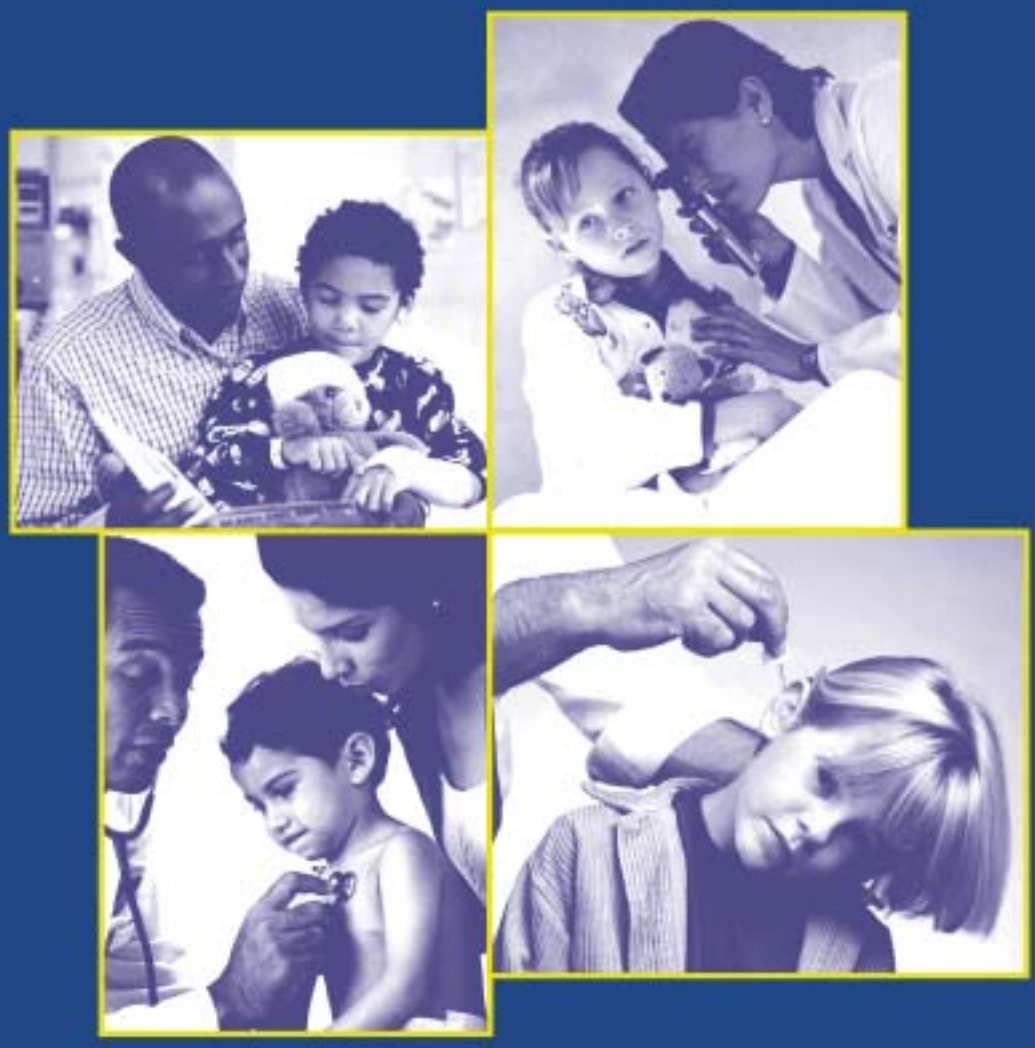
Continuing the Progress:

Enrolling and Retaining Low-Income Families and Children in Health Care Coverage



CMS
Centers for Medicare & Medicaid Services

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INTRODUCTION

In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was signed into law. This comprehensive bipartisan welfare reform plan dramatically changed the nation's welfare system by creating the new Temporary Assistance for Needy Families (TANF) program. TANF replaces the former Aid to Families with Dependent Children (AFDC) and Job Opportunities and Basic Skills Training (JOBS) programs. The same legislation made a critical change in Medicaid eligibility by severing the automatic link between eligibility for cash assistance for families and children and Medicaid.

Delinking eligibility for cash assistance and Medicaid has provided new opportunities for States to offer health care coverage to low-income families regardless of whether the family is receiving cash assistance. Families with incomes and resources below certain State-established thresholds are guaranteed eligibility for Medicaid under Federal law, and States have new flexibility under the law to expand Medicaid to cover more low-income families. Several States have taken advantage of this new flexibility.

The delinkage of cash assistance and Medicaid, however, also has created new challenges for States and the people they serve. In the past, most low-income families first learned about Medicaid when they applied for AFDC. Under current law, however, States must ensure that low-income families have access to Medicaid, *regardless of their connection to the cash assistance system*. That is, families must have the ability to learn about and enroll in Medicaid even if they are not seeking cash assistance. Further, families who no longer receive cash assistance need to be informed that they may remain eligible for Medicaid, and State systems must be in place to ensure that eligible families retain their health care coverage. Medicaid coverage provides critical health security to families who are moving into the workplace as well as to families who have not received cash assistance and work at jobs that do not offer affordable health coverage.

In March of 1999, the Department of Health and Human Services (DHHS) published a guide titled *Supporting Families in Transition* to assist State officials and others in understanding Medicaid eligibility, enrollment, redetermination, notice, appeal rights, and other program and policy issues in the context of the new TANF program. In 1999, DHHS reviewed State Medicaid application and eligibility policies and procedures in all 50 States, plus the District of Columbia and some Territories. Working closely with States, we have analyzed the findings of those reviews and have identified practices that need improvement as well as some promising practices that will be interesting models for other States.

This guide is part of the Department's ongoing effort to work with States to ensure that low-income families and children have access to health benefits. It is intended to serve four major purposes:

First, to assist State officials and others in understanding what is required of States in the administration and operation of their Medicaid application and eligibility determination processes. Our goal is to ensure that the requirements under the Federal rules and regulations are clearly stated and understood.

Second, to provide technical assistance and guidance on options available to States to streamline application and eligibility determination processes consistent with the principles of both simplicity of administration and program integrity. Again, we want to ensure that States are aware of the options available under Federal law to help them continue their efforts to simplify the application and eligibility determination processes and to extend their efforts to families as well as children. Most States have simplified the enrollment for *children* in SCHIP and Medicaid but have not adopted similar methods for *families*.

Third, to provide States with guidance on a range of issues and process concerns specific to Medicaid/TANF delinkage, including the updating of computer systems. We identified issues that arose in the onsite State reviews and provide concrete suggestions, based on State practices, for addressing barriers to program participation.

Fourth, to provide State officials with an explanation of how States may use the flexibility in the law to expand coverage of low-income families and children and simplify their Medicaid eligibility rules. We hope that disseminating information about promising practices being tried throughout the country will help States move beyond the challenges of delinkage of Medicaid and cash assistance to consider ways to make health care coverage available to more low-income families.

We recognize that State officials and others may have questions regarding the policies outlined in this guide. To address these questions, we have established an electronic mailbox to which individuals may submit questions. Questions should be sent to: MedicaidEligibility@cms.hhs.gov. The Centers for Medicare and Medicaid Services (CMS, formally the Health Care Financing Administration) staff will attempt to respond to all questions in a timely manner.

The guide is organized into six chapters:

- **Medicaid Application and Eligibility Processes.** Chapter one explains Medicaid's statutory and regulatory requirements concerning the application and eligibility determination processes. It includes a restatement of Medicaid policy regarding requests for Social Security numbers and citizenship/immigration information of household members not applying for benefits and a clarification of policy regarding requests for paternity and third party information. In addition, it reviews options States can take to simplify the application process to remove barriers to participation.

- **Medicaid Renewal and Termination Processes.** Chapter two clarifies Federal policy regarding redetermination or "renewal" of Medicaid for families including the frequency of reviews and the required information and provides information on how States can simplify the redetermination process. It also restates Federal policy regarding terminations.

- **Medicaid/TANF Delinking.** Chapter three addresses specific concerns and barriers that States and CMS have identified with respect to efforts to delink Medicaid from TANF. A major focus of the chapter is on the basic requirements that State eligibility determination systems must meet in order to ensure that Medicaid procedures are properly delinked from the TANF program.

- **Medicaid Eligibility Policies and Expansions.** Chapter four explains how the flexibility in the Medicaid law provides States with the opportunity to expand coverage for low-income families and simplify eligibility rules, and profiles some States that have taken advantage of this flexibility.

- **Program Monitoring by States.** Chapter five contains information to help ensure program integrity, including ensuring that local offices correctly apply State policies and procedures. It describes Federal financial participation that is available for monitoring and oversight activities that can aid in simplifying and improving program administration.

- **State Simplification Efforts.** Chapter six contains four tables summarizing State simplification efforts.

Chapter I

MEDICAID APPLICATION AND ELIGIBILITY PROCESSES

The Medicaid application process typically is a family's introduction to the program. As such, it plays a key role in determining whether or not the family successfully obtains coverage through Medicaid. If the application process is simple and easy to complete, a family is more likely to complete it. By the same token, if the process is complicated, because other programs are involved, a family may be deterred and not complete the process.

Some States and local governments continue to use the application process for one program such as Medicaid to also determine eligibility for other benefit programs such as cash assistance, child care and Food Stamps. This “one stop shopping” approach presents both advantages and disadvantages for low-income families. Because different programs have different eligibility requirements, applications and the application process can become complicated. However, there has been a shift to present Medicaid as a health care program separate and distinct from the welfare system. Marketing Medicaid as a separate program presents States and local governments with new challenges and decisions.

Most States have simplified the Medicaid application process for *children* by adopting mail-in applications and streamlined documentation requirements. However, these policies often have not been extended to *families* applying for Medicaid. Under Federal law, States have the ability to adopt the same strategies that they have used to simplify their application process for children to the application process they use for determining family eligibility.

This chapter outlines the statutory and regulatory requirements under Medicaid concerning the application and eligibility determination processes that States must follow. To help State officials and others considering strategies for simplification, this chapter also identifies programmatic options designed to promote the enrollment of eligible low-income families with children.

A. Medicaid Application Process

The results of a national survey conducted by the Henry J. Kaiser Family Foundation show that many low-income parents misunderstand the delinkage of Medicaid and TANF, and most want a more user-friendly Medicaid enrollment process.[1] According to the Kaiser survey, the top three strategies that would make low-income parents more likely to enroll their children include mail-in or phone-in enrollment; immediate enrollment (with completion of forms later); and extended office hours for application. Parents also said they would be much more likely to enroll if they could apply when their children enrolled in the school lunch program or if they could apply at more convenient locations within their community. Some States have adopted these enrollment strategies to help more families access Medicaid. States also are increasing their outreach and marketing efforts to improve public understanding about Medicaid eligibility rules and to reinforce the value of Medicaid as providing health care coverage.

1. Minimum Application Requirements

Federal law requires that Medicaid eligibility be determined in a manner consistent with simplicity of administration and in the best interests of recipients (Section 1902 (a)(4) and (19) of the Social Security Act).

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[1]Medicaid and Children: Overcoming Barriers to Enrollment, Findings from a National Survey, the Kaiser Commission on Medicaid and the Uninsured, January 2000.

Opportunity to Apply. Under CMS regulations, the State agency must afford an individual the opportunity to apply for Medicaid without delay (42 CFR 435.906). TANF or other program requirements or actions must not have the effect of delaying or deterring application for Medicaid.

Medicaid Application Forms. CMS regulations require a written application for Medicaid on a form prescribed by the State Medicaid agency (42 CFR 435.907). The application must be signed under penalty of perjury. States have considerable flexibility in designing the form or forms they will use. A form must solicit the information the State needs to make a Medicaid eligibility determination and, at the same time, be designed "in a manner consistent with the simplicity of administration."

Online Applications and Electronic Signatures. States may use computerized or online Medicaid applications provided they have in place safeguards that restrict the use or disclosure of information about applicants or recipients to purposes directly related to the administration of the Medicaid program. CMS suggests that States use an automatic encryption process that safeguards the confidentiality of the information consistent with CMS 's internet security policy posted on the web at:

www.hcfa.gov/security/isecplcy.htm.

Electronic signatures are permitted as long as they are authorized by State law. However, adequate safeguards must be in place to protect the confidentiality of the information collected in accordance with Federal law (Section 1902(a)(7) of the Act).

Documentation Requirements. Surveys and reviews have revealed that a leading reason why eligible families fail to successfully enroll in Medicaid is that the families do not supply State-required documentation. Federal law imposes only one documentation requirement for Medicaid: individuals seeking coverage who are not citizens or nationals of the United States must provide proof of alien or immigration registration from the Immigration and Naturalization Service (INS), or other documents that the State determines constitute reasonable evidence of satisfactory immigration status.

Rhode Island: Self-Help

Rhode Island's Providence Regional Center provides a self-help area for clients in the main waiting room. The self-help area includes forms, a free copy machine and drop boxes for submittal of applications. It allows applicants and recipients to provide documents, report changes and gather information without waiting to see a worker.

Documentation Checklist

Documentation Requirements for Applicants	Federal Requirements to Provide Documentation	State Option to Allow Self-Declaration
Immigration status for qualified aliens	X	
Citizenship		X
Income		X
Resources		X
Date of birth		X
Residency		X
Social Security Number		X
Child care expenses		X

States may require families to provide other relevant documentation, including proof of income and residency, but this documentation is not required by Federal law. If a State does require families to provide additional documentation, the request for documentation must be limited to elements that are relevant to eligibility or third party payment.

States have found that they can effectively preserve program integrity without requiring additional documentation from families. For example, States can verify financial eligibility through employers, banks and other collateral contacts. States that want to confirm the reliability of using self-declaration of income and resources also may use Medicaid Eligibility Quality Control (MEQC) pilot projects or other targeted studies on a Statewide basis or in a sub-State area. This option is described in CMS 's September 12, 2000, letter to State Quality Control Directors (see

http://www.hcfa.gov/medicaid/smd91200.htm.).

