April 7, 2000

Dear State Medicaid Director:

Over the past few years, States have made enormous progress increasing access to health care coverage for low-income, working families. As a result of eligibility expansions, simplified enrollment procedures, and creative outreach campaigns, millions more low-income children and parents are eligible for health care coverage through Medicaid or through separate State Children's Health Insurance Programs (SCHIP). And yet, at the same time that States have made expansions of coverage a priority, instances in which eligible children and parents have lost out on coverage have come to light.

The delinkage of Medicaid from cash assistance has made it possible for States to offer low-income families health care coverage regardless of whether the family is receiving welfare, but it has created challenges as well as opportunities for States. Last August, President Clinton spoke to the National Governors' Association (NGA) about the importance of ensuring that everyone who is eligible for Medicaid is enrolled, and directed the Department of Health and Human Services (HHS) to take several actions to improve the health care available to low-income families.

Today, I am writing to provide guidance and information that will build on our joint efforts to improve eligible, low-income families' ability to enroll and stay enrolled in Medicaid. We are concerned that some families who left the Temporary Assistance for Needy Families (TANF) program and who remain eligible for Medicaid or Transitional Medical Assistance (TMA) benefits may have lost coverage. In addition, it appears that some children who became ineligible for Supplemental Security Income (SSI) benefits due to a change in the SSI disability rules may not have been continued on Medicaid despite Congressionally mandated requirements.

This letter covers three related topics. First, it outlines a series of actions that all States must take to identify individuals and families who have been terminated improperly and to reinstate them to Medicaid. Second, it clarifies guidance on Federal requirements relating to the process for redetermining Medicaid eligibility. Third, it reviews the obligations imposed by Federal law with regard to the operation of computerized eligibility systems. We have also enclosed a set of questions and answers to help States implement the guidance. We will continue to issue written answers to questions that arise and make those questions and answers available to States on an ongoing basis. Reinstatement for Improper Medicaid Terminations

Over the past several years, cash assistance rules have changed at both the Federal and State levels. As a result of these changes to promote work and responsibility, and a strengthened economy, many fewer families are receiving cash assistance. When eligibility for cash assistance and Medicaid were delinked, Congress and the Administration took specific actions to assure that Federal law continued to guarantee Medicaid eligibility for children and families who formerly qualified for Medicaid through their receipt of cash assistance.

These changes required a significant retooling of Medicaid eligibility rules and procedures at the State and local level. In some cases, it appears that necessary adjustments to State and/or local policies, systems and procedures have not been made.

Several States have taken action to reinstate coverage for families and children who have been terminated improperly from Medicaid. Reinstatement is compelled by Federal regulations and prior court decisions. Under Federal regulation 42 CFR 435.930, States have a continuing obligation to provide Medicaid to all persons who have not been properly determined ineligible for Medicaid. This includes individuals whose Medicaid has been terminated through computer error or without a proper redetermination of eligibility. Therefore, all States must take steps to identify individuals who have been terminated improperly from Medicaid and reinstate them, as described below.

Identifying Improper Actions

A. Requirements for TANF-related terminations

States must determine whether individuals and families lost Medicaid coverage when their TANF case was closed, or when their TMA coverage period ended without a proper notice or without a proper Medicaid redetermination, including an ex parte review consistent with previous guidance. For example, States should review whether their computer system improperly terminated Medicaid coverage when TANF benefits were terminated, and they should consider whether families whose TANF termination was due to earnings were evaluated with respect to ongoing Medicaid eligibility, including TMA. In addition, if a State did not implement its Section 1931 category until some time after its TANF program went into effect, the State must review Medicaid/TANF terminations that occurred before the State had an operative Section 1931 category.

B. Requirements for terminations of disabled children eligible for Medicaid under Section 4913 of the Balanced Budget Act of 1997

Children who became ineligible for SSI due to the 1996 change in the SSI disability rules and then were terminated from Medicaid either without adequate consideration of their eligibility under Section 4913 of the BBA, or without a proper redetermination, including an ex parte review consistent with previous guidance, must be identified and reinstated. States must compare the Social Security Administration (SSA) list of children whose Medicaid eligibility was protected by Section 4913 and determine which, if any, of those children are not currently receiving Medicaid or are receiving Medicaid but are not

identified as a Section 4913 child. The Health Care Financing Administration (HCFA) and SSA will work with States to ensure that States have the information that they need to identify Section 4913 children. The results of these cross-matches should be promptly reported to the HCFA Regional Office.

