

# The Burden of Proof:

How Much is Too Much  
for Health Care Coverage?

Second Edition



covering kids  
& families

Southern Institute On Children and Families

October 2003

# **The Burden of Proof:**

## **How Much is Too Much for Health Care Coverage?**

**Second Edition**

Prepared For  
covering kids  
& families

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# INTRODUCTION

When families apply for Medicaid coverage for their children, they are advised of fraud penalties and must attest to their knowledge of the consequences of making untruthful statements when they sign the Medicaid application. Families generally are required by states to provide documentation to verify certain statements made on their application. Such documentation is called “verification.”

From the family’s perspective, this burden of proof can be problematic for many reasons. Obtaining required verification frequently involves third parties such as employers and noncustodial parents, who may not be cooperative. Complying with verification requirements can be particularly difficult for families with limited resources, especially those without transportation or child care. For parents who would lose wages if they take time off from work to collect the required documents, verification requirements present substantial application barriers. In addition to these practical concerns affecting access to coverage, a major problem is that the intrusive nature of the verification process adds considerably to the stigma associated with applying for government-sponsored child health coverage.

State Medicaid application procedures and verification requirements evolved from welfare rules. When welfare reform delinked Medicaid from receipt of cash assistance, states had the opportunity to reduce the welfare stigma attached to Medicaid by eliminating many of the procedural and verification requirements. Now more than ever, states have considerable flexibility in deciding the extent to which eligibility verification and other requirements such as face-to-face interviews are needed for Medicaid.

Over the past few years, many states have reduced verification requirements. Some states, however, have been reluctant to reduce these requirements due to concerns over quality control and the federal Medicaid Eligibility Quality Control (MEQC) system. In recent years, several states have demonstrated that it is possible to maintain eligibility quality control while alleviating the verification burdens placed on families. For instance, a pilot test project in Cuyahoga County, Ohio, found that self-declaration of income removed a “genuine” barrier to enrollment for families while maintaining a 98% accuracy rate for eligibility.<sup>1</sup> Through an ongoing monthly audit, Michigan has shown that allowing self-declaration of income for children’s Medicaid and the State Children’s Health Insurance Program (SCHIP) applications has not led to high error rates, and the state saw the proportion of applications “pending” due in large part to missing verification decline from 75% to below 20%.<sup>2</sup>

The MEQC program is an important tool for ensuring program integrity and states have flexibility under MEQC pilots and/or MEQC waivers to target areas that may be error-prone for review. Many states are using their MEQC programs to determine if simplification efforts to access Medicaid easier are affecting the accuracy of eligibility determinations. Further, some states have designed MEQC

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<sup>1</sup>Catherine Penn, MA, MBA, Evaluation Consultant and Robert O. Staib, County Project Director, Cuyahoga Health and Nutrition, “Income Self-Declaration Boosts Enrollment for Healthy Start/Healthy Families,” (Cuyahoga County, OH: Ohio Department of Job & Family Services, Cuyahoga Health & Nutrition, January 2002), pp. 1-2.

<sup>2</sup>U.S. General Accounting Office, Medicaid and SCHIP: States’ Enrollment and Payment Policies Can Affect Children’s Access to Care, (GAO-01-883), September 2001.

negative case action pilots, which focuses on denied and terminated Medicaid cases, to determine if eligible families and children are losing Medicaid coverage due to state-imposed procedural requirements at renewal. The corrective actions taken as a result of the MEQC findings are effective tools to ensure that Medicaid services are given only to eligible recipients and that state and federal Medicaid dollars are expended correctly.

Given that there are approximately 4 million uninsured children who are eligible but not enrolled in Medicaid and SCHIP, it is clear that action is needed to continue to improve access to coverage.<sup>3</sup> Actions are also needed to assure that eligible children do not lose coverage due to state-imposed procedural requirements at renewal.

The federal statute specifies that children who are eligible for Medicaid are ineligible for SCHIP. Final SCHIP regulations state that if a child is found through the screening process to be potentially eligible for Medicaid and the family fails to complete the Medicaid application process for any reason, the child cannot be enrolled in SCHIP because it has not been determined that the child is ineligible for Medicaid. Therefore, procedural requirements that restrict access to Medicaid can become barriers to SCHIP.

Because the issues are complicated, information and dialogue are essential to helping states ease the verification burden on families. This Second Edition report updates the December 1998 report by the Southern Institute on Children and Families, which was compiled as a result of a regional meeting held on September 15-16, 1998. Participants included Medicaid and/or SCHIP officials from 15 southern states, as well as regional and central office Centers for Medicare and Medicaid Services (CMS) representatives. (See Appendix A for complete list of eligibility verification meeting participants.) The dialogue at the Southern Institute 1998 meeting and subsequent follow-up with CMS in the preparation of the original report clearly demonstrated that states have substantial authority to take actions to reduce the verification burden on families while maintaining the integrity of the eligibility process. Since the 1998 meeting, CMS has issued additional guidance on actions states can take to simplify the Medicaid application and enrollment processes and help families retain Medicaid. The CMS responses to the questions posed at the meeting have been updated in this Second Edition to reflect this new guidance and include links to websites where states can access relevant State Medicaid Director Letters. These letters are also included in the appendices of this report.

It is worth noting that in August 2001 CMS published a guide entitled *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*. This guide provides information on how states can simplify the Medicaid application and enrollment processes for families and children as well as simplify Medicaid eligibility renewals so more families and children retain their benefits. The guide also addresses Medicaid/TANF delinking concerns and barriers, clarifies Medicaid eligibility policies, discusses Medicaid expansions and state best practices

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<sup>3</sup>Kenney, Genevieve, Lisa Dubay and Jennifer Haley, 2003. "Children's Insurance Coverage and Service Use Improve." *Snapshots of America's Families III*, No. 1 Washington, DC: The Urban Institute.

in the areas of outreach, application and enrollment simplification and program integrity that states can adopt. The CMS simplification guide can be found on CMS's website located at: <http://www.cms.hhs.gov/schip/outreach/progress.pdf>.

This report is intended to provide updated information on verification and other policy and procedural issues in order to facilitate exploration of strategies to simplify the application and renewal processes for Medicaid and SCHIP. Where the term SCHIP appears in CMS response, it refers to a separate SCHIP program under Title XXI; references to Medicaid include both regular Medicaid and Medicaid expansions.<sup>4</sup> In most cases, the original questions posed by state Medicaid and SCHIP officials in 1998 have been left intact in this Second Edition. The responses were reviewed and updated by CMS. It should be noted, however, that while CMS has reviewed this updated document and has offered technical comments that were incorporated, CMS does not necessarily subscribe to all of the opinions contained herein. In particular, CMS's review should not be construed as a governmental endorsement of this document nor an endorsement of any particular "best practice."

The meeting and the original report were made possible by a grant from The Robert Wood Johnson Foundation. The original report was extremely well received by state officials, advocates and policy-makers who indicated that it provided needed clarity on complicated eligibility policies and procedural requirements. This Second Edition is being published by popular request and is also sponsored by The Robert Wood Johnson Foundation through its Covering Kids & Families initiative, which is guided by the Southern Institute.

The Southern Institute wishes to express appreciation to CMS, especially Marty Svolos, Cheryl Camillo and Judith Rhoades, for their assistance. It is hoped that this Second Edition will assist public and private groups in their efforts to simplify the application and renewal processes for families seeking health coverage for their children.

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<sup>4</sup>As part of the Balanced Budget Act of 1997, Congress created title XXI of the Social Security Act, the State Children's Health Insurance Program.

# VERIFICATION REQUIREMENTS

## AT APPLICATION

### State Questions and CMS Responses

#### *Income*

##### **Question 1**

**What are the minimum requirements for income to be supplied by families according to federal Medicaid and SCHIP regulations?**

For Medicaid and SCHIP, there are no federal requirements that families provide documentation to verify income amounts included on the application form. Documentation by families to verify income is at a state's option.

##### **Question 2**

**Are there any minimum requirements for verification by state agencies according to federal Medicaid and SCHIP regulations?**

For the state Medicaid agency, the only federal income verification requirement is the requirement in Section 1137 of the Social Security Act for the state to have an income and eligibility verification system (IEVS). Under IEVS, the state must request information from other federal and state agencies to verify the applicant's income and resources to the extent that it is useful, although states may, with CMS's approval, target the use of IEVS information in ways that are most cost-effective and beneficial. The applicant must be informed in writing, at the time of the application, that the agency will be requesting this information. The regulations implementing IEVS are at 42 CFR 435.940 through 435.965.

For SCHIP there are no income verification requirements for the state agency, although, per federal regulations at 42 CFR 457.380, states must establish procedures to ensure the integrity of the eligibility determination process.

##### **Question 3**

**Can a state accept self-declaration of income for Medicaid or SCHIP?**

Yes. For both Medicaid and SCHIP, the state can accept self-declaration of income to establish eligibility.

For Medicaid, verification of income is required under the IEVS system even when the family is allowed to self-declare income. For income that cannot be verified under IEVS, CMS encourages random verifications or the adoption of other procedures, such as targeted MEQC reviews to verify income, designed to assure program integrity is being maintained. (See CMS letter dated September 10, 1998, in Appendix B.)



For SCHIP, there are no federal income verification requirements. However, states must establish procedures to ensure the integrity of the eligibility determination process, which may include random income verifications.

#### **Question 4**

**Is self-declaration of income acceptable if a client is within a certain range of the income limit? For instance, is it acceptable to allow a family with income well below the eligibility threshold to self-declare income while requiring families with income closer to the eligibility threshold to provide verification?**

Yes. Self-declaration of income, based on income limits, can be used to establish eligibility for both Medicaid and SCHIP.

#### **Question 5**

**Can verification for SCHIP be limited to information required for Medicaid poverty-level children?**

For a separate SCHIP program, the state may establish whatever income verification requirements it desires. Verification of income is not required under SCHIP by current federal law.

#### **Question 6**

**How is income earned that is ultimately given to another family unit for child support, health insurance, day care, etc. counted?**

For Medicaid, gross income earned by a member of the Medicaid family unit is income to that unit. Some of the income must be deducted when determining eligibility because it was deducted under the state's AFDC state plan in effect on July 16, 1996. For example, the first \$90 of earned income and child care expenses paid by the family up to certain limits must be deducted.

States have the option under sections 1902(r)(2) and 1931 of the Social Security Act to deduct additional amounts of earned income. For example, a state could deduct the amount of certain mandatory withholdings from an individual's wages or could deduct total child care expenses paid regardless of amount. A state also could deduct income used for specific purposes such as child support payments made to a child living outside the household.