Self-Declaration of Income and Resources

More States are turning to self-declaration of income and resources, as the chart attached to this guide shows. As of December 2000, Arkansas, Florida, Georgia, Idaho, Kentucky, Maryland, Michigan, Oklahoma, Vermont and Washington use self-declaration of income for children's health coverage under Medicaid and SCHIP; Alabama, Arizona and Wyoming rely on self-declaration of income for their separate SCHIP program.

States that require documentation must clearly inform the applicant what documentation to provide and what forms of proof are acceptable. Document check lists or other written notices of documentation requirements are very helpful in ensuring that documentation requirements are met, especially if they are provided before a family mails in the application or arrives at a local office. Also, States can improve participation in Medicaid by offering assistance in obtaining required documentation, providing facilities for copying required documentation, and following up with applicants to ensure that they submit any needed documentation.

Requests for Social Security Numbers (SSNs) and Citizenship/Immigration Information. Concerns about disclosing family members' Social Security Numbers (SSNs) and citizenship or immigration status can deter eligible individuals from applying for Medicaid. These concerns appear to stem from uncertainty among immigrant families and others regarding the confidentiality of information they provide to States.

Under Federal rules, *applicants* for Medicaid (including Medicaid expansion programs under SCHIP) must disclose their SSNs (though they do not have to show the card) as a condition of eligibility (Section 1137). The State is required to verify the SSN with the Social Security Administration. States use the SSN to help complete the Income and Eligibility Verification System (IEVS) income verification process required by law. The State may assign an alternate identifier for a person who expresses a religious objection to furnishing a SSN, or for an alien not in a satisfactory immigration status who is seeking emergency services.

States may *not* require non-applicant household members to furnish their SSNs as a condition of the applicant's eligibility. To do so would violate Federal law and could deter eligible individuals with immigrant family members from applying for Medicaid. We recognize that *voluntary* disclosure of a parent's SSN may contribute to a speedier determination of a child's eligibility (as a means of verifying family income) and alleviate burdensome paperwork requirements for families and the agency. However, if a State requests a SSN from a non-applicant, it must: (1) make clear that the disclosure of the SSN is voluntary; (2) inform the applicant how the information will be used; and (3) advise the applicant that the

application will not be denied if the non-applicant's SSN is not provided.

Obtaining Social Security Numbers

Recently published SCHIP regulations allow States to require the child's SSN as a condition of eligibility for separate SCHIP programs effective August 24, 2001. Different rules for SSN's under SCHIP and Medicaid present challenges to States trying to design simple and understandable joint applications for children. California's approach meets the legal requirements. California's joint Medicaid/SCHIP (the State's Title XXI program is called Healthy Families) application for pregnant women and children says, "Tell us about the children under 19 and/or the pregnant woman who want health coverage" and asks for the SSN and/or immigration status for these applicants. The form states, "Social Security Numbers are not required for Healthy Families or for persons who want emergency or pregnancy related services only." Families often will not know when they complete the form whether their children will qualify for Healthy Families; if a family does not provide the child's SSN on the application, and the child turns out to be Medicaid eligible, the California agency will follow up with the family to obtain the child's SSN.

As with SSNs, only persons *applying* for Medicaid are required to document their citizenship or immigration status. States may not: (1) require parents or other household members who are not applying for themselves to disclose this information; (2) make this disclosure a condition of eligibility for the applicant; or (3) deny the application because non-applicant household members do not provide the information.

CMS recently joined with the Administration for Children and Families, the Food, Nutrition, and Consumer Services, and the Office for Civil Rights (OCR) to provide policy guidance in this area. You can refer to the September 21, 2000, letter to health and welfare officials for detailed information on SSN and citizenship/immigration requirements under the Medicaid, TANF and Food Stamps programs. A copy of the letter is posted on CMS 's website at

www.hcfa.gov/medicaid/shw92100.htm.

Paternity and Assignment of Rights as a Condition of Eligibility. Parents of children born out of wedlock applying for Medicaid for themselves and their child/children must cooperate in establishing paternity and pursuing third party benefits and assign rights to medical support and payments (42 CFR 433.147) as a condition of their eligibility (but not the eligibility of the child). A State may not require cooperation, however, if the parent has good cause for not cooperating (e.g., in cases of domestic violence). Furthermore, non-cooperation by the parent does not affect the child's eligibility for Medicaid. States must inform applicants of the exemptions for good cause and advise applicants that their decision whether or not to pursue support will not affect their child's eligibility for Medicaid.

States cannot require information about paternity if a parent or other individual files an application for Medicaid only on behalf of a child and can choose not to ask about it. (However, the State must ask about health insurance that the child may have and the State must have laws in effect that automatically assign to the State the child's rights to third party payment by health insurers.) If the application asks for paternity information in situations where it is not required (e.g., in a child-only application), the form must make it clear that providing the information is optional.

In those situations where a State Medicaid agency must ask about paternity and medical support (for example, because the parent is applying for herself as well as for her child), it is sufficient to simply obtain a statement that the parent (if non-exempt) agrees to cooperate. The Medicaid agency does not have to solicit detailed and specific information about the absent parent as part of its application

process. Instead, it may provide parents with information on how to follow up with the Child Support Enforcement (CSE) agency, or the Medicaid agency, acting for the CSE agency, may follow up after the application process is complete.

There are no Federal requirements for cooperating with CSE under the SCHIP rules. If a State chooses to implement SCHIP through Medicaid, the Medicaid cooperation requirements apply because the SCHIP enrollees are Medicaid beneficiaries. For more information, see the CMS website at

www.hcfa.gov\Medicaid\smd12190.htm.

Linguistic Access. Medicaid applications, notices, and other program information must comply with linguistic access requirements under Title VI of the Civil Rights Act. In order to ensure compliance with Title VI, recipient/covered entities must take steps to ensure that limited English proficiency (LEP) persons who are eligible for their programs or services have meaningful access to the health and social service benefits they provide. The most important step in meeting this obligation is for recipients of Federal financial assistance to provide the language assistance necessary to ensure such access, at no cost to the LEP person.

Maine: Non-English Applications

Maine prints the informational portions of its Cub Care application in thirteen languages spoken by residents: English, French, Spanish, Amharic, Acholi, Somali, Arabic, Farsi, Russian, Chinese, Albanian, Bosnian, and Vietnamese. Families can learn about categorical and income eligibility standards, costs, services, application procedures, and civil rights safeguards in those languages.

The type of language assistance a recipient/covered entity provides to ensure meaningful access will depend on a variety of factors, including the size of the recipient/covered entity, the size of the eligible LEP population it serves, the nature of the program or service, the objectives of the program, the total resources available to the recipient/covered entity, the frequency with which particular languages are encountered, and the frequency with which LEP persons come into contact with the program. There is no "one size fits all" solution for Title VI compliance with respect to LEP persons. The DHHS Office for Civil Rights (OCR) will make its assessment of the language assistance needed to ensure meaningful access on a case by case basis, and a recipient/covered entity will have considerable flexibility in determining precisely how to fulfill this obligation. OCR will focus on the end result – whether the recipient/covered entity has taken the necessary steps to ensure that LEP persons have meaningful access to its programs and services.

Outstationing. Medicaid law and regulations require that States provide an opportunity for children under age 19 and pregnant women to apply for Medicaid at locations other than local TANF offices. States must have such "outstationing" arrangements at each facility designated as a disproportionate share hospital (DSH) and federally qualified health center (FQHC) unless there is an approved alternative arrangement. Regulations (42 CFR 435.904) permit alternative outstationing arrangements under certain limited circumstances; States must obtain approval of alternate arrangements through a State Plan Amendment. The regulations also allow States to establish additional outstation sites at other locations where children and pregnant women receive services.

Kentucky: Outstationing Staff

Kentucky has outstationed staff from all social service agencies, including Medicaid, at various locations in the community connected to middle schools or high schools. In Jefferson County (Louisville), each of these locations is called a "Neighborhood Place" and offers one-stop shopping for residents interested in applying for Medicaid and other program benefits.

The initial processing of the Medicaid application at outstation sites can be done by individuals other than State eligibility staff, such as the hospital's or health center's staff. The eligibility determination also can be done at the outstation site if conducted by State personnel authorized to make the determination. States that have expanded their outstationing activities have found that outstationing helps facilitate enrollment of eligible families and children into Medicaid. For more information, please see the January 18, 2001 State Medicaid Director letter. It can be found at:

www.hcfa.gov/Medicaid/smd01181.pdf.

New York: Facilitated Enrollment

The New York State Department of Health has initiated "facilitated enrollment," a $10 million program that funds community-based coalitions to enroll children in Medicaid and SCHIP, known in New York as Child Health Plus. The facilitated enrollers help families fill out the Growing Up Healthy application (NY's joint application for Medicaid and Child Health Plus), gather the required documents and ensure that the child becomes enrolled. The interview with the facilitated enrollers counts as face-to-face interview requirement for Medicaid purposes. Some of the facilitated enrollers also can help explain to families how managed care works, help them choose a health plan and select a doctor. The facilitated enrollers work in community-based settings (like schools, day care centers and social service agencies) during weekdays, evenings and on the weekends.

Montana: Helping Migrant Workers

Montana sets up a tent near a cherry packing plant where many migrant workers are employed during the summer months. Eligibility workers accept and process applications on site. The Montana Migrant Council brings its mobile clinic and provides needed health services on site. Other entities, which may include Rural Employment Organization, Montana Food Bank, Job Service and Migrant Legal Services, also are available on site.

2. Applications: What Else Can Be Done?

Offer a Medicaid-only application and joint program applications. There are advantages to having both Medicaid-only applications and joint program applications. Some States offer a short Medicaid-only application to families who do not want to apply for other program benefits, such as TANF or Food Stamps. A Medicaid-only application can be shorter and simpler than a joint program application. In addition, some States have found that they can dramatically shorten the processing time for Medicaid-only applications by creating separate, specialized administrative units to process these applications.

Medicaid-only applications typically are used at outstationed sites to make Medicaid easily accessible to pregnant women and children. To reach a wider population, some States use Medicaid-only applications at other places in the community (e.g., family court, community mental health centers, community centers, schools, and health fairs). Several States also have developed Medicaid-only applications for families as well as children and pregnant women and allow families to use these forms to apply by mail.

All States use joint applications so that families can apply for several programs for which they

may be eligible. Many families appreciate the efficiency of a combined application process. While States typically have joint Medicaid/FoodStamp/TANF applications and most States with separate SCHIP programs have joint Medicaid/SCHIP applications for children, other joint program applications present promising outreach possibilities. Coordinating enrollment in Medicaid with enrollment in school lunch or Women Infants and Children (WIC) programs, for example, provides a good method of outreach to the community and can promote enrollment among eligible children. Joint Medicaid/Food Stamp applications might also be a good way to reach low-income working families who are not eligible for cash assistance.

Coordinating Medicaid Outreach

Coordinating Medicaid outreach with the school lunch program can be particularly effective in reaching uninsured children. Under recent legislation (the Agricultural Risk Protection Act of 2000, Public Law No.106-224, H.R. 2559), effective October 1, 2000, school food authorities can share information from school lunch applications with State child health agencies for the purpose of identifying uninsured children and providing them with information about Medicaid and SCHIP. To adopt this option, a State must have a written agreement assuring that shared information will facilitate enrollment, and families must be able to elect the option not to have the information on the school lunch application disclosed.

Joint applications typically are longer than Medicaid-only applications and frequently involve different program requirements. The Medicaid parts of the joint application must specify the information pertaining to Medicaid eligibility to ensure that the requirements of other programs neither delay the processing of the Medicaid application, nor have the effect of carrying over other program rules to the determination of Medicaid eligibility.

Shorten and simplify the application. Characteristics of a simple application are:

Clear instructions. Include instructions explaining who can apply (e.g., children only or parents too), where applicants can get help with the application, and how they can submit the form (e.g., what to attach, where to mail).

Omission of all unnecessary questions, clear designation of optional items, and explanation of reasons for questions. Applications should not include questions that are not necessary to determine eligibility. It also may be helpful to applicants to provide an explanation for optional items or reasons for questions. For example, several States have found it helpful to explain that Medicaid applications ask about already-incurred medical bills in order to help families pay these expenses if they were incurred during the 3-month retroactive period.

Massachusetts Member Benefit Brochure

Families in Massachusetts applying for Medicaid and SCHIP benefits receive a MassHealth member booklet similar to what individuals receive when enrolling in private insurance plans. This colorful booklet is given out with the MassHealth application called the “Medical Benefit Request.” It describes in plain language: how to apply for benefits; provides details on who can get benefits, income standards, covered services and when coverage begins; and it explains other pertinent facts such as how to choose a health plan and a doctor, out-of-state emergency treatment, how to report changes, how the State will use the individual’s Social Security Number and who to call with questions.

Simple and understandable reading level and wording. The reading level and wording on the application should be in "plain language" and easy to understand. "Writing and Designing Print Materials for Beneficiaries" is a guide, which CMS issued in 1999, that contains useful suggestions for designing Medicaid applications. Copies are available from CMS , Office of Internal Customer Support, Administrative Services Group, SLL-B-15, 7500 Security Boulevard, Baltimore, MD, 21244-1850.

Clear but brief explanation of the applicants' rights and responsibilities. States must inform applicants and recipients about their rights and responsibilities (42 CFR 435.905 (a)(3)). For example, States must inform applicants how their SSN will be used. However, such information does not need to be on the application form unless it relates directly to a question asked on the application. States can provide information on rights and responsibilities in other program publications to make the application form simpler. If a State wants assurance that the applicant is informed, the application form can include a signature line attesting that the applicant has been given, read and understood his/her rights and responsibilities.

Eliminate face-to-face interviews. Face-to-face interviews are not a Federal requirement. Families may find it difficult or inconvenient to meet face-to-face with an eligibility worker, especially families who are employed, live in rural areas, or have limited access to transportation. Requiring interviews at the local TANF office also may raise concerns about the stigma of welfare. Some States, as an alternative, have eligibility caseworkers visit job sites and homes or conduct interviews by phone. When office visits are necessary, some States provide transportation vouchers, and many arrange evening and weekend hours to accommodate working families. Most States have dropped the interview requirement for children-only applications but have not yet taken that step for children applying with their families. The following are options States have adopted.

