which consisted of only copies of computer print screens since no hard copy case files were available for review. For the Section 4913 eligibles, the State provided (for each case), a package that included the Client Information System (CIS) recipient eligibility segments, recipient base segment, and SSI recipient data.

At the entrance conference, the review team asked all 93 questions from the Assessment Tool so that both DHHS and DSS staff could hear each other's responses. Both staffs were also present at the exit conference.

II. Analysis of Documentation, Case Reviews, and Finding from On-Site State and Local Office Reviews

Documentation Review

The review team reviewed State documentation which was already available in the Regional Office, including: South Carolina’s approved TANF plan, Medicaid State plan materials, advocate letters and reports, and internal SCHIP material. The team also requested from the State and reviewed: excerpts from State Administrative Rules,

excerpts from the State Medicaid Policy Manual, all policy transmittals from June 1996 to the present and application forms. We found the material reviewed to be mixed in terms of accuracy, clarity and compliance with Federal guidelines, as described in the following subsections.

The team reviewed a total of 52 cases from the three counties, including TANF/Medicaid cases and Medicaid-only cases. Findings are discussed in the relevant subsections below.

A. Eligibility Categories, Application, and Enrollment Processes

Terms (additional terms in appendix)

FI – Family Independence Program (TANF program)
MAO – Medicaid-only
LIF – Low Income Families Group (1931 Medicaid-only group)

Eligibility Categories

Section 1931 Policy - Delinkage of Medicaid from TANF

The welfare reform provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) amended title IV-A of the Social Security Act (the Act) by eliminating the Aid to Families with Dependent Children (AFDC) program and replacing it with a new program, known as the Temporary Assistance to Needy Families (TANF). Before the enactment of PRWORA, receipt of AFDC conferred automatic eligibility for Medicaid. PRWORA severed the link between receipt of cash assistance and Medicaid. Section 114 of PRWORA added a new Section 1931 to the Act. Under Section 1931 of the Act, States are required to provide Medicaid eligibility to low-income families who meet the pre-welfare reform AFDC income and resource standards, methodologies and certain other requirements under the State's AFDC plan in effect on July 16, 1996. Under Section 1931 of the Act, States have the option to lower their income standards, but not below the AFDC standards in effect as of May 1, 1988. States also have the option to increase their income or resource standards based on a percentage that does not exceed the percentage increases in the Consumer Price Index that have occurred since July 16, 1996. Section 1931(b) of the Act also gives States the option to use income and resource methodologies that are less restrictive than those used under the AFDC State plan as of July 16, 1996 and to continue Title IV-A waivers which were in effect at that time.

South Carolina implemented its TANF plan, called the Family Independence (FI) Program, on October 1, 1996. The State has amended its Medicaid State plan section related to Section 1931 several times. State staff acknowledged that initially during the startup the State did not implement coverage for the Section 1931 group correctly. They

indicated that when they implemented TANF in October of 1996, they provided eligibility under Section 1931 only to children and nonsanctioned adults who were receiving TANF. The first Section 1931 State Plan Amendment (SPA) had an effective date of April 1, 1997 and the State did not actually establish the LIF group until October of 1998. At the time of the review, the State had chosen through a subsequent SPA, to apply the following less restrictive income and resource methodologies:

1. Disregard the first $1,500 (above $1,000) of otherwise countable resources for applicants and recipients.
2. Disregard one motor vehicle per family member who works or participates in a training program.
3. Disregard income from interest or dividends up to $400 annually.
4. Disregard earned income of dependent children.
5. Disregard cash value of life insurance policies up to $10,000.
6. Disregard up to $10,000 in an Individual Development Account.
7. For purposes of the 185% gross income test, disregard all income more than 185%.
8. Disregard lump sum payments from income. If lump sum payments are retained for more than a month, the amount is counted as a resource.
9. Disregard 50% of earned income for the first 4 months after employment begins and apply a standard disregard of $100 for each month thereafter that earned income is received.

According to Section 4.01 of the State Medicaid Policy Manual, Revision Number 98-1, "The South Carolina Medicaid Program selected the option to make the Medicaid eligibility for TANF cash assistance and related Medicaid-only groups as close to the TANF criteria as possible." Basically, the State's income and resource criteria for TANF and 1931 Medicaid are the same. (State staff informed us that the State is currently considering plans to remove the asset test and to increase the earned income disregard for Medicaid.)

The Medicaid policy manual explains delinkage and defines Low Income Families basically as:

- Parents and children who receive TANF cash assistance;
- Children of parent(s) who are sanctioned by TANF for failure to comply with work requirements; and
- Parents and children who meet the financial criteria but do not receive cash.

The process for submitting and processing applications is discussed in the *Application and Enrollment* section of this report. As noted in that section, the TANF application is only considered a Medicaid application if the family is determined to be TANF-eligible. If the family is denied TANF, a separate Medicaid application must be completed.

Section 1931 - Findings

The review team noted that there were no materials, fliers, or posters in the local DSS offices that were available to applicants advising them of the availability of Medicaid.

Local DSS staff were given revised §1931 policy in manual revision Number 98-1, noted above, which explained that welfare reform legislation of 1996 was intended to de-link Medicaid from TANF. DSS issued notice in July 1998, that as part of its Medicaid regional quarterly training for local DSS offices, it would conduct training on Low Income Families and an overview of transitional Medicaid. Staff indicated that the training was conducted August 1998 for both TANF and Medicaid workers.

Based on our interviews it appears the policy in the manual is not well understood by State or local DSS staff. Delinkage between the two programs has not been successfully implemented in practice. At the entrance conference, copies of the guidebook *"Supporting Families in Transition"* were distributed to the executive staff. We later found out the guidebook had previously been downloaded off the Internet by State DSS staff.

In reviewing TANF cases (27 total cases for the three counties visited), we found that ex parte reviews for several cases were not done. Some cases were not examined for Medicaid eligibility under alternative eligibility categories before being denied or they were placed into incorrect categories. As for TANF sanctioned cases, there was one case with a full family sanction for TANF and the children continued to receive Medicaid. However, another TANF sanctioned case did not have evidence of continued Medicaid for the children in the case.

In examining closed cases, there was no evidence in file of a closure notice being mailed in a few case records and no documentation that a client had voluntarily withdrawn from the program (as indicated by a code) in one case. Field interviews with local staff indicated that before any full TANF family sanction or closure, there is a 100% review by the supervisor.

Section 4913 Policy - Medicaid Eligibility for Disabled Children Who Lost SSI

Documentation

According to staff at the exit conference, the DSS agency requested the necessary files from the Social Security Administration (SSA) and a computer run was done comparing the agency's data with SSA's files. South Carolina is a Section 1634 State and uses SSA criteria for eligibility determinations. An ad-hoc report was run to identify SSI recipients under the age of 19 (Payment Category 81) who were declared Medicaid ineligible on or after July 1, 1997. These cases were identified by reason code "SC."

