CENTER ON BUDGET AND POLICY PRIORITIES

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Issues for Consideration As States Reinstate Families That Were Improperly Terminated from Medicaid Under Welfare Reform

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On April 7, 2000, the Health Care Financing Administration issued a letter to State Medicaid Directors expressing concerns that families have lost Medicaid coverage when they stopped receiving benefits under the state's Temporary Assistance for Needy Families program.[1] The letter notes that states have expanded eligibility for and simplified access to Medicaid for low-income working families in many respects, but at the same time many families may have improperly lost access to Medicaid when leaving welfare. Building upon federal and state efforts to improve the ability of eligible, low-income families that left TANF to enroll and remain enrolled in Medicaid, the HCFA letter specifically addressed three topics related to families improperly losing Medicaid coverage under welfare reform.

- The letter requires states to identify and reinstate families that, since the inception of the state's TANF program, had Medicaid benefits improperly terminated when their TANF case was closed or when Transitional Medical Assistance ended. States must then review the reinstated families for ongoing Medicaid eligibility prior to stopping the reinstated benefits.[2]

- The letter clarifies longstanding federal requirements that states must review ongoing Medicaid eligibility on an *ex parte* basis — that is, whenever possible, without contacting the recipient — prior to stopping Medicaid, and addresses the circumstances under which a state can ask a family to provide additional information.

- The letter also addresses state obligations to ensure that state computer systems are not improperly denying or terminating persons from Medicaid.

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[1] The HCFA letter is available at http://hcfa.hhs.gov/medicaid/smd40700.htm. HCFA subsequently has posted additional questions and answers on the April 7 letter on its website at http://hcfa.hhs.gov/medicaid/q&a40700.htm.

[2] The letter also requires states to identify and reinstate any children who lost eligibility for SSI due to the 1996 law change in the SSI disability standards and who were terminated from Medicaid when they lost SSI either without adequate consideration of their potential Medicaid eligibility under Section 4913 of the Balanced Budget Act (which provided a basis for ongoing Medicaid eligibility) or without a proper redetermination. The HCFA letter directs states to compare the Social Security Administration list with their current Medicaid rolls and reinstate any children not properly terminated or, if receiving Medicaid, not properly identified as a 4913 child. This memorandum focuses on the reinstatements arising from TANF-related Medicaid terminations, which present a different set of issues than the reinstatements of children who lost SSI.

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This memorandum discusses some of the issues that state Medicaid agencies and non-profit organizations are likely to consider as states act in accordance with the HCFA directive to reinstate families that lost Medicaid improperly. It also draws upon some of the experiences of the three states that have already taken steps to reinstate large numbers of families that experienced TANF-related loss of Medicaid benefits.[3]

1. What steps must each state take?

The April 7 letter requires states to examine their enrollment policies and practices and to identify and reinstate those families that have improperly lost Medicaid. Specifically, if it appears there have been improper terminations, states must develop a timetable for reinstating coverage and conducting follow-up eligibility reviews. While HCFA does not set any specific deadlines or require a uniform reporting document, it does indicate that states should act to reinstate coverage as quickly as possible and should keep their HCFA regional office informed.

2. What if a state determines that there have been no improper terminations?

If, after a statewide review of Medicaid policies and practices, a state determines that there have been no instances of improper terminations, the state is expected to inform the HCFA regional office of the review undertaken and the basis for its conclusions. Client, community, or other non-profit groups may wish to obtain and review any such written communications, as well as any other agency memoranda or analyses of the issue. In most cases, any such written documents should be available to the public.

Client, community, or other non-profit groups may wish to communicate with the state agency as it is undertakes its review and share additional information for the agency to consider. For example, non-profit groups could provide the state agency with an analysis of agency procedures or policies, including a review of manuals and training materials, that may have resulted in improper terminations. In addition, evidence regarding whether eligible families may have lost Medicaid improperly may be available through analyses of state Medicaid caseload trends or through studies of families that have left welfare ("leaver studies") that indicate the extent of Medicaid receipt by such families.[4] Additional information may be available through some providers, particularly health clinics or public hospitals, who may be seeing significant numbers of uninsured low-income families that may have lost Medicaid improperly. All of this information could be shared with a state as it conducts its review and raised with the HCFA regional office in the event of a state determination that there have been no improper terminations.