For SCHIP, there are no federal requirements on determining what income counts in the eligibility determination. The state, therefore, may follow Medicaid policy or adopt another policy.

#### **Question 7**

**How can we predetermine eligibility with other programs that require income verifications, such as free and reduced school meal programs?**

Schools provide a good location to begin the Medicaid and SCHIP enrollment process. Under the Agriculture Risk Protection Act of 2000, states can opt to share school lunch enrollment data with the

Medicaid and SCHIP agencies in the state. The kind of information shared is the child's name, eligibility status and any other information obtained from the free and reduced lunch application or from direct certification. States can also accept other programs' determinations, such as Temporary Assistance for Needy Families (TANF), Food Stamps and Women, Infants and Children (WIC), related to particular eligibility requirements provided that the rules for determining eligibility with respect to those requirements are the same or more restrictive than the rules in Medicaid. (See CMS letter dated April 7, 2000 in Appendix C. Follow up technical questions and answers regarding this letter are in Appendix D.) For example, if a child has recently been found income eligible for Food Stamps and the income requirements for Food Stamps are the same or more restrictive than the state Medicaid rules, the state's Medicaid agency can accept the Food Stamps program's determination of the family's income. In addition, verifications of income obtained by other programs can be used under Medicaid or SCHIP if that information is disclosable by the program.

Under a separate SCHIP program, the state would have the flexibility to deem eligible for SCHIP a child who is eligible under another program. States do not have the flexibility, however, to deem individuals who already are Medicaid eligible to be eligible for SCHIP.

### **Question 8**

#### **Should the income of a live-in boyfriend or girlfriend be counted in the family's total income?**

Under Medicaid, the income of a live-in boyfriend or girlfriend who is not the parent of the child would not be counted in determining the eligibility of the child, except to the extent that it is actually contributed. A boyfriend's income is not counted even if the girlfriend is pregnant and eligibility is being established under the group for poverty-level pregnant women. After the birth and after the one-year period of deemed newborn eligibility ends, if the live-in boyfriend is the father, his income would be considered in establishing the eligibility of the infant.

Under SCHIP, there are no federal requirements for determining what income counts in the eligibility determination. The state may, therefore, follow Medicaid policy or adopt another policy.

### **Question 9**

#### **For applicants who are paid in cash, will a statement from a credible third party to corroborate stated income be acceptable?**

That determination is within state discretion for both Medicaid and SCHIP. (See CMS letter dated September 10, 1998, in Appendix B.) A state may accept a statement from a credible third party or it could accept the applicant's own statement of his or her income.

### **Question 10**

#### **Can the state complete an application for Medicaid without an interview? For SCHIP?**

Yes in both Medicaid and SCHIP, an interview is not required by federal law.

## *Resources*

### **Question 1**

**What are the minimum requirements for verification of resources according to federal regulations?**

There are no federal requirements for Medicaid applicants to provide verification of resources. For state Medicaid agencies, the only requirement to verify resources is the IEVS verification requirement that is discussed in the answer to Question 1 under the income section. (See CMS letter dated September 10, 1998, in Appendix B.)

For SCHIP, there are no federal verification requirements for resources. However, states must establish procedures to ensure the integrity of the eligibility determination process.

### **Question 2**

**Is self-declaration of resources acceptable?**

Yes. For both Medicaid and SCHIP, the state can use self-declaration of resources to establish eligibility.

For Medicaid, state verification of self-declared resources is required under the IEVS system. For resources that cannot be verified under IEVS, CMS encourages states to conduct random verifications or to adopt other procedures designed to assure program integrity is being maintained.

For SCHIP, there are no federal resource verification requirements. However, states must establish procedures to ensure the integrity of the eligibility determination process, which may include random resource verifications.

### **Question 3**

**Is self-declaration of resources acceptable if a client is within a certain range of the resource limits? For instance, is it acceptable to allow a family with countable resources well below the threshold for allowable resources to self-declare resources while requiring families with resources close to the allowable resource threshold to verify resources?**

Yes. Self-declaration of resources by families with few resources can be used to establish eligibility for both Medicaid and SCHIP while the state requires verification of resources by families with more resources.

#### Question 4

**Is it possible to eliminate resource tests, streamline resource rules and standardize resource limits for all family and children covered groups?**

Yes, for both Medicaid and SCHIP.

Under Medicaid, this can be achieved through the use of the authority in Sections 1902(r)(2) and 1931 of the Social Security Act to adopt more liberal resource methodologies than those under the state's AFDC plan in effect on July 16, 1996. Most states have now eliminated the resource requirement for children and many states have dropped a resource test for families with children.

For SCHIP, the state has complete discretion in terms of setting resource requirements, including no resource test at all.

### *Citizenship*

#### Question 1

**What is the minimum standard?**

#### Medicaid

There is no requirement to verify citizen or national status. As a condition of eligibility, citizens or nationals must declare in writing under penalty of perjury that they are U.S. citizens or nationals. Current policy permits states to accept that declaration or to require further verification as a condition of eligibility.

Immigration status must be verified. Applicants, who are neither U.S. citizens nor nationals, as a condition of eligibility, must declare in writing, under penalty of perjury, whether they are a qualified alien and, if so, present US Citizenship and Immigration Services (USCIS) documents or other documents the state finds as reasonable evidence of satisfactory immigration status. [Qualified aliens are defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)].

For Medicaid, states are required to verify the immigration status of qualified aliens with the USCIS through the automated Systematic Alien Verification for Entitlements (SAVE) system, or by using an alternative verification system approved under a waiver granted by the Secretary of Health and Human Services. Current policy on Medicaid verification of immigration status is found at Section 3212.9 of the State Medicaid Manual. It should be noted that the Department of Justice previously published a proposed regulation under which all states would be required to verify the immigration status of non-citizens applying for Medicaid using SAVE; states currently using an alternative system under an approved waiver would no longer be permitted to do so. States would have 24 months to begin using SAVE after publication of the final rule.

It is important to note that states may not require Medicaid or SCHIP applicants to provide information about the citizenship or immigration status of any non-applicant family or household

member or deny benefits to an applicant on the basis that a non-applicant family or household member has not disclosed this information. States can ask for this information but must make it clear that such disclosure is voluntary and that benefits to an otherwise eligible applicant will not be denied for non-cooperation.

## SCHIP

For SCHIP, there is no requirement to verify citizenship or national status. States may accept self-declaration of citizenship (or national status) provided the state has implemented effective, fair, and nondiscriminatory procedures for ensuring the integrity of the eligibility process. The state may obtain this declaration under penalty of perjury.

For immigrants, immigration status must be verified. States must follow the interim guidance for verification of qualified alien status issued by the DOJ on November 17, 1997 (at 62 Federal Register, Page 61344). This guidance provides that applicants must declare in writing, under penalty of perjury, that they are qualified aliens, and must provide documentation of immigration status. If the documentation does not appear on its face to be genuine, the state should further verify immigration status with the USCIS.

## Question 2

### **Must the state verify alien status for Medicaid? For SCHIP?**

Yes, for Medicaid, except for non-qualified aliens. See the response to Question 1 under Citizenship above. Verification is not required for those who are not qualified aliens. However, non-qualified aliens are eligible under Medicaid only for coverage of emergency services.

For SCHIP, verification is required. Also, non-qualified aliens are not eligible for coverage under SCHIP.

## Question 3

### **Can the state accept self-declaration that the client is lawfully admitted for Medicaid? For SCHIP?**

No. See the response to Question 1 under Citizenship above.

For Medicaid and SCHIP, as part of application, a qualified alien must provide documentation of the claimed status. Either USCIS documentation or other documentation that the state determines reasonable evidence of satisfactory status must be presented. For Medicaid, if documentation is provided at application, the state must verify such documentation with USCIS using a system approved by the USCIS. For SCHIP, if the documentation appears on its face to be genuine and to relate to the individual presenting it, the state should not further verify immigration status. However, if based on the review of the documents presented, the state is considering determining that an applicant is not a qualified alien, the state should verify immigration status by filing Form G-845 and Supplement along with copies of the pertinent immigration documents provided by the applicant with the local USCIS office.

#### **Question 4**

**Will CMS be revising all official documents (i.e. State Medicaid Manual, SCHIP regulations, etc.) per the January 23, 1998, letter to state health officials stating that there are no verification requirements under federal law other than those related to alien status of non-citizens?**

The State Medicaid Manual is currently being updated to incorporate the applicable state verification requirements, including the requirement to verify citizenship or national status.

It should be noted that the January 23 letter also cited the IEVS requirement to verify income and resources under Medicaid. (The CMS letter dated January 23, 1998, may be accessed at <http://www.cms.hhs.gov/schip/sho-letters/chotrch.asp>).

#### **Question 5**

**When verifying alien status via SAVE, should the alien's date of entry into the U.S. be part of the response?**

The alien's date of entry is not part of the response provided by USCIS under automated primary verification at this time. The date of entry can be obtained under the secondary verification process.

#### **Question 6**

**How can a separate SCHIP program verify alien status?**

For SCHIP, if documentation presented by the applicant appears on its face to be genuine and to relate to the individual presenting it, the state should not further verify immigration status. However, if based on the review of the documents presented, the state is considering determining that an applicant is not a qualified alien, the state should verify immigration status by filing Form G-845 and Supplement along with copies of the pertinent immigration documents provided by the applicant with the local USCIS office.

#### **Question 7**

**Can a citizen or qualified immigrant child be denied Medicaid because his or her parents are not citizens or qualified immigrants?**

No. The citizenship or immigration status of non-applicant parents or other household members is irrelevant to a child's Medicaid eligibility, and states may not require that parents provide this information about themselves. For children who are citizens applying for Medicaid, states currently may establish the child's citizenship on the basis of self-declaration. Children applying who are qualified aliens must present documentation of their immigration status, which states must verify using systems established for that purpose. (See CMS letter dated September 10, 1998, in Appendix B.)

## *Age of Child*

### **Question 1**

**What is the minimum verification requirement?**

There is no federal requirement for verification of the age of the child under either SCHIP or Medicaid.

### **Question 2**

**Is self-declaration of age acceptable?**

Self-declaration is acceptable for both Medicaid and SCHIP. However, CMS encourages random verifications of age or the adoption of some other process that assures program integrity is being maintained.

## *Family Composition*

### **Question 1**

**Is self-declaration acceptable?**

Yes. Under both Medicaid and SCHIP, self-declaration can be used to establish family composition. However, CMS encourages random verifications or the adoption of other procedures to assure program integrity is being maintained.