The State identified 1,403 children who lost SSI on the basis of childhood disability. Of that total, 53 moved out of State, 914 are currently eligible for Medicaid, 509 have reached the age of 18 (some of these children are included in the count of current eligibles), and 12 are not accounted for. The State is attempting to determine who these 12 cases are and take appropriate action.

The State extended Medicaid eligibility for one year for the children who lost eligibility for SSI due to changes in the definition of childhood disability contained in the PWORA legislation. The State extended eligibility for the SSI children for one-year using the payment category code 16 (Pass Along). The State staff indicated that it issued instructions to complete an ex parte review of all cases. To give staff more time to complete the reviews, DHHS sent DSS letters dated January 23, 1998 and November 5, 1998 requesting that the review date be extended to one year for this protected class of children. The ex parte redetermination was based, to the maximum extent possible, on information contained in the recipient's case record which contained SDX, unemployment, food stamps, etc. Eligibles whose Medicaid ID cards were returned for incorrect addresses were contacted when possible. Termination notices were sent when no response was received. (The State provided a revised manual explaining ex parte redetermination instructions with an October 1, 1999 effective date.)

Section 4913 - Case Review - SSI Terminated Cases

The Federal team reviewed thirty 1997 or 1998 SSI children termination cases from the three counties. Because most of the process is automated, the case record was printed off the computer terminal. There was no hard copy information stored in a case folder for our review. Findings from these case record reviews revealed the following:

Section 4913 - Findings

There were breaks in coverage of from 3 – 12 months in ten of the cases reviewed between being terminated from SSI and being reinstated to Medicaid. There is no evidence that an ex parte review was conducted prior to contacting individuals to come in for a redetermination. Some terminated cases had reapplied and were placed in other program categories.

At the entrance conference State staff stated that there is no break in coverage for a §4913 eligible child due to: (a) increased household earnings; (2) medical improvement; or (3) failing to comply with an administrative requirement. Actual case reviews did not confirm this.

Application and Enrollment

Application Forms

The Department of Social Services, under an agreement with DHHS, is responsible for processing applications and determining eligibility for Medicaid, TANF, and Food Stamps. It uses a joint application (DSS-3800) for Medicaid, TANF, and Food Stamps. However, the joint application only refers to "Medicaid" as "Other." The word "Medicaid" never appears on the application itself, just in the statement of "Your Rights and Responsibilities." It is questionable whether this application is technically an application for Medicaid because it does not state anywhere that it is an application for Medicaid and the TANF office does not determine eligibility for Medicaid if the family is denied TANF. Families must reapply for Medicaid at the Medicaid office.

There is a separate application form for the Partners for Healthy Children program. There are also other forms used for Medicaid-only. The process for eligibility determination varies depending upon which form is completed as described below.

DSS-3226 Application for Medical Assistance-only for pregnant women and children (OCWI) - Encourages recipient to complete form and leave it with the receptionist if unable to participate in an interview the day the application is submitted. However, State staff indicated that a face-to-face interview is not required.

DSS-3800 Joint Application for FS/TANF/Medicaid - However the form does not say "Medicaid" and it is not always processed for Medicaid eligibility if TANF is denied.

DSS-3214 Medicaid Application for Low Income Families

DSS-505 Partners for Healthy Children application. Copies in both English and Spanish were provided.

Federal policy concerning requests for citizenship, immigration status and Social Security Numbers is as follows: 1) States may not inquire about the citizenship or immigration status of any person other than the applicant, and 2) States may only require the disclosure of Social Security Numbers for applicants and recipients. The application forms request a Social Security number for each family member, not just for applicants.

Joint applications may be obtained from any of the county DSS offices. (There is at least one in each county, if not more.) There were no examples of clear application instructions posted in the local DSS offices. However, according to staff, applicants are told that they can talk to the intake worker for clarification, if needed. Separate Medicaid

applications can be obtained at the DSS office, via mail or telephone, or from outstationed eligibility workers at hospitals, FQHCs, rural health clinics and in health departments. While there is a local DSS office for each county, only 30 of the 46 counties have outstationed eligibility workers. Healthy Children applications can be obtained from the county office, via a toll-free hotline, or at schools, pharmacies, and providers' offices.

State staff reported that a State workgroup, comprised of members from DHHS and DSS, have been working on revising the joint application form and enrollment process. Interviews with local staff were unclear as to whether the application form itself was perceived to be a barrier by applicants. The review team did not have an opportunity to ask applicants if the application form was considered a barrier.

Enrollment

Applications are taken in each county office, by mail, and by outstationed workers in the aforementioned sites. There is no waiting period for receiving or filing a joint TANF/Medicaid or Medicaid-only application.

According to State staff, procedures are in place to assure that a Medicaid application made in person can be filed without delay. Clients are usually seen on the same day as they apply. In fact, one of the Medicaid application forms (DSS Form-3226) encourages applicants to complete and sign the application and leave it with the receptionist if they are unable to participate in an interview that day. Staff indicated that this practice also applies to other Medicaid application forms as well.

An application for Medicaid as a pregnant woman, child or low-income family can be done entirely by mail without a face-to-face interview. If the application is incomplete, the applicant is contacted. The applicant can decide if he wishes to complete the application by personal interview, telephone or by mail

Applying for Medicaid and TANF are two separate processes since the caseworkers are specialized and not cross-trained. State staff indicated that if the family is not going to receive Food Stamps or TANF, the worker will deny the joint application and send the individual to complete a separate Medicaid application because that is less burdensome than processing the joint application as a Medicaid-only application. The applicant must sometimes see two separate intake workers, one for TANF/Food Stamps and the other for Medicaid. In fact, in Spartanburg, the client must go to two separate buildings. As explained in subsection II.G, separate computer systems are used for the separate programs as well. If found eligible for TANF, Medicaid can be automatically approved by the TANF intake worker at the same time. However, if TANF is denied, there is no Medicaid eligibility determination and the client is referred to the Medicaid intake worker with a new separate Medicaid application. Some local DSS staff felt that the reviews are

not well coordinated.

State staff indicated that DSS does not impose a waiting period or otherwise delay an eligibility decision on a Medicaid application. The State's Medicaid policy manual (Chapter 1, Appendix A, Standards 2 and 3, effective 10/01/99) states that the applicant must be granted the opportunity to apply without delay and that a worker must enter information into the system by the 4th working day after the application is received. However, if the family applies for TANF and is determined to be ineligible for TANF, the separate application for Medicaid is not made until after the decision of TANF ineligibility is reached. This causes a delay in the application for and determination of Medicaid eligibility.