C. Improper Denials of Eligibility

In some States, eligible individuals applying for both Medicaid and TANF may have been denied Medicaid improperly because eligibility determinations continued to be linked. While HCFA is not requiring States to identify and enroll these applicants, we encourage you to do so.

Reinstatement

If, after a State-wide examination of enrollment policies and practices, it appears that there have been improper terminations since their TANF plan went into effect, States must develop a timetable for reinstating coverage and conducting follow-up eligibility reviews as appropriate. Action to reinstate coverage should be taken as quickly as possible, and States should keep their HCFA regional office informed as they review their policies and practices and develop their plans. This guidance should not delay State actions to reinstate individuals that are already under way.

Because it may not always be clear or easy for the State to determine whether a particular individual was terminated properly, States that determine that problems in policy or practice did cause individuals to lose Medicaid improperly may reinstate coverage without making a specific finding that an individual termination was in fact improper. Such action is consistent with Federal regulations that require that eligibility be determined in a manner consistent with simplicity of administration and the best interests of the applicant or recipient (42 CFR 435.902).

Federal Financial Participation (FFP) will be available for up to 120 days of coverage after reinstatement, pending a redetermination of ongoing eligibility, regardless of the outcome of the redetermination process. States that have developed reinstatement procedures have typically reinstated individuals and families for a period of 60 or 90 days. Coverage provided during this time period will not be considered for any Medicaid Eligibility Quality Control (MEQC) purpose.

If a State determines that there have been no instances of improper terminations, it should inform the Regional Office of the review undertaken and the basis for its conclusions. HCFA will provide assistance to States throughout this process.

Contacting Individuals and Families

States may have to reinstate individuals and families who have not been in contact with the Medicaid agency for some time, and should take all reasonable steps to identify the individual or family's current address. For example, States could check Food Stamp program records for a more up-to-date address and alert caseworkers to the list of affected individuals so that these individuals are identified if they

contact the agency for other reasons. Other outreach efforts might include notices to families receiving child care services and television and radio spots.

Redetermining Eligibility Once Reinstatement is Accomplished

In most situations, States will need to redetermine eligibility after reinstatement to assess whether the family or individual is currently eligible for Medicaid. To ensure that families understand the process and have adequate time to respond to requests for further information, States should allow a reasonable time for the review process. As noted above, FFP will be available for up to 120 days after reinstatement to allow States adequate time to review ongoing eligibility.

Individuals and families whose most recent Medicaid eligibility determination or redetermination occurred less than 12 months before reinstatement may be continued on Medicaid until 12 months from the date of that last eligibility review, without any new redetermination of eligibility. In these situations FFP will not be limited to 120 days. Individuals and families who have earnings may be covered under TMA and therefore would be subject to the State's TMA reporting and review procedures.

When States redetermine the eligibility of children identified by SSA as a Section 4913 child, the child does not lose protection under Section 4913 because of a prior break in eligibility. Continuous eligibility is not a requirement of Section 4913.

Covering Services Provided Prior to Reinstatement

Many of the individuals and families who were terminated improperly will have incurred medical expenses that would have been covered under Medicaid. States have the option to provide payment to providers and individuals for the cost of services covered under the State's Medicaid plan provided between the time the individual was terminated from Medicaid and reinstatement. FFP will be available to States that provide such retroactive payments, including direct payments by the State to individuals who had out-of-pocket costs for services that would have been covered by Medicaid had the individual not been terminated from the program. FFP in direct payments will be based on the full payment amount. FFP in payments to participating Medicaid providers will be at the Medicaid rate.

Review of Federal Requirements for Eligibility Redeterminations

Over the past few years, HCFA has issued guidance on the redetermination process (see letters issued February 6, 1997, April 22, 1997, November 13, 1997, June 5, 1998 and March 22, 1999). This guidance instructs States that individuals must not be terminated from Medicaid unless the State has affirmatively explored and exhausted all possible avenues to eligibility. It also outlines requirements for ex parte reviews. However, recent reports indicate that inadequate redetermination procedures have caused some eligible individuals and families to lose coverage, and some States have asked for more guidance in this area. As such, this letter restates and clarifies the previous guidance on (1) information that can be required at redeterminations; (2) ex parte reviews; and (3) exhausting all possible avenues of

eligibility.

Information Required at Redeterminations

Pursuant to Federal regulations (42 CFR 435.902 and 435.916), States must limit the scope of redeterminations to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and residency. States cannot require individuals to provide information that is not relevant to their ongoing eligibility, or that has already been provided with respect to an eligibility factor that is not subject to change, such as date of birth or United States citizenship.