### **Question 2**

**Should a live-in boyfriend or girlfriend be counted as a member of the family and part of the household size?**

For Medicaid, if the live-in boyfriend or girlfriend is a parent of a child in the family, the parent is counted as a member of the family of the child. Otherwise, the boyfriend or girlfriend's income is not counted except to the extent it is actually contributed toward the support of the family. For more detail, see the response to Question 8 under Income above.

For SCHIP, there are no federal requirements. The state may, therefore, follow Medicaid policy or adopt another policy.

## *Insurance Verification*

### Question

#### **What are the minimum requirements for verification of insurance status?**

For Medicaid, states are not required to ask families to verify insurance status if the family does not have any health coverage other than Medicaid. Under IEVS, the state is required to obtain information from various agencies, not only for purposes of verifying income and resources for Medicaid eligibility but also for verifying the correct amount of Medicaid payments. IEVS data matches may disclose potential legally liable third parties, including insurers, which states must follow up on unless the eligibility case file includes information about the potential legally liable third party. CMS also has issued guidelines (Section 3904 of the State Medicaid Manual) about obtaining health insurance information from the applicant that may be useful in identifying legally liable third party resources.

For SCHIP, there are no federal verification requirements. However, children who are insured are not eligible for SCHIP and states are expected to monitor the crowd-out in their approved Title XXI plans.



# VERIFICATION REQUIREMENTS

## AT RENEWAL

### State Questions and CMS Responses

#### *Income*

##### Question 1

**What are the minimum requirements for income verification according to federal regulations?**

There are no federal requirements for income verification to be provided by Medicaid beneficiaries for renewals of eligibility. A state can rely on self-declaration. Furthermore, a state must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements) that the state considers accurate, such as current TANF and Food Stamps files, before requiring families to provide state-required verifications. This internal review of eligibility based on available information is called an ex-parte renewal. (See CMS letter dated April 7, 2000 in Appendix C.)

Federal regulations require state Medicaid agencies to verify income at renewal under the IEVS system, although, states may, with CMS's approval, target the use of IEVS information in ways that are most cost-effective and beneficial. The beneficiary must be informed in writing at the time of the renewal that the agency will be requesting this information.

For SCHIP, there are no federal verification requirements. However, federal regulations require states to establish procedures to ensure the integrity of the eligibility determination process.

##### Question 2

**Can the state accept the beneficiary's statement at renewal without verifying income or changes in income for Medicaid? For SCHIP?**

Yes. For both Medicaid and SCHIP, the state can use self-declaration of income to renew eligibility. For Medicaid, states must verify income at renewal under the IEVS system regardless of whether the state accepts self-declaration of income. For income that cannot be verified under IEVS, CMS encourages random verifications or the adoption of other procedures designed to assure program integrity is being maintained.

For SCHIP, there are no federal income verification requirements. However, the state must have procedures to ensure the integrity of the eligibility determination process, which may include random income verifications.

### **Question 3**

**Can the state complete a renewal for Medicaid without an interview? For SCHIP?**

Yes, for both Medicaid and SCHIP, an interview is not required by federal law.

### **Question 4**

**In general, would verification requirements for renewals remain the same or differ from verification requirements at application?**

It is up to the state to determine for both Medicaid and SCHIP whether to use the same or different verification requirements.

## *Resources*

### **Question 1**

**What are the minimum requirements for verification of resources at renewals according to federal regulations?**

They are the same as minimum requirements for income. See response to Question 1 under Income above.

### **Question 2**

**Is self-declaration of resources acceptable?**

Yes. For both Medicaid and SCHIP, the state can accept self-declaration of resources. The verification rules for resources are the same as those for income. See response to Question 2 under Income above.

### **Question 3**

**Can the resource test be dropped or can families self-declare resources at renewal even if the state requires verification of resources at application?**

If a state eliminates a resource test, it must eliminate it for both applicants and recipients. While the resource test must be the same, the verification requirement may differ. A state that requires verification of resources at application may choose to accept self-declaration at renewal. For further details, see Resources Question 4 above under "At Application."

## *Citizenship*

### Question

#### **Is self-declaration acceptable?**

For both Medicaid and SCHIP, there is no need to revisit citizenship or national or immigration status except where the beneficiary reports a change in circumstances or the state has reason to believe that a change in circumstance has occurred. In that event, states must follow the applicable requirements for Medicaid and SCHIP outlined in the answer to Question 1 in the Citizenship section under “Verification Requirements At Application” to establish the changed status.

## *Age of Child*

### Question 1

#### **Is self-declaration of age acceptable?**

Yes. Under both Medicaid and SCHIP the state can use self-declaration of age. States should not request verification of information that is not subject to change. However, because age is a circumstance that will not affect the renewal of eligibility unless the child ages out of the program (i.e. turns 18), the state should rely on the age determination made at the time of the initial eligibility determination. States should not request verification of information that is not subject to change.

### Question 2

#### **What happens if a child turns 19 during the 12-month period of continuous eligibility?**

Eligibility under continuous eligibility ends when the child reaches age 19 under Medicaid unless the state determines that the child is eligible for Medicaid on some other basis, such as an optional group for children under age 21, disability or pregnancy.

Under SCHIP, eligibility ends at age 19. At the time of the last renewal, the state will know that the child will turn age 19 before the end of the period. The state could review the child’s eligibility to determine whether the child who turns 19 is eligible for Medicaid, for example, based on disability or pregnancy.

### Question 3

#### **Will a statement from a credible third party be acceptable?**

Whether to require a statement is up to the state to determine for both Medicaid and SCHIP. As noted in the responses to Question 1, there is no need to reevaluate age.

#### **Question 4**

**Is there any need to reevaluate since, once verified, age can be calculated?**

No, for both Medicaid and SCHIP.

### *Family Composition*

#### **Question 1**

**Is self-declaration acceptable?**

Yes. Under both Medicaid and SCHIP the state can use self-declaration of family composition to renew eligibility. CMS encourages random verification of self-declared family composition or some other process to ensure program integrity where family composition is declared to have changed from the time of application.

#### **Question 2**

**Would using the same definitions for family composition for both Medicaid and SCHIP help facilitate eligibility determination and renewal?**

Yes. Using the same definitions for both Medicaid and SCHIP would simplify administration. It would facilitate the screening process required for separate SCHIP programs and assure that all Medicaid-eligible children and families were identified. In addition, it also helps to keep families enrolled when their circumstances change. To do this, states would have to conform their SCHIP policy to Medicaid because of the Medicaid statutory restrictions on countable income and family composition. Several states have adopted this approach.

#### **Question 3**

**Would a statement from a credible third party be acceptable?**

That is for the state to determine for both Medicaid and SCHIP. If there has been no declared change in family composition from the time of application, verification may not be warranted.

### *Insurance Verification*

#### **Question**

**What are the minimum requirements for verification of insurance status?**

For Medicaid, states are not required to ask families to verify insurance status if the family does not have sources of health coverage other than Medicaid. For SCHIP, there are no federal verification requirements. See further details under the application section.

## *Signature*

### Question

**Is a signature required in order to renew coverage for Medicaid or SCHIP?**

No. Federal regulations do not require a signature on the Medicaid or SCHIP renewal form.

# ADDITIONAL ISSUES

## State Questions and CMS Responses

### *Medicaid Versus SCHIP*

#### Question 1

**Are there any differences between federal Medicaid and SCHIP verification requirements?**

The federal rules regarding what information a family must provide for verification are the same for Medicaid and SCHIP. However, unlike Medicaid, there is no requirement under SCHIP for the state agency to verify income and resources under IEVS.

#### Question 2

**Does CMS expect SCHIP verification procedures to differ from the verification procedures for Medicaid coverage groups?**

Outside of verification that is required under federal law and regulations, it is up to the state to establish verification requirements for Medicaid and SCHIP. To the extent they can be made the same, it would facilitate the application process in situations where a joint application is being used.

#### Question 3

**If a child enrolled in SCHIP is involved in an accident at age 18 and turns age 19 while still needing treatment, can SCHIP coverage be extended?**

No. However, the state should consider whether the child has become eligible for Medicaid.

### *Random Verification Checks*

#### Question

**Can eligibility be granted based on statements in the application with random checks used to verify? If so, what is the minimum standard for random checks?**

Yes. Self-declaration can be used for both Medicaid and SCHIP (except when an individual is required to provide documentation of immigration status) with random checks as determined by the state. There is no minimum standard for random checks. It is up to the state to set a standard it considers reasonable.

With CMS approval, states can develop MEQC reviews that determine whether eliminating certain verification requirements is impacting the number of erroneous eligibility determinations. For example, states could conduct focused reviews to determine if self-declaration of income is affecting the accuracy of eligibility determinations.

## *Continuous Eligibility*

### Question 1

**For continuous eligibility, is verification of change in any information (age, income, etc.) required during the period of continuous eligibility?**

No. Since changes other than a move out of state or age do not affect eligibility during a continuous eligibility period, there is no need to require families to report changes in income or resources during a period of continuous eligibility. Furthermore, there would never be a need to require a family to report changes in a child's age.

### Question 2

**Instead of annual reviews, why not allow reviews to be based on income of the family and extend it to 24-month or 36-month reviews? Why not allow extended Medicaid coverage periods for categorically needy families?**

This is not allowed because reviews at least annually are required for Medicaid and SCHIP by regulation (but not the law) with respect to circumstances that may change. Also, except for continuous eligibility, the regulations require a prompt review when the agency receives information about changes in a recipient's circumstances that may affect his/her eligibility.

## *Regulation Clarification*

### Question

**42 CFR 431.17 (b), which requires case records to contain information on facts essential to determination of initial and continuing eligibility, and 42 CFR 435.913 and 457.965, whereby the agency must include in each applicant's record facts supporting the agency's eligibility decision?**

These regulations do not impose an obligation to obtain verification. Unless independent documentation or verification is required by federal law, regulations or guidelines, the requirement to have facts to support the eligibility determination may be satisfied by information based on a self-declaration of the applicant, or states can choose to supplement self-declaration with verification.

