

## ARKANSAS TANF/MEDICAID DRAFT REPORT

### I. DESCRIPTION OF REVIEW PROCESS

#### A. Review Team/Purpose

Federal Government representatives conducted an on-site review of certain aspects of the Arkansas Medicaid program the week of November 15, 1999. The review team members were Gary Martin of the Health Care Financing Administration (HCFA) Dallas Regional Office, Bob Sluss of the Administration for Children and Families Regional Office, and Elena Juarez of the Office for Civil Rights Regional Office. There were no individual tasks assigned during the review, rather all team members participated in all aspects of the review. Ms. Juarez, although participating in all parts of the review, focused primarily on civil rights issues and concerns. This report contains information gathered through reviews of the State's documents, policies and procedures as specified below. As such, this report is limited to the information gathered from these sources regarding Arkansas' Medicaid program as of November, 1999 with respect to the areas addressed.

Subsequent to the review, State and local advocacy groups were given the opportunity to comment on the review team's findings. However, in Arkansas, local advocate organizations did not afford themselves the opportunity to comment on this report prior to its issuance in final. Therefore, this report may reflect the State's comments 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.]**

#### B. Site Visit

The review was conducted primarily at the Arkansas Department of Human Services (DHS) State office in Little Rock, in conjunction with the DHS Division of County Operations. Additionally, onsite visits were conducted in local DHS offices in both Little Rock and Lonoke on November 17th.

The review was structured around four main areas: written and verbal information received from the State office outlining their program and processes for conveying eligibility, case reviews from various geographical areas of the State, discussions with caseworkers and supervisory personnel in two local field offices, and an afternoon meeting with advocacy groups for children's health and other community groups. The review team held both an entrance and an exit meeting with the State in Little Rock. As such, this report contains information gathered from these sources regarding the Arkansas Medicaid program as of the week of November 15, 1999, with respect to the areas addressed.

#### C. Background on Review Process

It should be noted that, at the time this review was conducted, the State of Arkansas and HCFA were in high-level discussions regarding the enrollment of children into the ARKIDS FIRST program (a section 1115 waiver) versus enrollment in the regular Title XIX Medicaid program. Although those discussions were in process, this review was not focused on the ARKIDS FIRST program.

## **State Organization**

The Arkansas Department of Human Services (DHS) is the single State Medicaid agency, which also oversees the implementation of the TANF program. The State Medicaid Director is a Division Director overseeing the Division of Medical Services. The DHS Division of County Operations is responsible for Medicaid eligibility issues. The Division Directors report to the Director of the Department of Human Services.

## **II. ANALYSIS OF DOCUMENTATION AND CASE REVIEWS**

### **A. Written Documentation**

The review team reviewed written manual instructions furnished by the State for local county staff regarding eligibility determinations for TANF, transitional Medicaid, and low-income families and children and found the instructions to be clear and concise.

Although the Transitional Employment Assistance (TEA) Manual updated 7/1/97 for the Arkansas TANF program has very little information about Medicaid eligibility requirements, the Medical Services Program Manual describes the State's 1931 category under Section 2085, "Transitional Employment Assistance (TEA) Related Medicaid." Section 1931 is also addressed under MS 98-12 and MS 99-4.

### **B. Case Reviews**

The review team looked at cases selected from around the State: Little Rock (Central), Jonesboro (Northeast), Camden (Southeast), and Forrest City (East). Approximately 80 cases were sampled and included TANF approval and denials, transitional Medicaid, and Section 1931 cases.

Based on the cases reviewed, the State does not appear to be conducting ex parte redeterminations of Medicaid eligibility when cash assistance is terminated. There was no evidence of discriminate or systematic failure to move individuals from cash assistance to Medicaid-only when the individual or family participated in a redetermination of eligibility. However, case reviews also showed that, in cases where individuals or families became ineligible for TANF, Medicaid was terminated when the individuals or families did not complete the redetermination process for Medicaid.

When an individual or family's circumstances changed making them ineligible for TANF, the State sent a termination notice. Some TANF termination notices the review team saw advised the recipients to contact the State for possible continuing Medicaid eligibility (and did not explain for which category they might qualify). Other TANF termination notices stated that "if there are any changes in your Medicaid eligibility, you will receive a separate notice." Notice recipients who did not participate in the Medicaid redetermination process may have either ignored the notice, been discouraged by the phrase

your cash assistance is being closed, or not felt the need to go back for some other reason to secure Medicaid coverage.

The review team suggested that Arkansas conduct studies (as is already being done in the Pulaski County (South) office) to follow up on samples of these cases to see what additional steps could be taken by the State to ensure that these clients continue to get any benefits for which they may be eligible.

### **C. Notices**

Arkansas Medicaid notices are both systems and/or manually generated. Caseworkers have discretion about when to use system-generated notices and manually generated ones. According to State policy staff, case workers use the system-generated notice unless there is something unique about the situation causing the caseworkers to use a manual notice. The review team found that caseworkers often prefer to use the manually generated notices, because they feel they can be more specific. Although notices from the State need to be made more uniform, the clients are being advised of potential or continued Medicaid eligibility; however, as mentioned above, in certain cases, clients need to complete the redetermination process to be found Medicaid eligible.