Use phone-in applications. Alternatively, or in addition, States can offer telephone interviews. Caseworkers can obtain information over the phone, complete the application, and mail it to the applicant to sign and return, without requiring the applicant to obtain and fill out an application form or appear for an interview.

Use mail-in applications. Mail-in applications can make it convenient for families to apply and thus help ensure that families complete the application process.

Use convenient locations. States may place eligibility workers at additional outstationed sites beyond those required by Federal law. Application assistors who are not eligibility workers also can help people apply at various sites where potentially eligible families seek health care or information.

Regulations at 42 CFR 435.904(d) specify that the agency must provide for the receipt and initial processing of Medicaid applications at each outstation location. Initial processing means taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation and conducting any necessary interviews. Therefore, if a State requires a face-to-face interview, it must allow for that interview to take place at the outstation site.

Presumptive Eligibility for Children and Pregnant Women. Presumptive eligibility provides the opportunity to grant immediate health care coverage without first requiring a full Medicaid eligibility determination. This option also offers the advantage of providing additional "entry points" into the Medicaid program because qualified health care providers and other qualified entities can grant temporary coverage on the spot when children and pregnant women seek health care or other services.

States have the option to provide presumptive eligibility for children (under Section 1920A of the Social Security Act) and pregnant women

(under Section 1920 of the Act). At State option, entities deemed qualified by the State may determine, based on preliminary information (e.g., self-declaration), whether the family's income is within the State's income limits for Medicaid. If so, the child or pregnant woman may receive coverage immediately and have until the end of the following month to submit a full Medicaid application. (The Medicare, Medicaid, SCHIP Benefits Improvement Act of 2000 provides States with the same option under SCHIP.) States that have a simplified Medicaid application may use this same form to establish presumptive eligibility, thereby eliminating the need for a two-step application process for pregnant women and children.

Inform the Community. Medicaid eligibility rules are not generally well-known to the families in the community who are likely to be eligible. Indeed, misperceptions about Medicaid abound, many originating in the former linkage between Medicaid and cash assistance. A widely held misbelief is that families must be on "welfare" to qualify for Medicaid. Research has shown that many parents do not understand that their children, and perhaps they too, may be eligible for Medicaid even though they are not receiving cash assistance and/or are employed. Many mistakenly believe that TANF provisions, such as time limits, apply also to Medicaid. These misunderstandings suggest the need for continued and more effective outreach efforts that convey basic eligibility information to target the community, particularly working families. Use of appropriate languages and media outlets are crucial to the effectiveness of outreach efforts.

B. Medicaid Eligibility Determination Process

This section outlines Federal rules for determining Medicaid eligibility for families and children. States must make proper and timely determinations, ensure that the actions of other programs, such as TANF or Food Stamps, do not delay the Medicaid eligibility determination, and provide applicants with adequate and clear notice of the State's determinations. This section also describes some optional policies and procedures that States may adopt to improve their efficiency and success in boosting participation among eligible children and families.

Eligibility Pilots

To explore ways to simplify the application process and eliminate barriers to enrollment, CMS awarded five States with grant funds to pilot projects that remove barriers in States' application, enrollment, and renewal processes. With these funds, Florida is piloting a new electronic application process targeted at minority children served by day care centers. Massachusetts is attempting to increase retention rates by simplifying its renewal process and allowing primary care providers to renew a child's coverage when the family comes in for care. Ohio and Pennsylvania will eliminate income verification requirements for some families applying for coverage, and Pennsylvania will examine further the effect of intensive outreach combined with a simplified process. Finally, Washington will increase its efforts to effectively link children receiving school lunch subsidies with health care coverage. Results from these pilots will be shared with States and other interested parties by the end of 2001.

1. Minimum Eligibility Requirements

Single State Agency Requirements. Federal law (section 1902(a)(5)) and regulations (42 CFR 431.10) require that the Medicaid State plan designate a single State Medicaid agency to administer or supervise the administration of the Medicaid program. The plan may designate that either the Medicaid agency or the State TANF agency make Medicaid eligibility determinations for families and individuals under age 21. While

multiple agencies can assist with the application process, the single State Medicaid agency has final authority over all Medicaid policies and procedures. In addition, the Medicaid agency may allow appropriate State eligibility workers at outstation locations to make the determinations of eligibility if the workers are authorized to determine eligibility for the Medicaid agency. Federal law (section 1902(a)(55)) and regulations (42 CFR 435.904) do allow persons other than State employees, however, to perform initial processing functions at outstationing sites.

Working with Immigrant Populations

Some counties in California have an immigrant liaison in their district to address concerns specific to immigrants. New Mexico (via their Covering Kids contractors) entered into an agreement with the Immigration and Naturalization Services (INS) whereby Medicaid staff provides Medicaid training for INS staff, and INS does public service announcements in Spanish on public charge policy to help alleviate immigrant mistrust of government agencies. Delaware has revised its application form for Medicaid and SCHIP to contain a statement that alien verification information will not affect any public charge determination or lead to deportation proceedings.

Time Standards for Determinations. Federal regulations (42 CFR 435.911) require that Medicaid eligibility for families and children, except for those who apply on the basis of disability, be determined and proper notice provided within 45 days of the date of application. Exceptions are allowed for circumstances beyond the agency's control, such as when the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action. The State agency must not use the time standard as a waiting period or a reason for denying eligibility. If an individual applies for Medicaid through a joint program application (e.g., a Medicaid, Food Stamp and TANF application), the State must still determine Medicaid eligibility within the Medicaid time standard. If processing of the application for another program is delayed due to a requirement that does not relate to Medicaid, processing of the Medicaid portion of the application must continue so that a determination is made in a timely manner consistent with Medicaid rules.

Exhaustion of All Avenues of Eligibility. States may not deny a completed Medicaid application (or terminate coverage) unless it has affirmatively explored and exhausted all possible eligibility categories. Therefore, States must have effective processes in place to consider all possible avenues of coverage. The extent to which and the manner in which a State must explore other possible categories will depend on the circumstances of the case, the information contained in the application, and the availability of other supporting documentation.

For example, if the application is for a family and the State determines the family does not qualify under the family coverage category (Section 1931), it must consider coverage for the children in the family under the poverty-level group or other children's eligibility groups. If the children and the parents do not meet coverage requirements for categorically needy family and children's groups, and the State has a medically needy program, the agency would need to consider medically needy coverage for the child and the parents. If the application or any other available information indicates a member of the family is disabled, Medicaid eligibility under the disability category must be considered. However, if there is no indication of a disability (and the applicant has been advised that he or she might qualify for Medicaid on the basis of disability), no further exploration of eligibility under the disability category need be done.

Basis of Denial. States must base the denial of a completed Medicaid application on the failure to meet a Medicaid eligibility requirement. States

may not deny Medicaid eligibility to a family or any family member simply because the family is ineligible for another program, such as TANF, or fails to complete the TANF portion of the application process. For example, a requirement that TANF applicants submit proof of job contacts should not result in the denial of Medicaid. (The exception to this rule is that a State may opt in its State plan to deny Medicaid to a non-pregnant individual adult in the family who does not cooperate with the TANF work requirements.)

Further, States must proceed with the Medicaid determination based on the joint application, exploring all possible avenues of Medicaid eligibility. States are required to dispose of each Medicaid application by a finding of eligibility or ineligibility unless the applicant either withdraws the application or is deceased (42 CFR 435.913). Therefore, the agency can not deny the Medicaid portion of a joint application based on ineligibility for TANF and ask the family to file a new application for Medicaid.

Retroactive Coverage. Federal regulations (42 CFR 435.914) require States to grant retroactive Medicaid benefits for up to three months preceding the month of application. States must grant Medicaid for any or all months of the retroactive period in which the applicant received services and would have been eligible for Medicaid if application had been made in that month. Under retroactive eligibility, Medicaid covers medical bills incurred prior to the date of the application.

Notice of Agency Decision. Federal regulations (42 CFR Part 431, Subpart E, and 42 CFR 435.912) require that States provide notice to applicants who are denied Medicaid that informs them of the denial, the reasons for it, and their appeal rights. Notices must be clear and understandable.

CMS is working with States to develop model notice language and is prepared to provide other technical assistance to States with regard to notices. A State Health Official letter dated December 21, 2000 providing more information can be found at CMS ’s website at:

www.hcfa.gov/init/ch122100.htm. In addition, CMS 's 1999 guide, “Writing and Designing Print Materials for Beneficiaries,” contains useful suggestions that could be applied to writing notices that beneficiaries can understand. This guide is available by requesting copies from CMS, Office of Internal Customer Support, Administrative Services Group SLL-B-15, 7500 Security Boulevard, Baltimore, MD 21244-1850.

2. Eligibility Determinations: What Else Can Be Done?

Accept Other Programs’ Determinations. The authority to make Medicaid eligibility determinations generally is limited to the State Medicaid agency or the State agency administering the TANF program. (Title IV-E determinations confer automatic Medicaid for IV-E foster care children. States also can opt to provide automatic Medicaid eligibility to SSI recipients.) The State may accept other programs’ determinations, however, concerning 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.

To illustrate, if the resource standard and method for determining countable assets under the State’s TANF program were the same as or more restrictive than the rules in the Medicaid program, the Medicaid agency can accept the TANF agency’s determination that a family’s assets fall below the Medicaid 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 remaining eligibility requirements. Likewise, if a State’s Medicaid income standard and method for computing income for children is as broad or broader than the standard and rules used in the school lunch program, the Medicaid agency can rely on the school lunch program’s determination of income to find children income-eligible for Medicaid.

Effective Date. States have flexibility under the Medicaid regulations (42 CFR 435.914) to determine the effective date of eligibility. For example, a State may grant Medicaid eligibility effective as of the date of application or as of the first day of the month in which the application was submitted. However, the State must ensure that retroactive eligibility is provided for up to three months preceding the month of application to applicants who qualify as discussed above in the Retroactive Coverage section.

Kansas and Michigan: Co-location of Eligibility Workers

A growing number of States that use joint applications for children also co-locate eligibility workers to expedite determinations. In Kansas, State Medicaid eligibility workers and employees of a private contractor responsible for HealthWave (SCHIP) are housed in one location. Families seeking health insurance for their children complete an application and mail it to a central clearinghouse. The application is first screened for Medicaid eligibility. State workers make final Medicaid eligibility determinations; private contractor employees make final HealthWave eligibility determinations. Similarly, in Michigan, applications received in the MIChild (SCHIP) office are screened for Medicaid by the MIChild contractor. If a beneficiary appears to be Medicaid-eligible, the application is given to the Medicaid-eligibility worker located on-site at the MIChild contractor's office. Coverage begins on the day that the Medicaid-eligibility worker determines that the child is eligible. This process eliminates delays in determining eligibility that might otherwise occur.

Chapter II

MEDICAID RENEWAL AND TERMINATION PROCESSES

Once families or their children are enrolled in Medicaid, States must redetermine or "renew" their eligibility at least once a year or when a State learns of a change in household circumstances that may affect the family's eligibility for Medicaid. During a renewal, a State must consider all potential eligibility categories before it terminates coverage.

Many States have found that eligible families appear to be losing Medicaid coverage at the point when their eligibility is being reviewed; this chapter describes some steps States are taking to reduce this possibility. Simplified renewal procedures will make it easier for eligible families and children to maintain coverage and could improve Medicaid participation rates among children as well as their families.

Improved coordination between Medicaid and other programs also can be particularly effective in ensuring continued Medicaid coverage for eligible families and children. For example, through improved coordination with the Food Stamps and TANF programs, States can ensure that they do not terminate Medicaid inappropriately due to the requirements of these programs. Information from other programs also can help States retain eligible children and families. During redeterminations, States can rely on eligibility information from other programs to verify continued Medicaid eligibility and, in fact, must rely on any such information that is available rather than requiring families to re-supply this information. (This internal review of eligibility based on available information is called an ex parte redetermination.)

If a State determines that a family is no longer eligible for Medicaid, the State should coordinate with other coverage programs, particularly SCHIP, to make certain that the family or children continue to receive health care coverage if eligible. This chapter outlines the statutory and regulatory requirements and options under Medicaid regarding the renewal and termination processes.

A. Maintaining Eligibility During Medicaid Redeterminations or "Renewals"

States must periodically review a beneficiary's Medicaid eligibility. Within broad Federal requirements, States have flexibility to design and simplify their eligibility review procedures, which a growing number of States (e.g., Connecticut) are calling their renewal procedures. The terms "renewal" or "eligibility reviews" are used in place of "redetermination" throughout this guide.

1. Minimum Renewal Requirements

Frequency of Renewals --CMS regulations (42 CFR 435.916) require States to redetermine eligibility at least every 12 months with respect to circumstances that may change. (States may use longer intervals for reviews of blindness and disability.)

The regulations also require States to establish procedures for timely and accurate reporting of any change in circumstances that may impact an individual's or family's eligibility (except for children if the State has opted to provide "continuous eligibility" as discussed in Chapter 4).

These minimum requirements are the framework in which States design their renewal process. However, families often find these and other renewal procedures complicated or burdensome which can make participation by families difficult. For example, some States require face-

to-face interviews at renewal, require signatures on the renewal form, or require that a new application be filed even though information requests must be limited to circumstances that are likely to change and to items the State cannot obtain from its existing Medicaid or other program files. Medicaid losses result when families fail to respond to requests for information or to attend an interview.

Scope of Review of Changes. When a State receives a report of changed circumstances, it must conduct an eligibility review. The State has the option to treat this review of the changed circumstances as a full eligibility review (since presumably all other information is unchanged) or conduct the full eligibility review at the regularly scheduled time. This review of changed circumstances constitutes a redetermination for purposes of meeting the Federal requirement that eligibility be redetermined at least once every twelve months. No additional redetermination is required until a year from the date that the State considered the reported change unless another change is reported.

For example, assume a family applies for Medicaid in January and reports an increase in income in March. The State finds that the family remains eligible despite the increase in income, and no further changes are reported. The State is not required to redetermine the family's eligibility until the following March, one year from the last reported change.

