Effective April 1, 1990, the Family Support Act of 1988 (FSA) requires that states provide up to 12 months of Transitional Medical Assistance (TMA) benefits to Medical Assistance (MA) recipients who lose ADC eligibility due to increased earnings or loss of earned income disregards. Since there was no enabling State legislation as of April 1, districts were requested via 90 LCM-47 to maintain lists of affected cases that were entitled to TMA benefits.

Another LCM was sent to social services districts on July 17, 1990 (90 LCM-102) in which districts were informed that State legislation (Chapter 453 of the Laws of 1990) had passed and HR families are included and are also eligible for TMA if ADC or HR cash assistance is terminated as a result of increased earnings or loss of income disregards.

These LCMs were issued to ensure State compliance with the federal requirements of FSA once enabling State legislation was enacted. One of the major federal requirements in providing TMA is that states must periodically contact TMA recipients and collect certain household and income information to determine clients' on-going eligibility for TMA benefits. During the weekend of July 21, the Department completed its initial mailing of quarterly reports to TMA clients to collect such information and the number of cases reported is extremely low. Our preliminary analysis indicates that a larger number of cases should have been offered than currently reported.
Therefore, we are requesting that social services districts review the cases maintained on the lists referenced in 90 LCM-47 to determine if TMA has been properly authorized. Furthermore, since the legislation was late in passing and we did not anticipate that HR families would be included, it is essential that HR closings be re-examined for possible TMA eligibility. Districts should use the following WMS instructions to make necessary changes. These instructions were originally issued in GIS Message 90 MA037 on July 25, 1990.

WMS Instructions

In 90 LCM-102, social services districts were requested to use the following MA opening reason codes when opening a TMA case:

088 Beginning of Extension of TMA Eligibility after Finding of Ineligibility for PA Resulting from Employment.

089 Beginning of Extension of TMA after Finding of Ineligibility for PA Resulting from Loss of $30 + 1/3 or $30 Disregard.

However, MA opening reason code 089 is only allowed with MA case opening and reopening transactions. The system will be changed in the near future to also allow code 089 with transaction type 05 (change) and 06 (Recertification/Reauthorization). We will notify you via GIS when this change is scheduled for production.

Therefore, in the interim, TMA cases opened as a result of ADC/HR closings on or after April 1, 1990, and having a current opening reason code other than 088 or 089, will not be included in the Quarterly Reporting Mailer pulldown (scheduled for the third weekend each month). To include such cases in subsequent quarterly reporting pulldowns, districts must perform an undercare entry (Transaction Type 05 or 06) using reason code 088 and the original TMA Authorization From Date.

In addition, districts must send the attached letter and questionnaire to all TMA recipients who were not included in the Department's initial mailing. Districts may verify which clients were sent mailers by accessing the Quarterly Reporting Inquiry function of the new WMS MA Quarterly Reporting Menu. The returned questionnaires will be used to determine TMA clients' ongoing eligibility for MA coverage.

Lastly, we are exploring the feasibility of developing a report of all families receiving transitional child care benefits. This report would be sent to districts to assist in identifying families that may be eligible for TMA benefits.
These instructions will be included in the forthcoming Administrative Directive on Transitional Medical Assistance Benefits.

Any questions should be directed to your MA Eligibility County Representative at 1-800-342-4100, extension 3-7581.

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance
Dear_______________________:

If you became ineligible for Aid to Dependent Children or Home Relief (ADC or HR) cash assistance after April 1, 1990 because of increased earnings or loss of earned income disregards you may be eligible for extended Medical Assistance (MA) coverage.

This MA coverage should have begun immediately after your ADC or HR case was closed and may continue for up to one year from that time.

To be eligible for this MA extension:

1) your family must have received ADC or HR during 3 of the 6 months immediately prior to your case being closed;

2) a child of yours under age 21 must be living with you; and

3) you or your spouse must be working or recently employed.

You may be eligible to receive additional MA after the first 6 months of extended Medicaid has ended if your earned income remains below certain levels. You must complete the information on the attached questionnaire and on the reports we will send you every 3 months of this MA extension. This includes returning paystubs with the questionnaire and reports by the 7th day of the month after you receive the report. The information you provide will be used to determine your eligibility for the additional 6 months of MA benefits.

The Department of Social Services will automatically determine your eligibility for extended MA. You do not need to complete another application for this benefit.

If your case was closed after April 1, 1990 and you believe you were eligible for MA, you should bring in any medical bill you incurred during this time period. If you already paid the bills, you may be reimbursed at the MA rate. If these bills are unpaid, MA may pay these bills.

If you have any questions, call the MA office at:__________________.

Sincerely,

Enc.
TRANSITIONAL MEDICAL ASSISTANCE EXTENSION QUESTIONNAIRE

1. Did you or anyone in your household (including stepparents) receive income during the previous 8 weeks? [ ] No [ ] Yes

   If yes, enclose paystubs.

2. Does your household contain a child of yours under the age of 21? [ ] No [ ] Yes

3. Did anyone move in or out of your household during the period (including births)? [ ] No [ ] Yes

   If yes, write in names of the persons who moved in or out, a parent who returned home, someone who is pregnant, a baby is born, etc.:

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<th>NAME</th>
<th>RELATIONSHIP</th>
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4. Did anything else change or do you expect any changes in your household during the next 3 months? (i.e., marriage, moving, persons moving in or out of home, only child in home turning age 21) [ ] No [ ] Yes

5. List the weekly amount spent on child care costs $_____. List the amount, if any, of child care costs reimbursed to you (Transitional Child care or other child care reimbursement) $___________.

6. Do you have health care insurance coverage? [ ] No [ ] Yes

   Insurance Company__________________ Policy No.____________________

You must complete and return this questionnaire with your signature in the enclosed envelope with proof of any changes. Photo copies are allowed.

_________________________________        ________
Recipient's Signature                 Date

________________________________________
Telephone number

NOTE: DO NOT FORGET TO ENCLOSE YOUR PAYSTUBS