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[3] Pennsylvania, Maryland and Washington state each have reinstated thousands of families that lost Medicaid when they left TANF.

[4] For discussion of the evidence from state "leaver studies" on the decline in Medicaid receipt among families leaving welfare, see Jocelyn Guyer, *Health Care After Welfare: An Update of Findings from State-level Leaver Studies*, Center on Budget and Policy Priorities, June 2000 (forthcoming).

Pennsylvania's Medicaid Reinstatement

In July 1999, Pennsylvania automatically reinstated approximately 32,000 individuals (24,000 children and 8,000 adults) who lost Medicaid when they left TANF cash assistance between July 1, 1997 and September 30, 1998. Families were reinstated for a 60-day period during which their eligibility for ongoing benefits was reviewed. Those reinstated families for which the welfare agency had wage information at the time of the TANF closing (which included approximately 4,700 parents and children) were automatically extended for an additional four months, for a total reinstatement period of six months.

The July 1999 automatic reinstatement was in addition to an earlier effort by the state to re-enroll families that had lost Medicaid when they lost TANF. This earlier effort, which involved mailing a simplified re-enrollment form to the household, required the family to request reinstatement and provide verification of income. Several thousand families were re-enrolled under the earlier effort, approximately half of the families that responded.

Medical services received during reinstatement were paid on a fee-for-service basis. Twelve percent of those who were reinstated in July 1999 — 3,802 individuals — used fee-for-service Medicaid benefits during the 60-day reinstatement period.

Over 5,000 of the individuals reinstated in July 1999 continued receiving Medicaid beyond their reinstatement period; this is about 16 percent of those reinstated. The state attempted to determine ongoing eligibility on an *ex parte* basis. If information in the food stamp file established Medicaid eligibility, the state automatically continued Medicaid, scheduling the next review in 12 months. For those families that had 60-day reinstatement periods and for which the agency did not have current income information, the state agency required verification of current wage data to establish ongoing eligibility. For some families, this verification requirement may have served as a barrier to receiving ongoing Medicaid.

Pennsylvania provided reimbursement for past medical bills incurred during the period since July 1, 1997 if it was determined that benefits had been terminated in error.

During the reinstatement period, the state established a toll-free information line, dedicated trained staff to respond to calls generated by the help line, and spent approximately $300,000 on public service announcements. In addition, an independent enrollment counselor made follow-up calls to some reinstated families that did not provide current information in a further attempt to establish the families' ongoing eligibility for Medicaid.

3. Does the state have to identify improper terminations on a case-by-case basis, or may a state reinstate categories of families when policy or practice problems led to improper terminations?

The HCFA letter allows states to reinstate coverage without making a specific finding for each case that an individual termination was in fact improper. Instead, states can determine that problems in policy or practice caused individuals to lose Medicaid improperly. Reinstating classes of persons terminated improperly will generally be more feasible administratively than

making extensive individualized determinations of whether the Medicaid termination was improper. Such individualized determinations, as HCFA acknowledges, may not be clear or easy.

The three states that have already taken action to reinstate families that improperly lost Medicaid due to loss of TANF — Maryland, Pennsylvania, and Washington — each reinstated thousands of families without first making an individual finding of improper termination. Instead, these states took the reinstatement action upon determining that problems in policy or practice may have lead to improper terminations. In these three states, nearly all families that lost TANF and Medicaid during a certain time period were reinstated automatically. Several categories of families were not reinstated because the computer closing code indicated that the termination was not improper (for example, because the family moved out of state).

The costs of reinstating a large number of families may not be as high as states initially project because only a small fraction of reinstated families are likely to use Medicaid during reinstatement. (See discussion under Question 9 below.) In fact, the more significant cost may be the administrative cost of reviewing ongoing eligibility of reinstated families. Reviewing the current circumstances of these families for ongoing eligibility, however, is likely to be easier than reviewing a past case closure to determine if the family was improperly terminated. Moreover, it is a better use of resources. Focusing administrative resources on enrolling eligible families that have left welfare would provide an important support to the families and could bolster state welfare reform efforts.