Required Information. Regulations (42 CFR 435.902 and 435.916) provide that the scope of eligibility reviews must be limited to information that is necessary to determine ongoing eligibility and related to circumstances that are subject to change, such as income and residency. States may not require families and individuals to provide information that: (1) is not relevant to their ongoing eligibility; or (2) has already been provided and relates to an eligibility factor that is not subject to change, such as date of birth or United States citizenship.

Maryland: Automatic Computer Updates of Medicaid, TANF and Food Stamps

In Maryland, a redetermination may be completed according to schedule (every 6 months) or due to a change in circumstances (including a change in circumstances in TANF or Food Stamps). Maryland established an electronic data base system that interfaces with the TANF, Food Stamps and Medicaid programs. This interface automatically updates a household's changes for Medicaid when a change is reported for TANF or Food Stamps. When a change is reported, an ex parte review for continued Medicaid eligibility is conducted at that time and the next regular redetermination is rescheduled from the date of the ex parte review. This automated coordination of programs ensures that case information is current, extends Medicaid for the family and reduces the number of redeterminations in which the family must participate.

Ex Parte Reviews. States must conduct ex parte reviews of ongoing eligibility to the extent possible. This means that States must rely on information already available to the State before contacting the family or individual. States have discretion in determining if information from sources (other than sources presently relied on such as IEVS) is current based on reasonable judgment or experience. By relying on available information, States can simplify administration and avoid unnecessary and repetitive requests to families and individuals. They also can reduce the risk that an eligible family or individual will not complete the renewal process and thus be denied continued coverage even when the information establishing eligibility is available to the agency. However, States are not prohibited by Federal regulations from requiring a signed form at an

annual renewal even if the State has all the information it needs to determine eligibility during an ex parte review.

States should use the following sources in conducting ex parte reviews:

Program Records. States must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements). State Medicaid agencies generally have ready access to Food Stamp and TANF records, wage and payment information, and information from SSA through the SDX or BENDEX systems. They sometimes have access to State child care, child support and Department of Motor Vehicle files as well. CMS issued a State Medicaid Director letter, dated June 13, 2000, explaining how States can use the information available through the SDX system to help them in ex parte reviews. It can be found at

www.hcfa.gov/Medicaid/SMD61300.htm.

Food Stamp Eligibility

In the Food Stamps program, Federal law requires States to recertify eligibility on a regular basis, and individuals receiving Food Stamps must promptly report any change in their circumstances that would affect eligibility. Thus, States should consider information in Food Stamp Program files of individuals currently receiving Food Stamp benefits accurate for purposes of Medicaid ex parte reviews.

Family Records. A State must consider records in the individual's name, as well as records of immediate family members who live with that individual, if the State knows the names or has other identifying information on these individuals. For example, if the State is reviewing a child's eligibility for Medicaid and has current information about the parent's income in the parent's SSI and Medicaid record, the agency must consider and rely on that information unless the State has reason to believe it is no longer accurate. In accessing and using data from other case records, State agencies need to comply with all relevant privacy laws and regulations.

Accuracy of Information. States must rely on information that is available and considered to be accurate. Information that the State or Federal government currently relies on to provide benefits under other programs (e.g., TANF, Food Stamps, or SSI) should be considered accurate as long as those programs require regular redeterminations of eligibility and prompt reporting of changes in circumstances.

Obtaining Information from Individuals. If a State cannot establish ongoing eligibility through an ex parte review, or the ex parte review suggests that the individual may no longer be eligible for Medicaid, the individual must be given a reasonable opportunity to present additional or new information before Medicaid is terminated.

Documentation Requirements. As noted above, Federal law imposes minimal requirements on States with respect to the documentation families must supply. The only documentation applicants must provide relates to the verification of immigration status of qualified aliens. If the immigration status has not changed since the application was filed, no additional verification is required at the time of renewal.

Allow Families Sufficient Time to Complete the Process. Medicaid may not be terminated until families and individuals have had sufficient time to provide information and complete the renewal process.

2. Renewals: What Else Can Be Done?

Failure to complete the renewal process has emerged as a significant cause of coverage losses and non-participation among eligible families and children. Many States have been reevaluating their renewal process for Medicaid, identifying

barriers or problem points, and taking steps to remove them. Following are some ways that States have simplified the process:

Drop the Face-to-Face Interview Requirement. Federal law does not require interviews. States may use a mail-in or phone-in renewal process. Face-to-face interviews can be burdensome for beneficiaries and agencies and reduce the likelihood that families and individuals will complete the renewal process.

Eliminate or Reduce Documentation Requirements. States may want to consider accepting self-declarations from families with respect to changed circumstances. Verification of self-declared income is required under the IEVS system. For income that cannot be verified under IEVS, we encourage random post-eligibility verifications or the adoption of other procedures designed to assure program integrity is being maintained.

While self-verification clearly makes sense in States that accept self-declaration in the initial application process, other States that do not rely on self-declaration at the application stage may want to consider it at the renewal stage. By the time of renewal, the State will have been able to verify the family's income through IEVS or other computer matches. Even if the information available through such matches is not current, it should be recent enough to allow the State to assess whether the individual or family has reported information accurately in the past.

Simplify the Renewal Form. Short, simple renewal forms that ask only for information on circumstances that may change will promote ongoing coverage and help reduce stigma. States that use the application form for eligibility reviews may have difficulty complying with the Federal requirement to obtain information only on circumstances that may change. Also, use of the application form for renewals may be confusing and unnecessarily difficult for beneficiaries.

Use Pre-printed Renewal Forms. States may send the family or individual a pre-printed form showing current information from State files concerning circumstances that could change (e.g., income), and ask the family or individual to indicate whether the information has changed. States can take at least two approaches with pre-printed forms. A State can send the form and instruct the family or individual not to send anything back if the information is accurate; some States call this option "passive renewal." Alternatively, a State could require the family or individual to sign a confirmation that the information is correct and return the form, even if there is no change (signatures on renewal forms are not required by Federal law). States that rely on passive renewal should have some mechanism to ensure that the beneficiaries continue to reside in the State. Information from the beneficiaries' provider or managed care organization that care is being provided can provide such assurance.

Accept Other Programs' Determinations. In addition to accepting other programs' determination at the initial point of application, States may accept other programs' determinations at renewal. For example, if a family has recently been approved to receive subsidized child care and the income standard and rules for that program are the same as or more restrictive than the rules for children under Medicaid, the Medicaid agency can rely on the child care program's income determination when it reviews the child's Medicaid eligibility.

Schedule Reviews Based on Date of Ex Parte Review. When a State, in an ex parte review, relies on information from another program to determine Medicaid eligibility, the State may schedule the next regular Medicaid eligibility renewal based on the date of this ex parte review, or the date of the last review performed by the program whose information the State used.

For example, a family's annual Medicaid renewal is scheduled for June 2001. In April 2001, the Food Stamps agency determined the family

continued to be eligible for benefits. In May, the Medicaid agency conducted an ex parte review based on information from the Food Stamps program and determined the family was still eligible for Medicaid. The State can choose to cancel the upcoming renewal scheduled for June 2001 and reschedule the family's next annual renewal either in April 2002 (12 months from the date of the Food Stamps review) or in May 2002 (12 months from the Medicaid ex parte review). Using the later review date will extend the period of Medicaid eligibility for the family, and reduce administrative burdens on both the family and the State agency.

Washington: Medicaid Review

For families receiving both Medicaid and Food Stamps, Washington automatically performs a Medicaid review at the time of the Food Stamps review and certifies twelve new months of Medicaid for those who remain eligible.

Use Outstation Sites for Eligibility Reviews. States may rely on outstation sites, including disproportionate share hospitals and FQHCs, to facilitate eligibility renewals. State personnel at these sites can complete the process, and other staff or trained volunteers can assist families in completing renewal forms and conduct any required interviews.

Adopt "Rolling" Renewals. At least one State allows eligibility reviews to be completed whenever a family visits a location where such reviews are conducted. For example, if a family expects to visit an FQHC or a community-based organization that assists in Medicaid application and enrollment, the State could allow the Medicaid renewal process to occur whenever the family had reason to visit the FQHC even if the visit occurred before the next regularly scheduled eligibility review. Using this option, the family could complete the Medicaid renewal process at the alternative location at the family's convenience and avoid a separate contact with the Medicaid office.

Massachusetts: Rolling Renewals

As noted earlier, CMS has provided grants to five States to pilot projects that remove barriers in States' application and enrollment processes. Massachusetts' pilot focuses on simplifying the renewal process. The pilot will create the opportunity for families to complete the renewal process at points of service, such as primary care providers' offices, early-childhood service providers, or schools, and will allow the family to submit the renewal form to extend the 12-month period of eligibility at any time during the year.

Education and Outreach. Putting the renewal date on the individual's Medicaid card can serve as a helpful reminder to beneficiaries. It is essential that families and individuals know that their eligibility will be reviewed periodically, what the process will be, when it will occur, and why it is important to complete the process if they are asked for information. Some States are sending more than one notice to alert families to the need for renewal.

Education can occur at the time of application, through written materials provided prior to the renewal, through community-based organizations, and other strategies. It also is important to use program names that beneficiaries will recognize when renewal forms are sent to them. Since the beneficiary's enrollment cards may be issued by their managed care organization, renewal forms might need to identify the managed care organization to help beneficiaries realize that they must respond to the Medicaid agency's request for renewal information.

In addition, providers can help alert families to the renewal requirements. Managed care plans, for example, have an interest in retaining current enrollees and may be able to supplement the Medicaid agency's efforts to inform families of the renewal obligations.

Follow Up with Families that Fail to Complete the Process. It is a good practice to give families and individuals more than one opportunity to provide information needed to complete the renewal process. Several States have developed a process that follows up on non-responses through written reminders, phone calls, or personal contact. A summary of follow-up activities undertaken by States in SCHIP (including Medicaid expansions) is included in Mathematica Policy Research's January 2001 report titled "Implementation of the State Children's Health Insurance Program: Momentum Is Increasing After a Modest Start." It is available at http://www.mathematica-mpr.com/pdfs/schip1.pdf. States may enlist the support of community-based organizations and other groups to assist in follow-up. For example, States that rely on "application assistors" to help enroll children are considering ways to involve them in the renewal process.

Illinois: Personal Notes

The Livingston County Office in Illinois sends follow-up letters to their beneficiaries that supplement letters generated by the State's computer system. The language in the letters explains exactly what the family must do to maintain assistance. The personal notes are sent to beneficiaries by the caseworkers to remind them of redeterminations, or to explain terminations or denials and to suggest they call the local office if they have questions.

B. Medicaid Eligibility Termination Process

States must ensure that termination from Medicaid occurs only after a determination that the family or individual is not eligible under any category of coverage, or after the individual or family fails to complete the renewal process after receiving a reasonable opportunity to do so.

Minimum Termination Requirements

Basis of Termination. A State must terminate Medicaid eligibility if it has made a determination that the individual is no longer eligible under any eligibility category. A State may not terminate Medicaid eligibility based on requirements that relate to other programs, such as TANF and Food Stamps, but that do not directly affect Medicaid eligibility, except for a non-pregnant adult in the family who fails to meet the TANF work requirements if a State has elected this option in its State plan.

Exhaust All Possible Avenues of Coverage. Similar to the rules relating to initial eligibility determinations, States may not terminate Medicaid eligibility unless they have affirmatively explored and exhausted all possible avenues to Medicaid eligibility. States may not determine eligibility for some categories and require families to reapply in order to determine eligibility for other categories.

States must have processes in place that explore and exhaust all possible avenues of eligibility. These processes must first consider whether the family or 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 the manner in which a State must explore other possible categories 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., on the basis of disability or pregnancy), the State must consider eligibility under that category on an ex parte basis without requiring the family to reapply.

If the ex parte review (i.e., a review based on information available to the State) does not establish eligibility under any category, the State must provide the family or individual a

reasonable opportunity to provide information to establish the potential bases for ongoing Medicaid eligibility, including disability or pregnancy. A State does not have to maintain coverage unless the individual has provided some reasonable indication that he or she may be eligible under some other basis.

Since Medicaid has many eligibility categories, some States have developed computer systems that automatically explore all the various possible eligibility categories. In the absence of such systems, it is particularly important to have ongoing State training and institutionalized methods to ensure that the policy to consider alternative eligibility categories before terminating coverage is implemented properly.

In States with separate SCHIP programs, children who become ineligible for Medicaid due to excess income are likely to be eligible for coverage in SCHIP. Under Federal law, States must coordinate Medicaid and SCHIP coverage. States should develop methods for ensuring that these children are evaluated and enrolled in SCHIP, as appropriate.

Medicaid Termination Notices and Appeal Rights. CMS regulations (42 CFR, Part 431, Subpart E, and 42 CFR 435.912) require that individuals who are terminated from Medicaid receive timely notices informing them of the termination, the reasons for the termination, and their appeal rights. With very few exceptions Medicaid coverage for current beneficiaries continues during an appeal that is requested in a timely manner. States must give at least 10 days advance written notice of its intention to terminate eligibility.

Transitional Medical Assistance (TMA). When a family loses eligibility for Medicaid under the Section 1931 group because of earned income and has received Medicaid under that group in 3 of the preceding 6 months, the family is entitled to transitional medical assistance (TMA), which also is known as extended Medicaid benefits or transitional benefits, for 12 months. (In order to be eligible for TMA in the second 6 months, the family must file certain reports and the family's earned income, minus the cost of child care, must not exceed 185 percent of the Federal poverty level.) TMA is no longer tied to prior receipt of cash or loss of cash but is related only to eligibility for Medicaid under the 1931 group. Therefore, the receipt or loss of TANF has no bearing on TMA eligibility.

TMA is like any other eligibility category -- States may not terminate individuals from Medicaid at the end of the transitional Medicaid period without first conducting an eligibility review, including an ex-parte review. Coverage must be continued if any individual in the family is eligible under an alternate eligibility category.

Moves Within the State. A State plan for Medicaid must provide that it shall be in effect statewide (section 1902(a)(1)). This means that the State plan must be in effect statewide and all counties within the State must comply with the State plan provisions.

