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

Set #3 (Revised)

REINSTATEMENT

Question 42: **Can States send a pre-notification to families who may be reinstated to ensure the most recent address is on file?**

Answer 42: 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 or other program records for a more up-to-date address and alert caseworkers to the list of affected individuals in case they contact the agency for other reasons. Other outreach efforts might include phone calls, notices to families receiving child care services, television and radio Public Service Announcements (PSAs), and contacts with community-based organizations (CBOs). After reinstating individuals, Pennsylvania contracted with an enrollment broker to place a minimum of two phone calls to a specific subset of reinstated families. The State of Washington distributed a packet of information about its Family Medical Project to "primary stakeholders," including legal aid and advocacy organizations.

States can send pre-notifications to families to obtain current address information if it cannot otherwise be obtained. Both Pennsylvania and Washington mailed pre-notifications to families to apprise them of their upcoming reinstatement and obtain up-to-date contact information. These States have continued to update their records as they have been notified of new addresses by the Post Office and the families.

Question 43: **If the State has exhausted all avenues of contacting a potential reinstatee, when is it reasonable to discontinue efforts to locate the individual?**

Answer 43: If the State has searched an individual's program records and the records of any family members who live with that individual, attempted to notify the individual using all known contact information, and alerted caseworkers to the list of potential reinstatees, then it is reasonable to discontinue active efforts to locate the individual. However, if the individual presents herself in the future, the State should reinstate her and redetermine her eligibility in accordance with the April 7 guidance.

Question 44: **Can States properly by-pass the reinstatement requirement by immediately**

Questions and Answers About April 7, 2000 State Medicaid Director Letter - Set 3

redetermining the current eligibility of individuals who may have been improperly terminated rather than waiting until after they have been formally reinstated to perform the

redetermination?

Answer 44: States have a continuing obligation to provide Medicaid to all persons who have not been properly determined ineligible for Medicaid. Therefore, States must reinstate coverage for individuals who have been terminated improperly from Medicaid. In most cases, States must then redetermine eligibility after reinstatement to assess whether the individual is prospectively eligible for Medicaid. Federal Financial Participation 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.

Question 45: **When must States report the results of their cross-matches of the Social Security Administration's list of children whose Medicaid eligibility was protected by Section 4913 of the Balanced Budget Act and their Medicaid rolls?**

Answer 45: Pursuant to HCFA's April 7 guidance, States must promptly match their State-only Disabled Children's File against their Medicaid rolls to determine which, if any, of the children are not currently receiving Medicaid or are receiving Medicaid but are not identified as a Section 4913 child. States must promptly report the results of the match to their HCFA Regional Office and reinstate any children who were improperly dropped from coverage. Most States have already performed the cross-match and reported their findings. HCFA expects the remainder to do so without further delay.

Question 46: **If a State chooses to provide payment to 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, must the payment be based on the full amount paid by that individual, or can it be at the Medicaid rate?**

Answer 46: Pursuant to the April 7 guidance, States have the option to provide payments to individuals or providers for the cost of services covered under the State's Medicaid plan provided between the time the individual was terminated from Medicaid and reinstatement. HCFA will provide Federal Financial Participation (FFP) to States for such retroactive payments; FFP in payments to participating Medicaid providers will be at the Medicaid rate and FFP in direct payments will be based on the full amount, provided that States pay the full amount. A State may choose to make direct payments in the amount which it pays for the service under its Medicaid plan (i.e., the Medicaid rate). In that event, HCFA will only provide FFP in that amount rather than in the amount actually paid for the service by the individual.

Question 47: **Must a State reinstate an individual for the entire pre-defined reinstatement period or can a State close the case of a reinstatee once it completes a proper redetermination of his ongoing eligibility and determines that he is not currently eligible for Medicaid?**

Answer 47: Under Federal law, State policies and procedures must ensure that eligibility is determined and services provided in a manner consistent with simplicity of administration and

the best interests of

the applicant or recipient. States should select reinstatement periods that allow reasonable time for the State to complete proper redeterminations of ongoing eligibility and for reinstatees to access services and to provide information to the State that is necessary for the redetermination of ongoing eligibility. States that have developed reinstatement procedures have typically reinstated individuals and families for a period of 60 or 90 days. As noted in our April 7 guidance, 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.

If a State has properly determined that a reinstated individual is no longer eligible for Medicaid, it may terminate the case at that time or at the end of the reinstatement period, provided that it gives the individual timely and adequate notice of the proposed termination and the opportunity to appeal the redetermination decision as required under Federal regulation 42 CFR 431.220.

Question 48: **Are reinstatees eligible for ongoing Transitional Medical Assistance (TMA) provided that they meet the eligibility requirements? Will the reinstatement period count toward the requirements?**

Answer 48: States have several options. States may count months in the reinstatement period as months of receipt of Section 1931 Medicaid when determining whether a family has met the three out of the preceding six-month requirement to be eligible for TMA. States also may consider months prior to the original termination. In addition, States have the option to make actual determinations of eligibility under Section 1931 for each month in the reinstatement period and count only those months during which the family actually met all Section 1931 eligibility requirements. HCFA encourages States to take advantage of those options that expand health care coverage to working families and children.

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