Questions about the proper scope of a redetermination also arise when an individual reports a change in circumstances before the next regularly scheduled redetermination. Federal regulations require a prompt redetermination in such cases, but States may limit their review to eligibility factors affected by the changed circumstances and wait until the next redetermination to consider other factors. For example, if a State generally conducts a redetermination every 12 months and a parent reports new earnings three months after the family's most recent redetermination, the State must assess whether the individuals in the family continue to be eligible for Medicaid in light of the new earnings. However, it may wait until the next regularly scheduled redetermination to consider other eligibility factors.

Ex Parte Reviews

States are required to conduct ex parte reviews of ongoing eligibility to the extent possible, as stated in HCFA's previous guidance. By relying on information available to the State Medicaid agency, States can avoid unnecessary and repetitive requests for information from families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. States should use the following guidelines and enclosed questions and answers in conducting redeterminations.

Program records. States must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements) in order to conduct ex parte reviews. States generally have ready access to Food Stamp and TANF records, wage and payment information, information from SSA through the SDX or BENDEX systems, or State child care or child support files.

Family records. States must consider records in the individual's name as well as records of immediate family members who live with that individual if their names are known to the State. Again, this should be done in compliance with privacy laws and regulations.

Accuracy of information. States must rely on information that is available and that the State considers to be accurate. Information that the State or Federal government currently relies on to provide benefits under other programs, such as TANF, Food Stamps or SSI, should be considered

accurate to the extent that those programs require regular redeterminations of eligibility and prompt reporting of changes in

circumstances. Even if benefits are no longer being provided under another program, information from that program should be relied on for purposes of Medicaid ex parte reviews as long as the information was obtained within the State's time period for conducting Medicaid redeterminations unless the State has reason to believe the information is no longer accurate.

Timing of redetermination. States have the option to schedule the next Medicaid redetermination based on either the date of the ex parte review or the date of the last eligibility review by the program whose information the State relied on for the ex parte review. Since the date of the ex parte review will be the later of the two dates, States could reduce their administrative burden by scheduling the next redetermination based on the ex parte review date.

Use of eligibility determinations in other programs. The responsibility for making Medicaid eligibility determinations is generally limited to the State Medicaid agency or the State agency administering the TANF program. However, the State may accept the determination of other programs about particular eligibility requirements and decide eligibility in light of all relevant eligibility requirements.

Obtaining information from individuals. If ongoing eligibility cannot be established through ex parte review, or the ex parte review suggests that the individual may no longer be eligible for Medicaid, the State must provide the individual a reasonable opportunity to present additional or new information before issuing a notice of termination.

Exhausting All Possible Avenues of Eligibility

The Medicaid program has numerous and sometimes overlapping eligibility categories. For eligibility redeterminations, States must have systems and processes in place that explore and exhaust all possible avenues of eligibility. These systems and processes must first consider whether the individual continues to be eligible under the current category of eligibility and, in the case of a negative finding, explore eligibility under other possible eligibility categories.

The extent to which and the manner in which other possible categories must be explored will depend on the circumstances of the case and the information available to the State. If the ex parte review does not suggest eligibility under another category, the State must provide the individual a reasonable opportunity to provide information to establish continued eligibility. As part of this process, the State will need to explain the potential bases for Medicaid eligibility (such as disability or pregnancy).

In addition, in States with separate SCHIP programs, children who become ineligible for Medicaid are likely to be eligible for coverage in SCHIP. States should develop systems for ensuring that these children are evaluated and enrolled in SCHIP, as appropriate. As is consistent

with the statutory requirements, States must coordinate Medicaid and SCHIP coverage.

Computerized Eligibility Systems

Changes in eligibility rules affecting cash assistance and Medicaid have required States with computerized eligibility systems to modify their computer-based systems. If a State has not modified its system properly, some applicants may be erroneously denied enrollment in Medicaid. In addition, some beneficiaries may lose coverage even though they still may be eligible.

States have an obligation under Federal law to ensure that their computer systems are not improperly denying enrollment in, or terminating persons from, Medicaid. The attached questions and answers explain this obligation and present some practical suggestions on how States might meet their responsibilities under the law.

Conclusion

Most States are addressing the challenges associated with changing eligibility rules and systems, and many have developed promising new strategies for ensuring that children and families who are not receiving cash assistance are properly evaluated for Medicaid. HCFA will work with States as they assess the need for reinstatement, provide technical assistance to States implementing reinstatements, and facilitate exchanges among States to promote best practices to improve and streamline redetermination procedures. We anticipate that there will be many questions about the reinstatement process and the redetermination guidelines. We will make every effort to address your questions promptly, and to post and maintain a set of questions and answers on HCFA's website so that all States will be aware of how particular situations should be handled.