Adequacy of Notices Sent to Recipients

The State provided copies of actual notices sent to recipients; computer generated and standard form letters. A review of South Carolina's notices of approvals as well as adverse actions found them clear and easy to understand. The standard form letter denial notice (DSS-3251) explains the reason for denial, cites the rule that supports the action and provides at least a 10-day notice. It is a "triplicate" form and the worker must add the reason for the action. The back of the DSS-3251 contains information about the fair hearing process. A hearing must be requested in writing within 30 days from the date of the notice. If requested within 10 days of the notice the "assistance will be continued in the present amount" until a hearing decision has been reached. The information on the reverse side of the form includes a statement about cooperation requirements, which seems out of place, and notifies the individual that s/he may be eligible for family planning services although Medicaid is terminated. It appears that some of the language has been picked up from the old AFDC forms rather than developed for a Medicaid-only form.

The computer-generated notices did state the reasons for denial or termination and cites the specific rule that supports or requires the action. Some of the notices (computer generated) did contain language that TANF denial or termination does not mean ineligibility for Medicaid and some notices (form letter) did not.

Unfortunately, illiteracy is a problem in some of the sites we visited. Local staff said that a family member or friend would usually explain the notice to the recipient. Often the recipient will call their caseworker for an explanation.

Determine Medicaid eligibility within 45 days of application.

The State's Medicaid policy manual (Section 1.07 - Standards of Promptness) states that the Medicaid application must be "approved or denied and the applicant notified of the decision within 45 days from the effective date of the application." The federal team's

review of the 52 Medicaid/TANF active and negative cases showed that applications are usually processed on the same day or within five days. While this is commendable, review of the case records indicates they are processing the applications so fast that they are making mistakes. We noted that workers were not looking at all avenues of eligibility and were making erroneous determinations. Some cases were incorrectly denied and others placed in an incorrect category. Case reviews did not find any instance of a joint TANF/Medicaid application pending after 45 days.

Complying with Civil Rights Requirements

South Carolina's Medicaid manual on Citizenship/Alienage (Section 2.04, effective 7/1/97) states that certain qualified aliens, who entered before August 22, 1996, are eligible for the full range of Medicaid benefits. Certain aliens (parolees, conditional entrants) who entered the United States after August 22, 1996 cannot receive public benefits for the first five years in the United States. Lawful permanent residents who entered the U.S. on or after August 22, 1996 must accumulate 40 quarters of wages and/or self-employment income which require payment of Social Security taxes before full Medicaid benefits can be authorized.

States have an obligation under 45 CFR Part 80 to ensure that persons with limited proficiency in English because of their national origin have a meaningful opportunity to apply for, receive or participate in, or benefit from the services offered. States also have an obligation under the Americans with Disabilities Act to ensure that applicants with sensory or speech impairments, have the same meaningful opportunities.

The State insists their non-English speaking immigrant population is low, hence non-English speaking staff was not available at the three DSS offices visited. Also, there were no Medicaid posters in the waiting areas in foreign languages. However, procedures were in place to provide interpreters. For example, their resource manual for sign language interpreters and translators for the Limited English Proficient (LEP) is well put together. Each county office had a list of resources to contact to provide services for the sensory or speech impaired. Also, there is access to AT&T language translation services.

B. Maintaining Coverage for Families Who Leave Public Assistance Programs

Section 1925 Policy - Providing Transitional Medicaid for Families

Under Section 1925 of the Social Security Act, states must provide transitional Medicaid (TMA) to families who, because of hours worked or income from employment, lose their eligibility under Section 1931. (States must also provide 4 months of transitional Medicaid when eligibility would otherwise be lost due to child support income.)

States are required to provide an initial six-month period of transitional Medicaid and, subject to certain report requirements and the income limit explained below, additional six months coverage to families. To be eligible for transitional Medicaid, a family must have received Medicaid under Section 1931 in three out of the preceding six months before becoming ineligible under this category. No income limit applies to families for the initial six-month period of transitional Medicaid. However, the second six-month period is limited to families whose average gross earned income (less necessary childcare expenses) does not exceed 185% of the Federal Poverty Level for the size of the family.

South Carolina's FI Policy Manual section on TMA states that FI cases that become ineligible are eligible for "work transition MAO." Transitional MAO may be received for a maximum of 24 months due to a waiver granted by the Administration on Children and Families (ACF). Benefits may be terminated during the last 18 months if:

- the family fails to file a quarterly report,
- the caretaker relative did not have earned income in one or more of the previous three months,
- the family's earned income minus unreimbursed child care exceeds 185% FPL,
- TANF eligibility was lost due to earned income, or 100% FPL,
- eligibility was lost due to a time limit.

South Carolina was granted costs not otherwise matchable under section 1115 as part of their welfare reform demonstration project to do the following:

- Provide an additional 12 months of transitional Medicaid benefits to families who become ineligible for AFDC due to an increase in earned income or hours of employment but who did not receive AFDC in 3 of the 6 months prior to becoming ineligible;

- Provide an initial 12 months of standard transitional Medicaid to families that lose eligibility for AFDC due to the time limit in which someone becomes employed with earnings sufficient to terminate AFDC eligibility were the family still receiving AFDC but below 100 percent FPL and who would not be eligible for transitional benefits in absence of the demonstration;

- Provide an additional 12 months of transitional Medicaid benefits to families who become ineligible for AFDC due to an increase in earned income, or hours of employment, or due to time limits, whose family earnings are less than the Federal poverty level and whose employment could be jeopardized by medical expenditures; and

- Provide 90 days of Medicaid eligibility to individuals participating in an alcohol or drug program after termination of AFDC benefits due to removal of the dependent children from the home because of abuse or neglect.

These waivers expire September 30, 2003. According to State manual instructions, in July 1999 the State began providing a second 12 months of transitional Medicaid benefits to families who lose eligibility for cash assistance due to earnings if their earned income minus child care expenses does not exceed 185 percent FPL rather than 100 percent. They are also providing the second 12 months to families who lost eligibility due to the time limits without regard to whether their employment could be jeopardized by medical expenditures. These policies have only been applied to cash assistance recipients. State staff informed us that they are planning to adopt less restrictive methodologies for the 1931 group which will effectively eliminate the 3 out of 6 requirement for most families, allow all families to have 24 months of transitional benefits, and eliminate the reporting requirements. (The State has since submitted a State plan amendment to do this with a 1/1/00 effective date.)

For TANF recipients, transitional Medicaid in South Carolina is triggered automatically. Clients are informed of TMA either during the interview or in the TANF closure notices.

