- When the child receives Title IV-E Foster Care from a state other than West Virginia, coverage is provided in West Virginia as an SSI Recipient. See Section 16.6,A.

C. TRANSITIONAL MEDICAID (TM) (ME I, ME T, ME D)

Income: Phase I - N/A **Assets: N/A**
Phase II - 185% FPL

This coverage group consists of families which lose eligibility for AFDC Medicaid because of earned income, the loss of earned income disregards or the number of hours worked. TM provides continuing medical coverage after AFDC Medicaid eligibility ends and occurs in 2 phases as described below.

There are no application procedures for Transitional Medicaid. Instead, when an AFDC Medicaid case becomes ineligible, the Worker must automatically determine eligibility for TM. If the case is closed in error instead of being converted to a TM case, the case must be reopened without reapplication by the client.

The periodic review letter (PRL) dates throughout this Section will vary due to adverse action deadline and non-work days. See Appendix A.

NOTE: Transitional Medicaid (TM) is not related in any way to DCA eligibility or ineligibility or the loss of WV WORKS eligibility. TM eligibility is related only to ineligibility for AFDC Medicaid.

NOTE: Recipients of TM are not referred to nor required to cooperate with child support activities.

NOTE: Loss of TM coverage must not affect 12 months of continuous Medicaid eligibility for the children in the AG. See Section 2.8.

1. Phase I Coverage

a. Eligibility Requirements

In order to be eligible for Phase I coverage, all of the following conditions must be met:

- The AG became ineligible for AFDC Medicaid due to hours of employment, amount of income from employment or from loss of the AFDC/U time-limited earned income disregards ($30 + 1/3 or $30 disregard).*

NOTE: In determining ineligibility for AFDC Medicaid, the Worker must consider income of the AG and any individual who would normally be included in the AG, but who has been penalized.

- The AG received AFDC Medicaid in any 3 or more months during the 6-month period immediately preceding the 1st month of ineligibility for AFDC Medicaid.

  NOTE: Receipt of WV WORKS or a DCA payment does not meet this requirement. It is met only by receipt of AFDC Medicaid for at least 3 of the last 6 months.

- The AG did not receive AFDC Medicaid fraudulently during any of the 6 months prior to the 1st month of AFDC Medicaid ineligibility.

- The family has a dependent child who would be included in the AFDC Medicaid AG, if the family were eligible.

* When the AG becomes ineligible for AFDC Medicaid for a combination of reasons, the Worker must determine if the amount of earned income, hours worked or loss of time-limited disregards (or the addition of an individual with earnings who has received AFDC Medicaid in 3 of the past 6 months), had an effect on the ineligibility. Only when this is the case is the AG eligible for TM.

* The steps below are to be followed to determine if such factors had an effect on ineligibility for AFDC Medicaid:

* Step 1: Determine if the increase in income (or hours of employment or loss of the AFDC/U earned income disregards) would have resulted in loss of AFDC Medicaid if all other factors in the case remained the same (i.e., there was no other change in income, no change in family composition, no change in AFDC Medicaid standards, etc.).

* If yes, the AG meets the requirement.

* If no, go to Step 2.

* Step 2: Determine if events other than the increase in income (or hours of employment or loss of the

AFDC/U earned income disregards) would have resulted in loss of AFDC Medicaid if the income (hours or disregards) had stayed the same.

* If yes, the AG does not meet the requirement.

* If no, go to Step 3.

* Step 3: Determine if the AG is ineligible for AFDC Medicaid when all changes are considered.

* If yes, the AG meets the requirement. The increase in earnings (or hours of employment or loss of the AFDC/U earned income disregards) was essential to the loss of AFDC Medicaid eligibility. Without that increase, the AG would not have lost eligibility.