## *Paternity Establishment/Assignment of Rights/Medical Support*

### Question

**Does assignment of rights and cooperation with paternity establishment and pursuing medical support and payments from third parties apply to children applying for and receiving coverage under SCHIP? Under Medicaid?**

These federal requirements do not apply to SCHIP. For Medicaid, under federal law a parent's cooperation in establishing paternity, assigning rights to medical support and payments, and providing information about liable third parties cannot be required as a condition of a child's eligibility for Medicaid. Therefore, states are not required to ask about paternity or to seek cooperation in pursuing medical support and third party payments when an application for Medicaid is filed, or a renewal is performed, only on behalf of a child. If a state does ask about paternity or otherwise pursues medical support in the context of an application on behalf of a child, it must advise the parent or other individual completing the application on behalf of the child that such information and cooperation is not required in order for the child to be enrolled in Medicaid. Children (including infants) cannot be denied or terminated due to the refusal of a parent or another legally responsible person to assign rights or cooperate in establishing paternity or obtaining medical support and payments on behalf of the child.

If a parent is applying for himself or herself, the parent must cooperate in establishing paternity and pursuing support unless there is good cause not to cooperate or the parent is applying as a poverty level pregnant woman. Pregnant women eligible under Section 1902(l)(1)(A) of the Act (poverty level pregnant women) are exempt from the requirement to cooperate in establishing paternity of a child born out of wedlock, and in obtaining medical support and payments for themselves and the child born out of wedlock.

CMS released a Dear State Medicaid Director Letter on December 19, 2000 addressing these and other matters relating to paternity, child support and medical support and payments. This letter can be reviewed in Appendix E.

## *Social Security Number*

### Question

**If a parent fails to supply a valid Social Security number for himself, can the child be denied eligibility for Medicaid?**

No. Only applicants for and beneficiaries of Medicaid must supply this information. Note that applicants must disclose their Social Security Numbers (SSN) or apply for one but are not required by federal law to provide documentation of their SSN, although states are required to verify it. States, however, may not delay or deny eligibility pending issuance or verification of the SSN.

States cannot deny a Medicaid application on the basis that other members of the household members do not disclose their SSNs. States are expressly prohibited from requiring the SSN of a parent or family member as a condition of a child's eligibility. A SSN is required only for the child applying for Medicaid benefits. However, voluntary disclosure by the parent may facilitate income verification and expedite determination of the child's eligibility. If a state asks non-applicants for SSNs, it must let them know that their SSNs are not required to process the application.

Note that, for Medicaid, if a person or family cites religious grounds as the basis for refusing to obtain an SSN, the state can exempt them from the SSN requirement as provided in federal regulations.

For separate (non-Medicaid) SCHIP programs, a state has the option to require an SSN for the child.



## *Quality Control Concerns*

### Question

**Quality control errors remain a concern for some states. Does CMS plan to ease or eliminate the threat of Medicaid Eligibility Quality Control (MEQC) errors in Family Medicaid?**

Medicaid eligibility quality control cannot be eliminated because it is a requirement of federal law. However, CMS has given states considerable flexibility, within the parameters of the law, to implement the quality control process. In lieu of the traditional review of a case sample, states may carry out pilot projects designed to focus the state's quality control efforts on areas where there may be problems. States also have the option to conduct alternative MEQC projects as part of an approved section 1115 waiver. States with approved pilot projects or section 1115 waivers are assigned an error rate, which is the rate for their last full year under the regular system. For further information about MEQC pilot projects access

<http://www.cms.hhs.gov/medicaid/meqc/mqcguid.asp>.

## *Confidentiality*

### Question

**Is confidentiality a concern in coordinating verification across programs?**

Yes, it is a concern because confidentiality requirements vary from program to program. Some programs have strict disclosure requirements. For example, under Medicaid, disclosure of information about a Medicaid applicant or recipient must be for a purpose directly connected with the administration of the Medicaid program.

The new privacy rule, which took effect on April 14, 2001, does not change these Medicaid requirements. The privacy rule imposes some additional procedural and administrative requirements on states than those already required under Medicaid confidentiality regulations, such as specific requirements for providing notice of privacy practices.

## *Remote Eligibility Determination*

### Question

**To facilitate enrollment, why not allow remote eligibility determination sites for Medicaid and SCHIP? What about letting entities other than welfare, Medicaid and SSI agencies determine eligibility?**

For Medicaid, the law requires the determination of Medicaid eligibility to be made by state merit system employees. (The law allows states to contract with the Social Security Administration to determine Medicaid eligibility for aged, blind or disabled individuals.) However, the law does not preclude the entire eligibility process from taking place at sites, other than welfare offices. Application assisters and others who are not state merit employees can take and help with applications, but they cannot actually determine eligibility.

States are required to provide pregnant women and children opportunities to apply for Medicaid at locations other than welfare offices. CMS issued additional guidance in a Dear State Medicaid Director Letter on January 18, 2001, regarding outstationing efforts. That letter can be viewed in Appendix F.

For SCHIP, who performs application, eligibility determination and enrollment activities and how they are done is left to the state to determine.

## *Applying for Children*

### Question

**Is a parent the only person legally able to file a child's Medicaid application?**

No. According to regulation 42 CFR 435.907, "The agency must require a written application (either from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant." Therefore, someone other than a parent is permitted to initiate a Medicaid application on behalf of a child.

## *Pregnancy*

### Question 1

**If a female is pregnant when she reaches age 19, can SCHIP coverage be extended?**

No. However, the state should determine whether the child is eligible as a poverty-level pregnant woman under Medicaid.

### Question 2

**If a home pregnancy test indicates that a woman is pregnant, is that sufficient verification of pregnancy?**

Yes. The agency may accept self-declaration that a woman has used such a test and it has indicated that she is pregnant.

## **APPENDIX A**

**Eligibility Verification Meeting Participants  
September 15-16, 1998  
Southern Institute on Children and Families**

**Southern Institute on Children and Families**  
Eligibility Verification Meeting  
The Mills House Hotel•115 Meeting Street•Charleston, SC  
September 15-16, 1998

**Participant List**

Barbara Barr  
Program Associate  
The Robert Wood Johnson Foundation

Beverlee Brown  
Programs Supervisor  
Family Support Services Division  
OK Department Of Human Services

Wanda Davis  
Policy & Training Specialist  
AL Medicaid Agency

Rita Dobrich  
Program Manager II  
Office Of Family Support  
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Gretel Felton  
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AL Medicaid Agency

Charles Bentley  
Income Maintenance Unit Manager  
Division Of Family Services  
MO Department Of Social Services

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Bureau Of Children's Health  
TX Department of Health

Donna Dedon  
Program Manager  
LA Department Of Health & Hospitals

Howard P. Estes, Jr.  
Deputy Director  
VA Department Of Medical Assistance Services

Lynda Flowers  
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Christine Gerhardt  
Chief, Division of Eligibility Services  
Medical Care Policy Administration  
MD Department Of Health & Mental Hygiene

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Department For Public Health  
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Services

Andriette Johnson  
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Jesse Williams  
Internal Policy Analyst  
Beneficiary Services Branch  
KY Department For Medicaid Services

**APPENDIX B**

**Centers for Medicare and Medicaid Services  
Dear State Medicaid Director Letter  
September 10, 1998**



**DEPARTMENT OF HEALTH & HUMAN SERVICES**  
**Health Care Financing Administration**

**Center for Medicaid and State Operations**  
**7500 Security Boulevard**  
**Baltimore, MD 21244-1850**

SEP 10 1998

Dear State Health Official:

This letter is a follow-up to a letter issued by the Department of Health and Human Services on January 23, 1998 regarding opportunities for outreach to uninsured children. First, it highlights the flexibility States have to simplify the application and enrollment processes. Second, it provides clarification of two eligibility-related issues that have come to our attention as a result of the January letter: the provision of Social Security numbers (SSNs) for applicants and non-applicant family members; and establishment of immigration status for non-citizens.

**I. Application and Enrollment Simplification**

As we indicated in our letter dated January 23, 1998, a major key to successfully enrolling children in CHIP and Medicaid is a simple application and enrollment process. While it is important to maintain program integrity, a burdensome application and enrollment process can be a significant barrier to successful enrollment.

Many States have already begun to simplify their application and enrollment processes. Listed below are actions that States already have taken, as well as some other recommendations that States could adopt to change their current processes and to reduce the stigma and complexity of seeking assistance:

- ◆ Shorten application forms and/or use mail-in applications;
- ◆ Create joint CHIP/Medicaid applications;
- ◆ Use joint Medicaid and CHIP applications;
- ◆ Eliminate assets test;
- ◆ Allow self-reporting of income by the family with follow-up verification by the State;
- ◆ Reduce verification/documentation requirements that go beyond Federal regulation;
- ◆ Allow redeterminations to be done by mail;
- ◆ Speed up processing;
- ◆ Develop a follow-up process for families not completing the application process;
- ◆ Establish an effective referral system between the State's CHIP eligibility agency, the Medicaid and maternal and child health programs, schools as well as other Federal and State agencies that serve low-income families;



- ◆ Offer phone interviews, or have transportation vouchers to assist individuals in getting to face-to-face interviews;
- ◆ Expand outstationing opportunities;
- ◆ Increase staff with multi-lingual ability;
- ◆ Extend office hours so that applicants do not have to take off work to apply for benefits;
- ◆ Take advantage of new options like presumptive eligibility and 12 month continuous eligibility; and
- ◆ Try to reduce stigma of seeking public assistance by using techniques such as a different name for program (such as Arkansas' ARKids, Michigan's MICHild, and Connecticut's HuskyCare).

The Federal requirements for the application and enrollment process for Medicaid and for separate State CHIP programs provide a great deal of flexibility to States to design an application and enrollment process that is streamlined and simple, and avoids burdensome requirements for families that apply for benefits. For example, under Medicaid with the exception of obtaining documentation of immigration status for qualified alien applicants and the applicant's Social Security numbers, States have flexibility to determine documentation requirements, including self-declaration of income and assets. In addition, States with separate CHIP programs can streamline and coordinate their application and enrollment processes for CHIP and Medicaid in a number of ways to make it easier for families to apply, including use of a joint application.

The current application and enrollment requirements for Medicaid and separate State CHIP programs are listed in an attachment to this letter. They do not call for families to provide extensive amounts of documentation and information in order to file for benefits. For the most part, they deal in a very broad way with the basic elements of the application and enrollment process, and provide a great deal of flexibility to States to design a process that best suits their needs.

Enrolling America's uninsured children in Medicaid and CHIP is a national priority that requires an aggressive, sustained effort. There are many ways that States can, and are, modifying their processes to make them more user friendly. It is our hope that you will make, or continue to make, a firm commitment to simplify your application and enrollment processes in an effort to reduce barriers to enrolling uninsured children.