When TMA is terminated, there is no systems check for possible eligibility under other Medicaid categories. Computer systems changes are planned to alert caseworkers to review for other categories of assistance. These are currently being worked on and the State expects the changes to be completed by October 1, 2000.

Procedures Related to the Denial/Termination of Medicaid

DSS staff (State and local levels) indicated that TANF sanctions do not have an effect on Medicaid eligibility.

When a TANF case is closed, this triggers movement to Medicaid. Their policy manual states that it is mandatory for eligibility workers to make an ex parte determination for continued Medicaid eligibility when TANF is terminated. (This must be done manually until the system changes are completed.) When a recipient requests that a case be closed, care is taken to determine what specific program the recipient wants closed, not just a blanket closure of all programs. In addition, the client must sign a voluntary closure statement for the case record.

Medicaid only cases are redetermined on an annual basis. When one family member loses Medicaid eligibility, this does not necessarily affect the eligibility of other family members. Eligibility under alternative categories is partially computerized and partially manual.

Exhaustion of All Possible Avenues for Eligibility

There is conflicting evidence on whether or not Medicaid is denied or terminated only

after all possible avenues for eligibility have been exhausted. At the entrance conference State staff said their policy requires that ex parte reviews be done. The Medicaid policy manual clearly requires ex parte determinations when eligibility for cash assistance (SSI or FI) is lost. (However, the effective date of this manual section is October 1, 1999.) In interviews with local DSS staff, some said ex parte reviews were not done and one said they were not aware of the ex parte review requirements. Case record reviews did not show evidence that ex parte reviews were consistently done. The ex parte redetermination was based on information contained in the recipient's FI and Medicaid case record. If the individual is not determined to be eligible based on the ex parte review, the case is terminated and the individual is told that s/he must reapply for Medicaid for any further consideration of eligibility.

C. Reaching Families Potentially Eligible for Medicaid

Public Charge

State staff felt that this was not an issue since their non-English speaking immigrant population is low. The review team distributed copies of the public charge policy (State Medicaid Director's Letter - May 26, 1999) during the entrance conference to both DHHS and DSS staff. Field staff, based on the review team interviews, was not aware of public charge policy since no memo had been issued. However, field staff indicated a growing Hispanic population where public charge might become more of an issue.

Outstationed Eligibility Workers

In addition to the 46 county offices, outstationed workers at hospitals, FQHCs, rural health clinics and in health departments take Medicaid applications. While there is a local DSS office for each county, only 30 of the 46 counties have outstationed eligibility workers. Mail in applications are allowed in all counties.

This program appears to be working in those counties in which it is operating. For example, one reviewed case showed that when the client was in the hospital, the outstationed eligibility worker enrolled the client that day. The retroactive Medicaid provision was also evident for that case.

D. State Children's Health Insurance Program Review (SCHIP)

Screen and Enrollment Requirements

South Carolina has a Medicaid expansion program under SCHIP, which provides Medicaid coverage to children under age 19 with family incomes at or below 150 percent of the Federal Poverty Level (FPL). The State began providing coverage to these children under their existing Medicaid program effective August 1, 1997. South Carolina submitted the Title XXI State Plan Amendment and began to cover these children as

Optional Targeted Low Income Children, at the Title XXI matching rate effective October 1, 1997. On this date, they also adopted continuous eligibility for all children under Medicaid. (At the time of the review, the State did not apply continuous eligibility to children who were receiving TANF but the State informs us that this was corrected this past spring and continuous eligibility is now applied to all children.)

"SCHIP" enrollment as of July 31, 1999 was 45,737. The State calls their program Partners for Healthy Children (PHC).

South Carolina has had a very successful outreach program for their PHC program. Most PHC applications are mailed directly to the State where they are processed by the PHC unit. The application is processed in this order: 1) determine if the applicant is already on Medicaid, 2) determine if Medicaid eligible under another group, and 3) determine PHC eligibility. If the applicant goes directly to the local DSS office, the PHC application is processed in the same manner. If the application for PHC or Medicaid is denied, the hearing rights are on the notice sent to the applicant.

E. Optional Policies for Medicaid - Outreach Activities and Eligibility Expansions

Maintaining Coverage for Families Who Leave TANF Assistance

States have several options for maintaining coverage for families who leave TANF. South Carolina has chosen two options. State staff indicated that they provide continuous Medicaid eligibility to children for up to 12 months. This has not affected procedures regarding eligibility reviews for children covered under §1931 or under transitional Medicaid. The State also has elected to pay the premium and cost sharing for employer-sponsored health insurance when it is cost effective to do so.

Reaching Families Potentially Eligible for Medicaid

South Carolina has expanded Medicaid to cover two-parent families and have used an AFDC waiver to grant up to 24-months of transitional Medicaid.

SCHIP was implemented through a Medicaid expansion, however the State has not opted to expand coverage to families. The SCHIP outreach program has been very successful and has become a model for the nation. It has resulted in a significant increase in the number of children determined to be eligible for Medicaid who would have been eligible prior to SCHIP. (As of July 31, 1999, Medicaid cases receiving regular Federal match increased by 56,214 because of SCHIP outreach.)

F. Ensuring Administrative Efficiency and the Medicaid Quality Control Negative Case Action Program

Negative Case Action Program - Medicaid Quality Control

South Carolina operates a negative case action program as required under 42 CFR 431.812. They conduct a review every quarter. However, State staff at the entrance conference indicated that they believe that the denial rates are low and they have not used this program to determine how many cases are being erroneously denied or terminated from Medicaid as a result of a TANF eligibility determination. No reports are produced out of this data and no corrective action plan is prepared. The State does not coordinate the findings from its negative case action program with eligibility managers, systems mangers or other appropriate staff.

The State is aware that they can target problem areas of the program and have used it to target their Optional Coverage for Pregnant Women and Infants (OCWI) aspect of Medicaid.

Coordination Between Medicaid and Other Public Assistance Programs

DHHS is the single State Medicaid agency and DSS is the TANF agency that also administers Medicaid eligibility. At the State level regular monthly meetings are held between the two agencies to discuss mutual concerns.

At the local level, there are caseworkers for the TANF/Food Stamp programs and separate caseworkers for the Medicaid program. These workers are not cross-trained. A person will apply for TANF and if approved is automatically put onto Medicaid. If not approved for TANF the client is referred to the Medicaid caseworker. However, the client must initiate a separate application with the Medicaid caseworker. Hence, coordination only occurs for TANF recipients. Applications for Medicaid that are denied or terminated become available for sampling as part of the negative case action program

Program Assurances

At the entrance conference, State staff said they have provided training to caseworkers on the requirements of welfare reform as it relates to Medicaid in the areas of TMA and §1931. Documentation later submitted verified that training sessions were held. However, interviews with local staff indicate they never received training or that it was inadequate. One county said they were trained after-the-fact and that the trainers were not up-to-date on facts. Another example is that copies of the guidebook *"Supporting Families in Transition"* has not been shared statewide with local DSS staff yet it was known to be available for downloading off the Internet by State DSS staff.