4. How can states identify problems in policy or practice that caused improper terminations?

Prior to terminating Medicaid, states are required to review each case and consider whether each family member could continue to be eligible for Medicaid, either in the same coverage category or in another one. If a state's procedures or computer system did not provide such a review, many or most Medicaid terminations may have been improper. Even if a state's policies were not improper, actual practice — such as complicated actions that caseworkers must take in some cases to override automatic termination by the computer — may have resulted in improper terminations in a significant percentage of cases. A termination without a review for ongoing Medicaid eligibility is improper even if the individual would not have been found eligible if such a review had been made.

HCFA stresses that such reviews for ongoing Medicaid eligibility must be conducted without the involvement of the recipient if possible. This is known as an *ex parte* review. (*Ex parte* is a legal term that means "on one side only.") The April 7 HCFA letter specifies that a Medicaid termination would be improper if it did not include an *ex parte* review consistent with prior HCFA guidance. The previous HCFA guidance required that the review be based to the

Washington State's Family Medical Project

Washington state is currently in the midst of a project to reinstate Medicaid coverage for a 90-day period for families that lost Medicaid benefits when their TANF cash grant was terminated between August 1, 1997 and August 31, 1999. (The state changed its procedures as of August 1999, so that families leaving TANF would no longer lose Medicaid improperly.) The state identified 42,732 such families and sent them two mailings in February and April 2000 informing them about the upcoming reinstatement and seeking address confirmation.

The state automatically reinstated 29,610 families for the 90-day period starting May 2000. (Families for which the earlier mailings were returned without a forwarding address and no current address was available were not mailed a reinstatement packet in May.) The state will continue to reinstate any additional families that are identified or located through September 2000, with the last 90-day reinstatement period being October through December 2000. Medical services received during reinstatement will be paid on a fee-for-service basis.

The state will review all reinstated families for ongoing Medicaid eligibility. Reinstated families are being asked to return a short reapplication form. As of May 19, 2000, six percent of reinstated households had returned the form indicating a desire to continue Medicaid. The state plans to send a reminder letter in mid-June. In addition, the state will check its food stamp files for any information that establishes ongoing eligibility. If the state has information establishing eligibility in its files, it will continue Medicaid beyond the period of reinstatement even if the family does not send in the reapplication form. When the state reviews for ongoing Medicaid eligibility, it will provide Transitional Medical Assistance benefits on a prospective basis to families that do not qualify for ongoing Medicaid under section 1931 because of earnings.

Washington state also is providing reimbursement for past paid and unpaid medical bills incurred during the period since a family lost TANF and Medicaid benefits unless it is clear the family was correctly terminated from Medicaid. The state will reimburse families directly for bills the family has paid and will pay providers for unpaid bills.

The reinstatement process includes a toll-free information number and an outreach campaign with a flyer in English and seven additional languages. Additional information, including copies of letters and flyers provided to families and the memoranda provided to staff, are available at the project's website at http://maa.dshs.wa.gov/FamilyMedical/Index.html.

maximum extent possible on information contained in the individual's Medicaid file including information available through Social Security that the State believes is accurate.[5]

[5] The previous HCFA guidance on *ex parte* redeterminations was articulated in two HCFA State Medicaid Director letters dated February 2, 1997 and April 22, 1997 addressing this issue primarily in the context of reviewing the Medicaid eligibility of individuals losing SSI benefits. The previous guidance, therefore, gives specific examples of Social Security Administration files as sources of information the state should check as part of an *ex parte* review. The letters can be found at http://www.hcfa.gov/Medicaid/wrdl2697.htm and http://www.hcfa.gov/medicaid/wrdl422.htm.

If the state is unable to establish ongoing eligibility solely on an *ex parte* basis, the state should contact the recipient or take other reasonable steps to obtain the information it needs. The state must then give the recipient an opportunity to provide any additional information needed to establish eligibility prior to termination. To the extent that a state's redetermination procedures did not fully incorporate the *ex parte* requirements of the prior HCFA guidance, it would appear that the state has improperly terminated classes of families.