## **II. Clarification of Eligibility Requirements**

### **Provision of Social Security Numbers (SSNs)**

Attached to the January 23, 1998 outreach letter was a model joint CHIP/Medicaid application States could use in order to simplify the eligibility process for this new program. One of the pieces of information requested on the model application was a SSN for all family members, including those who were not applying for benefits. We wish to clarify that, under Section 1137

of the Act, a SSN must be supplied only by applicants for and recipients of Medicaid benefits. In all other cases, including non-applicant parents of children applying for Medicaid and children applying for a separate State CHIP program (non-Medicaid), States are prohibited from making the provision of a SSN by another family member a condition of the child's eligibility. This also applies to other members of the household whose income might be used in making the child's eligibility determination.

A revised joint application form for CHIP/Medicaid children is enclosed. As you will see, the form now requires a SSN only for children applying for Medicaid benefits. For children applying for a separate State CHIP program (non-Medicaid) and members of the household not applying for benefits, the SSN is indicated as being optional.

Some States use parents' SSN as a means of verifying family income in the process of making an eligibility determination. While the statute does not require disclosure of the SSN for non-applicants, voluntary disclosure by the parent may facilitate the verification of income and contribute to a speedier and more accurate determination of the child's eligibility. States may advise parents and other household members of this as long as they do so in a manner that does not coerce provision of the SSN or deter application for benefits. Once more, we wish to clarify that States have no legal basis for denying an application based upon the failure to supply the SSN for verification purposes.

### **III. Establishing Citizenship and Immigration Status of Non-Citizens**

Children who are citizens and who are applying for either Medicaid or a separate State CHIP program may establish their citizenship on the basis of self-declaration; States are permitted to require further verification as a condition of eligibility. Children applying for either program who are qualified aliens must present documentation of their immigration status, which States must verify using systems established for that purpose. The citizenship or immigration status of non-applicant parents (or other household members), however, is irrelevant to their children's eligibility. States may not require that parents disclose this information.

There are both statutory and programmatic bases for our policy. Under the statute (Section 1137 of the Act), there is no authority for requiring individuals other than those applying for benefits to provide their SSNs or to document their immigration status. Furthermore, the Privacy Act makes it unlawful for a State to deny benefits to an individual based upon that individual's failure to disclose the SSN, unless the disclosure is required by Federal law or was part of a Federal, State, or local system of records in operation before January 1, 1975. States may only seek the SSN of these individuals on a strictly voluntary basis. The CHIP law does not require applicants to provide SSNs and the Medicaid law only requires it for applicants and recipients of Medicaid benefits.

From a programmatic point of view, asking non-applicants for their SSNs or evidence of immigration status may discourage immigrant parents, who may not wish to disclose information

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about themselves, from applying for benefits on behalf of their children who are U.S. citizens. When this occurs, the children are, in effect, denied access to medical care that they both need and are eligible for under the law.

We encourage States to actively provide information to adults applying for benefits on behalf of their children to inform them that their children's eligibility for Medicaid or CHIP is not contingent on disclosure of a parent's SSN (or lack thereof), or on information about non-applicant parents' immigration status.

If you have questions or suggestions on any of these eligibility-related issues and the use or adaptation of the model form and guidance attached, please contact your HCFA regional office staff.

Sincerely,

Sally K. Richardson  
Director

Attachments

cc:

All HCFA Regional Offices

All PHS Regional Offices

HHS Regional Directors

Lee Partridge  
American Public Human Services Association

Nolan Jones  
National Governors Association

Joy Wilson  
National Conference of State Legislators

Cheryl Beversdorf  
Association of State and Territorial Health Officials

Mary Beth Senkewicz  
National Association of Insurance Commissioners

## MODEL JOINT APPLICATION FOR CHIP/MEDICAID FOR CHILDREN

[Revised 8/31/98]

**Purpose:** The attached model joint application can be used for both the Children's Health Insurance Program (CHIP) and children's Medicaid eligibility (under the children's poverty level related groups). States could allow individuals to use this form to apply for both programs and the information on this form would be sufficient for determining which program a child is eligible for. It includes only the information that is required in all circumstances, and it is provided as a base form that a State can adapt to meet its own needs. As presented, the form is suitable for completion by an intake worker. Modifications would be required to make the form suitable for direct completion by the applicant.

**Screening:** This application will meet the statutory requirement in Title XXI that States identify children who are eligible for Medicaid.

NOTE: Non-State employees cannot determine Medicaid eligibility. Therefore, in a State that has contracted out the process of CHIP eligibility determination (i.e., determinations are performed by non-State employees), this model application would have to be modified for use as a pure screening form (or a combination of an application for CHIP and a screening form) by removing all references to it as a Medicaid application. The statement about the use of the Social Security Number [33] still would be required. The inclusion of the section on rights and responsibilities [34] (but omitting any reference to Medicaid), however, would be at State option.

If the form were so modified, in order to permit the information on the form to be submitted for use in making a Medicaid determination, the eligibility workers could provide a separate page to be completed by those whom the screen indicates are Medicaid-eligible. On that page, the individual should consent to submission of the information as part of a Medicaid application, and accept the rights and responsibilities outlined in this model (including a statement under penalty of perjury that the information provided on the "attached screening form" or "attached CHIP application" is correct). Once this page is completed, the form could be forwarded to the State for a Medicaid eligibility determination.

**Mandatory Information About Medicaid:** If a State uses a joint CHIP/Medicaid application and denies the Medicaid application, then the State must thoroughly inform the individual about the availability of Medicaid and his or her right to apply for Medicaid on a basis other than as a poverty-level child. This includes an explanation of the Medicaid program and the various eligibility groups, the advantages of Medicaid over CHIP and information about how and where to apply for Medicaid.

**Federal Verification Requirements:** Under Federal law, there are no verification requirements pertaining to eligibility for the children under Medicaid other than those related to alien status of non-citizens, the post-eligibility requirements of §1137 pertaining to use of the individual's Social Security Number and an income and eligibility verification system. Eligibility of a citizen child may be established on the basis of self-declaration under penalty of perjury. States are permitted, however, to require further verification as a condition of eligibility.

Section 1137's requirement for furnishing a Social Security number applies only to the applicants for and recipients of Medicaid. It does not apply to the parents of Medicaid applicants, nor does it apply to a State-run Children's Health Insurance Program that is separate from the State's Medicaid program. The Privacy Act, § 7 of Public Law No. 93-579, 88 Stat. 1896, makes it unlawful for a State to deny benefits to an individual based upon that individual's failure to disclose the Social Security number unless the disclosure is required by federal law or was part of a federal, State, or local system of records in operation

before January 1, 1975. Since the new CHIP program does not require that Social Security Numbers be supplied and the Medicaid program requires it only for applicants and recipients, States may seek these account numbers from applicants for a non-Medicaid CHIP program only on a strictly voluntary basis.

**Additional Simplification of Medicaid Eligibility Determination:** If the total gross income of the family is at or below the applicable Medicaid income standard, the questions in the shaded areas need not be answered. The individual is obviously income eligible for Medicaid without further information.

**Explanation of Certain Fields:** There are some questions on the application that may not elicit all the information needed to make a determination. Under certain circumstances, additional information will be required. For example:

- If the answer to the question about citizenship [18] is no, actual status will need to be determined, official documents submitted, etc.
- If the child has insurance [22] and is Medicaid-eligible, information about the insurance company and policy number will be needed; and
- If the child had medical bills in the last 3 months [32] and is Medicaid-eligible, eligibility information for the last three months will be needed to establish retroactive eligibility, in addition to information about the bills.

In addition, the question concerning employment by a public agency in the State [25] is only needed for CHIP eligibility and is not needed for Medicaid. This field does not ask directly about the availability and nature of health insurance, on the assumption that the eligibility worker would have access to a list of public agencies that offer State health insurance of the type that would preclude CHIP eligibility. If this is not the case in your State, this field would need to be expanded.

**Examples of State Modifications:**

- A State may wish to include voter registration; or
- A State may want to use this as an application for Medicaid for the adults, which would require additional information about the adults and stock affidavits concerning assignment of rights and pursuit of support.
- A State will need to add a question concerning each individual's resources (assets) if:
  - the State applies a resource test for the poverty level children; or
  - the State has not chosen to cover children born before 10/1/83 under the poverty level group AND the State applies a resource test for the optional group of categorically needy children ("Ribicoff children").

**-- SAMPLE --  
 CHILDREN'S HEALTH INSURANCE PROGRAM / MEDICAID  
 JOINT APPLICATION FORM [Revised 8/31/98]**

<b>I. Person Applying for the Child or Children</b>					
<b>Name [1]</b>	<b>FIRST</b>	<b>MIDDLE</b>	<b>LAST</b>	<b>Home Phone [2]</b>	<b>Work Phone [3]</b>
<b>Home Address [4]</b>	<b>Street</b>	<b>Apt. # [5]</b>	<b>City [6]</b>	<b>State [7]</b>	<b>Zip [8]</b> <b>County [9]</b>
<b>Mailing Address (if different from above) [10]</b>	<b>Street</b>	<b>Apt. # [11]</b>	<b>City [12]</b>	<b>State [13]</b>	<b>Zip [14]</b> <b>County [15]</b>

<b>II. Family Members Living in the Home (Attach extra sheet if needed)</b>						
<b>Children (under 19) living in the home NAMES [16]</b>	<b>Date of Birth [17]</b>	<b>Citizen (Yes or No -- If no, see also attachment) [18]</b>	<b>Social Security Number [required for applicants -- otherwise optional] [19]</b>	<b>Mother's Name [20]</b>	<b>Father's Name [21]</b>	<b>Covered by Health Insurance other than Medicaid [Yes or No] If yes, what insurance? [22]</b>
<b>Adults living in the home NAMES [23]</b>	<b>Social Security Number [optional] [24]</b>	<b>If employed by a public agency in the State, what agency? [25]</b>				

**III. Income and Child Care Payments**

List all the Income Received by Family Members Listed Above (Attach Extra Sheet if Needed)

Name of person(s) working or receiving money* [26]	Who provides the money? [27] Employer, program or person	How Often? [28] Weekly, twice a month, monthly	What amount? [29] Before taxes or any deductions
1.			
2.			
3.			

\*Be sure to include all sources of gross income (before taxes) such as wages, dividends & interest, TANF, SSI annuities, pension, disability, child support, alimony, cash gifts, & other unearned income.

List the payments made for child care (or care for an adult who cannot care for himself) so that someone in your household can work. [30]

Name of person(s) who works	Name of Person Care For	Under Age 2? Yes <input type="checkbox"/> No <input type="checkbox"/>	How Often?	What amount?