The State uses technical assistants to monitor accurate and consistent implementation of Medicaid policies at the local level. They are assigned to a group of counties and review

case files for correct implementation of new policy. The State also conducts an analysis, called Leaver Studies, on Medicaid participation levels and identifies barriers to TANF/Medicaid interactions.

Staff indicated that program supervisors also conduct random case file review on an on-going basis. A sample of each worker's cases is reviewed. Mistakes are corrected and training provided, if needed. Information from Quality Control reviews is shared with local offices via the Medicaid Quality Control Report.

The State produces Medical Technical Assistance Reports (MTAR) to help identify problems with the administration of the Medicaid/TANF application and termination process at the local level. Corrective action is then developed and reported in the MTAR reports, which is used to verify that corrective actions are actually being implemented. These reports are sent to higher level management as well as local staff.

Interviews with the Appleseed advocacy group and DHHS and DSS staffs at the State and county levels indicated that training is needed on the changes in welfare reform policy. For example, it needs to be emphasized that it is the loss of Medicaid, not TANF, which triggers transitional Medicaid. A review of §1925 policy should be conducted and training done in this area for all county staff. In addition, DHHS non-emergency transportation policy requires three days advance scheduling for arranging a ride (State Transportation Policy Manual - Page 200-3), yet DSS field offices think it is five days. A Medicaid recipient must contact the local DSS office five days in advance to arrange for non-emergency transportation.

G. Computer Systems

The State has two separate programs, TANF/Food Stamp and Medicaid. This is reflected in separate caseworkers, applications and eligibility systems. The system is mainly TANF driven. When a person is approved for TANF, the system automatically approves them for Medicaid. However, if denied TANF, a separate application must be initiated for Medicaid and approved on the Medicaid system. Since there are two separate systems, the computer system does not allow the Medicaid part of the application to stay open if TANF is denied.

Interviews with local DSS staff indicate that the computer systems need to be upgraded. The eligibility system does not completely conform to current policies and must be manually overridden when inconsistencies are found.

The State plans to implement a new system, called Medicaid Eligibility Determination System (MEDS), within 2-3 years. The present system is hard to maintain and is not

consolidated with the MMIS system. Several enhancements are planned. The MEDS system will streamline the intake process and reduce the chances of error by automating most of the functions. For example, the current system does not check for possible eligibility for SCHIP or other Medicaid categories when Transitional Medicaid is terminated. Computer systems changes are planned to alert caseworkers to review for other categories of assistance when Transitional Medicaid is terminated.

However, it is still planned as two separate eligibility systems. Since it is planned as two separate systems, the State needs to consider enhancing the Medicaid eligibility system so that it functions more independently. As stated, the system is presently driven by TANF. The State might also want to consider combining the three programs (Medicaid, TANF, and Food Stamps) into one integrated system as other States have done. At minimum, the State will need to ensure that improper denials and terminations do not occur until a new system is put into place.

III. Consumer Advocacy Groups

The review team met with Ms. Beth Hutto of the South Carolina Appleseed Legal Justice Center (Appleseed) on November 1, 1999. They have a good relationship with the DHHS agency. She has had many discussions and visits with the agency. This was also demonstrated when she attended both the entrance and exit conferences with State staff concerning this review. However, their program concerns were:

- The State has not done enough analysis to determine the number of people who lost Medicaid due to welfare reform. While not having specific case information, Appleseed thinks there has been a substantial loss of Medicaid eligible clients.
- State staff does not understand the delinking of Medicaid from TANF; local eligibility workers need better training. Extensive training needs to be conducted regarding the §1931 eligibility category.
- Some recipients who are eligible do not get TMA.
- Joint application is of little real use and needs to be redesigned; the joint application under types of assistance applied for says "Other" instead of Medicaid. In actuality the form is not often used as a joint TANF / Medicaid application. The form requests the Social Security number for all family members, not just the applicant.
- There is no coordination between TANF and Medicaid in the application process. It is two separate procedures.
- Medicaid agency has a budget shortfall of $63.7 million. This is partly due to increased Medicaid enrollment from SCHIP and increasing Medicaid adult prescriptions from 3 to 4 per month.
- In an October 12, 1999 letter to DHHS, Appleseed expressed concerns in the delay of new transitional Medicaid policy, which provides 24 months of TMA, until January 1, 2000.
- The PHC (SCHIP) application requires the applicant to give information on all people

living in the household, instead of only for the child and their parent or guardian.

IV. Relevant Studies Conducted

The State also conducts an analysis, called Leaver Studies, on Medicaid participation issues and barriers to TANF/Medicaid interactions. Corrective action is then developed and reported in their Medical Technical Assistance Reports (MTAR). These reports are sent to higher level management as well as local staff.

DSS issued a June 1999 report on former FI clients that surveyed their well being after welfare. Interviews were conducted with 384 former clients during January - April 1999. In the enclosed summary section, the report stated that many respondents "once again said they did not know about transitional benefits available to former FI clients. This sample of respondents seemed no better informed than did previously surveyed samples." (Transitional benefits include Food Stamps, Medicaid coverage and child care.) Six surveys were done. More respondents in all six surveys knew about Food Stamps and Medicaid coverage for children than those benefits conditioned on work, adult Medicaid coverage and Transitional Child Care Assistance. In the first and second surveys of former clients, a considerable number of respondents said they did not know about transitional benefits, and particularly, about those benefits conditioned on employment. Awareness was better for those in the four most recent samples.

Other highlights of the DSS report are:

- Former clients have more problems after leaving public assistance with buying food and getting medical care than when they were on the program.
- An estimated 85% of children and only 45% of the adults had some form of health insurance coverage, with the majority covered by Medicaid.

V. Promising Effective Practices

1. SCHIP outreach effort has been one of the most successful in the country. They have developed a simplified application, placed applications in pharmacies, and have used the school systems to distribute applications. In addition, several African-American denominations distribute applications to their congregations.

2. The State has a TANF Transitional Medicaid waiver. This waiver allows the State to coordinate the TANF/FS/Medicaid reviews and have the client come in for only one interview when a redetermination needs to be done. The Medicaid quarterly review is a mail-in, saving the client time.