* If no, the AG is still eligible for AFDC Medicaid.

b. Loss of Eligibility Before Expiration of Full Phase I Coverage

The following circumstances will result in case closure (after proper notice) before the expiration of the Phase I coverage:

(1) No Dependent Child

When there is no child in the home who would be eligible for AFDC Medicaid, the AG loses eligibility. Eligibility ends at the end of the 1st month in which the AG no longer includes such a child.

EXAMPLE: Last dependent child leaves the home on February 10th. The case is closed effective February. Advance notice is required.

(2) Fraud

When it is determined that AFDC Medicaid benefits received in one or more of the 6 months prior to the start of Phase I coverage were received fraudulently, the AG is ineligible. Eligibility ends on the last day of the month when the advance notice period expires.

(3) Enrollment in Free Employer's Plan

When the person whose employment caused ineligibility for AFDC Medicaid does not enroll or maintain enrollment in the employer's health plan, provided such coverage is free to the client, the AG becomes ineligible. Eligibility ends on the last day of the month when the advance notice period expires. Benefits are not delayed pending compliance with this requirement. The client must be allowed 30 days to prove he has taken the steps necessary to comply.

NOTE: There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

NOTE: Failure, without good cause, to return a complete PRL3 by **1st work day after the 20th** of the 4th month results in ineligibility to participate in Phase II of TM, but has no effect on Phase I coverage.

c. Eligible Situations

Provided the AG meets all of the eligibility requirements in item a above, it is eligible for Phase I TM in the following situations:

- The AG's gross income is above 185% or 100% of the AFDC/U Standard of Need or the countable income is above the payment level, and the beginning of employment or increase in hours or payment rate had an effect on AFDC Medicaid ineligibility.

- The earned income of an individual who received AFDC Medicaid in 3 of the last 6 months and who is added to the AG, has an effect on the AG's AFDC Medicaid ineligibility.

- The case becomes ineligible for AFDC Medicaid due to failure to report or provide verification of new earnings, provided that fraud is not indicated.

- The case becomes ineligible for 1 month only due to a temporary increase in hours worked or rate of pay.

d. Ineligible Situations

The AG is not eligible for Phase I coverage in the following situations:

- The AG becomes ineligible because of the earnings of an individual being added to the AG who has not received AFDC Medicaid in 3 of the last 6 months.

- The AG becomes ineligible for a reason other than those found in item 1,a above.

- There is an indication, with supporting evidence, that the AG received AFDC Medicaid fraudulently during at least 1 of the 6 months prior to the first month of AFDC Medicaid ineligibility. The Worker must determine from the case record if a referral has been made to IFM or if an IFM decision has been rendered on any fraud claim. If there is a substantive indication that fraud was involved, the AG is not eligible for Phase I coverage.

NOTE: There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

NOTE: There is no provision to discontinue Phase I coverage due to the AG's becoming eligible for AFDC Medicaid again. Instead, the AG is dually eligible for AFDC Medicaid and TM. See item 3 below for the significance of dual eligibility.

e. Beginning Date of Phase I Coverage

An AG is eligible for Phase I coverage beginning the month following the last month of AFDC Medicaid eligibility. When AFDC Medicaid is continued beyond the month ineligibility occurs because of an agency or client error, the beginning date of TM is the 1st month for which the client should have lost eligibility, taking into consideration advance notice requirements.

f. Client's Reporting Requirements

The client is required to report his gross earnings and day care costs for the first 3 months of Phase I coverage by the **1st work day after the 20th** of the 4th month. He is also required to report

the earnings and day care costs of any person in the home who is included in the AFDC Medicaid Income Group. In addition, he must report his gross earnings and day care costs for the last 3 months of Phase I coverage by the **1st work day after the 20th** of the 1st month of Phase II coverage.

RAPIDS letter PRL3, is mailed to the client **by** the **3rd Friday** of the 3rd month.

If the client returns the completed PRL3 form, he has met one of the eligibility requirements for Phase II coverage.