In addition, if a state did not promptly de-link TANF and Medicaid as required by the federal welfare law, Medicaid terminations generally would be improper. The federal welfare law created a new family coverage category in Medicaid — under section 1931 of the Social Security Act — that extended Medicaid to families even if they were not receiving cash TANF benefits. If a state did not have a Medicaid coverage category for low-income families not receiving cash TANF benefits, it could not properly consider whether a family no longer on TANF was eligible for ongoing Medicaid. Because the state could not have properly considered *all* bases of Medicaid eligibility, the Medicaid terminations were likely improper.[6] Moreover, even after a state technically established a coverage category under section 1931, it may not have fully incorporated that category into practice until some later date.

5. How far back does a state have to look for improper Medicaid terminations?

For TANF-related Medicaid terminations, a state should review its policies and procedures for a time period that starts with the date that the state's TANF plan went into effect and should continue forward until the present. Under the federal welfare law, the requirements of section 1931 on the de-linking of TANF and Medicaid became effective on the date that a state's TANF plan became effective. About half of the states technically started their TANF plans in 1996 by filing a state plan with HHS.[7] Many of these states, however, later made substantial changes in their TANF programs through 1997 state legislation and often regard the state's program as having a later start date. The review for improper Medicaid terminations should consider, however, terminations since the effective date of the state's TANF *plan*, which is the date that the state should have started a coverage category under section 1931.

The review period should extend until the present. Some states may have already addressed one or more of the reasons that a category of terminations was improper, such as the lack of a section 1931 coverage category or a computer's failure to consider eligibility under all bases. In such situations, it is still appropriate to review policies and practices after a systematic

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[6] In some circumstances, a state's failure to promptly establish a coverage category under section 1931 would not always lead to improper terminations. A state that did not establish a coverage category under 1931 may have avoided improperly terminating families if it had a family-based medically needy category that covered all persons who would have qualified under section 1931 *and* if the state considered all families losing TANF for ongoing eligibility under such category. In such states, however, families may have improperly lost access to Transitional Medical Assistance because of the state's failure to establish a coverage category under section 1931.

[7] The effective date of each state's TANF plan is posted at: http://www.acf.dhhs.gov/news/welfare/stplans.htm.

problem was fixed to ensure that the change effectively stopped improper terminations. Often there is a transition period as caseworkers receive training until agency practice conforms to changes in procedure. After such a review, a state might conclude that broad groups of families were improperly terminated before — but not after — the correction was made and thus only reinstate the groups of families that lost Medicaid prior to the state's correction of the problem.

6. What do families have to do to be reinstated?

The burden is on the state to review and identify families (or classes of families) that have been improperly terminated and automatically to reinstate all such families that are identified. The rationale is that these families should still be receiving Medicaid since they were terminated improperly. A state cannot require that the family first establish current eligibility to be reinstated. Instead, benefits should be automatically restored until the state conducts a proper review for ongoing eligibility. States cannot require that a family request reinstatement or otherwise prove improper termination. While a state should certainly review any case in which a family claims improper termination and seeks reinstatement, this would not be sufficient compliance with the HCFA directive.

The state generally should reinstate the identified families (or classes of families) automatically into the category of Medicaid that they were receiving when terminated improperly. In most cases, families were receiving, and will be reinstated into, Medicaid under section 1931, which covers families that receive cash TANF benefits and low-income families that do not receive cash TANF benefits.

7. How will states notify families subject to reinstatement?

While states must automatically reinstate any families (or classes of families) improperly terminated, it is still very important that a state be able to contact the family to inform it about the reinstatement and, if necessary, to ask for any additional information to make a redetermination. States may not have current addresses for many families, as some may have lost Medicaid over three years ago and low-income families tend to move more frequently than the general population. Those states that have mailed notices of reinstatement to families that lost Medicaid under TANF have experienced a significant percentage of returned mail. For example, in Washington State, more than one-fourth of the notices sent to families subject to reinstatement were returned as undeliverable with no forwarding address. Therefore, states will need to make additional efforts to contact reinstated families.

The April 7 HCFA letter instructs states to take all reasonable steps to identify current addresses, such as checking food stamp records or alerting caseworkers to the list of affected individuals in the event the families contact the agency for other reasons. A state may also find current addresses through its own Medicaid files as a child may have been re-enrolled in a poverty-level category for children through an outreach campaign when instead the entire family could qualify for Medicaid under section 1931 through reinstatement.