3. Hospital outreach appears to be working in those counties in which it is operating.

4. The resource manual for sign language interpreters and translators for the LEP groups is well put together.

5. There is a good relationship with the advocacy groups. Appleseed has had many discussions and visits with DHHS. This was also demonstrated when Appleseed attended both the entrance and exit conferences with State staff concerning this review

VI. Next Steps - Recommendations that Should be Considered

This section summarizes areas of findings that warrant further State attention and reflects those findings on which the State and advocates had comments as well as the HCFA response.

1. **Initiate and Increase Training for Caseworkers** – Even though the State has conducted training sessions covering TMA and §1931, interviews with local DSS workers and advocates indicated a need for more training. Our interviews with local and State staff suggested that the policy guidance the State has issued on section 1931 coverage is not well understood by State or local staff. The State needs to ensure that its policy guidance is clear and is not contributing to caseworker confusion or lack of understanding. We encourage the State to institute regular, ongoing training on section 1931 and TMA and to assure that State staff and caseworkers understand State policy on section 1931 and TMA eligibility. It also appears that training is needed on when ex parte reviews need to be done.

State Comment:

Training to disseminate proper policy and procedure regarding ex parte reviews will be conducted in January 2001 to coincide with the reinstatement process. A workgroup is currently addressing this issue to ensure proper policy and procedure development. As a part of the reinstatement corrective action process, additional training needs relating to TMA and 1931 will be identified, developed and conducted in the fall of 2001. Script and handouts will be developed in an effort to ensure that policy guidance is clear and is not contributing to caseworker confusion or lack of understanding. Future plans for an established monitoring process of county procedure will additionally address training needs.

Advocate Comment:

The South Carolina Department of Health and Human Services has always been very receptive to our concerns and comments. We are currently working with the agency as it moves toward reinstating Medicaid recipients that were wrongfully terminated from benefits. The report accurately reflects the agency's general lack of understanding of the

delinking of TANF and Medicaid at the time the site visit was made. It was clear during the visit that both the Department of Health and Human Services as well as the Department of Social Services were unclear as to the requirement they were under to determine eligibility for Medicaid for those individuals who either did not desire cash benefits or lost their TANF benefits since 1996. This has resulted in 60,000 individuals who were wrongfully terminated from benefits and approximately 70,000 others who were never afforded the opportunity to apply for Medicaid only.

HCFA Response:

We commend the State for its efforts to provide additional training to staff and for working with advocates in its reinstatement efforts. We believe the State should review its policy manual to determine if clarifications should be made to make the policy more understandable to State and local staff. We also suggest that the State monitor local offices to ensure that training has been effective and policies are being applied properly.

2. TMA Policy—The policy in place at the time of the review incorrectly linked transitional Medicaid to loss of TANF/cash. Since the review was completed, the State has rewritten its TMA instructions.

State Response:

TMA instructions have been rewritten and disseminated to staff. Regional training was conducted in August 2000.

HCFA Response: Revising policy instructions and providing training are good steps to addressing this matter. However, we recommend that the State ensure that the new TMA instructions are being properly implemented at the local level through second party case reviews, a special review of a sample of TMA cases or some other means as the State deems appropriate.

3. Applications and Enrollment—We are concerned about the joint application form DSS-3800. The joint application is not processed for Medicaid eligibility when TANF is denied. Furthermore, the application does not clearly state that it is an application for Medicaid and does not clearly state the individual's rights and responsibilities under Medicaid. If Medicaid is provided to TANF recipients on the basis of the joint application, the application needs to be clear that it is also an application for Medicaid, and should contain the rights and responsibilities of the individual under Medicaid.

More importantly, when TANF is denied, the TANF office does not make a Medicaid eligibility determination in accordance with its agreement with the State Department of Health and Human Services and Federal rules. The client is referred to the Medicaid intake worker with a separate Medicaid application. If a joint TANF/Medicaid

application is used, the State cannot require the individual who is denied TANF to file a separate, new application for Medicaid. The State needs to modify its application and enrollment procedures to come into compliance with its interagency agreement and Federal rules.

State Response

The goal of the single application process was to improve knowledge to provide recipients with better access to all programs for which they qualify. This is a part of a plan to focus on federal mandates to assure that everyone who qualifies for Medicaid receives it. It is our desire to affirm proper coordination of procedure between cash assistance and Medicaid staff, addressing this issue as having critical impact on whether or not eligible families obtain Medicaid. Additionally, as a part of the reinstatement process, the application redesign will be addressed and will be a part of future training. In the meantime, a workgroup will be established to address this issue, specifically considering if it is a proper and complete application for Medicaid per HCFA guidelines and if timeliness and/or quality assurance standards will be jeopardized. Future plans for an established monitoring process of county procedure will additionally address these issues. Supporting Families in Transition, A Guide to Expanding Health Coverage in the Post-Welfare Reform World is being reviewed by staff and used as a guide in addressing these issues.

HCFA Response:

The State does not address its practice of requiring applicants to reapply for Medicaid at a Medicaid office when TANF is denied. As noted in the *Supporting Families in Transition* guide, when a State uses the State TANF agency to make Medicaid eligibility determinations (which is the case in South Carolina), the TANF office is considered a Medicaid office. TANF offices in these States must furnish the joint application (or a separate Medicaid application) immediately upon request and cannot send the family elsewhere to apply for Medicaid. If a joint application is furnished and TANF is denied, the State is required to make an independent Medicaid eligibility determination on the joint application. South Carolina must conform its application processes to these requirements.

Additional State comment:

TANF applicants are no longer required to file a separate application for Medicaid. The Medicaid and TANF workers review the single application simultaneously. Independent Medicaid eligibility determinations are made.

4. Notices—We are concerned about the lack of clarity in all of the Medicaid notices reviewed. The Medicaid notices have extraneous language that appears to be a

holdover from old AFDC notices. This unnecessary language could be confusing to applicants and contribute to the welfare stigma that is sometimes associated with Medicaid. Notices approving transitional Medicaid need to clarify the benefit and reporting requirements. We also encourage the State to consider adding language to its notices indicating that TANF denial or termination does not mean ineligibility for Medicaid.

State Response

All forms of communication are being reviewed for accuracy, readability and proper informing by DHHS and DSS eligibility staff. This review process is not only a part of the reinstatement process but also a part of the development of the new Medicaid Eligibility Determination Systems (MEDS) with expected piloted implementation in 2001.

Advocate Comment:

SCALJ would ask that SCDHHS work with the advocacy community on the readability of all computer generated notices that are sent to clients. This will help to ensure that the notices are clear and properly explain all rights, responsibility and benefits. We would also ask that all notices have the Legal Aid Telephone Intake Service telephone number so that clients may contact them if they are in need of representation due to an adverse action by the agency.

