Questions About the April 7, 2000 Letter to State Medicaid Directors

Set #1

This document responds to questions raised by States about our April 7, 2000 guidance regarding reinstatement, redeterminations, and computerized eligibility systems. This is part of ongoing guidance about the delinkage of Medicaid and cash assistance resulting from the passage and implementation of Federal welfare reform law. Past guidance is available on the Internet at http://www.hcfa.gov/medicaid/ wrefhmpg.htm or by calling Cheryl Camillo at (410) 786-1068. This list is not all-encompassing and will be updated as appropriate. The Health Care Financing Administration (HCFA) remains committed to providing timely responses to important issues and will issue additional guidance as it becomes available.

REINSTATEMENT

Question 1: Has HCFA already given specific instructions to States regarding the changes to cash assistance and Medicaid laws which required a significant retooling of Medicaid eligibility rules and procedures at the State and local level?

Answer 1: Yes. Since shortly after the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which ended the automatic link between eligibility for cash assistance for families with dependent children and eligibility for Medicaid, HCFA has issued a great deal of guidance regarding the delinkage and other welfare reforms that impact Medicaid. This guidance includes fact sheets, letters to State Medicaid Directors, updates to the State Medicaid Manual, and the publication of a 28-page, plain-English guide entitled, *"Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World."*

State Medicaid Director letters dated October 4, 1996, February 5, 1997, September 22, 1997, and August 17, 1998 dealt with the implementation of the Section 1931 category; letters dated February 6, 1997, April 22, 1997, and November 13, 1997 discussed redetermination procedures and the Section 4913 group; and eight additional letters covered immigration, outreach and enrollment, Medicaid Eligibility Quality Control (MEQC) errors, and the availability of the $500 million delinkage fund. These letters and the other instructions can be found under the heading "Welfare Reform and Medicaid" on HCFA's website at: http://www.hcfa.gov/medicaid/wrefhmpg.htm.

Question 2: What specifically does HCFA consider an improper termination from Medicaid?

Answer 2: Improper terminations will vary according to State circumstances, but usually result from improper or inadequate processes and systems. Examples include: the automatic termination of Medicaid coverage at the termination of Temporary Assistance for Needy Families (TANF) benefits, whether manually or by computer; the automatic termination of Medicaid coverage at the

end of the Transitional Medicaid (TMA) period without proper notice or a proper Medicaid redetermination; and termination of Medicaid coverage for children who became ineligible for Supplemental Security Income (SSI) due to the change in the definition of disability who did not receive a proper redetermination, including an ex parte review consistent with previous guidance.

Question 3: Please define "without a proper redetermination?"

Answer 3: To have conducted a proper Medicaid redetermination, a State must have conducted a redetermination in accordance with HCFA's February 6, 1997 and April 22, 1997 guidance. A key point of this guidance is that States must perform an ex parte review as the first step of the redetermination process.

Question 4: Does HCFA consider an "ex parte review consistent with previous guidance" insufficient?

Answer 4: For the purposes of identifying improper terminations, an ex parte review conducted consistent with the previous guidance issued in 1997 satisfies the ex parte review requirements of a redetermination. State Medicaid Directors letters dated February 6, 1997 and April 22, 1997 instructed States to conduct ex parte reviews "based to the maximum extent possible on information contained in the individual's Medicaid file, including information available through the SDX or BENDEX that the State believes to be accurate."

The April 7 letter restates and clarifies the earlier guidance by providing more detailed guidelines for ex parte reviews. States must make reasonable efforts to obtain relevant information from program records they can readily access like Food Stamps and TANF records, wage and payment information, State child care or child support files, and information from the Social Security Administration (SSA) through the SDX (State Data Exchange) or BENDEX (Beneficiary and Earnings Data Exchange) systems. They must also consider records of immediate family members. They may accept the determinations of other programs about particular eligibility requirements and decide eligibility in the light of all relevant eligibility requirements.

States should rely upon the most recent guidance when performing future redeterminations, including those of individuals reinstated to Medicaid due to this guidance.

Question 5: Did a State act properly if it terminated a recipient who failed to respond to an

information request?

Answer 5: Assuming that the request for information was identified as needed to assess Medicaid eligibility, the State acted properly if it conducted an ex parte review, took reasonable steps to contact the beneficiary, considered all possible avenues of eligibility in accordance with HCFA's 1997 guidance, and provided a proper notice of termination. The termination would not be considered improper if the State took these steps and the individual failed to respond.

Question 6: If, in the conduct of an ex parte review, States did not obtain information from family records or other program files, was a subsequent termination improper?