It also means when a family moves within the State even in a State with a county-administered Medicaid program, the State and the counties are responsible for transferring the case record from the old county of residence to the new county of residence so that Medicaid can continue without interruption. The State cannot require the family to reapply for Medicaid or have its Medicaid eligibility reviewed solely based upon a move to a new county. An eligibility review may be appropriate if there are changed circumstances that might affect eligibility; for example, if the family moved because a parent obtained a new job.

Chapter III

TANF/MEDICAID DELINKING

This chapter focuses on ways States can improve Medicaid coordination with the TANF program and effectively delink Medicaid and TANF. It covers mandatory and optional policies discussed above, as applied to the Medicaid/TANF context. It draws on the findings from the 50 State Medicaid/TANF reviews and identifies practices States are employing to delink Medicaid and TANF more effectively.

With the end of the automatic link between Medicaid and TANF eligibility, many States are working to improve the coordination between the TANF and Medicaid programs and are simplifying Medicaid enrollment at TANF offices. TANF offices can be instrumental in ensuring that eligible families get enrolled in Medicaid and SCHIP even if families are not eligible for TANF or do not want TANF. At the same time, poor coordination between the TANF and Medicaid agencies can create barriers to Medicaid enrollment and contribute to declines in coverage among Medicaid-eligible families.

A. Application and Enrollment

Enhanced Federal Matching Payments for Delinking Activities. As set forth in State Medicaid Director letters dated May 14, 1997 and January 6, 2000, Congress established a $500 million fund to help States make appropriate modifications in their Medicaid program enrollment and eligibility determination processes in light of welfare reform. Federal funding is available at an enhanced match rate for computer modifications and other activities related to implementation of welfare reform. As of March 2001, many States have not yet used their full allotments under this fund. We encourage States to review the expenditures of their allotments and to access any funds that might still be available to make necessary changes related to delinking in their integrated eligibility systems. For example, in the context of delinking, these funds can be used to pay for:

- Upgrades to automated eligibility determination systems;
- New notices and brochures that explain delinking to families;
- Staff training; and
- Outreach to families and children.

Ensure the Opportunity to Apply for Medicaid in TANF Offices. Medicaid regulations (42 CFR 435.906) require States to provide families the opportunity to apply for Medicaid without delay. When States use joint program applications or use the State TANF agency to make Medicaid eligibility determinations, their TANF offices also serve as their Medicaid offices. These offices must furnish an application (either a joint application or a separate Medicaid application, as appropriate) immediately upon request. They may not impose a waiting period in order to conform their Medicaid determinations to TANF policy or procedural requirements. Also, they may not ask applicants to wait to apply for Medicaid until they meet such TANF eligibility conditions as job training or job search. Finally, States may not require individuals applying for Medicaid at the TANF office to repeat any aspect of the joint application process, such as the interview, at the Medicaid office in order to complete the Medicaid application.

Many States encourage individuals to apply for all assistance programs for which they are eligible. While this approach has many advantages, it must be implemented in a way that does not discourage individuals from applying just for Medicaid. If an individual is not eligible for other program benefits or decides not to apply for another

program (for example, after receiving a full explanation of TANF program requirements), the State must advise the individual at that time that he or she may apply for Medicaid and allow the individual to apply without delay.

Eligibility Worker Training

Iowa has a help desk for income maintenance workers with questions and answers on policy and systems available to them at their desk. The help desk plans to have an internet or intranet site for frequently asked questions that income maintenance workers would access from their desktops. Other States provide ongoing training that engages worker attention and participation by offering refresher quizzes (Missouri), board games focusing on eligibility issues (Massachusetts), and an on-line interactive training session (Utah).

Make the Process Simple. States using a joint TANF/Medicaid application must make sure that the TANF application process does not present barriers to applying for Medicaid. States are using different approaches to eliminate such barriers:

States can structure a joint application form so that the basic form incorporates only the fundamental information applicable to all programs and then attach short, simple supplemental forms for each of the programs. In this way, applicants provide information common to all programs and complete only the forms for the specific program benefits they are seeking.

Alternatively, States can develop a joint application that identifies which portion(s) of the application need to be completed for each of the programs for which the application is being used.

States must clearly identify the documentation requirements of the different programs. For example, if TANF requires proof of assets, but Medicaid does not, the form (or the document listing required verification) should so indicate so that applicants know what information they must provide for each program. Making the forms and application packages clear in this way also will help to remind eligibility workers of the different program rules.

States may use a Medicaid-only application or a Medicaid/Food Stamp application for families who do not want TANF. A Medicaid-only application is often shorter and easier to complete than a joint TANF/Medicaid application and relieves the family from furnishing information not relevant to the benefits they wish to receive.

Ensure TANF Caseworkers Understand Medicaid Rules and Processes. TANF agency staff who are determining Medicaid eligibility must be fully informed of Medicaid eligibility rules. Staff training, supervisor sign-off on Medicaid denials (and terminations), and other mechanisms help send the message that the rules for Medicaid are different than the TANF rules and ensure that workers apply Medicaid rules properly.

TANF caseworkers often are the families' primary source of information on public benefits, including Medicaid. Thus, workers must be able to impart information about Medicaid accurately. It is important to inform families early in the application process that even if they don't qualify for TANF, their application for Medicaid could well be approved. Families receiving TANF also need information about how employment and time limits will or will not affect their Medicaid eligibility. A study released in January 2000 by the Kaiser Commission on Medicaid and the Uninsured shows that most families thought that time limits applied to Medicaid as well as TANF. The Southern Institute on Children and Families has prepared State-specific brochures for 13 States describing the range of benefits, including Medicaid, that working families can receive even if they are no longer eligible for TANF. For more information on these brochures, contact the Southern Institute at (803) 779-2607 or check their website at www.kidsouth.org.

B. Determining Eligibility for TANF and Medicaid

Timely Medicaid Determinations. Federal rules that require Medicaid eligibility to be determined within 45 days apply to joint Medicaid/TANF applications. A TANF requirement may not substantially delay a Medicaid eligibility determination. For example, when a family applies for Medicaid and TANF through a joint application, but needs to meet certain TANF requirements before establishing TANF eligibility (e.g., make a certain number of job search contacts), the TANF requirements should not result in a delay in the processing of the Medicaid application. The State must make a timely determination of Medicaid eligibility based on the joint application.

Delink eligibility determinations. States can "delink" the processing of joint applications by forwarding the Medicaid information to a Medicaid processing system that also handles Medicaid-only applications for families. Some States have adopted this option and found that it ensures the proper processing of all Medicaid applications, including those for families who are denied TANF. It also can dramatically shorten the timeframe for making Medicaid eligibility determinations.

C. TANF Denials and Terminations: Effects on Medicaid

Proper Medicaid Denials and Terminations. Since Medicaid eligibility is not tied to TANF eligibility, States may not delay, deny, or terminate Medicaid to a family or any family member simply because the family is ineligible for TANF (e.g., due to employment, time limits, sanctions or any other reason). (The one exception is that States may opt in their Medicaid State plan to terminate Medicaid for a non-pregnant adult in the family who loses TANF due to a failure to comply with the TANF work requirements.) Further, States cannot deny joint applications based on the TANF denials and then advise families to reapply for Medicaid if they think they may be eligible.

As noted earlier, States are prohibited from denying or terminating Medicaid eligibility unless they have explored and exhausted all other avenues to Medicaid eligibility. Medicaid generally covers a broader group of children and families than may be eligible for TANF. Thus, some or all members of a family who are ineligible for TANF are likely to be eligible for Medicaid. There are a number of possible avenues to Medicaid for family members denied or terminated from TANF, including the family coverage (Section 1931) category, poverty level groups and transitional medical assistance.

Notices. States must give written notice to individuals denied or terminated from Medicaid informing them of the reason for the action and of their appeal rights. Since many families believe that TANF and Medicaid are linked, they may assume that Medicaid is denied or terminated when TANF is lost. Therefore, it is important that notices regarding TANF denials and terminations convey clearly that the TANF action does not necessarily mean that the family is ineligible for Medicaid. If the family is not currently enrolled in Medicaid or does not have a Medicaid application pending, the TANF notice should advise the family how to apply for Medicaid benefits.

The following are some strategies States may use to ensure that TANF denials and terminations do not adversely impact Medicaid.

- **Checklists.** In Durham County, North Carolina, the local Medicaid agency staff use an "at a glance" checklist to cross reference TANF closure codes against potential Medicaid eligibility categories. The checklist includes the possible options for continuing Medicaid coverage (e.g., 12-month continuous coverage and transitional Medicaid), lists the steps to establish this coverage, and requires a certification with caseworker signature, as well as the date and result of the Medicaid redetermination.

- **Second-Party Case Reviews.** States may establish second and third-party reviews of TANF/Medicaid denied and terminated cases to ensure that Medicaid is not inappropriately lost when TANF is denied or terminated. Some States use a multi-layer process of case reviews conducted by district, county and State supervisors. Tennessee uses independent contracted staff to perform third-party reviews of closed or denied TANF cases before taking negative actions. These contractors also explain to families what additional opportunities for coverage are available.
- **Computer Blocks.** States may use computer blocks or other methods to ensure that Medicaid eligibility is not erroneously lost when TANF is denied or terminated. Maryland has placed a computer block on all TANF work-related terminations and denials. This block remains in place until cases have undergone second and third-party reviews to ensure that Medicaid eligibility is not improperly lost. North Carolina has conducted systems queries to identify terminated TANF cases that have not been reviewed for Medicaid eligibility.

D. Computer Systems

As Medicaid eligibility is complex, States have found computer-based eligibility determination systems to be critical to making accurate eligibility decisions. There is considerable evidence that manual systems, or computer-based systems that rely heavily on manual intervention, are much more prone to error than updated, fully-automated systems.

Delinking of Computer Systems. Automated eligibility systems play a critical role in assuring that States make proper eligibility determinations. States have an obligation under Federal law to ensure that their computer systems are not improperly denying enrollment in, or terminating persons from, Medicaid. A major finding that emerged from the DHHS Medicaid/TANF delinking reviews is that, at the time, many States had not reprogrammed their computer eligibility systems to delink Medicaid from cash assistance.

Implementation of Interim Back-up Processes. In a State Medicaid Director letter dated April 7, 2000, CMS directed States to review and, if necessary, correct their computer systems in order to reflect current Medicaid eligibility rules. States are under an obligation to take immediate action to correct any identified computer eligibility systems problems. If States cannot make programming changes immediately, they must institute an interim system that overrides computer errors and ensures that Medicaid is not being denied or terminated improperly.

CMS has identified a number of approaches adopted by some States to prevent erroneous computer actions. In each case, the State adopted a formal and systematic approach to identifying and correcting computer-based errors until such time that reprogramming could occur. A simple instruction to workers to override or work around computer errors is insufficient to ensure that erroneous denials and terminations will not occur. The back-up approaches States have used are listed below.

- Supervisory Review- Supervisors review all TANF denials or case closures before any Medicaid denials or terminations proceed. Having trained supervisors review denials and terminations can help prevent wrongful actions from occurring.
- Centralized Review - Local supervisors and a State-level task force review all Medicaid denials and terminations that coincide with a TANF denial or termination.
- “Preemptory” reinstatement- Caseworkers and managers give cases scheduled for termination "next-day" audits. Cases that continue to be eligible for Medicaid are "reinstated" before the scheduled Medicaid closure.

Medicaid Management Information Systems (MMIS). Most States have an automated claims processing and information retrieval system (commonly known as MMIS). In addition to assuring that computer eligibility systems are properly programmed to reflect ongoing Medicaid regardless of eligibility for TANF, States may be able to take advantage of the already existing interface between their MMIS and their integrated eligibility systems (IES). Currently, most IES transmit data daily to an MMIS. This data transmission is necessary to assure that the MMIS is operating from the most current eligibility decisions.

States may want to program their MMIS to "talk back" to their integrated eligibility system to disallow improper terminations. Alternatively, a similar but simpler approach is to program a block of MMIS closures until a supervisor reviews the cases in question. For example, a State could select TANF closing codes (excepting out certain closures, e.g., death and loss of residency) and apply a block to automated MMIS closures in cases that have the selected TANF closing codes. The MMIS system could be programmed to produce a daily report of blocked closures. After a central or supervisory review of the blocked closures, the State could manually enter the confirmed closures into the MMIS system. Periodic reconciliation of an IES and a MMIS would assure that accuracy and consistency are maintained.

MMIS enhanced Federal funding may be available for changes to MMIS. We encourage States to consult with their regional offices about the availability of enhanced funding.

Systems Automation. An additional finding from the TANF/Medicaid reviews was that there is wide variation among States as to the degree of modernization and automation of integrated eligibility systems. The number of eligibility categories has grown over the last several years. Each category has a set of complex rules and many options, and States need to exhaust all categories of possible eligibility before denying or terminating Medicaid. Computer systems can more effectively and efficiently manage these complexities than manual procedures. A manual determination process, or a process that requires manual intervention by the caseworker, is much more likely to be error prone and to create problems for applicants, beneficiaries and the agency.

Chapter IV

MEDICAID ELIGIBILITY EXPANSIONS AND POLICIES

A. Minimum Requirements

Enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) delinked eligibility for Medicaid from receipt of cash assistance and established a new Medicaid eligibility category for low-income families. Under Section 1931 of the Social Security Act, States must provide Medicaid to families with children who meet the eligibility criteria regardless of whether or not they are eligible for or receive TANF cash assistance.

Section 1902(a)(17) of the Social Security Act requires States to establish eligibility standards for a given Medicaid group that are the same for all members of that group. This means that, generally, the eligibility rules must be the same for all Medicaid applicants and recipients within the Section 1931 group.

Under Section 1931, States have numerous options that allow them to cover additional families and/or simplify eligibility requirements and administration.

Using Section 1931 flexibility, a number of States:

- Disregard all resources;
- Disregard a car of any value;
- Disregard the cash value of life insurance;
- Disregard the actual cost of child care;
- Disregard more income than required; and,
- Eliminate the time limits on the earned income disregards.