**IV. Medicaid Questions**

Is any child: [31] Pregnant: Yes  No  In an Institution: Yes  No  Do any of the children have unpaid medical bills from the last 3 months? [32] Yes  No

**Social Security Number (SSN) [33]**

If you are applying for Medicaid for a child, you are not required to provide your own Social Security Number (SSN), but we must have the child's SSN in order for the child to receive Medicaid. If you are applying for CHIP (State-specific program name) for a child, you are not required to provide either your own or the child's SSN. If you are applying for Medicaid for yourself, you must provide your SSN. This policy is dictated by section 1137(a)(1) of the Social Security Act and the Medicaid regulations at 42 CFR 435.910. The Medicaid agency will use the SSN to verify your income, eligibility, and the amount of medical assistance payments we will make on your behalf. It is possible that the Medicaid agency will also use the SSN to determine another person's right to Medicaid or to comply with Federal law requiring that we release information from Medicaid records. The information may be matched with the records in other agencies, such as the Social Security Administration or the Internal Revenue Service. These matches may be done by computer or on an individual basis.

**Rights and Responsibilities [34]**

I agree to the release of personal and financial information from this application form and supporting documents to the agencies that run these programs so that they can evaluate it and verify eligibility. I understand that the agencies that run the programs will determine confidentiality of this information according to the federal laws, 42CFR 431.300-431.307.1, and any applicable federal and state laws and regulations. Officials from the programs that I, or members of my household, have applied for may verify all information on this form.

I understand that I must immediately tell the Medicaid agency about any changes in information on this form.

I understand that I may be asked to provide additional information.

I understand my eligibility will not be affected by my race, color, national origin, age, disability, or sex, except where this is required by law.

I understand that this application is an application for one kind of children's health benefits under Medicaid and is not a full Medicaid application. I understand that if I am not found eligible for this kind of children's health benefits under Medicaid, I may be eligible for Medicaid benefits on some other basis and have a right to complete a full Medicaid application.

I have the right to appeal any decisions made by a local Medicaid program. Information on the appeals process can be obtained from the local Medicaid agency.

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime which can be punished under federal law, state law, or both. I understand that I may also be liable for repaying in cash the value of the benefits received and may be subject to civil penalties.

I certify under penalty of perjury that everything on this application form is the truth as best I know.

Signature [35]

Date

Date Received by Agency [36]

## **Application and Enrollment Requirements for Medicaid and Separate State CHIP**

### **1. Requirements for Separate State (non-Medicaid) CHIP**

If a State chooses to develop a separate State (non-Medicaid) CHIP program, the only Federal requirements for the application and enrollment process for CHIP are:

- ◆ A screening and enrollment process designed by the State to ensure that Medicaid eligible children are identified and enrolled in Medicaid; and
- ◆ For qualified aliens, verification of applicant's immigration status with INS.

### **2. Requirements for Medicaid**

The Federal requirements for the application and enrollment process for Medicaid (including CHIP-related Medicaid programs) are explained in 42 CFR 435.900ff. Specifically, States must:

- ◆ Give individuals the opportunity to apply for Medicaid without delay. Pregnant women and infants must have the opportunity to apply for Medicaid at required outstation locations other than welfare offices.
- ◆ Require a written application on a form prescribed by the State Medicaid agency and signed under a penalty of perjury. The application must be filed by the applicant, an authorized representative, or if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.
- ◆ Provide written (or oral, if appropriate) information to all applicants on Medicaid eligibility requirements, available services, and the rights and responsibilities of applicants and recipients. The State also must have pamphlets or bulletins that explain the eligibility rules and appeal rights in simple, understandable terms.
- ◆ Obtain the Social Security number (SSN) of the applicant. (Note that the SSN cannot be required of other family members who are not applying for Medicaid).
- ◆ If the applicant is a qualified alien, obtain documentation of satisfactory immigration status and verify immigration status with INS. (Note that this requirement does not apply to parents if the parents are not applying for Medicaid).
- ◆ Take action on applications within a time standard set by the State (not to exceed 45 days for individuals who apply on a basis other than disability) and inform the applicant about when a decision can be expected.
- ◆ Record in each applicant's case record facts to support its eligibility decision.
- ◆ Send a written decision notice to every applicant. If the application is denied, the notice must include the reasons for the denial, the specific regulations supporting the action and an explanation of the applicant's right to a hearing.



It also is important to note that the State's application and enrollment process must be consistent with our data collection requirements.

Federal law requires no verification of information pertaining to eligibility for children under Medicaid other than the requirement for verification of immigration status of qualified aliens, and the post-eligibility requirement in Section 1137 for an income and eligibility verification system (IEVS). Under IEVS, the State must request information from other Federal and State agencies to verify the applicant's income and resources. The applicant must be informed in writing, at the time of application, that the agency will be requesting this information.



**APPENDIX C**

**Centers for Medicare and Medicaid Services  
Dear State Medicaid Director Letter  
April 7, 2000**



**DEPARTMENT OF HEALTH & HUMAN SERVICES**  
**Health Care Financing Administration**

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**Center for Medicaid and State Operations**  
**7500 Security Boulevard**  
**Baltimore, MD 21244-1850**

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.

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### 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,

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

## 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 its 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.



## **APPENDIX D**

**Centers for Medicare and Medicaid Services  
June 8, 2000 Q&A Regarding April 7, 2000 Letter**

# Center for Medicare & Medicaid Services

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## 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 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 its 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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**APPENDIX E**

**Centers for Medicare and Medicaid Services  
Dear State Medicaid Director Letter  
December 19, 2000**



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Health Care Financing Administration

DEC 19 2000

Center for Medicaid and State Operations  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Dear State Medicaid Director:

Over the past year, questions have arisen about Medicaid policy regarding establishing paternity and obtaining and pursuing medical support and payments. The Child Support Enforcement (CSE) program can provide valuable assistance to families seeking health care, as well as financial support, for their children. However, many States and organizations doing outreach and enrollment have identified paternity and medical support questions on Medicaid applications as a barrier to enrollment of eligible children. This letter explains the Federal Medicaid requirements and options pertaining to paternity and medical support and briefly describes the child support enforcement services available to families receiving Medicaid.

Under Federal law, a parent's cooperation in establishing paternity, assigning rights to medical support and payments, and providing information about liable third parties cannot be required as a condition of a child's eligibility for Medicaid. Therefore, States are not required to ask about paternity or to seek cooperation in pursuing medical support and third party payments when an application for Medicaid is filed, or a redetermination is performed, only on behalf of a child. If a State does ask about paternity or otherwise pursues medical support in the context of an application on behalf of a child, it must advise the parent or other individual completing the application on behalf of the child that such information and cooperation is not required in order for the child to be enrolled in Medicaid. Cooperation is, however, a condition of eligibility for a parent, unless the parent meets one of the exceptions described below. And for all applications, States must comply with the third party information collection and rights assignment provisions under Section 1902(a)(25) of the Act.

Background

Several provisions in Federal Medicaid law pertain to paternity establishment, medical support, and third party liability for medical services. Section 9142 of the Omnibus Budget Reconciliation Act (OBRA) of 1987, as reiterated by Section 301 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), requires State CSE agencies to provide child support services, where appropriate, to families who receive Medicaid. These services include establishing paternity, locating noncustodial parents, and establishing and enforcing child support and medical support obligations. These services are available to all families receiving Medicaid whether or not the parent is obligated to cooperate with the CSE agency as a condition of eligibility for Medicaid. Paternity may be established voluntarily without CSE referral if done at the hospital, through the State vital records office, or in other social service settings.



Paternity establishment is the necessary first step in the support enforcement process. In addition to child support and medical support, paternity establishment may result in other financial benefits for a child, including Social Security dependents benefits, pension benefits, veterans benefits, and possible rights of inheritance. Furthermore, paternity establishment may give a child social and psychological advantages and a sense of family heritage, be a first step in creating a psychological and social bond between father and child, and provide important medical history information.

Cooperation with CSE is a requirement for some individuals' Medicaid eligibility. Section 1912(a)(1) of the Act requires individuals applying for Medicaid who have the legal capacity to execute assignments to assign the State their right to support and payment for medical care from a third party. Also, to the extent that they have the legal authority to do so, Section 1912 requires these individuals, with respect to any other Medicaid eligible individual, to assign the State their rights to support and payment for medical care by any third party. Finally, these individuals, except as described below, are required as a condition of eligibility to cooperate with the State in establishing paternity, obtaining medical support and payments, and in identifying and providing information to assist the State in pursuing third parties who may be liable for payment.

A related provision of the law, Section 1902(a)(25) of the Act, requires States to take reasonable measures to determine whether a third party may be liable for the medical care and services provided to a Medicaid beneficiary and to collect third party information at the time of any determination or redetermination of Medicaid eligibility. It also requires States to adopt laws, which automatically assign to the State the individual's rights to payment for medical care by third parties, whether or not the individual has executed an assignment of rights under Section 1912(a)(1).

#### Applications On Behalf of Parents and Other Adults

If parents or other adults apply for Medicaid on behalf of themselves and their children, they must assign medical support and payment rights to the State and cooperate in establishing paternity, obtaining medical support and payments, and providing information about liable third parties as a condition of their own eligibility, unless they are exempt. Pregnant women eligible under Section 1902(l)(1)(A) of the Act (poverty level pregnant women) are exempt from the requirements to cooperate in establishing paternity of a child born out of wedlock, and in obtaining medical support and payments for themselves and the child born out of wedlock. (These women must, however, assign the rights to medical support and payments). In addition, individuals with good cause, as described by Federal regulation 42 CFR 433.147(c), are exempt from cooperating in establishing paternity, obtaining medical support and payment, and pursuing third party liability. Applicants must be effectively informed of these exemptions and told that the decision whether or not to cooperate will not affect their child's eligibility for Medicaid.

Although the establishment of paternity is a requirement for some parents seeking Medicaid, the Medicaid agency does not have to solicit information about paternity during the Medicaid application process; a simple statement on the application that the parent agrees to cooperate is sufficient to meet this requirement. Parents can be given information on how to follow up with

the CSE agency, or the Medicaid agency or CSE can request further information once the application process is complete. Parents who are not exempt from the requirement have an ongoing obligation to cooperate in order to maintain their eligibility for Medicaid, except during a period of Transitional Medicaid (TMA); parents are not required to establish paternity or pursue medical support if they are receiving time-limited TMA coverage.