While a state should implement reinstatement promptly, it could consider sending a first mailing before the actual reinstatement mailing to alert the family to the importance of the upcoming mail, just as the Census Bureau recently alerted households to upcoming census forms. Maryland, Washington and Pennsylvania all used such pre-reinstatement mailings as part of their reinstatement plans. States also can use such a first mailing to identify current addresses for as many of the reinstated families as possible. For example, Washington State asked families to provide a current address but automatically reinstated families even if the address was not provided *unless* the mailing was returned with no forwarding address. Washington State also used a postal endorsement to notify the sender of any forwarding address on its pre-reinstatement mailings and has a process for identifying bad addresses and entering the forwarding addresses.

States can take additional steps to follow up with families that have been reinstated and do not provide needed information. For example, in Pennsylvania, the state contracted with a telephone counseling service to conduct follow-up calls to families that had not returned paperwork necessary to continue their benefits beyond an initial period of reinstatement.

8. What is the role of outreach and media campaigns?

To ensure that families know they have been reinstated and that the families follow up, if needed, to establish ongoing Medicaid eligibility, states should consider using media and outreach campaigns as part of the reinstatement process. The HCFA letter specifically mentions use of media or providing notices to families that receive other services, such as child care. States may also be able to reach families through WIC clinics, local health clinics, housing agencies and other service providers. For example, the National Association of Community Health Centers has urged all health centers to offer their assistance to states and to become involved helping to identify current and former patients who lost Medicaid improperly and to assist them to regain coverage.

An outreach campaign around reinstatement may have an additional benefit of increasing enrollment in Medicaid among eligible families that, although not improperly terminated, become enrolled in response to the campaign. Washington State, for example, is coordinating its reinstatement project with a marketing and outreach campaign. The state recently mailed outreach packets to over 600 individuals and organizations.

A media campaign provides a state with broad public exposure, can assist states in locating families, and can remind families to act on any requests for information needed to establish ongoing eligibility. A family that lost Medicaid can contact a toll-free number in response to a television spot and can provide the state with its current address and quickly learn whether it has been reinstated. In Pennsylvania, the media campaign is credited with playing a key role in increasing the number of families that provided information in response to reinstatement.

9. How to estimate the costs of reinstatement?

Reinstatement of broad classes of families may be less expensive than states anticipate for several reasons. As discussed above, some families may not use any medical services because, although they are automatically reinstated by the state, they may not be aware of it (because the state is unable to contact them). In any given time period, such as 60 days, a family may not have any current medical needs. For example, in Pennsylvania, only about 12 percent of reinstated families actually used Medicaid during the 60-day period the state chose for reinstatement. (Medicaid usage during the period of reinstatement is not yet available for Maryland which reinstated families in November and December 1999, or Washington State, which is starting reinstatement in May 2000.) In addition, not all families will continue to receive Medicaid beyond the initial reinstatement period. Only 16 percent of the families reinstated in Pennsylvania received ongoing Medicaid after redetermination of ongoing eligibility.

A fee-for-service approach may be the most cost-effective and reasonable way for a state to pay for medical costs during a temporary period of reinstatement even if the state generally uses a managed care system with capitated rates for Medicaid payment. It may not be prudent for a state to pay a full capitated rate if a portion of the reinstated population is not aware of the coverage and therefore will not use the benefits. The three states that have already implemented such reinstatements have all taken the fee-for-service approach.

10. What happens after a family is reinstated?

The state cannot stop Medicaid to reinstated individuals without first making an *ex parte* redetermination of the eligibility of each individual for ongoing Medicaid eligibility under any coverage category. In most situations, a state will want to conduct such reviews during the reinstatement period. HCFA will provide Federal Financial Participation for up to 120 days without a review; after that time a state will generally only receive federal match for families that have been redetermined as eligible for ongoing Medicaid. There is one group of families, however, that need not be reviewed during the reinstatement period. For those families that lost Medicaid recently and are still within 12 months of their last Medicaid review, a state can wait to review eligibility for up to 12 months from the last review.[8]

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[8] The April 7 HCFA letter allows a state to continue to provide Medicaid beyond 120 days without a redetermination to families that are, at the time of reinstatement, within 12 continuous months of their most recent Medicaid redetermination. In such cases, the state may continue Medicaid until the regularly scheduled redetermination. For example, if a family had a Medicaid redetermination in November 1999 and subsequently improperly lost Medicaid benefits in February 2000, the state may reinstate benefits and not make an *ex parte* Medicaid redetermination until November 2000. Even though the review is more than 120 days after reinstatement, a state can receive FFP for the continuing benefits in this example.