Additional Resources

The National Governors' Association (NGA) has released two Issue Briefs on State policy options for extending health care coverage to low-income families. "State Policy Options for Health Care Coverage for Families On, Leaving, or Diverted from Welfare and Other Low-Income Families" provides options for States to ensure that current welfare recipients, former welfare recipients and those diverted from welfare have access to health care coverage. It also discusses options for extending coverage to low-income families that may never have received cash assistance. A companion Issue Brief, "State Outreach and Enrollment Strategies to Improve Low-Income Families' Access to Medicaid," focuses on State best practices to enhance Medicaid coverage such as expanding outreach efforts, updating automated eligibility systems and simplifying eligibility determination and redetermination processes. These Issue Briefs can be found on NGA's website at:

www.nga.org/Pubs/IssueBriefs/2000/Sum000915Lowincome.asp

and

www.nga.org/Pubs/IssueBriefs/2000/Sum000915TANF.asp.

B. Policies and Expansions: What Else Can Be Done?

Less Restrictive Policies under Section 1931. States have significant flexibility in establishing Medicaid eligibility for low-income families under Section 1931.

First, States have the option to raise their income standard by the percentage increases in the urban component of the CPI since the enactment of PRWORA. This provision allows additional families to become eligible under Section 1931. If a State chooses to raise its income standard for the Section 1931 group, it may raise the medically needy standard accordingly. This change would allow additional families to become eligible as medically needy through a spenddown.

District of Columbia: Gross Income Test

The District of Columbia now basically uses a gross income test of 200 percent of the FPL for families with children under 19 years of age. Child care expenses and income excluded under other Federal statutes are the only allowable income deductions. To accomplish this, the District disregards income in the amount of the difference between its AFDC standard in effect on July 16, 1996 and 200 percent of the FPL plus the cost of child care necessary for someone to work. This was done through a State plan amendment (no waiver needed). The District receives SCHIP enhanced matching funds for the children (but not adults) in the expansion group.

Second, States have the option to adopt methods of determining countable income and resources that are less restrictive than those used under the State's AFDC State plan in effect on July 16, 1996. States may take advantage of this flexibility to simplify family eligibility by disregarding certain types of income that AFDC counted. For example, they could disregard income that was irregular or incidental, such as interest income. States also may cover additional families, who would not be eligible using the July 16, 1996 policies, by disregarding additional income and/or resources.

Less Restrictive Methods

As of December 2000, Maine, New Jersey, Connecticut, Ohio, California, Rhode Island and Washington, D.C. use less restrictive methods to determine eligibility under Section 1931. Missouri, Wisconsin and New York have waivers to implement more liberal methods. Several other States are considering using more liberal methods including Louisiana and Indiana.

While States must carry out a prompt renewal of eligibility when they learn of changes in circumstances, they can use less restrictive methodologies under Sections 1902(r)(2) and 1931 to disregard small fluctuations in income. For example, a State can choose to disregard increases in income of less than $100 until the next regularly scheduled redetermination or until a redetermination is triggered by some change other than an increase in income. If a State chooses to do this, individuals would not be required to report increases in income of less than $100 above the amount reported at application or redetermination until the next redetermination. This both eases the reporting burden on the family and simplifies administration for the State.

Furthermore, States may use this “less restrictive method” to effectively raise the income standard to any level chosen by the State. For example, a State could disregard the difference between the July 16, 1996, AFDC standard and 200 percent of the Federal poverty level (FPL), effectively raising the income standard for families with children to 200 percent FPL.

If a State expands eligibility of the Section 1931

group after March 31, 1997, enhanced Federal matching funds at the SCHIP rate are available for children without insurance who would not have been eligible for Medicaid in absence of the expansion.

Converting to a Gross Income Standard. States also may use less restrictive methods to eliminate the 185-percent gross income test that existed under AFDC of July 16, 1996 and that otherwise continues to apply to Medicaid under Section 1931. (Generally, under AFDC there were two income tests. The first test was whether a family's gross income was at or above 185 percent of the State's AFDC "need standard." If gross income was at or above 185 percent of the need standard, the family was ineligible and there was no need to apply the second test. If the family's gross income was less than 185 percent of the State's need standard, the State determined countable income by applying income disregards and comparing countable income to the AFDC payment standard. To be eligible, the family's income after application of the disregards had to be below the payment/need standard.) Alternatively, a State may combine the 185 percent gross income test and less restrictive methodologies to establish a simpler gross income test.

Eliminating the "100-hour" Rule.
States now have the option to provide Medicaid eligibility to all families, including two-parent families in which the principal wage earner works full time. Under Section 1931, States must provide Medicaid eligibility to a family with a child who is deprived by the absence, death, incapacity or unemployment of a parent and has income and resources below the old AFDC standards. By regulation, the AFDC program defined unemployment as working less than 100 hours per month. Thus, a two-parent family in which the principal wage earner worked full time could not qualify for AFDC except under very limited circumstances. Prior to PRWORA, many States had been granted a waiver of the 100-hour rule as part of a welfare reform demonstration project. Section 1931 allowed States to continue waivers of Part A of title IV that were in effect on July 16, 1996. Most States opted to continue the waivers of the 100-hour rule.

On August 7, 1998, DHHS revised the old AFDC rules to allow States to define unemployment (Federal Register / Vol. 63, No. 152 / pages 42270-4). States now can, without a waiver, define unemployment in such a manner that they can cover two-parent families in which a parent works full time. All States now have the option to effectively determine the Medicaid eligibility of a two-parent family on the basis of income and resources.

Options for Children and Pregnant Women Coverage. Section 1902(r)(2) applies to most Medicaid eligibility groups for children and pregnant women. It provides States with the same flexibility described under Section 1931 discussed above. That is, the State may choose to disregard income and/or resources that otherwise would be counted under Federal rules.
If a State uses the 1902(r)(2) authority to expand

Gross Income: Another Approach

One State is considering converting its Section 1931 income standard to a gross income standard. It would do this by disregarding income in the amount of the difference between 185 percent of the AFDC standard in effect on July 16, 1996, and 185 percent of the Federal poverty level for purposes of the 185 percent gross income test. As a result, any family with gross income below 185 percent of the poverty level passes the first income test. The State would then effectively eliminate the second income test by disregarding all income for purposes of that test. As a result, all families with gross income below 185 percent of the poverty level will be eligible. The State could adopt this policy through a Medicaid State plan amendment.

eligibility after March 31, 1997, enhanced Federal matching funds at the SCHIP rate are available for children without insurance who would not have been eligible for Medicaid in absence of the expansion.

Simplifying Eligibility Determinations by Merging Eligibility Groups. States may use the flexibility explained above to effectively eliminate the differences in the eligibility standards and methodologies used to determine the eligibility of all low-income families, children and pregnant women. States can have one set of financial eligibility rules (e.g., disregards and exemptions) for all of its Medicaid categories relating to families and children.

Continuous Eligibility for Children. Under a provision of law enacted in 1997, States may choose to provide Medicaid to children under age 19 for a continuous period of up to 12 months. Once a State determines that a child is eligible, the child remains eligible for the period of continuous eligibility chosen by the State regardless of changes in the child's circumstances (other than reaching age 19 or moving out of State). If a State chooses this option, continuous eligibility applies to all children found eligible for Medicaid regardless of the basis of eligibility. For example, if a State adopts the continuous eligibility option, continuous coverage must be provided to children in the Section 1931 family category as well as to the poverty-level children.

States have asked what can be done when an additional child in the family becomes eligible for Medicaid to avoid different periods of continuous eligibility in the same family. At the same time that the additional child is determined eligible, the State can redetermine the eligibility of the children already receiving Medicaid and begin a new period of continuous eligibility for them so that all children in the family will have the same period of continuous eligibility. If the State determines at the redetermination that the children are no longer eligible, however, the State must continue to provide Medicaid until the end of the original period of continuous eligibility.

Ensuring Access to Transitional Medical Assistance (TMA). In many circumstances, families find employment and lose eligibility under the Section 1931 group after one or two months. These families are not entitled to TMA because they did not receive Medicaid under the Section 1931 group in three of the preceding six months. However, States may use the flexibility available under the "less restrictive methods" provision to enable these families to qualify for TMA. To do this, the State would exclude all earned income in the first 3 months of eligibility once eligibility under the Section 1931 group is established. (Earned income disregards constitute the sole exception to the rule that States must treat applicants and recipients comparably; that is, States can apply these disregards to recipients only. This is because the AFDC rules that underlie Section 1931 eligibility allowed AFDC applicants and recipients to be treated differently in this respect.) This 3-month disregard allows the family to remain eligible under Section 1931 for 3 months regardless of earnings. At the end of the third month, the earnings will count, and the family will be eligible for 6 or 12 months of TMA. A State may implement this policy through a State plan amendment.

Nevada: Transitional Medicaid

Nevada uses a 100 percent earned income disregard for three months and a 50 percent earned income disregard for the next nine months as well as disregarding the full cost of child care. The three month 100 percent earned income disregard makes it easier for families to receive transitional Medicaid by facilitating the requirement that Medicaid must be received in three of the six months prior to losing Medicaid under Section 1931 because of earnings.

Extending Transitional Medical Assistance (TMA). Some States have chosen to provide TMA for more than 12 months when someone finds employment that would otherwise make the family ineligible for Medicaid under the Section 1931

group. As families work towards self-sufficiency, they often begin in jobs that do not offer health insurance or do not pay sufficient wages for the family to afford the premiums and other costs associated with most private health insurance or the employer health insurance package may not include services provided under Medicaid. An additional period of Medicaid eligibility may allow the family to raise the level of their employment before losing Medicaid or it may provide coverage until the point that it becomes available through the work place.

Technically, States may not provide TMA for longer than 12 months. However, States may use the flexibility under Section 1931 to provide more than 12 months of additional Medicaid benefits to almost all families that would otherwise lose eligibility under the Section 1931 group because of earnings. For example, to provide 24 months of additional Medicaid, a State would exclude all earnings for 12 months beginning with the month that the family would otherwise be ineligible under the Section 1931 group. This policy would allow the family to remain eligible under the Section 1931 group for 12 months regardless of earnings. (NOTE: During this period, a family could lose eligibility for a reason other than earnings.) At the end of the 12 months, the State would begin counting the earnings, and the family would be ineligible under the Section 1931 group. The family would then be eligible for TMA for 6-12 months. The State may implement this policy through a State plan amendment. New Jersey, North Carolina and South Carolina have extended transitional Medicaid to families in this manner.

Diversion Payments. Some States provide a diversion payment to a family in the month that they apply for cash assistance, in lieu of offering ongoing cash payments. These payments usually go to families that need only temporary help to resolve a specific problem that prevents them from being self-sufficient. For example, a family might not be able to afford to repair a car that is needed for employment. Diversion payments are countable income for Medicaid purposes unless a State chooses to disregard them. A State may use the flexibility under Section 1931 to exclude these payments from income, thus allowing a family to become eligible under the Section 1931 category.

Disregarding Resources. States have used the flexibility available under Section 1931 to: (1) simplify the resource test; (2) effectively raise the resource standard; or (3) eliminate the resource test altogether.

Alaksa: Transitional Medicaid

Alaska encourages families receiving transitional Medicaid to report decreases in income that might enable them to reestablish eligibility under Section 1931. The State also provides a special envelope for families to save paystubs and receipts for child care payments during the extended Medicaid period when reports are due every three months.

To simplify the resource test, States have chosen to exclude resources that were counted under AFDC. For example, a number of States now exclude one car of any value. Other States have chosen to exclude resources that are not frequently encountered or seldom affect eligibility, such as the cash value of a life insurance policy.

Some States have chosen to effectively raise the resource standard above that used in AFDC by disregarding a flat amount of resources. For example, a State which had a resource standard of $1000 under AFDC can raise the resource standard to $5000 by disregarding $4000 in otherwise countable resources.

Finally, some States have chosen to exclude all resources as a less restrictive methodology. This effectively eliminates a resource test for the Section 1931 group.

Chapter V

PROGRAM MONITORING BY STATES

State oversight of operations at the local level is essential if States are to ensure consistent and correct application of State and Federal policies and procedures. Without monitoring of local operations, policy application and program practices can vary from county to county and there is often no method to alert the State to problems occurring in any particular area. Many of the TANF delinking problems identified by States and CMS were not due to improper policies but rather to improper implementation of policies at the State or local level.

A. Minimum Requirements

Statewide operation. Under Federal law, (Section 1902(a)(1)), Medicaid State plans must be in effect statewide. This requirement applies even where counties administer the Medicaid program.

Monitoring. CMS regulations (42 CFR 431.50) require States to ensure that the plan is continuously in operation in all local offices by informing staff of State policies and procedures and through regular monitoring of operations in local offices.

Training and clear instructions to all levels of administration, including eligibility workers, are part of the State's responsibilities to ensure that policies and procedures are correctly and consistently applied at the local level as well as statewide.

Review systems and procedures. As part of their responsibility to ensure that the State and Federal laws and polices are followed statewide, States must review their systems and procedures to determine if they are functioning properly. For example, States must ensure that the systems and procedures operating statewide are in compliance with Federal requirements to consider all possible categories of coverage before denying or terminating Medicaid benefits.

B. Monitoring Strategies

No one strategy will assure ongoing compliance with State and Federal requirements. Some of the ways that States have monitored local actions are discussed below.

Visit local offices. Regular visits to local offices can help States determine how well they are implementing the Medicaid program in accordance with Federal and State policies and procedures. Interviews with managers and front line caseworkers and receptionists can help the State assess the level and accuracy of knowledge about correct policies and procedures, to determine where problems are occurring, and to get feedback about the office operations. States also should review Medicaid eligibility manuals, locally-generated notices, and other relevant material that local offices are using to ensure they have up-to-date instructions, policy interpretations and other information.

Georgia: Field Consultants monitor program administration.

Georgia Medicaid program Field Consultants monitor, assess and report on county offices' Medicaid program administration. They visit several county offices each quarter, then write and submit quarterly reports. These reports identify problem areas and provide corrective action plans with detailed training recommendations, timelines, and follow-up monitoring steps. The Field Consultants also attend field coordinator meetings with county office directors and provide feedback on any counties with problematic error rates.