The systems-generated notices are for denials, approvals and terminations only. Field offices can use manual notices for those decisions as well. The manual notices we saw tended to be more descriptive in providing information to the client. The manual notices tended to show the reason for the action being taken (e.g., termination for excess income, non-participation in work or training requirements) and were more descriptive in explaining what could occur next, for example, that this was only a temporary action. Basically, the manual notices seemed to be more tailored, and did not just contain standardized computer language. The overall Arkansas eligibility system is not fully automated, and it appeared from the case files reviewed that the manual notices probably are more beneficial in terms of transitioning individuals from one category of eligibility to another.

Standard client rights and responsibilities language is on both the systems-generated and the manual notices.

## **III. ANALYSIS OF FINDINGS FROM ON-SITE STATE AND LOCAL OFFICE REVIEWS**

### **A. Eligibility Categories/Application and Enrollment**

#### **1. Eligibility Categories**

##### Section 1931

*Draft Report - Not for Public Disclosure*

The welfare reform provisions of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA) amended Title IV-A of the Social Security Act by eliminating the Aid to Families with Dependent Children (AFDC) program and replacing it with the new Temporary Assistance to Needy Families (TANF) block grant program. Prior to enactment of PRWORA, Medicaid eligibility was linked to receipt of AFDC cash assistance. PRWORA severed the link between Medicaid eligibility and receipt of cash assistance. Section 114 of PRWORA added a new Section 1931 to the Act to preserve Medicaid eligibility for former AFDC recipients. Under Section 1931, States are required to provide Medicaid eligibility to low-income families who meet the pre-welfare reform AFDC income and resource standards in effect as of July 16, 1996.

Arkansas submitted a State plan amendment in September 1997, establishing a Section 1931 eligibility category, using the 1996 AFDC income and resource standards. That SPA was approved in December 1997 with an effective date of July 1, 1997. The Transitional Employment Assistance (TEA) cash assistance program (the State's TANF program) and the TEA Medicaid (the State's section 1931 group) use the same income and resource methodologies. Deprivation as a condition of eligibility applies under Medicaid but TANF does not include deprivation as an eligibility requirement. This means that parents in some two-parent families who qualify for cash assistance are not eligible for Medicaid.

When originally implemented, families found eligible for TEA cash were also certified by the Arkansas Client Eligibility System (ACES) for TEA Medicaid (coded as category 20). When TEA cash assistance was terminated, Arkansas policy required caseworkers to make a separate Medicaid determination, and then to certify the case for Medicaid accordingly. The ACES system is completely dependent upon caseworker manual activities to process a Medicaid case.

According to State staff, when TANF was lost, usually Medicaid was not continued unless the family participated in an eligibility redetermination.<sup>1</sup> State staff advised that their data has shown some families being terminated from cash assistance were not transitioning into another medical eligibility category in the numbers one would suspect to be appropriate. In the first six months of the State's TEA (TANF) program, the rolls dropped by almost forty percent with an almost equal drop in the TEA-Medicaid (the State's section 1931 category). Advocate research of the State's monthly statistical reports showed that recipients who were leaving the TANF rolls were not retaining Medicaid under section 1931. Some were found to be migrating to other Medicaid categories and some of the children were moving onto ARKids First.

---

<sup>1</sup> In its response to this draft report, the State commented that the process [that requires a separate and new Medicaid eligibility determination whenever the TANF cash assistance case closes] does not accurately reflect the Medicaid eligibility process that has been in effect since the TANF program was implemented in July of 1997. The full text of the State's response is set forth in Next Step #1 at the end of this report.

*Draft Report - Not for Public Disclosure*

According to State staff, the State recognized in 1998 that there were some misconceptions about Medicaid eligibility still being linked to cash assistance, and they took steps to remind local caseworkers and managers of the differences in eligibility for both programs. The State became aware that households with two parents were not being considered for Medicaid in some counties because these counties were not properly applying deprivation rules (e.g. determining family as Medicaid eligible in two parent families when one parent is receiving SSI, or where principal wage earner works less than 100 hours per month; or determining if any family member is Medicaid eligible, when family does not meet deprivation, in another category such as a poverty level child or a pregnant woman). The review team did not determine the extent to which two-parent families were not considered for Medicaid.

On August 24, 1998, the State issued a policy directive clarifying that TEA Medicaid and TEA cash assistance "are not linked" and that "extended Medicaid (TMA) is based on TEA Medicaid eligibility, not eligibility for cash assistance" instructing county offices to place applicants eligible for Medicaid under section 1931 in TEA Medicaid rather than TEA cash (State circular #98-12 dated August 1998). The intent of the directive was to ensure that applicants receive Medicaid even though they are not eligible for or do not want TANF and that transitional Medicaid is tied to the loss of section 1931 rather than the loss of TANF.

In 1999, the State modified its computer coding procedures for its TEA Medicaid determinations. Beginning in 1999, caseworkers certified TEA Medicaid separately from TEA TANF from the first eligibility determination, such that a family could be certified two times in the ACES system.

Finally, the State further addressed this issue with a manual transmittal released on March 15, 1999 (MS 99-4; TEA 99-4) encouraging caseworkers to test for the deprivation requirement in families receiving TEA cash assistance in order to properly ascertain Medicaid eligibility for eligible household members. Manual instructions, policy memos, and training sessions also were used to emphasize this approach to both the State and local DHS offices.

The review team also found evidence that eligible persons are receiving section 1931 Medicaid who are not applying, or eligible, for cash assistance.

