DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

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SMD #09-002
ARRA #1

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5. Section 5004 of the ARRA extends Transitional Medical Assistance (TMA) through December 31, 2010, and provides States with options to modify TMA eligibility requirements. The amendments made by this section take effect on July 1, 2009. This letter provides a brief overview of the TMA program prior to the passage of the ARRA and guidance on the changes made by the ARRA. Additionally, a State plan preprint is enclosed with this letter to assist you in submitting an amendment.

Background

Under section 1902(e)(1)(A) of the Social Security Act (the Act), States are permanently required to provide 4 months of TMA for families who lose Medicaid eligibility due to an increase in earned income or hours of employment. In the Family Support Act of 1988 (FSA), Public Law 100-485, Congress expanded TMA under section 1925 of the Act, requiring States to provide coverage for at least 6, and up to 12, months for families who no longer qualify for Medicaid, and authorizing a "wrap-around" option for payment of employment-related health coverage costs. At that time, Medicaid eligibility for these families was still tied to eligibility for cash assistance under title IV-A of the Act. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, in de-linking Medicaid from cash assistance, established a new mandatory Medicaid eligibility group of low-income families with children under section 1931 of the Act. The requirements of section 1925 then became applicable to families covered under section 1931. While the FSA expansion of TMA was effective only through fiscal year 1998, Congress passed a series of extensions, the most recent of which, prior to the ARRA, provided funding through June 30, 2009. The ARRA amended sections 1902(e)(1)(B) and 1925(f) of the Act to extend and further expand TMA through December 31, 2010.

Section 1925 of the Act requires States to provide Medicaid coverage for low-income families who no longer qualify under section 1931 of the Act due to increased earned income or working hours from the caretaker relative's employment, or due to the loss of a time-limited earned income disregard. In order for Medicaid-eligibility to be extended through TMA, families must have been Medicaid eligible under section 1931 during at least 3 of the 6 months immediately

preceding the month in which the family became ineligible under section 1931. This may include months of retroactive eligibility.

Through TMA, families' Medicaid eligibility is extended for an initial 6-month period. In order for TMA eligibility to continue into a second 6-month extension period, the family must:

- Have been covered under TMA during the entire 6-month initial period; and
- Submit a report, by the twenty-first day in the fourth month of the initial period, on the family's gross monthly earnings and any costs for child care necessary for the caretaker relative's employment in each of the 3 preceding months.

In order for a family to remain covered throughout the second 6-month extension period, the following requirements must be met:

- The family must submit, by the twenty-first day in the first and fourth months of the second 6-month period, two additional reports on the family's gross monthly earnings and any costs for child care necessary for the caretaker relative's employment in each of the 3 preceding months.
- The family's TMA coverage is terminated at the end of the first or fourth month of the second 6-month period (with at least 10-days advance written notice) if:
    - The family fails to submit the required report by the due date, without good cause;
    - The caretaker relative had no earnings in one or more of the previous 3 months, unless the lack of earnings was caused by an involuntary loss of employment, illness, or other good cause established to the State's satisfaction; or
    - The family's average gross monthly earnings (less the costs of child care necessary for the caretaker relative's employment) during the previous 3 months exceed 185 percent of the Federal poverty level (FPL) for the family size.
- The family's TMA coverage is also terminated with a 10-day advance notice during the second 6-month extension period if the family:
    - No longer includes a child living in the home; or
    - Fails to pay any premium, except for good cause.

<u>New State Option of 12-Month Initial Period for TMA Eligibility</u>

The ARRA amends section 1925(a)(1) of the Act to provide States the option to extend families' Medicaid eligibility under TMA for an initial period of 12 months, rather than an initial period of 6 months followed by a second 6-month period. If a State amends its Medicaid State plan to select the option for a single 12-month TMA period, the reporting, income, and technical eligibility requirements specified in section 1925(b) of the Act will not be applied, and an additional 6-month extension will not be received when the single 12-month TMA period ends.

<u>New State Option to Revise Requirement for Previous Receipt of Medicaid</u>

The ARRA also amends section 1925(a)(1) of the Act to give States the option to waive the TMA eligibility requirement that families must have been covered by Medicaid under section 1931 during at least 3 of the 6 months immediately preceding the month in which the family became ineligible under section 1931. A State may submit a Medicaid State plan amendment to

cover families under TMA if they were Medicaid eligible under section 1931, or had applied and been determined eligible for such coverage, for fewer than 3 of the 6 previous months.

Collection and Reporting of Participation Information

Finally, the ARRA establishes a new section 1925(g) of the Act, which requires all States to collect and submit to the Department of Health and Human Services (HHS) and to make publicly available, information on the average monthly enrollment and average monthly participation rates for adults and children covered under TMA. States must also report the number and percentage of children who, after TMA eligibility ends, retain their Medicaid eligibility in another eligibility group or are enrolled in the Children's Health Insurance Program (CHIP) under title XXI. The HHS Secretary will specify the format, timing, and frequency for this reporting. HHS must submit an annual Report to Congress concerning these enrollment and participation rates.

Draft State Plan Template

Attached is a draft Medicaid State plan template that States may use for a State plan amendment to elect the option for a single 12-month period of TMA eligibility and/or the option for deleting the requirement for section 1931 eligibility in 3 of the 6 preceding months.

Contact Information

If you have questions regarding this guidance, please contact Ms. Dianne E. Heffron, Acting Director, Family and Children's Health Programs Group, who may be reached at (410) 786-5647.

Sincerely,

/s/

Jackie Garner
Acting Director
Center for Medicaid and State Operations

Enclosure:
Draft State plan template

cc:

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