Monitor and assess the culture in local offices. According to recent studies, a significant proportion of families deterred from enrolling their children cited poor treatment at the local office and the need to go to the local office as negative factors. States should assess the culture in local offices to determine whether the way individuals and families are treated may be deterring eligible people from seeking or retaining coverage. States can consult with community-based organizations, consumer advocacy groups, and health care providers to get feedback on how local practices are affecting family participation. Also, they could adopt enrollment goals as a performance measure for offices or workers (or both) in order to provide incentives for workers to focus their efforts on enrolling children and families into Medicaid.

Indiana: Enrollment Goals

Indiana set county enrollment goals in their Hoosier Healthwise (SCHIP Medicaid expansion) program. Each local county determined their own strategies for expanding enrollment of children; the central office supported their local decision with regard to outreach implementation and monitored data to assess progress toward goals. Clear and ongoing communication about progress in meeting goals, including data, created a collaborative spirit. Both state and local staff say the county discretion and local flexibility contributed to their success in meeting and exceeding their enrollment goals.

Meet with Beneficiaries. Beneficiaries can help to identify problems in State or local practices that are hindering families from enrolling or retaining their Medicaid eligibility and they can partner with State and local administrators to plan ways to improve operations and boost participation. Several States have conducted focus groups to pinpoint such problems and some States meet regularly with consumer groups.

Monitor enrollment data. Data on denials, terminations and enrollment trends for families and children, by locality, can alert the State to potential problems. For example, declines in enrollment in a particular city or county may signal the emergence of enrollment or reenrollment barriers related to the procedures followed in that area. States may also use enrollment data as the basis for establishing reasonable enrollment goals for State and local offices. As seen in the Indiana example, enrollment goals help reinforce the importance of enrollment as a key objective of State and local offices.

Monitor TANF and Medicaid eligibility determination processes. States can develop a program of regular monitoring of the TANF/Medicaid delinking effort at the local level to help ensure that processes in place are working properly and do not delay or impede Medicaid eligibility determinations or result in erroneous Medicaid denials and terminations. Some States have established extra supervisory reviews or special audits of Medicaid terminations and denials that coincide with terminations and denials of cash assistance.

Assess Medicaid and TANF denial and termination notices. Incomplete and unclear denial and termination notices can contribute to misunderstanding about Medicaid eligibility, discourage families from pursuing legitimate appeals, and deter families from seeking benefits in the future (when they may be eligible). A review of standardized notices can help to ensure that they clearly explain the agency's action and reflect current policies. In the case of TANF denials and terminations, States should review their notices to see if they provide the appropriate message regarding the continued availability of Medicaid eligibility and provide a phone number that individuals can call for assistance.

Medicaid Eligibility Quality Control (MEQC). The MEQC program was enacted as a means to reduce high State error rates and monitor the accuracy of Medicaid eligibility determinations. At that time, Medicaid application and enrollment

procedures closely followed cash assistance program rules. States relied on MEQC requirements to help ensure that: (1) Medicaid eligibility determinations were accurate; and (2) their error rates stayed below the 3 percent tolerance level allowed by Federal law.

CMS regulations (42 CFR 431.800 ff.) set forth the process by which States must monitor the accuracy of Medicaid eligibility determinations. States may follow this process or develop MEQC pilots as alternative ways to identify and reduce erroneous payments. CMS has an Internet website

(http://www.hcfa.gov/medicaid/regions/mqchmpg.htm)

that summarizes current State MEQC pilots and other information. States can visit this website to learn about the ways States are using MEQC to help them monitor their programs.

States also must operate a negative case action program (as part of their MEQC activities) whereby a sample of Medicaid denied and terminated cases are reviewed for accuracy. These reviews provide States with data for developing corrective actions that improve beneficiary protection against erroneous Medicaid denials and terminations. States also can develop alternative negative case action programs, similar to MEQC pilots.

Some States have voiced concern that the MEQC program is a barrier to their efforts to simplify Medicaid enrollment procedures. We see no evidence that State simplification procedures have contributed to an increase in errors and, indeed, simplification can reduce erroneous denials and terminations. Thus, while MEQC remains an important tool for ensuring program integrity, States should not view it as a barrier to simplification. CMS issued guidance on September 12, 2000 that provides examples of how MEQC can serve as a valuable aid to simplification efforts. In addition, CMS and the Office of Inspector General (OIG) issued a letter on January 19, 2001 clarifying that program integrity is not limited to accurate eligibility determinations and payments but also includes ensuring that eligible individuals and families receive the benefits to which they are entitled. There is no evidence that program simplification strategies designed to make accessing and retaining Medicaid benefits easier for individuals and families impact proper eligibility determinations.

Idaho: MEQC Pilot

Idaho simplified the application process in November 1999. This included a shorter application form (3 pages), self-declaration of income and assets, and twelve continuous months of eligibility. Idaho reviews a monthly sample of the SCHIP Medicaid expansion cases to determine accuracy rates for the approval and denial process. Case reviews that show improper actions are referred to the regional offices for appropriate action. Based on the reviews, Idaho determines the accuracy rates for the approval and denial process. The State has maintained a 99-percent accuracy rate for the approval process. The accuracy rate for the denial process was 73-percent for the initial two months but has steadily improved to a 93-percent rate for the last quarter. Training for specialists working the cases has been ongoing, and has facilitated the continued improvement of accuracy rates for the denial process.

C. MEQC Strategies to Aid Simplification Efforts

Conduct focused reviews. Eliminating or reducing documentation requirements on the family by relying on other sources to verify information (e.g., State program files, banks, employers) is one way to simplify the application process. States can develop MEQC pilots that determine whether eliminating certain Medicaid requirements on families is impacting the number of erroneous eligibility determinations. For example, a State could conduct focused reviews to determine if self-declaration of resources is affecting the accuracy of eligibility determinations.

Review a targeted sample. States can review Medicaid denial cases to determine if Medicaid was improperly denied when TANF was denied. They can also review Medicaid terminated cases to determine if Medicaid was improperly terminated when TANF benefits were terminated, e.g., due to noncooperation with TANF work requirements.

States also can review a targeted sample of Medicaid cases that were denied or terminated due to procedural requirements (for example, when a person failed to participate in a face-to-face interview), and conduct interviews with individuals and families to find out why they did not reenroll. States could use such findings to help develop enrollment practices and procedures designed to overcome problems, or to minimize this effect.

Chapter VI

TABLE ON SIMPLIFICATION EFFORTS

States have undertaken numerous strategies to make it easier for children to apply for, obtain, and retain health coverage, many of which are captured in the following tables. Simplification strategies have included shortening applications, reducing or eliminating documentation requirements, lengthening periods of eligibility, offering continuous eligibility and presumptive eligibility, and streamlining renewal processes.

The following tables provide information about States' current application and enrollment processes for children as of December 2000. These efforts highlight the numerous activities States have undertaken to simplify the process for children and families to obtain and retain health coverage.

Medicaid/SCHIP Application and Enrollment Simplification Matrix Definitions

In partnership with State Medicaid and SCHIP agencies and the National Governor's Association, CMS has compiled information about States' current application and enrollment processes for children. The information in the attached charts was collected from State Medicaid and SCHIP agencies and verified by these agencies, as well as the National Governor's Association, before publication. The primary purpose of collecting and disseminating information on Medicaid and separate child health program application and enrollment simplification efforts is to make available comparable, usable, and accurate information. This document will provide operationalized definitions of the information collected.

Application: Information about the application is based upon the State's joint Medicaid/SCHIP application. If the State does not have a joint Medicaid/SCHIP application, Medicaid information is based upon the Medicaid-only application that children may use, and separate program information is based upon the separate program application. If the State does not have a joint Medicaid/SCHIP application or a Medicaid-only application that children may use, Medicaid information is based upon the Medicaid application available for children to use, including joint Medicaid/TANF applications if applicable, and separate program information is based upon the separate program application.

Application Length: Includes the total number of pages in the application, including instructions necessary for completing the application but not including any attached brochures describing program benefits. It should be noted, however, that some States include much of the informational material about the program with the application while other States include it in a separate brochure. Information included as part of the application or instructions was included when determining application length, but information contained in separate brochures was not. Most States have made efforts to shorten the application children use to apply for Medicaid or SCHIP. When examining the length of applications, most of them appeared to be five pages or less. Thus, while the decision to classify applications using a five-page threshold was somewhat arbitrary, it seemed the most logical place. Short application length is one indicator of a simplified application, but there are many other critical factors to consider when determining whether an application is simplified, particularly the perceptions of persons filling out the application.

Application Supplements: Any form necessary for an initial eligibility determination that is not included in the application, even if it is not required from every applicant. Necessary forms that may be completed after the initial eligibility determination is made are not considered application supplements.

Continuous Eligibility: A period of time, specified by the State, during which a child is guaranteed a period of eligibility without regard to change in circumstances, except attainment of the maximum age or non-payment of premiums if premiums are involved.

Documentation: Forms or other types of proof of income, expenses, or other eligibility criteria that the State requires to verify eligibility.

Documentation of Earned Income: Proof of earned income so that the applicant or beneficiary can obtain or retain health coverage. Some States may request a specific number of paystubs or documentation for a specified period of time (e.g. 1 month, 2 months, etc.). For purposes of this report, the specific number of paystubs is listed for States that request a specific number of paystubs. States that request documentation for a specified period of time are classified into three categories: (1) States that request less than or equal to one month of income documentation, (2) States that request less than or equal to three months of income documentation, and (3) States that request more than three months of income documentation. States may have different requirements for self-employed persons and may also accept alternative forms of documentation such as income tax returns or an employer's statement.

Frequency of Eligibility Renewal: The number of months between regularly scheduled eligibility renewals.

Mail-In Application: An application that may be mailed in and is not followed up with a face-to-face interview. States that require face-to-face interviews are not considered to have a mail-in application for purposes of this matrix.

Mail-in Renewal Form: A renewal (redetermination) form that may be mailed in and is not followed up with a face-to-face interview. States that require face-to-face interviews are not considered to have a mail-in renewal form for purposes of this matrix.

Medicaid: Columns titled Medicaid include information about children eligible for Medicaid under poverty level groups (excluding children eligible under Section 1931), including any Medicaid expansions funded by SCHIP dollars. Section 1115 waivers that affect children eligible for Medicaid under the poverty level groups are described in a separate line.

Monthly or Quarterly Reports: Reports that must be submitted by beneficiaries to the Medicaid or SCHIP agency as a condition of Medicaid or SCHIP eligibility, regardless of changes in circumstances, not including reports required for TANF eligibility, transitional Medicaid, or requirements that changes be reported within ten days of occurring.

Passive Renewal Process: Renewal (redetermination) process in which families do not have to return a renewal form unless changes have occurred that might affect eligibility.

Pre-Printed Renewal Form: Renewal (redetermination) form which includes a printed copy of the information currently in the eligibility file that the family reviews, signs, and returns with any appropriate changes.

Separate Program: Columns titled Separate Program include information about separate child health programs funded by SCHIP dollars.

Separate Renewal Form: Renewal (redetermination) form that is different and distinct from the initial application form.

Application and Enrollment Simplification Profiles
Medicaid for Children and SCHIP
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State	INITIAL APPLICATION										
	Translated Applications		Application Length of Five Pages or Less		Application Supplements		Mail In Application		Joint Medicaid SCHIP Application	Absent Parent Information Requested on the Application	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program		Medicaid	Separate Program
Alabama	English Spanish	English Spanish	Y	Y	N	N	Y	Y	Y	N/A	N/A
Alaska	English	-	Y	-	N	-	Y	-	-	N	-
American Samoa[1]	-	-	-	-	-	-	-	-	-	-	-
Arizona	English Spanish	English Spanish	Y	Y	N	N	Y	Y	Y	Y	Y
/1115 Waiver	English Spanish		Y		N		Y			Y	
Arkansas	English Spanish	-	Y	-	Y	-	Y	-	-	N	-
/1115 ArKids Waiver	English Spanish		Y		Y		Y			N	
California	English Spanish Vietnamese Cambodian Hmong Armenian Cantonese Korean Russian Farsi	English Spanish Vietnamese Cambodian Hmong Armenian Cantonese Korean Russian Farsi	N	N	N	N	Y	Y	Y	N	Y
CNMI	English	-	Y	-	Y	-	Y	-	-	N/A[2]	-
Colorado	English Spanish	English Spanish	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Connecticut	English Spanish	English Spanish	N	N	N	N	Y	Y	Y	Y	Y
Delaware	English Spanish	English Spanish	Y	Y	N	N	Y	Y	Y	Y	Y
/1115 Waiver	English Spanish		Y		N		Y			Y	
DC	English Spanish	-	Y	-	N	-	Y	-	-	Y	-
Florida	English Spanish Creole	English Spanish Creole	Y	Y	N	N	Y	Y	Y	Y	Y
Georgia	English Spanish	English Spanish	Y	Y	N	N	N[3]	Y	Y	N	N
Guam	English	-	N	-	N	-	Y	-	-	Y	-
Hawaii	English[4]	-	Y	-	Y	-	Y	-	-	Y	-
/1115 Waiver	English[4]		Y		Y		Y			Y	

[1] American Samoa does not determine eligibility on an individual basis; a system of presumptive eligibility is used. HCFA pays expenditures for Medicaid based upon a yearly estimate of the percentage of the population below the poverty level. This estimate is approved by HCFA. For Federal Fiscal Year 20014, American Samoa had a total population of approximately 64,500, and the Census Bureau estimated that 58.6% of this population, minus an estimated 535 illegal aliens residing in American Samoa, is below the poverty level.

[2] CNMI does not collect information on absent parents. Effective October 1989, CNMI began administering its Medicaid program under a broad waiver pursuant to §1902(j). This waiver provides them with flexibility to simplify eligibility. Since they do not have a TANF program, CNMI bases Medicaid eligibility on the SSI criteria. Prior to the waiver, CNMI did collect absent parent information but decided to eliminate this question to simplify the application once it was no longer needed.

[3] Georgia currently has a face-to-face interview requirement, although the interview can be completed at sites other than the welfare office and required outstationed sites. The State anticipates eliminating the interview requirement in February 2001.