### Section 4913

Section 211 of the PRWORA revised the definition of childhood disability under the Supplemental Security Income (SSI) program. The new SSI childhood disability definition is more stringent than the old definition and resulted in the loss of SSI for some children. A legislative remedy under Section 4913 of the Balanced Budget Act (BBA) requires States to provide Medicaid to children who were

receiving SSI benefits on August 22, 1996 but lost SSI due to the new disability definition provided they continue to meet current SSI income and resource standards.

Arkansas is a Section 1634 State. Based on discussions with the State staff and the advocacy groups, the team did not find any loss of Medicaid benefits for the SSI children under Section 4913. Advocacy groups did not raise this as an issue in Arkansas, but rather told the review team how happy they were with the State's coverage of these children.

According to State staff, Arkansas originally instructed counties to put 4913 children into an already existing category, 41, (a general Aid to Disabled Children category) but to code them separately in the computer system. The State printed out the SSA tapes of children who had lost SSI by county (several times) and sent the county-specific lists to the county offices. The State instructed the counties to certify all children on the lists to receive Medicaid and to do an annual redetermination of eligibility.

According to the April 2000 lists received by the Social Security Administration, the State has 1978 children terminated from SSI who may be eligible for Medicaid under Section 4913. The State has identified 800 of these cases and coded these cases Medicaid eligible under Section 4913 (which also protects Medicaid in cases of breaks in eligibility). The State is working to identify the remaining cases and believes they may have "aged-out" of that category. Despite the lack of concern from local advocacy groups, HCFA is concerned by the fact that more than half of the children on the April 2000 SSA list are not receiving Medicaid.

If a case is terminated from SSI for any other reason (e.g., excess income, failure to cooperate), the State notifies the family of the need for a Medicaid redetermination for continuing eligibility. The family is provided notice to contact DHS within 10 days. If the individual does not respond, the due process for termination procedures begin.

## **2. Application and Enrollment**

### Provide the Opportunity to Apply for Medicaid without Delay

At the time of the review, the State used five different applications for medical assistance depending on the type of assistance being sought. The applications are for: (1) Application for Transitional Employment Assistance (also used for Medicaid for joint applicants); (2) Medicaid only Application (also used for pregnant women); (3) Application for ARKids First Program; (4) family planning waiver<sup>2</sup>; and (5) aged, blind, or disabled. The State has separate applications for the different program types, some of which are interchangeable. For example, a family can obtain Medicaid from a couple of the

---

<sup>2</sup> The Family Planning Waiver provides limited Medicaid coverage (family planning and related benefits only) for women who have recently lost Medicaid eligibility. It does not provide the full range of Medicaid benefits.

*Draft Report - Not for Public Disclosure*

applications. The TEA application (4 pages) is primarily used for the State's TANF program but can be used as an application for both TANF and Medicaid. The ARKids First application is also four pages long. None of the applications are currently available in a language other than English, although the State is developing Spanish versions.

All applications have lead questions, which allows the State to explore options for additional benefits (WIC, food stamps). They are generally 1&1/2 to 3 pages in length for questions, and another 1 or of a page on rights and responsibilities. The applications include information about seeking employment, retroactive Medicaid, and family planning assistance available under State and Federal guidelines. Although the applications appear cumbersome at first glance, they are comprehensive and explore all opportunities for assistance that may be available to the applicant. In discussing this with caseworkers in the county offices, none of them perceived the line of questioning in the applications as a barrier to the client's eligibility. A review of random cases indicates that this process does not appear to be causing delays due to the requirements of the other programs.

All applications ask for all household members and their SSN's and citizenship/immigration status (long term care applications ask for the SSN of the spouse), contrary to HCFA policy. The joint TANF and Medicaid application and Medicaid-only application do not include good cause statements as part of the explanation that cooperating in establishing paternity and obtaining medical support are conditions of Medicaid. Rather, the information concerning good cause exemptions is explained during the interview with the caseworker. Written information is contained on a separate form that the applicant and the caseworker signs. For mail-in applications, the form is mailed to the applicant with a request to read and sign. Under no circumstances are absent parents referred to the Office of Child Support Enforcement until this signed form is obtained.

Clients are initially screened at the reception area in the local offices to ascertain the type of benefits they are seeking. Arkansas requires a face-to-face interview for the TANF, Food Stamps and Medicaid programs unless the applicant cannot come into the office, e.g., homebound, no transportation, in which cases the caseworker will visit the home or complete the interview by telephone. Medicaid-only applicants are also required to complete a face-to-face interview (this requirement was eliminated in August 2000). The State does allow mail-ins for Medicaid redeterminations.

The State's procedure, according to their medical assistance manual, is to use the Medicaid-only application if the individual is not seeking cash assistance. If it appears the individual would qualify for cash in addition to Medicaid, the individual would subsequently file a concurrent application for TANF, which can be done at the same time in offices with generic workers. In offices without generic workers, a second face-to-face interview with the TANF caseworker may be required.

The State has maintained a collateral contact form that is used to verify information provided by the

applicants in the application. The review team did not review any such forms.

Local office reviews and interviews with staff revealed a localized interaction between Medicaid, TANF, and Food Stamps. Caseworkers generally are generic with less than 100 cases per worker. The caseworkers appeared to be familiar with all the programs of public assistance they administer. Most of the offices, both rural and urban, appear to be very community orientated.