HCFA Response:

The State may want to refer to HCFA's 1999 guide, "Writing and Designing Print Materials for Beneficiaries" which contains useful suggestions that could be applied to writing notices that beneficiaries can understand. The guide is available by requesting copies from HCFA, Office of Internal Customer Support, Administrative Services Group, SLL-B-15, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

5. **Implementation of the Section 1931 Group**—We are concerned about the consequences of the State's initial implementation of the section 1931 group. State staff acknowledged that initially the State did not implement the 1931 group correctly. According to State staff, 1931 coverage was provided only to children and nonsanctioned adults who received TANF. It is likely that this policy resulted in improper denials and terminations of Medicaid eligibility. Under the Dear State Medicaid Director letter HCFA issued on April 7, 2000, States are required to identify individuals who may have been improperly terminated from Medicaid as a result of improper implementation of the Section 1931 coverage group and reinstate them to Medicaid. We encourage the State in its implementation of this requirement to pay careful attention to identifying potential improper terminations during its initial implementation of Section 1931. While not

required under the April 7 letter, we also encourage the State to identify improper denials as a result of improper implementation of section 1931, and to reinstate these individuals to coverage.

State Response:

Improper terminations and denials are being addressed by the reinstatement workgroup. DHHS and DSS executive staff are jointly working to ensure appropriate corrective action measures are initiated.

Advocacy Group:

SCALJC strongly urges HCFA to require SCDHHS to include the 70,000 individuals who were never informed or assessed for Medicaid under Section 1931 when they applied for TANF. SCALJC is also concerned that another group of more than 10,000 individuals may not be afforded the right to Medicaid reinstatement. This is the group of recipients that were reenrolled in the program at some point, yet illegally terminated again after reenrollment. Under the State's reenrollment plan, they will not be afforded the opportunity to be reinstated and evaluated for transitional Medicaid or the low income family program nor will their children be evaluated for SC CHIP. HCFA should mandate SCDHHS to attempt to locate and reinstate all of these individuals.

HCFA Response:

South Carolina is to be commended for partnering with the Appleseed advocacy group in addressing this matter. We encourage the State to identify and reinstate those individuals who were improperly denied Medicaid. However, there is no statutory or regulatory basis on which to mandate this action. We are working with the State on its reinstatement efforts and will address the 10,000 individuals who were reenrolled but terminated to determine if this group should be included in the reinstatement plan. We will continue to track the State's progress in its reinstatement efforts as part of the follow-up to the on-site review.

*Additional State commen*t:

Based on our current budget situation, the State will reinstate those who did not have Medicaid subsequent to the TANF/TMA closure.

Additional HCFA comment:

The expectation under the April 7, 2000 letter was that individuals who were improperly terminated from Medicaid after loss of TANF would be reinstated, including situations where the improper terminations occurred after a prior improper termination.

6. Notification of Clients about TMA Benefits—We encourage the State to intensify its efforts to inform clients of TMA benefits when they lose coverage under Section 1931.

State Response:

All forms of communication are being reviewed for appropriateness and accurate notification ensuring proper efforts of informing clients of available programs and services.

HCFA Response:

The State's proposed action addresses our concern.

7. Public Charge—We are concerned that the State had not informed caseworkers of the public charge policy, and request that the State take steps to do so. Caseworkers indicated to the review team that there is a growing Hispanic population in the State, and that public charge could become more of an issue and barrier than it has been in the past.

State Response:

The issue of policy and procedure relating to public charge will be evaluated. We agree that the priority of this issue should be addressed, with the growing Hispanic population in the State, and this priority communicated to staff, however may seek further guidance from HCFA regarding this policy development.

Advocate Comment:

South Carolina has a growing immigrant population and not all of our counties have bilingual staff or understand eligibility criteria for immigrants. We have heard about tactics used to intimidate parents with Hispanic surnames that are applying for SC CHIP at the county level. HCFA needs to provide strong guidance to the State to ensure that the county staff is following the law as it applies to immigrant families.

HCFA Response:

HCFA is available to provide technical assistance regarding policy development. We refer the State to our Dear State Medicaid Director letter on this topic from May of 1999. The State should monitor its counties operations to ensure that caseworkers are providing an explanation of public charge to immigrant families and other interested parties appropriately.

Additional State comment:

Manual policy is being revised to include information regarding public charge. Training of staff will be conducted in Fall 2001.

8. **Computer Systems**—We are concerned that the separate TANF/Medicaid computer systems in the State may be creating barriers, particularly because of the need to input information separately for Medicaid. The review team found that when TANF terminates, caseworkers must manually determine whether family members are eligible for Medicaid under any other group. The effectiveness of this procedure can vary according to caseworker knowledge and experience. In light of guidance issued in the April 7, 2000 SMD letter, this segment of the former Medicaid recipient population should be carefully examined and reinstated if appropriate. We are encouraged that the State is developing a new computer system. However, because this is not an immediate fix, the State will need to examine its current computer system process to identify barriers that the system is creating to Medicaid enrollment, and to take interim steps to remove these barriers pending implementation of the new system.

State Response:

Interim steps will be taken (until MEDS is implemented) to remove barriers that the system may have created. When TANF is terminated, caseworkers must manually determine whether family members are eligible for Medicaid under any other group. Staff has been made aware of identified improper terminations and denials, and will be properly trained on ex parte review mandates.

HCFA Response:

Experience has shown that manual "workarounds" can be error prone and we recommend that the State institute a check, such as second party case reviews, on cases where manual workarounds were used to ensure that Medicaid is properly considered.

Additional State comment:

DHHS will coordinate efforts with DSS to develop a supervisory and secondary review process of denials and terminations. DHHS will monitor the process.

9. **Non-emergency Transportation Policy**—The State needs to clarify to local offices that State policy on non-emergency transportation requires three days advance scheduling for arranging a ride. Some caseworkers the team spoke to thought that five days advance notice was required.

State Response:

The Medicaid Transportation Manual was revised effective 9/5/00 to clarify three days advance scheduling and not five.

HCFA Response:

The State may want to make this clarification part of its training to ensure that caseworkers are aware of the clarification and will implement the policy correctly.

Additional State comment:

DSS conducted training on the new transportation manual.

10. Redeterminations at End of TMA—We are concerned that when TMA is terminated there is no check for continuing eligibility under other Medicaid categories. The April 7, 2000 guidance states that, under Federal rules, Medicaid can not be terminated until all avenues of eligibility are exhausted. The State has commented that planned computer systems changes will alert caseworkers to review for other categories of eligibility when TMA ends. It is important to institute these changes as promptly as possible.