11. How should the state get information it needs to determine current eligibility?

The review for ongoing eligibility must be conducted on an *ex parte* basis, which means the state must first see if it already has information available to determine ongoing eligibility before asking the recipient to provide information. If the state does not have the information establishing ongoing eligibility, it must then give the recipient an opportunity to provide such information. A review process that automatically stops benefits to reinstated families unless they send back an application or a review form and does not check to see if the state has the information it needs would be improper. Instead, a state must continue Medicaid to any reinstated individual if the state has information that it believes to be accurate that establishes ongoing eligibility even if the individual never responds to any mailings concerning reinstatement.

In the April 7 letter, HCFA addresses efforts states should make to obtain information from Medicaid or other files without asking the recipient. HCFA notes that states generally have ready access to Food Stamp and TANF records, wage and payment information, information from the Social Security Administration through the SDX or BENDEX systems, and information from child care or child support files. HCFA also notes that information that the state has about the circumstances of one family member who is receiving a needs-based benefit may provide all of the necessary information to determine the ongoing eligibility of the rest of the immediate family. For example, a state may have information about family income for a child enrolled in the state's CHIP program or in a Medicaid poverty level category for children that can establish eligibility of the entire family for Medicaid under section 1931.

12. When should a state consider information from other programs to be accurate?

In an important new clarification, the April 7 letter addresses when a state should consider information from other programs to be accurate. Specifically, the HCFA letter indicates that a state should consider information that the state or federal government relies upon to provide benefits under other programs such as TANF, Food Stamps or SSI to be as accurate so long as the program requires regular redeterminations of eligibility and reporting of changes in circumstances. Moreover, as long as the information was obtained within the time period for Medicaid redeterminations, information from another program should be relied on for Medicaid *ex parte* reviews *even if* benefits are no longer being provided under the other program, *unless* the state has a reason to believe the information is no longer accurate.

The HCFA letter also clarifies that a state may also accept the eligibility determination of another program with respect to specific eligibility requirements as it makes its own eligibility determination for Medicaid. For example, if the state's TANF program uses a test for assets that is the same as or more restrictive than the one used in Medicaid, the state may accept the TANF program's determination that the family's assets fall below the Medicaid asset standard.

As states review reinstated families for ongoing Medicaid eligibility, they should follow procedures that comply with this new clarification. This clarification provides an opportunity for states to lift unnecessary administrative burdens from both caseworkers and low-income working families. Moreover, states also may need to redesign the *ex parte* review procedures they use for all Medicaid reviews, not just those of reinstated families.

13. For what categories of Medicaid must a state consider ongoing eligibility? What about Transitional Medical Assistance ?

Redeterminations should consider *all* bases of Medicaid eligibility for each individual in the family. There may some bases of eligibility that only certain individuals (such as children or persons with disabilities) can meet. If the state needs information to determine, for example, whether an individual might qualify for Medicaid on the basis of pregnancy or disability, it must request the information and allow an opportunity for the individual to provide it before making a determination of ineligibility. Considering all bases of Medicaid coverage also includes expansion categories that a state may have implemented pursuant to a section 1115 waiver. In some states, these types of medical coverage are often seen as separate from Medicaid and may have a separate application process. If such expansions are Medicaid-funded, however, they must be considered in any Medicaid redetermination.