Answer 6: Not necessarily. For the purposes of identifying improper terminations, ex parte reviews conducted consistent with the February 6, 1997 and April 21, 1997 guidance are considered sufficient. If a State relied to the maximum extent possible on information in an individual's Medicaid file, including information available through SDX or BENDEX that it considered accurate, and, consistent with the guidance, took reasonable steps to contact the individual for information, then the subsequent termination was proper.

In performing future ex parte reviews, States must obtain relevant information from family records and program records they can readily access, such as Food Stamps and child support files.

Question 7: Will the Social Security Administration (SSA) be able to provide States with an all-inclusive list of every child that has lost SSI because of the change in the definition of disability (Section 4913 children)?

Answer 7: Yes. On April 14, the SSA sent States a sixth, updated listing of Section 4913 children residing in that particular State at the time their SSI case was closed. States must compare this list against their files to determine which, if any, children are not currently receiving Medicaid or are receiving Medicaid but are not identified as a Section 4913 child. On April 19, the SSA sent States a national file of all Section 4913 children. States can search this file to identify children who may have lost benefits while residing in another State. HCFA is coordinating with SSA and can help any States needing assistance with these files.

Question 8: Has any thought been given to having SSA retain responsibility for the Section 4913 children?

Answer 8: Once a Section 4913 child loses SSI, SSA closes the case and ceases contact with the individual. As with other SSI terminations, the case may then become a Medicaid-only case for which States have traditionally assumed administrative responsibility. If SSA retained responsibility, it would create a new coordination process (between States and SSA) which would further complicate Medicaid administration.

Question 9: How should States handle Section 4913 children who require reinstatement but who have already "aged out"?

Answer 9: States must reinstate Medicaid for Section 4913 children who have already "aged out" and redetermine their eligibility for Medicaid. These individuals may be eligible for ongoing Medicaid coverage under other eligibility categories. States have the option to provide payment to them and to providers for the cost of services covered under the State's Medicaid plan provided between the time the they were terminated from Medicaid and the time they were reinstated, but States can elect to limit payments to services provided between the time they were terminated and

the time they aged out.

Question 10: What are the exact Federal requirements which compel reinstatement?

Answer 10: Under Federal regulations at 42 CFR 435.930, States have a continuing obligation to provide Medicaid to all persons who have not been properly determined ineligible for Medicaid. Where individuals have not been properly determined ineligible, they continue to be eligible for Medicaid; reinstatement is compelled as part of the State's continuing obligation to provide Medicaid.

Question 11: In lieu of reviewing several thousand old cases in order to reinstate individuals and families for 120 days, can States air commercials, post posters, and conduct other public outreach activities in order to find individuals and families who were improperly terminated?

Answer 11: No. While it is important for States to conduct outreach activities aimed at informing families that they do not have to be receiving welfare to qualify for Medicaid and to more generally inform families about health care coverage available through Medicaid and the State Children's Health Insurance Program (SCHIP), such activities cannot substitute for specific actions designed to identify those who were improperly terminated. Because it may not always be clear or easy for States to review thousands of cases to determine whether a particular individual was terminated properly, States that determine that problems in policy or practice very likely caused individuals to lose Medicaid improperly may reinstate coverage without making a specific finding that an individual termination was in fact proper. For example, States with computer systems that automatically terminate TMA with a particular closing code at the end of the twelfth month may reinstate coverage for all of those who were terminated under that code since the implementation of welfare reform, even though some of those individuals may have been determined ineligible for Medicaid if a redetermination had been carried out at the time of the TMA termination.

HCFA will provide technical assistance to any State experiencing difficulties in identifying and reinstating individuals and families.

REDETERMINATIONS

Question 12: When should a State rely on information available through other program records?

Answer 12: 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.

Question 13: 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?

Answer 13: 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.

Question 14: When can the State schedule the next Medicaid redetermination if it relies on information from another program for its ex parte review?

Answer 14: 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).

Question 15: When can Medicaid accept another program's eligibility requirement determination?

Answer 15: 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.

Question 16: When an individual reports a change in circumstances before the next regularly scheduled redetermination, must the State conduct a full redetermination at that time?

Answer 16: 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.

Question 17: How must the State proceed to consider all possible avenues of eligibility before terminating (or denying) eligibility?

Answer 17: 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).

Question 18: 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?

Answer 18: No. States must affirmatively explore all categories of eligibility before it acts to terminate Medicaid coverage.

Question 19: 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?

Answer 19: 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

Question 20: 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?

Answer 20: 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.

Question 21: Have other States experienced these problems? How have they corrected the problems?

Answer 21: 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.

Question 22: Are there any actions that States must take before they alter their computer systems?

Answer 22: 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.

Question 23: Is there additional funding available to help with the changes in the computer system?

Answer 23: 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). Medicaid Management Information System (MMIS) enhanced funding may also be available for some MMIS changes; please consult with your regional office.

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