#### Determine Medicaid eligibility within 45 days from the date of application

A Medicaid application can be obtained through a variety of locales, including county offices, and outstationed workers in hospitals and FQHCs. The State is cognizant of their responsibilities to provide the opportunity to apply for benefits, and the case reviews seem to indicate that by and large they are meeting the 45-day Federal timeframe for determining Medicaid eligibility. Review of documentation shows that the State did have a significant problem meeting the 90-day timeframe for disability cases beginning in 1995 but has made meaningful progress in meeting those timeframes now.

Arkansas makes all TANF determinations within 30 days of application. In situations where a joint TANF/Medicaid application was used, we found no significant evidence in our review of sampled cases that the TANF requirements, including verification requests, were delaying the delivery of medical benefits. For Medicaid-only applications, only verification of items for Medicaid is required.

#### Comply with Civil Rights Requirements

County offices demonstrated a lack of knowledge about procurement for translators and the county offices visited by the review team do not have translators for LEP applications and recipients. Generally, LEP applicants and recipients bring their own translators to the office. Additionally, education and outreach about public charge is not being disseminated to both the caseworkers and the public. Based on comments from the advocates, who met with the review team, there are allegations that State staff may not be fully cognizant of the true cultural diversity currently existing in the State.

### **B. Maintaining Coverage for Families who Leave Public Assistance Programs**

#### **Denial/Terminations and Redeterminations**

##### Denials/Terminations

According to State staff, a TANF denial does not delay or otherwise affect the Medicaid eligibility determination since Section 1931 eligibility determinations are made independently.

*Draft Report - Not for Public Disclosure*

According to State staff, when TANF is lost, usually Medicaid was not continued unless the family participated in an eligibility redetermination. Based on discussions with the local office staff, some ex parte redeterminations are being done when TANF is lost, but this does not seem to be done on a uniform basis. The review team was unable to determine whether the separate certification process for TANF and Medicaid cases has changed the practice of terminating Medicaid when TANF is terminated unless the individual or family provides additional information for a redetermination.

The review team also found that when TANF is terminated, within 3 months, the caseworker would schedule a Medicaid eligibility redetermination which can be done on a mail-in basis. If the family responds to the notice of redetermination, Medicaid is continued if the family is eligible. If the family does not respond to the redetermination notice, Medicaid is terminated. Discussions with some local caseworkers established that, in the perception of some clients, TANF termination still equates to a Medicaid termination even though the notices (automated and/or manual) advise families to recontact DHS for a redetermination.

In the Pulaski South (Little Rock) office, a manual tracking file for terminated TANF or transitional cases has been instituted, and the office does routine follow-up contacts with the family to explore continuing eligibility under other categories. Data on their follow-ups was not currently available at the time of the review. The State is now additionally looking at these entire procedures, based on the April 7, 2000 State Medicaid Directors letter issued by HCFA. Arkansas is currently developing some additional local studies and follow-up procedures much like that being done in Pulaski County.

### Redeterminations

When redetermining Medicaid eligibility, Arkansas uses its application forms rather than a separate redetermination form. There is no face-to-face interview requirement for Medicaid redeterminations. To complete a redetermination, a family must contact the State either in-person, by telephone, or by mail-in. The no face-to-face interview policy for Medicaid redeterminations extends to families also receiving cash assistance since there are no redeterminations for time-limited TANF cases, and for those that are not time-limited, redeterminations are not formalized.

According to State staff, when a family responds to a TANF termination/notice of Medicaid redetermination, Arkansas uses manual rolldown to Medicaid-only to protect individuals losing cash assistance from losing medical assistance. Case workers interviewed in both offices visited by the review team were cognizant of the Medicaid-only categories available, the applicability of transitional Medicaid provisions, and take the appropriate steps to convert the recipients into other categories of eligibility during a redetermination.

The review team recommended that the State conduct studies to ascertain why individuals do not

pursue continuing Medicaid even though notices advise them to do so. Some additional, synchronized training of caseworkers also was suggested to ensure that new workers are cognizant of all categories of eligibility.

## **2. Transitional Medicaid**

According to State staff, transitional Medicaid is tied to the loss of eligibility under section 1931, not to the loss of TANF. The process for providing transitional Medicaid is not automated.

The August 24, 1998 Manual Transmittal (MS 98-12; TEA 98-13) clarifies the policy for the provision of Extended (Transitional) Medicaid. The transmittal emphasizes that for families moving from welfare to work in less than three months, retroactive Medicaid should be considered. It further emphasizes that TEA cash is not a requirement for Extended Medicaid and that it may be best if TEA Medicaid is the first category considered whenever a family with deprived children applies for Medicaid because of the possibility of qualifying for Extended (Transitional) Medicaid.

Nonetheless, the review team found that when Medicaid under Section 1931 is lost, contrary to Federal law, the family must participate in a redetermination before receiving transitional Medicaid. Notices are sent to eligible families advising them that Medicaid is extended for 6 months and provides a list of household members who are entitled to extended Medicaid. The notice also indicates that an additional six months of Medicaid is available if certain eligibility conditions are met and provides a date by which an income report must be filed. The State will terminate the second six months of extended Medicaid if the family does not file the income report.