The review should also consider the family's eligibility for Transitional Medical Assistance (TMA). A family that loses eligibility for Medicaid under section 1931 due to earnings qualifies for up to 12 months of TMA if the family has received Medicaid under section 1931 for three of the prior six months. For example, if the review indicates that an adult in a reinstated family is now working and has countable earnings that are above the section 1931 eligibility level, the family may qualify for TMA. One question that arises is how to count whether a reinstated family has received assistance for three of the last six months. If the family in this example has received Medicaid under section 1931 for a 90-day reinstatement period, the state may consider that the family has met the three-month requirement and thus qualifies for TMA.[9]

[9] HCFA has indicated that a state may consider three months of section 1931 coverage received through reinstatement as providing the three-month trigger for TMA eligibility, but has not yet indicated whether a state must do so. There also may be other approaches to the issue of how reinstated families can meet the "three of the prior six months" requirement so as to qualify for TMA. For example, a state might consider that, when a family was improperly terminated from Medicaid, months subsequent to termination and prior to reinstatement should count to qualify the family for TMA. A state wishing to take such an approach should consult with HCFA on this issue.

14. Under what circumstances can a state terminate Medicaid to a family that has been reinstated?

Under federal law, an individual receiving Medicaid must continue to receive benefits until there is a determination that the individual is not eligible. While states may view the reinstatement as a fixed period, the state cannot terminate any individual simply because the reinstatement period has expired. First, a state must complete an *ex parte* redetermination and provide an advance and adequate notice that there is no basis for ongoing Medicaid eligibility. If a state cannot determine that a family continues to be eligible, it can stop Medicaid. A state could do so, however, only after considering any information that state already has available and after requesting any additional information needed in a manner that gives the individual sufficient time to provide information prior to issuing a termination notice.

15. How long should reinstatement periods last?

HCFA has stated that Federal Financial Participation will be available for up to 120 days to allow adequate time to review ongoing eligibility. HCFA notes that the states that have reinstated families that were TANF-related Medicaid terminations have typically chosen a period of 60 or 90 days. Maryland and Pennsylvania generally reinstated families for 60 days although in Pennsylvania families that had earnings when they left TANF were reinstated for a total of six months. Washington state is reinstating families for 90 days. As discussed above, a state will need to conduct *ex parte* reviews for ongoing Medicaid prior to stopping reinstated benefits. A state should, therefore, choose a reinstatement period length that allows it to accomplish the required steps of such reviews, preferably at least 90 days. As discussed above, an additional benefit of a 90-day reinstatement period is that it can provide the "three of six month" trigger for Transitional Medical Assistance (TMA) eligibility for any family whose earnings place it above the income limits under section 1931.

16. Can a state cover medical services received by families prior to reinstatement?

Many families that have been improperly terminated from Medicaid have incurred medical expenses that otherwise would have been covered by Medicaid. The HCFA letter gives states the option to cover medical costs for this period and will provide Federal Financial Participation (FFP) to states that choose to do so. Maryland, Pennsylvania and Washington state have each provided (or will provide) such retroactive coverage.

States can receive federal match for both payment to providers and direct reimbursements to individuals for out-of-pocket costs they incurred. The FFP for direct payments to individuals will be based on the full payment amount while the FFP for payments to providers will be based on Medicaid rates.

States should consider that the back coverage group may include families that currently receive Medicaid and are therefore not subject to reinstatement. These are families presently

receiving Medicaid that had a gap in Medicaid coverage of several months, or even years, between an improper termination and a return to Medicaid that occurred before the state's reinstatement process. Washington state, for example, is providing retroactive coverage to current Medicaid recipients who have such gaps in coverage although the families are not part of the state's reinstatement process.

17. What steps can states take to provide Medicaid to applicants who may have been denied benefits improperly?

HCFA notes that in some states individuals applying for both Medicaid and TANF may have been denied Medicaid improperly because eligibility determinations continued to be linked. As these families were not recipients, they were not improperly terminated, and thus are not subject to the reinstatement directive of the letter. HCFA, however, encourages states to identify and enroll these applicants.

Typically, a family applying for cash welfare and Medicaid will complete a joint TANF/Medicaid application. A state cannot ignore the Medicaid portion of the application if TANF benefits are denied. There must be a separate determination that each individual in the family is not eligible for Medicaid on any basis. Nor can a state deny Medicaid automatically when it denies TANF and instead instruct the family to separately reapply for Medicaid under a different program or coverage category.