Failure to return a completed form, without good cause, by the **1st work day after the 20th** of the 4th month, automatically renders the AG ineligible to participate in Phase II, after proper notice. The client must be notified of the consequences of his actions when the form is not returned by the **due date** without good cause or is returned but is incomplete. The client has a right to a Fair Hearing on this issue since future eligibility is involved. The Worker must not wait until the end of Phase I coverage to notify the client of his ineligibility for Phase II. The process of determining eligibility or ineligibility, based on this reporting requirement, is completed prior to the end of Phase I coverage.

The PRL3 must be filed in the case record.

The good cause determination is made by the Worker and Supervisor and must be based on reasonable expectations; these generally will involve situations over which the client has little control.

A RAPIDS alert notifies the Worker when the form is due.

If the client provides the completed form within the 13-day notice period, this part of the eligibility requirement for Phase II is reestablished.

g. Special Agency Notification Requirements

During the 4th month of Phase I eligibility, the client is notified of the availability of Phase II coverage and what he must do to continue coverage.

2. Phase II Coverage

NOTE: When all eligibility factors for Phase II coverage are met, eligibility continues, without interruption, from Phase I to Phase II, unless the client has indicated he does not wish to continue such coverage.

a. Eligibility Requirements

In order to be eligible for Phase II coverage, all of the following conditions must be met:

- The AG received Phase I coverage for the entire 6-month Phase I period. The 6-month period includes months for which the client was dually eligible for Phase I and AFDC Medicaid, if applicable.

- The client completed and returned, in a timely manner, the PRL3 sent to him, or had good cause for not returning it. The form is considered to be returned in a timely manner when it is received within the advance notice period.

- The family has a dependent child who would be eligible for AFDC Medicaid.

- The earned income amount meets the financial test as described in Chapter 10. For Phase II coverage, information from the PRL3 is used. Information from the PRL3 determines eligibility for months 7 – 12 of Phase II TM coverage. Information from the PRL8 determines continued eligibility for months 9 – 12 of Phase II and the PRL9 determines eligibility for month 12 of TM.

- The client continues to have earnings, unless the lack of earnings is due to involuntary loss of employment, illness, or unless good cause is established.

- The client applies for and maintains enrollment in his employer's health plan, provided such coverage is free to the client

b. Beginning Date of Phase II Coverage

An AG is eligible for Phase II coverage beginning the 1st month immediately after Phase I coverage ends. When Phase II coverage

is, in error, not begun in the correct month, coverage begins upon discovery of the error and is backdated to the date coverage should have begun. In no instance is Phase II coverage extended beyond 6 months past the end of Phase I coverage.

c. Client's Reporting Requirements

The client is required to report his gross earnings, the gross earnings of other Income Group adults in the home, and actual out-of-pocket day care costs. This information is used to determine financial eligibility for Phase II coverage. The PRL3 is mailed **by** the **3rd Friday** of the 3rd month and must be completed and returned by the **1st work day after the 20th** of the 4th month, unless the client establishes good cause.

The PRL8 is mailed **by** the **3rd Friday** of the 6th month and the completed form is due by the **1st work day after the 20th** of the 7th month. The PRL9 is mailed **by** the **3rd Friday** of the 9th month and the completed form is due by the **1st work day after the 20th** of the 10th month. All PRL forms must be returned by the due date, unless the client establishes good cause.

The good cause determination is made by the Worker and Supervisor and must be based on reasonable expectations; these generally will involve situations over which the client has little control.

The PRL forms must be filed in the case record. A RAPIDS alert notifies the Worker that the forms are due.

d. Automatic Termination of TM

The data system will automatically terminate TM eligibility at the end of 8th month if the PRL8 is not returned by the due date.

RAPIDS will automatically terminate TM at the end of the 11th month if the PRL9 is not returned by the due date.

At the end of the TM Phase II, the data system will automatically terminate coverage.

NOTE: When TM eligibility ends for any reason other than expiration of the time period, the Worker must evaluate eligibility of the AG for all other Medicaid coverage groups.