## **C. Reaching Families Potentially Eligible for Medicaid**

### **1. Public Charge**

Arkansas has not done a great deal to publicize the 1999 INS policy guidance clarifying what constitutes a public charge, thereby limiting attempts to reach immigrants and other non-citizens. This lack of outreach was a specific concern of advocates.

### **Outstationing**

According to State staff, the State has out stationed DHS caseworkers in (mandatory) disproportionate share hospitals and FQHCs. Toll-free numbers for inquiries and applications are advertised in the community.

Arkansas has a best practice in their interaction with Community Health Center Clinic Sites, and their

work with local coalitions in providing/coordinating services for their Medicaid population. This was especially evident within the Pulaski County (Little Rock) area, and northwest Arkansas (Fayetteville, Rogers). The local coalitions, which were trained by local county offices, helps applicants fill out Medicaid applications. They also help prepare individuals for jobs by providing interview skills and techniques and training in social skills. Local coalitions sometimes drive applicants to the local offices for the face-to-face interview. The State may want to consider revising this policy as, pursuant to Federal policy, applicants may also be interviewed at the outstationing sites.

We believe other States could learn from Arkansas' efforts to coordinate eligibility and the delivery of services at the community level in this regard. The assistance provided by the community groups and the coordination with the DHS offices seems to have facilitated the delivery of many supportive services, especially transportation, child care services, and substance abuse treatments.

#### **D. States Children's Health Insurance Program (SCHIP)**

HCFA has approved Arkansas' ARKIDS FIRST program under the authority of a Section 1115 waiver. That program expands eligibility to children in families with income or assets above the standards for regular Medicaid but with income below 200 percent of the Federal poverty level (FPL), limits services otherwise afforded under the regular Medicaid program, and imposes co-pays not otherwise allowed under Medicaid.

The State has eliminated the face-to-face interview requirement for the ARKIDS First program but not for regular Medicaid. A SCHIP plan amendment is currently under review to allow Arkansas to receive SCHIP funds to cover a portion of its ARKIDS enrollees.

#### **E. Optional Policies for Medicaid - Outreach Activities and Eligibility Expansion**

Arkansas was one of the first States in the country to offer presumptive eligibility for pregnant women, cover the TEFRA 134 kids (Katie Beckett kids), and raise the income level for infants up to 185 percent of the FPL. They are continuing to work on outreach, especially as it pertains to their rural (PCCP) managed care programs, focusing on the Mississippi Delta counties in the southeast part of the State.

The State should consider adopting the option under existing Medicaid rules that permit states to eliminate the face-to-face interview requirement for families, as well as eliminating the assets test for children under the regular Medicaid program, although this option would be subject to the approval of the Legislature and the Governor's office in Arkansas. (Subsequent to the review, as of August 2000, the State eliminated the face-to-face interview requirement for Medicaid.)

## **F. Ensuring Administrative Efficiency and Medicaid Quality Control**

### Negative Case Action

The State has a negative case action program, primarily used for internal program integrity and continuous training purposes for the field office staffs. DHS continues to monitor case determinations both for TANF and Medicaid, including negative case determinations through a review of random case samples. It is similarly used to detect any programmatic policy flaws or glitches that arise in the processing of the case samples. The review team did not review the negative case action program.

### Program Assurances

State office staff said that Arkansas has standards and practices to verify that policies and practices are implemented at the local levels throughout the State. This is done through reports from the regions to the State office, as well as the State's quality control process, which includes the review of negative case actions.

Additionally, the State provides 2-week incremental training in aged, blind, and disabled eligibility categories, as well as an additional 2-week session on children and family-related groups to ensure local caseworkers and managers are aware of the possibilities to transition from one group to another. State staff advised the review team that they encourage the regional managers to conduct eligibility training for staff in local offices on an ad hoc basis.

Finally, program support specialists and state office staffs meet monthly to discuss technical issues, policy, administrative issues and to try to address problems on a statewide basis.

## **G. Computer Systems**

In Arkansas, eligibility for Section 1931 and TANF are determined manually by the caseworkers and the results are entered into the ACES system. The system is primarily a manual one, relying upon caseworkers to process most of the cases.

According to State staff, Arkansas is in the process of streamlining their system processing of cases, which will facilitate better interfacing with other program systems, and allow the inclusion of more data in the case file. It is believed this new system, anticipated to be fully operational in early 2001, will allow the State to better track and follow-up on individuals who do not contact the State when redetermination of their eligibility is necessary. The review team discussed the availability of funds from the \$500 million set aside for outreach and computer enhancement related to Section 1931, and the State will evaluate tapping more into those funds for making changes.

#### **IV. CONSUMER ADVOCACY GROUPS**

The Federal review team and State DHS staff met with child health advocates from across the State in Little Rock on Thursday, November 18th. Advocacy and other groups in attendance were:

- Industry Partners, Inc.
- Good Faith Fund
- Healthy Connections, Inc.
- ARKIDS FIRST - Direct Outreach
- St. Edwards Mercy Medical Center
- Mercy Health Systems of NW Arkansas
- Community Health Centers of Arkansas
- Hope Migrant/Community Health Center, Hope, Arkansas
- Arkansas Advocates for Children & Families

The advocates all seemed to agree that, although there was initial confusion about the delinkage of Medicaid from the TANF program, the State has taken positive steps to alleviate the confusion by educating their county workers to send the message that loss of cash did not mean loss of medical assistance.