As important as it is to correct problems that have led eligible children and families to lose coverage, it is equally important that we improve eligibility redetermination processes and computer systems to prevent problems in the future. We are committed to working with you to implement this guidance to help achieve our mutual goal of an efficient, effective Medicaid program that helps all eligible families. If you have any questions concerning this letter, please contact your regional office.

Sincerely,

/s/

Timothy M. Westmoreland
Director

Attachment

cc: All HCFA Regional Administrators All HCFA Associate Regional Administrators For Medicaid and State Operations Lee Partridge - Director, Health Policy Unit, American Public Human Services

Association

Joy Wilson - Director, Health Committee, National Conference of State Legislatures Matt Salo - Director of Health Legislation, National Governors' Association Director

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QUESTIONS AND ANSWERS

Redeterminations

Q. When should a State rely on information available through other program records?

A. States must rely on all information that is reasonably available and that the State considers to be accurate. Information that the State or Federal government is relying on to provide benefits under other programs, such as TANF, Food Stamps or SSI, should be considered accurate to the extent that those programs require regular redeterminations of eligibility and prompt reporting of changes in circumstances. For example, in the Food Stamp program, Federal law requires States to recertify eligibility on a regular basis, and individuals receiving food stamps are required to report promptly any change in their circumstances that would affect eligibility. Thus, information in Food Stamp files of individuals currently receiving food stamp benefits should be considered accurate for purposes of Medicaid ex parte reviews.

Q. If benefits are no longer being paid under another program, can information from that program be relied on for purposes of Medicaid ex parte reviews?

A. It can be relied on if the information was obtained within the time period established by the State for conducting Medicaid redeterminations unless the State has reason to believe the information is no longer accurate. For example, take the case of a State that normally schedules Medicaid redeterminations every 12 months. If a child was determined financially eligible for SSI in January, 2000 and then loses SSI on disability-related grounds in March, 2000, the SSA financial information should still be considered accurate when the State redetermines Medicaid eligibility in March, 2000.

Q. When can the State schedule the next Medicaid redetermination if it relies on information from another program for its ex parte review?

A. The State may schedule the next Medicaid redetermination based on the date of the ex parte review or the date when the last review of eligibility was conducted in the other program. For example, consider a State that normally schedules Medicaid redeterminations every six months and that determines, based on a Medicaid ex parte review in March, that the family continues to be

eligible for Medicaid. If the ex parte review relies on Food Stamp program information, and the last Food Stamp review took place in January, the State may wait until September (six months from March) to schedule its next Medicaid redetermination review, or it may schedule the next redetermination in June (six months after the last

Food Stamp recertification).

Q. When can Medicaid accept another program's eligibility requirement determination?

A. When an eligibility requirement under another program applies equally to the Medicaid program, the State may accept the other program's determination with respect to this particular eligibility requirement. For example, if the resource standard and method for determining countable assets under the State's TANF program were the same or more restrictive than the asset rules in the Medicaid program, the Medicaid agency may accept TANF agency's determination that a family's assets fall below the Medicaid asset standard without any further assessment on it own part regarding this requirement. The Medicaid agency would then proceed to make a final determination of eligibility in light of all relevant eligibility requirements.

Q. When an individual reports a change in circumstances before the next regularly scheduled redetermination, must the State conduct a full redetermination at that time?

A. No. The State may limit this redetermination to those eligibility factors that are affected by the changed circumstances and wait until the next regularly scheduled redetermination to consider other eligibility factors. For example, if a State generally conducts a redetermination every 12 months and a parent reports new earnings three months after the family's most recent redetermination, the State must assess whether the individuals in the family continue to be eligible for Medicaid in light of the new earnings. However, it may wait until the next regularly scheduled redetermination to consider other eligibility factors.

Whether the State conducts a full or limited redetermination when an individual reports a change in circumstance, Federal regulations require that the redetermination must be done promptly.

Q. How must the State proceed to consider all possible avenues of eligibility before terminating (or denying) eligibility?

A. The systems and processes used by the State must first consider whether the individual continues to be eligible under the current category of eligibility and, if not, explore eligibility under other possible categories. The extent to which and manner in which other possible categories must be explored will depend on the circumstances of the case and the information available to the State.