State Response:

Automatic closures no longer exist. Near the end of the eligibility period, the worker receives a notice as an alert to review for other categories before TMA ends. Benefits are not terminated until a review is completed. Appropriate written policy has been disseminated.

Advocate Comment:

SCALJC is still concerned that the State is not providing ex–parte reviews of Medicaid cases, especially Transitional Medicaid, to determine whether family members can be placed in an alternative Medicaid program. We have strongly urged that the State do this, but it has come to our attention that computers were not properly programmed to avoid automatic closures until January 2001. This can only mean that cases are not being reviewed for redetermination and we request that HCFA work close with the agency to ensure that this process of evaluation of case closures is being handled properly.

HCFA Response:

The State has indicated that caseworkers receive an alert to check for continuing eligibility when TMA ends. To ensure that continuing Medicaid is properly considered when TMA ends or when an individual becomes ineligible under any category, the State

must follow Federal guidelines on redeterminations as set forth in the April 7, 2000 letter to State Medicaid Directors. Under those guidelines, the caseworker must conduct an ex parte review to the extent possible using information from the case record, other agency files and sources such as program records and family records to determine eligibility. If a determination can not be made, the agency must give the recipient reasonable time to participate in a redetermination and present evidence of ongoing eligibility. Once these steps have been followed and the caseworker determines that the individual is no longer eligible, the agency must terminate Medicaid and provide the proper notice and appeal rights. We recommend that the State monitor local office operations to ensure that redeterminations are implemented properly.

Additional State comment:

Improper terminations of TMA cases and computer programming changes were corrected effective October 1, 2000. Training will be conducted on ex parte procedures in Fall 2001 for all appropriate staff. A monitoring process is under development.

11. Section 4913 Cases

Case reviews showed that, in 10 cases, there were breaks in coverage between when SSI was terminated and Medicaid was reinstated. Further, there was no evidence that the State conducted ex parte reviews prior to contacting the individuals to come in for a redetermination of eligibility. Some cases had reapplied for Medicaid and were placed in other program categories. The State also needs to provide clarification on the number of cases of children who were double-counted in two categories of children, (1) those who "aged out" of coverage, and (2) those who are covered under 4913. The State also needs to provide the results of their attempts to identify the remaining 12 cases.

Additional State comment:

We will follow these steps regarding these children:

1. Match the list of identified children against eligibility system
2. If the child is found active:
   - Child will be tagged for protection from closure
   - A report will be produced of those over 18 but under 19 as these cases will be reviewed for PHC.
   - When child reaches age 19, workers will be alerted to perform exparte
3. If found inactive
   - Unless closed for reason of death, moved out of state or cannot locate, child will be reinstated and will follow through that established process and #2 above.

12. Use of Social Security Numbers

We are concerned that the application forms request the social security numbers for each family member rather than just the applicant. This practice is contrary to Federal rules which requires that the applicant furnish his social security number. The State can request the social security number of other household members but must state clearly on the application forms that the provision of social security numbers by non-applicants is voluntary. The State must correct is forms accordingly.

Additional State comment:

Application forms are being corrected to indicate that SSNs are only required for individuals seeking coverage.

13. Face-to-Face Interviews

According to State staff, the application for Medicaid as a pregnant woman, child or low-income family can be completed by mail; there is no face-to-face interview requirement. However, applicants are encouraged to complete the form and leave it with the receptionist if they are unable to participate in an interview the day the application is submitted. It is not clear when applicants must participate in an interview with the caseworker and we are concerned that this requirement is being applied to applicants who, by the State's rules, can mail in an application. The State must ensure that its practices at the local level as well as written materials are clear and properly applied regarding when and for whom a face-to-face interview is required.

State comment:

Face to face interviews are not required. Specific instructions will be added to the Medicaid Policy Manual and training conducted.

HCFA reply:

We are pleased that the State is addressing the need to clarify its policy of not requiring face-to-face interviews at application.

14. Timeframes

Under Federal rules, eligibility must be determined within 45 days of the date of application. We are concerned that because Medicaid is being delayed due to the State's practice of referring the applicant to the Medicaid office when TANF is denied. The State must review its procedures to ensure that Medicaid is not being delayed when it corrects its practice of requiring the applicant to reapply at a Medicaid office.

State comment:

The State is developing a monitoring process to address timeliness deficiencies. Additionally, the new eligibility system under development will have alerts on applications pending beyond standards.

HCFA reply:

We are pleased the State is addressing its application process and hope that the new process will improve the timeliness of application processing. The monitoring process planned should also assist with this problem.

15. Continuing Medicaid for TANF Cases

Review of 27 TANF cases showed that ex parte reviews were not conducted for several cases. Some cases were not examined for Medicaid eligibility prior to being denied or they were placed into incorrect categories. Also, two cases did not continue Medicaid for the proper family members when an adult was subject to a TANF sanction.

We are concerned that Medicaid is not properly considered when TANF is denied. As stated above, the State must either process the Medicaid portion of the joint application at the TANF office or transfer the case to the Medicaid office for a Medicaid eligibility determination within the 45 day timeframe. We believe that the State should closely monitor ongoing operations at the local level after it has corrected this practice to ensure that Medicaid is properly considered in a timely manner when TANF is denied.

We are also concerned that caseworkers are not properly applying TANF sanctions. Under Medicaid rules, a TANF sanction does not affect Medicaid eligibility unless a State has opted in its State plan to terminate Medicaid for a person who does not cooperate with TANF work requirements. Under this option, Medicaid can only be terminated for a non-pregnant adult in the family; the Medicaid eligibility of other household members is not affected. We recommend that the State review its local office operations to ensure that caseworkers are not terminating Medicaid improperly based on TANF sanctions.

Glossary

Appleseed	South Carolina Appleseed Legal Justice Center - advocacy group
CHIP	The term used by the State for their TANF computer system.
CIS	Client Information System - The Medicaid computer system.
DHHS	Department of Health and Human Services - The State Medicaid Agency
DSS	Department of Social Services - Agency that processes applications and

determines eligibility for Medicaid, TANF and Food Stamps.

FI	Family Independence - The State's TANF program.
HCFA	Health Care Financing Administration
LIF	Low Income Families - §1931 Medicaid group, the old AFDC prior to 7/16/96.
MAO	Medical Assistance Only
MEDS	Medicaid Eligibility Determination System - The proposed new eligibility computer system slated to be operational in 2-3 years.
MEQC	Medicaid Eligibility Quality Control
OCWI	Optional Coverage for Women and Children (Medical Assistance Only)
PHC	Partners for Healthy Children - The State's SCHIP program.
PRWORA	Personal Responsibility and Work Opportunity Act of 1996 - Welfare Reform legislation
SCHIP	State Children's Health Insurance Program
TMA	Transitional Medicaid