When the issue of clients not responding to a request for redetermination of eligibility came up, the consensus was of concern with no apparent answers. The advocates felt that educational level, ethnicity issues and a general disregard of concern on the part of the clients all play a part in the nonresponse.

Other advocate suggestions included eliminating the resource test and the face-to face interview requirement, providing materials and applications for non-English speaking applicants, and the lack of health providers, most notably, dentists for children. Additionally, advocates stated concern about the State's lack of acknowledgment of the diversity of the ethnic populations, and the need for translators.

#### **V. IDENTIFICATION/DISCUSSION OF ANY RELEVANT STUDY, CASE REVIEW, OR ANALYSIS**

There was a TANF leaver study being conducted by the Pulaski County (South) office and, as mentioned earlier the review team recommended that the State expand on those types of internal studies.

#### **VI. IDENTIFYING BEST PRACTICES**

**1. Coordination with local advocate organizations**

The review team found that some of the efforts to coordinate with local community coalitions is outstanding, keeping the efforts on the local level, utilizing all the resources within their service area.

**South Pulaski County study on non-response to recertifications**

The office in South Pulaski County, already concerned about the number of families not responding to recertifications following cash terminations, has initiated its own study to determine why this is occurring and see what steps they can take to prevent families from losing Medicaid. Although it would depend on staffing and flexibility of each office, we believe that this is a best practice and one that could be considered by other counties and other States.

**VII. NEXT STEPS**

**1. Medicaid Terminations when TANF is terminated; Ex Parte Reviews**

We are concerned that, under the State's process at the time of the site visit, individuals and families were losing Medicaid when cash assistance was terminated.

According to State staff, when TANF was lost, usually Medicaid is not continued unless the family participated in an eligibility redetermination. Based on discussions with the local office staff, some ex parte redeterminations were being done when TANF was lost, but this did not seem to be done on a uniform basis. The review team was unable to determine whether the separate certification process for TANF and Medicaid cases has changed the practice of terminating Medicaid when TANF is terminated, unless the individual or family provides additional information for a redetermination.

The review team also found that when TANF was terminated, within 3 months, the caseworker would schedule a Medicaid eligibility redetermination which can be done on a mail-in basis. If the family responded to the notice of redetermination, Medicaid is continued if the family is eligible. If the family did not respond to the redetermination notice, Medicaid was terminated.

In the April 7, 2000 State Medicaid Directors letter, guidelines on proper redeterminations state that States must conduct ex parte reviews of ongoing eligibility to the extent possible using information available to the State. If the ex parte review does not suggest continued eligibility for Medicaid, the State must provide the individual the opportunity to provide information to establish continued eligibility but the State must limit its request to information that it necessary to determine eligibility.

Arkansas must revise its redetermination policies and practices to conform to these guidelines. In addition, pursuant to the April 7 guidance, the State must identify and reinstate those cases where an ex parte review was not conducted and Medicaid was terminated when TANF was lost because families failed to respond to a redetermination notice.

**State Response:** We believe the draft report does not accurately describe the process for determining TANF and Medicaid eligibility. Although both cash and Medicaid could be authorized together on our automated system until October 1999, the caseworker had to code the system to provide either cash or Medicaid, or both, and code the system to terminate cash or Medicaid, or both. In October 1999, we changed the process to require separate cash and Medicaid cases to be entered in the system. Medicaid redeterminations are scheduled annually, unless a change occurs that affects eligibility. If a change in TANF occurs, including closure, Medicaid continues unless the caseworker takes specific action to terminate the Medicaid. There is no process in place for the system to alert the Medicaid caseworker when a TANF case closes so that the client can be notified to reapply or otherwise redetermine eligibility because there is no need for such a process. If a change occurs that affects Medicaid eligibility, then Medicaid is redetermined based on the reported change.

This has been our established Medicaid eligibility redetermination procedure since July 1997. We acknowledge, however, that policy and procedural misinterpretations were made and some erroneous Medicaid closures occurred. During the period when those misinterpretations occurred, we had a more verification-oriented process in place. Thus, some closures occurred due to the client's failure to provide verification of the change (e.g. earnings verification for Medicaid continuation in the Transitional Medicaid category). However, that process was revised in December 1999 to accept the client's self-declaration of earnings and so those types of closures (i.e., for failure to provide verification) should no longer occur. A monthly management report was instituted in August 2000 that lists all TEA cash assistance cases that closed in the prior month and that do not have an open Medicaid case in the current month. With this report, counties are required to investigate each case to determine why the family is not receiving Medicaid and reinstate benefits if an erroneous closure occurred.

We continue to work on the section 1931 questionable closures in response to the April 7th letter. **HCFA Response:** The report describes the eligibility process in the State according to the review team's findings at the time of the on-site review. We acknowledge that the State has taken steps since then to improve the process. We commend the State for its actions to simplify the verification procedures for section 1931 recipients and for implementing monthly management reports to protect Medicaid for families who lose TANF. We will continue to work with the State to identify and reinstate cases that improperly lost Medicaid as part of our tracking under the April 7th directive.

## 2. Transitional Medicaid - Not automatic

We are concerned that, under the State's process at the time of the site visit, individuals and families were not receiving transitional Medicaid when eligibility under Section 1931 was lost because they did not contact the State for a redetermination. We are concerned that asking families to document

income changes when they lose Section 1931 eligibility may have been creating a barrier to continued coverage under TMA, particularly since ex parte reviews may not be the usual practice and the State uses application forms for redetermination forms.