### Child-Only Applications

If a parent or caretaker files an application for Medicaid on behalf of a child only, the requirements under Section 1912 do not apply to the parent or caretaker. It is not a condition of the child's eligibility that the parent or caretaker assign the child's rights to support and payment and cooperate in establishing paternity and pursuing medical support and payment. As a result, States are not required by Federal law to ask for cooperation by the parent or caretaker in a child-only application. If a State does seek cooperation, the parent or caretaker must be effectively informed that the child's eligibility for Medicaid will not be affected if the parent or caretaker chooses not to cooperate in establishing paternity and pursuing support at this time. Also, the family size (number of individuals in the household) and need standard that are used to determine the child's Medicaid eligibility cannot be reduced if the parent or caretaker refuses to cooperate.

Although the parent is not required to assign the child's rights, Section 1902(a)(25)(H) requires States to have laws which automatically assign an individual's rights to payment for medical care by third parties to the extent that Medicaid has made a payment. These laws assign to States an individual's rights whether or not an assignment was executed. In addition, although a State cannot require parents to cooperate in establishing paternity and pursuing medical support when only the child is applying for Medicaid, under Section 1902(a)(25)(A) the State must ask the parent whether the child has health insurance in order to identify legally liable third party resources. This information must be collected at the time of application and redetermination in accordance with HCFA regulations at 42 CFR 433.138.

### SCHIP Requirements

There are no Federal requirements for cooperation with CSE under Title XXI State Children's Health Insurance Program (SCHIP) rules. If a State chooses to implement SCHIP through Medicaid, all of the above Medicaid requirements will apply because the newly covered children will be Medicaid beneficiaries. If the State chooses to implement SCHIP through a separate child health program, these requirements do not apply. CSE agencies, however, can be a helpful source of information about SCHIP and Medicaid coverage for parents of uninsured children who are in contact with CSE. Effective coordination with CSE can help States meet their child health coverage enrollment goals.

### Child Support Enforcement (CSE) Services

CSE services are available to families who are eligible for Medicaid. States should advise parents of these services. Parents who have filed for Medicaid on behalf of a child only are not obligated but may choose to utilize CSE services. The Medicaid agency should ensure that

families that want to take advantage of child support services are referred to the CSE agency. HCFA and the Administration on Children and Families (ACF) will continue to work together with States to develop and provide models of effective applications, application processes, and agency coordination.

If you or your staff have any questions concerning this letter, please contact Marty Svolos at (410) 786-4582.

Sincerely,



Timothy M. Westmoreland  
Director

cc:

HCFA Regional Administrators

HCFA Associate Regional Administrators  
for Medicaid and State Operations

State IV-D Directors

Lee Partridge  
Director, Health Policy Unit  
American Public Human Services Association

Joy Wilson  
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National Governors' Association

Brent Ewig  
Senior Director, Access Policy  
Association of State and Territorial Health Officials



**APPENDIX F**

**Centers for Medicare and Medicaid Services  
Dear State Medicaid Director Letter  
January 18, 2001**



**DEPARTMENT OF HEALTH & HUMAN  
SERVICES**  
**Health Care Financing Administration**

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Center for Medicaid and State Operations  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
SMDL # 01-008

January 18, 2001

Dear State Medicaid Director:

I am writing concerning the requirement that States provide pregnant women and children opportunities to apply for Medicaid at locations other than welfare offices, such as Federally Qualified Health Centers (FQHCs) and disproportionate share hospitals (DSH).

Studies demonstrate that application sites outside the welfare office can greatly assist States in their efforts to enroll eligible children in Medicaid and the State Children's Health Insurance Program. Recent studies by the Kaiser Commission on Medicaid and the Uninsured and by George Washington University find that parents say they are much more likely to enroll children in Medicaid if they could do so in convenient locations within the community, such as a doctor's office or clinic, or a school or day care center.

This finding is supported by States' own experiences; many States have found outstationing to be a particularly effective strategy to enroll eligible children and their families and to address stigma issues that may arise when welfare offices are the primary point of entry into Medicaid. The need for outstationing has grown in importance as an increasing number of persons who are not eligible for either cash assistance or food stamps can establish eligibility for Medicaid and do not otherwise have a need to go to a welfare office. In addition, many people, such as homeless persons, frequently do not consider health coverage until a need for health care services arises. The opportunity to apply at the provider site can greatly facilitate enrollment in these circumstances.

Information that the Health Care Financing Administration (HCFA) has received from the Temporary Assistance for Needy Families (TANF)/Medicaid reviews, the Department of Health and Human Service's (DHHS) Office of the Inspector General, and university-based studies suggests that States are not all in full compliance with the outstationing requirement found at section 1902 (a)(55) of the Social Security Act, as implemented by regulations at 42 CFR 435.904. While the regulations give States considerable flexibility to determine how best to comply with the outstationing requirements, States must comply with the mandatory requirements imposed by this longstanding statutory provision and the implementing regulations. In this letter, we review both the requirements and flexibility to ensure States understand what is required and how the flexibility offered by the regulations can be used to meet these requirements in an effective and efficient manner.

In addition, we encourage you to expand your outstationing efforts beyond what the law and regulations require. Utah, Georgia, and Indiana, for example, have moved staff out of the traditional office setting into the community, and recognized staff activities to promote clearly articulated enrollment goals. The result, as reported by these States, has been increased enrollment, a higher level of staff satisfaction and

lower turnover rates, and increased overall program satisfaction on the part of families and the provider community.

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## **Requirements and Options**

### **1. Outstation Locations**

#### **A. Requirements**

##### **Locations at Each FOHC and DSH Hospital**

In general, unless a State has demonstrated to the HCFA that it has an equally or more effective alternative plan for outstationing, it must establish outstation locations at each DSH hospital and each FQHC participating in the State's Medicaid program.

For outstationing purposes, FQHC means an entity that meets the definition in section 1905 (1)(2)(B) of the Social Security Act. It includes an entity receiving a grant under section 330 of the Public Health Service Act; an entity receiving funding under a contract with the recipient of a section 330 grant that meets the requirements to receive a section 330 grant; an entity that the Secretary determines meets the requirements to receive a section 330 grant (FQHC look-alike); and an entity that was treated by the Secretary for purposes of Medicare Part B as a comprehensive Federally-funded center as of January 1, 1990. It also includes an outpatient program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary care services.

FQHCs are particularly important sites for outstationing because most, if not all, FQHC sites are frequently used by pregnant women and children. According to DHHS data, nationally, 59.4 percent of the 10 million FQHC patients are women and children below 200 percent of the Federal poverty line and 77 percent of FQHC patients are either receiving Medicaid or are uninsured. While we encourage States to consider outstationing at sites in addition to FQHCs and DSH hospitals (see options below), we strongly encourage States to comply with their outstationing obligation by outstationing at each FQHC site. As explained below there is significant flexibility in the regulations for staffing and implementing outstationing arrangements. For example, the regulations do not require State staff to be placed at each outstation location. There are various other ways that outstationing can be effectively implemented at most or all sites operated by an FQHC, through rotational arrangements, use of provider staff, and other means. Broad access at multiple FQHC sites greatly enhances the opportunities to enroll Medicaid-eligible children and families.

##### **Alternate Outstationing Plan**

Under the regulations, a State may develop an alternate outstationing plan it is reflected in the State's Medicaid plan and approved by HCFA. The regulations permit States to develop an alternate plan that includes at least some FQHCs and DSH hospitals and other locations. The State must demonstrate that the alternate plan is an equally or more effective method for reaching the target group, and that an equivalent level of funding and staffing would be committed to implement the alternate plan.

In reviewing these State Plan Amendments (SPAs), HCFA will take into account the following considerations and factors:

- number of full time equivalents (FTE) State staff and non-State staff devoted to outstationing under the alternate plan;
- number and location of FQHC and DSH hospital outstation location sites that will be part of the alternate plan and the number and location of FQHC and DSH sites that would not serve as outstation sites under the plan;
- the type, location and activity level of alternate sites under the plan;
- hours of operation of outstationing sites;
- number of sites that will provide initial application enrollment services only and the number of sites where eligibility determination will be made on site;
- availability of translation services at outstationing sites;
- available data on use of sites included in the alternate plan by pregnant women, infants, and children under 19 and available data on such use at the FQHC's and DSH hospitals not included in the plan;
- method for informing the public of the new sites; and
- any other pertinent data, information, or studies that have a bearing on the effectiveness of the alternate plan; and
- the method proposed by the State to evaluate the effectiveness of the plan.

## **B. Options**

### **Outstation at Every FQHC or DSH Hospital Satellite**

The regulations do not require States to outstation staff at every satellite site operated by a DSH hospital or FQHC. However, in order to be consistent with the intent and spirit of the law and regulations, all sites that are frequently used by pregnant women and children should be outstation sites.

### **Outstation at Additional Locations**

Outstation sites need not be limited to required outstation locations or locations that provide health care services. Additional sites may include school-linked service centers, family support centers and other community-based organizations that provide support services, homeless health centers and other community-based health care provider sites, job service centers, day care centers, and Head Start and other programs that provide support services to pregnant women, families, or children.

Beyond the requirements and choices available under the regulations which implement the outstationing requirement of the law, States are free to outstation State eligibility workers at any location that they believe will help facilitate the enrollment of families and children into Medicaid. In addition, outstationing can be used to facilitate the enrollment of other individuals into Medicaid, such as homeless persons and persons that are dually eligible for Medicare and Medicaid.



## **2. Outstation Functions**

### **A. Requirements**

#### **Initial Processing of Applications**

At a minimum, applications must be received and initially processed at each outstation location. Initial processing includes taking applications, providing information and referrals, obtaining required documentation, ensuring that information on the application form is complete, and conducting any required interviews. It does not include evaluating the information and making the determination of eligibility.

All initial processing activities must occur at the outstation location. Therefore, for example, if the State requires a face-to-face interview, the State must arrange for the interview to be completed at the outstation location. Requiring the applicant to go to the local welfare office to complete the interview defeats the purpose of the outstationing requirements.

Proper application forms must be available at all locations.

### **B. Options**

#### **Determine Eligibility at Outstation Locations**

In addition to initial processing, the determination of eligibility can be made at the outstation location by State staff authorized to make eligibility determinations. To the extent the State has staff available for this purpose, it promotes the proper and efficient administration of the program to do so.

#### **Link Outstation Sites to Automated Information Systems**

States also may consider linking outstationed sites to their automated information system so that applications taken at the outstation site can be input directly into the system. Safeguards would be needed to ensure that outstation workers who are not State employees only have access to information they are permitted to see under Federal and State confidentiality requirements. Federal law permits disclosure of information in State files which is directly connected to the administration of the program. The establishment of eligibility is a purpose directly connected to program administration. As such, Federal requirements do not preclude access to application information entered into the system. However, they do preclude giving a non-State employee access to eligibility information in State files about persons other than applicants on the application the non-State worker is initially processing.