Presumably, states can identify families that were denied Medicaid (or denied TANF without a Medicaid determination). A state could do a broad outreach mailing to such families providing information about eligibility and encouraging them to apply prospectively. It could also enclose a simplified application form. To the extent that families were improperly discouraged from even filing an application, the state is not likely to have a record. Such discouraged families may be most helped by an outreach or marketing campaign.

18. What steps should states take to redesign their process for all Medicaid reviews?

Reinstatement provides an opportunity for families that lost Medicaid improperly to obtain such coverage during reinstatement, and more importantly, on an ongoing basis. Nonetheless, many reinstated families may not qualify for Medicaid beyond the reinstatement period either because they are no longer eligible or, more likely, because they fail to provide information that the state requests to make a redetermination.

Perhaps the most significant effect of the April 7 letter will be its impact on the steps states take to redesign their procedures for *ex parte* reviews for all Medicaid recipients so that states first check their files for information they already have and do not request information unnecessarily from families. Unnecessary requests for information might cause a parent to miss work to bring the information to the welfare agency by a deadline, or it might cause the family to lose Medicaid although they are eligible. If families are continued on Medicaid after leaving

TANF without requiring any action on the family's part, the numbers of families at risk of losing Medicaid for failing to provide paperwork or verification should diminish significantly.

It is thus important that states revisit their procedures for *ex parte* reviews in general and not just for the reviews a state will conduct for families that are reinstated under the April 7 letter. The prospective improvements to state Medicaid review procedures and computer systems are key to stopping future loss of Medicaid either due to improper termination or unnecessary procedural requirements.

19. Can states use the $500 million fund to for any of these actions?

The federal welfare law established a fund of $500 million to help states improve their Medicaid program enrollment and eligibility determination process in light of welfare reform. Each state is allotted an amount that is available to it from this fund. Many of the activities that a state will take in response to the April 7 HCFA letter on reinstatement may be paid for from this fund. For example, in a recent letter to state Medicaid directors, HCFA notes that this fund can be used for outreach activities including public service announcements, as well as for administrative costs of eligibility determinations or redeterminations to consider eligibility under section 1931.[10]

20. As states review Medicaid, should states consider checking for food stamp eligibility at the same time?

The contact that states will have with families as they reinstate and review Medicaid provides an excellent opportunity to reconnect these families to food stamps as well. Many families that have left welfare are not receiving Medicaid or food stamps although generally these families should qualify for such benefits. Food stamps are available to families with incomes below 130 percent of the federal poverty line, and studies indicate that most families that have left welfare, even if employed, have earnings below this food stamp income level. Loss of food stamps lowers a low-income family's total income and may make the transition from welfare to work more difficult. Due to the loss of food stamps, some families may experience greater food insecurity after working their way off of welfare than when they were on the welfare rolls. Providing continuing supports such as food stamps to working families that have left welfare may help to bolster state welfare reform efforts.

States may want to consider taking action in three areas. First, state efforts to contact families about reinstatement in Medicaid represents an important opportunity to conduct food

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[10] The January 6, 2000 letter from HCFA is posted at http://www.hcfa.gov/medicaid/wrefhmpg.htm. For additional discussion on the allowable uses of the $500 million fund and state allocations and balances, see Donna Cohen Ross and Jocelyn Guyer, *Congress Lifts the Sunset on the "$500 Million Fund:" Extends Opportunities for States to Ensure Parents and Children Do Not Lose Health Coverage*, Center on Budget and Policy Priorities, December 1999.

stamp outreach. Many low-income families no longer connected with the welfare system may not know they may be eligible for food stamps. When a state sends a notice to families regarding Medicaid reinstatement, it could include information about the food stamp program. Second, a review of a family's case with respect to improper Medicaid terminations also may indicate that the family's food stamp benefits were inappropriately terminated within the prior 12 months. In such circumstances, the state should contact the family about the possibility of restoring back food stamp benefits. Third, as a state analyzes its policies and practices to determine if it had a systemic problem with improper Medicaid terminations, a state can assess whether similar problems led to improper food stamp closures as well. Efforts states make to resolve these systemic administrative problems for Medicaid could benefit the food stamp program as well.