According to HCFA policy, if the caseworker determines that the family is not eligible for Medicaid under Section 1931 because of increased earnings (and the family has received 1931 Medicaid for three of the last 6 months), eligibility must be evaluated for transitional Medicaid based on those earnings without requiring the family to reapply.

We commend Arkansas for its policy directives to county offices to place applicants eligible for Medicaid under Section 1931 TEA rather than TEA cash to ensure that improper Medicaid terminations do not occur when TANF is lost. However, the State is not conducting ex parte redeterminations prior to requiring the family to participate in a redetermination. This practice presents a barrier that results in the loss of Medicaid for families that fail to respond to the redetermination notice and is contrary to Federal rules.

**State Response:** The draft report does not accurately describe our Medicaid eligibility process that has been in effect since July 1997. Medicaid eligibility is redetermined based on a change in circumstance or at the scheduled redetermination date. During the period when procedural misinterpretations occurred, some closures occurred due to the client's failure to provide verification of the change (e.g., earnings verification for Medicaid continuation in the Transitional Medicaid category). However, that process was revised in December 1999 to accept client's self-declaration of earnings and so those type of closures should no longer occur.

**HCFA Response:** We commend the State for its actions to ease verification requirements. When the review took place in November 1999, the self-declaration policy had not been implemented and we were concerned that families were not receiving transitional Medicaid because they failed to provide proof of earnings. At the time of the site visit, the review team found that the State was out of compliance with HCFA policy. Instead of automatically providing TMA to eligible families, in cases where families became ineligible for 1931, families were required to complete a redetermination process. It is our understanding that this group of individuals is one of the groups that the State will be reinstating in accordance with the April 7, 2000 Dear State Medicaid Director letter, and we are pleased that the State will be reinstating these families.

Regarding the State's redetermination process, the review team did not ascertain if Medicaid redeterminations (including ex parte reviews) are conducted when transitional Medicaid ends to determine if eligibility continues for those families. Redeterminations are particularly important when transitional Medicaid ends because often the children are eligible for SCHIP. Since we are concerned that families do not lose Medicaid or SCHIP once transitional Medicaid ends, we

**recommend that Arkansas review its redetermination policies and practices to ensure that redeterminations are being conducted when transitional Medicaid expires.**

### 3. Using the Application Form as a Redetermination Form

When redetermining Medicaid eligibility, Arkansas uses the same application form rather than a separate redetermination form, which the family completes and mails, to the office. The practice of using the application form as the redetermination form may be contributing to the failure of individuals and families to complete the redetermination process. Moreover, if the State is asking clients for information at the redetermination re: circumstances that do not change, the practice is contrary to HCFA's April 7 Dear State Medicaid Director letter. We encourage the State to develop a separate, shorter redetermination form, or some other simpler process, that focuses only on changes in circumstances and is less likely to be a barrier to enrollment.

**State Response: In our continued effort to improve accessibility and enrollment for our customers, we are planning to implement a simplified reenrollment form for TEA Medicaid (section 1931). We plan to pattern this after the ARKids reenrollment form, which is a two-page form that asks only for relevant changes.**

**HCFA Response: Federal redetermination rules require States to limit their requests for information to changes that may affect eligibility and only after an eligibility determination cannot be made through an ex parte review. Items such as citizenship, birth date, etc., that are not subject to change should be eliminated from the information request. Arkansas plan to simplify the redetermination of families under section 1931 appears to conform to Federal rules and we urge the State to implement this new form as soon as possible to ensure compliance. We also encourage the State to consider using the same or similar form for redeterminations of all Medicaid categories and to review their current procedures to ensure that information requests that are necessary after an ex parte review can not determine eligibility, are limited to only those circumstances that are likely to change.**

### 4. Section 4913 Cases

According to the April 2000 Social Security Administration s lists of disabled children that the State reviewed, Arkansas has 1978 children terminated from SSI who may be eligible for Medicaid under Section 4913. The State has identified 800 of these cases and is working to identify the remaining cases. HCFA will be tracking Arkansas progress on these cases as part of its follow-up with all States as they implement the directives in the April 7, 2000 State Medicaid Directors letter.

The review team noted that if a case is terminated from SSI for a reason other than the definition of childhood disability, the State notifies the family of the need for a Medicaid redetermination and

terminates Medicaid for families that do not respond to the notice. The review team did not determine if the State is conducting ex parte redeterminations prior to contacting the family. As stated above, the April 7, 2000 letter clarifies Federal rules on proper redeterminations including ex parte redeterminations. Arkansas must review its policies and procedures on redeterminations when changes in circumstances affect eligibility and revise them accordingly.

**State Response:** We are continuing to work on these cases in response to the April 7th letter.

**HCFA Response:** HCFA will continue to work with Arkansas in completing these cases as part of our tracking efforts of the April 7th directive. We encourage the State to review its policies and procedures on redeterminations, including ex parte redeterminations to ensure they conform to Federal rules.

#### 5. Streamlining Application Procedures

We are concerned that Arkansas' application procedures require a face-to-face interview for joint applicants seeking Medicaid. The face-to-face interview requirement may be creating a barrier to enrollment. We laud the State for eliminating the face-to-face interview requirement for redeterminations, and for children's applications, and encourage the State to consider eliminating the requirement for the purpose of determining Medicaid eligibility for families.