For example, if the State has information in its Medicaid files (or other available program files) suggesting an individual is no longer eligible under the poverty-level category but potentially may

be eligible on some other basis (e.g., under the disability or pregnancy category), the State should consider eligibility under that category on an ex parte basis. If the ex parte review does not suggest eligibility under another category, the State must provide the individual a reasonable opportunity to provide information to establish continued eligibility. As part of this process, the State will need to explain the potential bases for Medicaid eligibility (such as disability or pregnancy).

Q. If a State has determined that an individual is no longer eligible under the original category of coverage, does the State have the option to terminate coverage and advise the individual that he or she may be eligible under other categories and could reapply for Medicaid?

A. No. States must affirmatively explore all categories of eligibility before it acts to terminate Medicaid coverage.

Q. Does this requirement to explore all categories of coverage apply to Transitional Medical Assistance? When the TMA period is over, can the State terminate coverage and advise the family to reapply for Medicaid?

A. No. TMA is like any other Medicaid eligibility category. Eligibility under other categories of coverage must be explored before coverage is terminated. In light of expansions in coverage, particularly for children, many children in families receiving TMA will continue to be eligible under other eligibility categories.

Computer Systems

Q. My State's computer system may be erroneously terminating Medicaid coverage when families leave cash assistance. Because of Y2K, programming on a number of priorities has been backed up. The delinking reprogramming is scheduled to take place this fall. Is this an acceptable corrective action?

A. No. HCFA recognizes that Y2K delayed other priorities, and we know that it takes time to make computer changes. However, States have an obligation to move expeditiously to correct computer programming problems that are leading to erroneous Medicaid denials and terminations. HCFA will be working with States to correct computer problems and will provide whatever assistance we can to help resolve the problem.

In the meantime, no person should be denied Medicaid inappropriately due to computer error, and no person should have his/her Medicaid coverage terminated erroneously due to computer error. Once a problem with a State's computerized eligibility system has been identified, the State must take immediate action to correct the problem. If programming changes cannot be made immediately, an interim system to override computer errors must be put in place to ensure that eligible individuals are not denied or losing Medicaid.

HCFA will review State procedures and State plans to adopt new procedures as follow-up

to the Medicaid/TANF State reviews.

Q. Have other States experienced these problems? How have they corrected the problems?

A. Each State's issues and processes are unique. The measures that will be effective to remedy computer-based problems will vary from State to State. There are a number of ways States can address these issues:

> **Correct the Computer Error -**The most direct way to remedy the problem is by making the necessary changes to the computer system. This should occur expeditiously.

Implement an Effective Back-Up System to Prevent Erroneous Actions-While corrections to the computer system are being made, States must ensure that erroneous actions do not occur. States that have identified computer-based problems in their systems have adopted different approaches; four different approaches are described below. In each case, the State adopted a formal and systematic approach to correcting computer-based errors. A simple instruction to workers to override or work around computer errors is insufficient to ensure that erroneous denials and terminations will not occur.

Supervisory review -To stop erroneous terminations from occurring due to Medicaid/TANF delinking problems, Pennsylvania required supervisors to review all TANF case closures before any Medicaid termination could proceed. Having trained supervisors review terminations (and denials) can prevent wrongful terminations (and denials) from occurring.

Centralized review -Maryland instituted a system in which local supervisors and a State-level task force review all Medicaid denials and terminations that coincide with a TANF denial or termination. This system has been instrumental in ensuring that thousands of eligible families were not denied or terminated from Medicaid while computer fixes were finalized.

"Peremptory" reinstatement -The State of Washington devised a system in which cases to be terminated were given a next-day audit by caseworkers and managers. Cases that continue to be eligible for Medicaid are ‘reinstated' before the case is scheduled to be closed.

Interim hold on case actions -A short-term moratorium on Medicaid case closings based on certain computer codes pending implementation of other solutions might be an option for some States. Medicaid case closings could be held as long as Federal requirements on the frequency of redeterminations are met. **Q. Are there any actions that States must take before they alter their computer systems?**

A. Yes. In general, prior authorization from HCFA must be obtained in order for a State to

receive federal matching funds for changes it makes to its computer systems. HCFA will work with States and provide technical assistance as early in the planning process as possible in an effort to help States accomplish their objective.

Q. Is there additional funding available to help with the changes in the computer system?

A. Yes. Per our letter of January 6, 2000 concerning the $500 million federal fund established in 1996,

there is federal funding available for computer modifications related to delinking. We encourage you to review that letter and the amount your State has available from the enhanced matching funds to make changes needed as a result of the enactment of Section 1931 (the delinking provision). MMIS enhanced funding may also be available for some MMIS changes; please consult with your regional office.

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