#### **Extend Opportunity to Apply to Families and Others**

In addition to taking and initially processing applications from pregnant women and children, as required, States may consider extending the process to low-income families, dual-eligibles, and other applicants. Many children may be eligible for Medicaid under the section 1931 family group. It makes sense to provide these children and their parents the opportunity to apply for Medicaid-only coverage at

the outstation site instead of requiring families to apply at the local welfare office. Several States have developed shortened family applications that are simple to complete and particularly appropriate for outstation sites and mail-in use. States have also found

Page 5 – State Medicaid Director

that training outstationed workers to be able to accept both State Children’s Health Insurance Program (SCHIP) and Medicaid applications as well as those for the dual eligible elderly has been beneficial. Most states with separate SCHIP programs use joint SCHIP/Medicaid applications for children.

#### Combine Outstationing with Presumptive Eligibility

Another available option is to combine outstationing with presumptive eligibility for children. Sites where presumptive eligibility determinations can be made for children, such as FQHCs, hospitals, WIC offices, Head Start Centers, and Child Care Eligibility Centers, also can serve as outstation locations. By combining presumptive eligibility determinations and outstationing at the same locations, presumptively eligible children can receive immediate Medicaid coverage and can begin the process for determining his or her continuing eligibility for Medicaid without the need to go elsewhere to file a formal Medicaid application. This will lessen the number of otherwise eligible children who lose Medicaid after a presumptive eligibility period because they failed to file a regular Medicaid application.

States can also combine outstationing with presumptive eligibility for pregnant women. Medicaid providers can presumptively enroll pregnant women in Medicaid to ensure that they can receive care pending a final determination of eligibility and, in addition, initially process the Medicaid application.

#### Use Outstation Locations in the Redetermination Process

States may consider using outstation locations to assist in the redetermination process. Retention is a major challenge for Medicaid programs, particularly when families and individuals do not reply to requests for information from the State in order to complete the redetermination process. Outstation locations, such as FQHCs, could assist in the process when an individual is at the outstation site for a follow up visit. At least one State is piloting a “rolling redetermination” process under which the information needed to redetermine the family’s or individual’s eligibility is obtained when the family or individual is at the outstationed site. The redetermination/renewal process is thereby completed whenever the information is available, as long as it is done at least every 12 months. FQHCs, in particular, are well suited to this type of rolling redetermination process.

### **3. Staffing**

#### **A. Requirements**

##### Hours of Staffing

Except for outstation locations infrequently used by pregnant women or children, States must have staff available at each outstation location during regular office operating hours of the State Medicaid agency to accept and initially process applications.

State failure to ensure adequate staffing at outstation sites has been reported as a major barrier to

successful outstationing and enrollment strategies. If States do not have available staff, the State is obligated to make other arrangements to ensure that the minimum requirements of the  
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regulations are met. For example, the outstationing requirement can be carried out by DSH hospital and FQHC staff, or by contractors, or volunteers. If States do not have sufficient staff for outstation sites, it is important that FQHCs and DSH hospitals understand that alternatives to the State staffing model can be used, and that states work with these facilities, as required, to implement alternative arrangements. Some States have contracted with their State Primary Care Association to manage and provide technical assistance to outstationed staff. Contact information for these organizations is currently available at [www.bphc.hrsa.gov/osnp](http://www.bphc.hrsa.gov/osnp) by double clicking on the Outreach and Enrollment button. Payment for outstationing activities is discussed below.

#### Staffing at Infrequently Used Locations

Initial application processing assistance must be provided at infrequently used locations but it is not necessary to have the location staffed with a full-time person during regular State Medicaid agency operating hours as noted above. Outstationing assistance must be provided at these locations during the regular operating hours (or when the location provides services during these hours) through staff on site or through telephone assistance, or a combination of both. On-site staff would include State staff, provider or contractor employees, or volunteers. The regulations provide that at these locations States must display a notice in a prominent place which advises potential applicants of when outstation intake workers will be available and provides a telephone number that applicants may call for assistance when staff are not available. In addition, the regulations require compliance with Federal and State laws and regulations governing the provision of adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.

The regulations do not define infrequently used location, and States have discretion to define this term utilizing reasonable criteria and guidelines. The definition must be related to infrequent use by pregnant women, infants, and children under 19; it is unlikely many DSH hospitals or FQHCs would properly be considered sites infrequently used by pregnant women and children in light of the patient mix at most DSH hospitals and FQHCs. The State's definition should be made publicly available.

#### Confidentiality and Conflict of Interest Requirements

The regulations provide that provider and contractor employees and volunteers are subject to the Federal confidentiality requirements that apply to Medicaid, and to State and Federal laws concerning conflicts of interest.

### **B. Options**

#### Use Persons Other Than State Workers to Perform Certain Outstationing Functions

States may use State employees, provider or contractor employees, or volunteers who have been properly trained to staff outstation locations. As noted previously, only State employees so authorized may make eligibility determinations.

Non-agency staff may perform initial processing services provided they are properly trained. States also may work with local community-based organizations to identify volunteers. However, it is very unlikely that a State will be able to fully comply with its responsibility to ensure that outstationing is operating as intended in all required sites by relying solely or primarily on volunteers. Payment for non-agency staff is discussed below.

#### Extend Outstationing Hours to Coincide with Provider Operating Hours

While the regulations require the availability of staff at each outstation location during the regular working office hours of the State Medicaid office, frequently, these hours do not coincide with the hours of health centers, which regularly have evening and weekend hours. We strongly encourage States to extend outstationing hours to coincide with provider operating hours, which often are more convenient for families in which the parents work regular daytime shifts.

#### Rotate Staff Among Outstation Locations

The regulations allow States to station staff at outstation locations or to rotate staff among several locations as workload and staffing availability dictate. While rotation is an option, it does not override the obligation of the State to provide staffing at outstation locations during regular office operating hours and to have either staff or telephone assistance at infrequently used locations. As a practical matter, rotation may be best suited as a means to provide staffing at infrequently used locations, or to cover evening or other nontraditional hours. States may also use State staff on a rotating basis to make eligibility determinations at several locations, or to provide guidance and assistance at several locations to provider staff or other persons performing initial processing activities.

### 4. Payment for Outstationing Activities

#### Requirements

##### Payment for Outstationing Functions

Staffing and resource limitations do not relieve States of the obligation to comply with and pay for the outstationing requirements of the law and regulations. Federal financial participation (FFP) is available in expenditures incurred by the State associated with outstation locations, regardless of whether the function is provided by a State or county employee or other person authorized to perform initial processing activities under the regulation. FFP is available for State expenditures for incurred outstationing costs at regular outstationing locations and at infrequently used and optional locations. The administrative functions of taking and processing applications are reimbursed at the 50 percent rate. Subject to the limitations noted below, this rate includes costs incurred by the State to implement and provide outstationing of intake workers who are State employees, provider employees, volunteers, or contractor employees. The rate covers such necessary administrative costs as salaries, fringe benefits, travel, training, equipment, and space directly

attributable to outstationing activities. To the extent that outstationing activities are directed at both Medicaid and SCHIP- eligible children, enhanced matching funds would be available for the SCHIP-related activities subject to the cap on SCHIP non-coverage expenditures.

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#### Funding Under the \$500 Million Fund

Funding for some outstationing activities is also available under the \$500 million fund authorized under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as part of cash assistance/Medicaid delinking. This fund can be used for a wide range of activities related to enrollment systems and outreach for individuals, including outstationing for individuals who could possibly be eligible under the Medicaid eligibility group for low-income families established by PRWORA in section 1931 of the Social Security Act. When a State performs such activities under—or related to—the 1931 provision, the State can consider the full cost of that activity as attributable to the enactment of section 1931. FFP is available under this fund at the 90 percent rate for outstationed staff, including State eligibility workers and provider employees; see Dear State Medicaid Director letter dated January 6, 2000 for further information. (This letter is available on HCFA's website at [www.hcfa.gov](http://www.hcfa.gov)). Funding under the \$500 million fund is not available for the minimum outstationing requirements mandated by Federal law (section 1902 (a)(55) and regulations at 42 CFR 435.904 (which were in effect prior to the enactment of PRWORA). However, the \$500 million fund would be available for new outstationing activity (including outstationing options beyond the minimum requirements) which is related to section 1931.

#### Use of Provider Donations

Provider-related donations made to a State by a hospital, clinic, or similar entity for the direct costs of State or local agency personnel who are stationed at the facility to determine eligibility or to provide outreach services may be used as the State share of such State costs, within a statutorily prescribed limit. Specifically, the provider-related donations for outstationed eligibility workers (i.e., State or local agency workers) are limited to 10 percent of a State's medical assistance administrative costs, excluding the costs of family planning activities. Direct costs of outstationed eligibility workers refers to the costs of training, salaries, and fringe benefits associated with each outstationed worker and a prorated cost of outreach activities applicable to the outstationed worker. The Medicaid statute permits this arrangement as an exception to the general prohibition on provider-related donations. The exception does not apply to donations made by a hospital, clinic, or similar entity for the direct costs of non-State personnel.

#### Financial Obligation of the State

Although FQHCs and DSH hospitals contribute toward the cost of outstationing in several states, they are not obligated to do so. The State is not relieved of its financial obligation to implement outstationing at a provider location if the provider is unwilling or unable to contribute toward the cost of the outstationing arrangements. The State must arrange for outstationing at that location consistent with the requirements and options of the law and regulations.

#### **Review of State Outstationing Arrangements**

As part of our reviews of State enrollment practices in delinking Medicaid/TANF, HCFA received information regarding State outstationing arrangements. We were made aware of shortcomings in some

States and successful outstationing efforts in other States. The DHHS Office of the Inspector General is following up on these reviews to examine State compliance with Federal requirements and to help identify model strategies.

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We encourage States to review their outstationing arrangements in light of this guidance and to come into compliance with the law and regulations promptly if they are not already in full compliance. States that seek to meet their outstationing obligations under an alternate plan must submit a SPA; in the absence of a SPA, the State will be held to the minimum requirements set forth in the law and regulations. Our goal in providing this guidance is to clarify Federal rules and opinions, and to offer technical assistance and encouragement so that innovative outstationing arrangements will continue to flourish. Outstationing has proven to be a very successful outreach and enrollment strategy for States seeking ways to reach families outside of the welfare office.

If you have any questions or would like technical assistance with respect to these outstationing requirements and options, please contact your regional office.

Sincerely,

/s/

Timothy M. Westmoreland  
Director

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