We are also concerned that in counties without generic caseworkers a separate TANF face-to-face interview is required if the Medicaid applicant appears to be eligible for TANF. However, the State should coordinate the TANF and Medicaid application process to eliminate the need for a separate TANF application and interview or, in the reverse, for a separate Medicaid application and interview since this practice creates a barrier in the application process.

We also suggest that the State again consider the possibilities of eliminating the assets test for children, to consider additional simplifications of their applications.

**State Response:** We believe the statement that a second face-to-face interview in offices without generic workers is inaccurate. It is the intent of the State for all TANF caseworkers to also conduct the TEA related Medicaid interviews. No second face-to-face interview should be required.

**We have simplified the application process for SOBRA Medicaid children. The ARKids First application form and process was revised to combine regular Medicaid for children (now ARKids A) and the ARKids First waiver (now called ARKids B) under the ARKids First umbrella. It also includes no interview requirement and the acceptance of self-declaration for all eligibility points except age and documentation of alien status.**

**HCFA Response:** We agree that the State's intent is to have all TANF caseworkers also process Medicaid applications. We are concerned that, in this kind of circumstance, separate interviews may be a barrier in the application process. We encourage the State to coordinate the interview process in these cases for both programs.

While we commend Arkansas for simplifying its enrollment of SOBRA children, we urge the State to ensure that persons applying on behalf of children are told of the differences in the two programs (e.g., that one program requires co-payments and the Medicaid program does not) so they may make an informed choice for which program they wish to apply.

#### 6. Applications: SSNs and Paternity Information Requirements

All applications ask for all household members and their SSNs and citizenship/immigration status (long term care applications ask for the SSN of the spouse). Arkansas must revise its applications to ask SSN and citizenship/immigration status information only for household members who are applying for Medicaid.

**State Response:** A review of all of our applications is being conducted to add language that informs applicants that SSNs and other information of non-eligibles are optional.

**HCFA Response:** Until the applications are revised to include this important information, we encourage the State to ensure that applicants are informed verbally or by other means necessary that SSNs and citizenship/immigration status is not required by non-applicants.

#### 7. Civil Rights Issues

We are concerned that county agencies do not have translators available for individuals with limited English proficiency (LEP). It is the State's responsibility, not the applicant/beneficiary's to provide interpreters at no cost whenever an applicant or beneficiary needs one to complete the eligibility process or to participate fully in federally funded benefits programs. Arkansas may: hire bilingual staff, hire staff interpreters, use volunteer staff interpreters, arrange for the services of volunteer community interpreters, contract with an outside interpreter service, or use a telephone interpreter service. In addition, the Medicaid and joint TANF/Medicaid applications are not available in a language other than English although we acknowledge that the State has a Spanish application package in the development stage. The State must make applications as well as notices and information materials in the non-English languages of each regularly encountered LEP group serviced by its federally funded programs. Translated notices and information also must be made available to inform LEP applicants and beneficiaries of the availability of language assistance services.

Based on the review team's visit, the Office for Civil Rights believes that Arkansas should undertake the following initiatives:

- Maintain data and analyze minority participation by all race/ethnic categories.
- Conduct an on-going demographic assessment of service areas to determine the need.
- Target activities for outreach and service delivery.
- Further educate local caseworkers on the requirements regarding the use and procurement of appropriate translators or interpreters;
- Finish developing Spanish translations of the applications; and,
- Educate staff and disseminate guidance concerning public charge and citizen status.

**State Response:** Since the November on-site review, Arkansas has translated all TANF and Medicaid applications, along with other notices and forms, into Spanish. We also plan to have all computer-generated notices include a statement in Spanish directing the individual to call a 1-800 number to receive Spanish-language forms or to receive client assistance in Spanish. A toll-free 1-800 number will be publicized through advocacy organizations and Spanish-speaking employees of the Division of County Operations, who are knowledgeable about TEA, Medicaid and Food Stamps.

**HCFA Response:** Arkansas is to be applauded for its actions to translate all applications, other notices and forms into Spanish. The State's plans for outreach and assistance with the 1-800 number is also commendable and we encourage the prompt implementation of these plans. We also encourage the State to consider the remaining suggestions from OCR regarding data analysis, educating caseworkers on interpreter services and public charge.

## 8. Notices

We are concerned that the systems-generated notices are contain ambiguous boilerplate language and are not descriptive in providing information to the client. The manual notices tended to show the reason for the action being taken (e.g., termination for excess income, non-participation in work or training requirements) and were more descriptive in explaining what could occur next, for example, that this was only a temporary action.

We encourage the State to review their notices and assure that all notices are clear and explain the action and the reasons for the action and to put more uniformity into their notices to ensure clients know that loss of cash does not necessarily mean loss of medical benefits. Discussions with some local caseworkers established that, in the perception of some clients, TANF termination still equates to a Medicaid termination even though the notices (automated and/or manual) advise families to recontact

DHS for a redetermination. Moreover, if the State were properly conducting ex parte reviews when TANF is terminated, notices should advise families that their Medicaid will continue without any need for the family to recontact DHS.

9. Public Charge

We are concerned that Arkansas has not publicized the 1999 INS policy guidance clarifying what constitutes a public charge, thereby limiting attempts to reach immigrants and other non-citizens. This lack of outreach in public charge was a specific concern of advocates.