[4] Hawaii provides flyers on Medicaid in several languages, including Korean, Ilacano, Tagalog, Vietnamese, Cambodian, Japanese, Chinese, and Samoan, but the State does not have translated applications.

INITIAL APPLICATION											
State	Translated Applications		Application Length of Five Pages or Less		Application Supplements		Mail In Application		Joint Medicaid SCHIP Application	Absent Parent Information Requested on the Application	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program		Medicaid	Separate Program
Idaho	English Spanish	-	Y	-	N	-	Y	-	-	N	-
Illinois	English Spanish	English Spanish	Y	Y	N	N	Y	Y	Y	Y	Y
Indiana	English Spanish	English Spanish	Y	Y	Y	Y	Y	Y	Y	N	N
Iowa	English Spanish	English Spanish	Y	Y	N	N	Y	Y	Y	Y	N/A
Kansas	English Spanish	English Spanish	Y	Y	N	N	Y	Y	Y	Y	Y
Kentucky	English Spanish	English Spanish	Y	Y	N	N	Y	Y	Y	Y	Y
/1115 Waiver	English Spanish		Y		N		Y			Y	
Louisiana	English Spanish	-	Y	-	N	-	Y	-	-	Y	-
Maine	English[5]	English[5]	Y	Y	N	N	Y	Y	Y	N	Y
Maryland	English Spanish	-	Y	-	N	-	Y	-	-	Y	-
/1115 Waiver	English Spanish		Y		N		Y			Y	
Massachusetts	English Spanish	English Spanish	Y	N	Y	Y	Y	Y	Y	Y	Y
/1115 Waiver	English Spanish		Y		Y		Y			Y	
Michigan	English Spanish Arabic	English Spanish Arabic	N	Y	N	N	Y	Y	Y	Y	Y
Minnesota	English Spanish Cambodian Hmong Laotian Russian Somali Vietnamese	-	N	-	N	-	Y	-	-	N	-
/1115 Minnesota Care Waiver	English Spanish Cambodian Hmong Laotian Russian Somali Vietnamese		N		N		Y			N	
Mississippi	English Spanish	English Spanish	Y	Y	Y	Y	Y	Y	Y	Y	Y
Missouri	English Spanish Bosnian Vietnamese	-	Y	-	N	-	Y	-	-	Y	-
/1115 MC+ Waiver	English Spanish Bosnian Vietnamese		Y		N		Y			Y	
Montana	English	English	N	N	Y	N	Y	Y	Y	N	N/A
Nebraska	English Spanish Vietnamese Russian Arabic	-	Y	-	N	-	Y	-	-	N	-

[5] Instructions are also provided in French, Amharic, Acholi, Somali, Arabic, Farsi, Russian, Chinese, Albanian, Vietnamese, and Bosnian (Serbo-Croation).

INITIAL APPLICATION											
State	Translated Applications		Application Length of Five Pages or Less		Application Supplements		Mail In Application		Joint Medicaid SCHIP Application	Absent Parent Information Requested on the Application	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program		Medicaid	Separate Program
Nevada	English Spanish	English Spanish	Y	Y	N	N	Y	Y	N	Y	Y
New Hampshire	English	English	Y	Y	N	N	Y	Y	Y	Y	Y
New Jersey	English Spanish	English Spanish	N	N	N	N	Y	Y	Y	Y	Y
New Mexico /1115 Waiver	English Spanish English Spanish	-	Y Y	-	N N	-	N[6] N[6]	-	-	N N	-
New York /1115 Waiver	English[7] English[7]	English[7]	N N	N	N N	N	N[8] N[8]	Y	Y	N N	N/A
North Carolina	English Spanish	English Spanish	N	N	N	N	Y	Y	Y	Y	Y
North Dakota	English	English	N	Y	N	N	Y	Y	N	Y	N/A
Ohio /1115 Waiver	English Spanish English Spanish	-	Y Y	-	N N	-	Y Y	-	-	N N	-
Oklahoma /1115 Waiver	English Spanish English Spanish	-	Y Y	-	N N	-	Y Y	-	-	N N	-
Oregon /1115 Waiver	English Spanish Vietnamese Cambodian Romanian Hmong Mien Russian Lao English Spanish Vietnamese Cambodian Romanian Hmong Mien Russian Lao	English Spanish Vietnamese Cambodian Romanian Hmong Mien Russian Lao	N N	N	N N	N	Y Y	Y	Y	N N	Y
Pennsylvania	English Spanish	English Spanish	N	N	N	N	Y	Y	Y	Y	Y
Puerto Rico	English Spanish	-	Y	-	N	-	N	-	-	N	-
Rhode Island /1115 Waiver	English Spanish English Spanish	-	N N	-	N N	-	Y Y	-	-	Y Y	-
South Carolina	English Spanish	-	Y	-	N	-	Y	-	-	Y	-
South Dakota	English	-	Y	-	Y	-	Y	-	-	N	-
Tennessee[9] /1115 Medicaid /1115 Expansion	English English	-	Y Y	-	N N	-	N[10] Y[10]	-	Y	Y Y	-

[6] Although New Mexico still has a face-to-face interview requirement, the interview can be completed at locations other than the welfare office and required outstationed sites.
[7] A Spanish application is currently being developed.
[8] Although New York still has a fact-to-face interview requirement, the interview can be completed at locations other than the welfare office and required outstationed sites.

INITIAL APPLICATION											
State	Translated Applications		Application Length of Five Pages or Less		Application Supplements		Mail In Application		Joint Medicaid SCHIP Application	Absent Parent Information Requested on the Application	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program		Medicaid	Separate Program
Texas	English Spanish	English Spanish[11]	Y	Y	Y	N	N	Y	N[12]	Y	N
Virgin Islands	English	-	Y	-	N	-	N	-	-	Y	-
Utah	English Spanish	English Spanish	Y	Y	Y	Y	N	N	N	Y	N/A
Vermont /1115 Waiver	English English	English	Y Y	Y	N N	N	Y Y	Y	Y	N N	N
Virginia	English Spanish	English Spanish	Y	Y	Y	Y	Y	Y	Y	Y	Y
Washington	English Spanish Vietnamese Cambodian Russian Ukrainian Mandarin Taglog	English Spanish Vietnamese Cambodian Russian Ukrainian Mandarin Taglog	Y	Y	N	N	Y	Y	Y	Y	Y
West Virginia	English	English	Y	Y	N	N	N[13]	Y	Y	Y	N
Wisconsin /1115 Badger Care Waiver	English Spanish Hmong English Spanish Hmong	-	Y Y	-	N N	-	N N	-	-	Y Y	-
Wyoming	English	English	Y	Y	Y	Y	N[14]	Y	Y	Y	N/A

[9] Tennessee operates a §1115 waiver with two separate populations that have somewhat different eligibility rules. The population referred to here as the §1115 expansion includes previously uninsured and uninsurable persons.

[10] Medicaid "rollovers", those terminated from Medicaid but eligible for TennCare as uninsured, may mail in their application. Uninsurables may mail in their application. Uninsured applicants and SCHIP applicants may mail in their application but must have a face to face interview. Any applicant for Medicaid or the expansion population who is disabled or otherwise cannot apply in person may mail in their application and have an application interview by telephone.

[11] Texas will also accept the Spanish application created by Covering Kids.

[12] Texas accepts the SCHIP application used by Tex Care Partnership for Medicaid as well

[13] West Virginia does not require face to face interviews if the joint Medicaid/SHIP application is used and is referred to Medicaid.

[14] Effective April 1, 2001, Wyoming will remove all face-to-face interview requirements.

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State	ELIGIBILITY DETERMINATION															
	County-Specific Documentation Policies		Resource (Assets) Test		Documentation of Age or Identity		Documentation of Assets		Documentation of Earned Income		Documentation of Unearned Income		Documentation of Child Care Expenses		Presumptive Eligibility	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program
Alabama	N	N	N	N	Y	Y	N/A	N/A	≤1 month	N	Y	N	Y	N/A	N	N
Alaska	N	-	N	-	N	-	N/A	-	≤1 month	-	Y	-	Y	-	N	-
American Samoa[1]	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Arizona	N	N	N	N	N	N	N/A	N/A	≤ 3 months	≤ 1 [2]month	N	N	Y	N/A	N	N
/1115 Waiver	N		N		N		N/A		≤ 3 months		N		Y		N	
Arkansas	N	-	Y	-	Y	-	N	-	N	-	N	-	N	-	N	-
/1115 ArKid s Waiver	N		N		Y		N/A		N		N		N		N	
California	N	N	N	N	N	N	N/A	N/A	1 pay stub	1 pay stub	Y	Y	Y	Y	N	N
CNMI	N	-	Y	-	Y	-	Y	-	2 pay stubs	-	Y	-	N	-	N	-
Colorado	Y[3]	N	Y	N	N	N	N	N/A	≤ 3 months	≤ 3 months	N	Y	N	N	N	N
Connecticut	N	N	N	N	N	N	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	Y	Y	Y[4]	N
Delaware	N	N	N	N	N	N	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N	N	N
/1115 Waiver	N		N		N		N/A		≤ 1 month		Y		N		N	
DC	N	-	N	-	N	-	N/A	-	≤ 1 month	-	N	-	Y	-	N	-
Florida	N	N	Y	N	N	N	Y	N/A	N	N	Y	N	Y	N	N	N
Georgia	N	N	N	N	Y	N	N/A	N/A	N	N	N	N	N	N	N	N
Guam	N	-	Y	-	Y	-	Y	-	≤ 3 months	-	Y	-	Y	-	N	-

[1] American Samoa does not determine eligibility on an individual basis; a system of presumptive eligibility is utilized. HCFA pays expenditures for Medicaid based upon a yearly estimate of the percentage of the population below the poverty level. This estimate is approved by HCFA. For Federal Fiscal Year 2001, American Samoa had a total population of approximately 64,500, and the Census Bureau estimated that 58.6% of this population, minus an estimated 535 illegal aliens residing in American Samoa, is below the poverty level.
[2] Applications may still be approved if an applicant fails to provide documentation of income.
[3] Colorado has joint administration with the County and State governments. The State develops the policy and the counties carry it out.
[4] Connecticut is phasing in presumptive eligibility starting with 5 school-based health clinics (SBHC) in October 2000 and plans to expand to other SBHCs, WIC, HeadStart, and child care providers.

State	ELIGIBILITY DETERMINATION															
	County-Specific Documentation Policies		Resource (Assets) Test		Documentation of Age or Identity		Documentation of Assets		Documentation of Earned Income		Documentation of Unearned Income		Documentation of Child Care Expenses		Presumptive Eligibility	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program
Hawaii	N	-	N	-	N	-	N/A	-	≤ 3 months	-	Y	-	N	-	N	-
/1115 Waiver	N		N		N		N/A		≤ 3 months		Y		N		N	
Idaho	N	-	Y	-	N	-	N	-	N	-	N	-	N	-	N	-
Illinois	N	N	N	N	N	N	N/A	N/A	≤1 month	≤1 month	Y	Y	Y	Y	N[5]	N
Indiana	N	N	N	N	Y	Y	N/A	N/A	≤1 month	≤1 month	Y	Y	N	N	N	N
Iowa	N	N	N	N	N	N	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N	N	N
Kansas	N	N	N	N	N	N	N/A	N/A	≤ 3 months	≤ 3 months	Y	Y	N	N	N	N
Kentucky	N	N	N	N	N	N	N/A	N/A	N	N	N	N	N	N	N	N
/1115 Waiver	N		N		N		N/A		N		N		N		N	
Louisiana	N	-	N	-	N	-	N/A	-	≤ 1 month	-	Y	-	Y	-	N	-
Maine	N	N	N	N	N	N	N/A	N/A	≤ 1 month	≤ 1 month	Y[6]	Y[6]	N	N	N	N
Maryland	N	-	N	-	N	-	N/A	-	N	-	N	-	N	-	N	-
/1115 Waiver	N		N		N		N/A		N		N		N		N	
Massachusetts	N	N	N	N	N	N	N/A	N/A	2 pay stubs	2 pay stubs	Y	Y	N	N	Y	Y
/1115 Waiver	N		N		N		N/A		2 pay stubs		Y		N		Y	
Michigan	N	N	N	N	N	N	N/A	N/A	N	N	N	N	N	N	N	Y
Minnesota	N	-	N	-	Y	-	Y	-	≤1 month	-	Y	-	N	-	N	-
/1115 Minnesota Care Waiver	N		N		Y		Y		≤ 1 month		N		N		N	
Mississippi	N	N	N	N	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N	N	N
Missouri	N	-	N	-	N	-	N/A	-	1 paystub	-	Y	-	N	-	N	-
/1115 MC+ Waiver	N		Y[7]		N		N		1 paystub		Y		N		N	
Montana	N	N	Y	N	Y	N	Y	N/A	2 pay stubs	2 pay stubs	Y	N	Y	Y	N	N
Nebraska	N	-	N	-	N	-	N/A	-	≤ 1 month	-	Y	-	Y	-	Y	-

[5] Illinois conducted a pilot Title XIX presumptive eligibility project in December 1998 and is continuing to explore the use of presumptive eligibility under Title XXI.
[6] Verification not required for SSI and Social Security
[7] Missouri utilizes a "net worth" test

State	ELIGIBILITY DETERMINATION															
	County-Specific Documentation Policies		Resource (Assets) Test		Documentation of Age or Identity		Documentation of Assets		Documentation of Earned Income		Documentation of Unearned Income		Documentation of Child Care Expenses		Presumptive Eligibility	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program
Nevada	N	N	Y	N	Y	N	Y	N/A	≤ 1 month	≤ 1 month	Y	N[8]	Y	N	N	N
New Hampshire	N	N	N	N	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	Y	Y	Y[9]	N
New Jersey	N	N	N	N	Y	Y	N/A	N/A	≤ 3 months	≤ 3 months	Y	Y	Y	Y	Y	Y[10]
New Mexico	N	-	N	-	Y	-	N/A	-	4 pay stubs	-	Y	-	Y	-	Y	-
/1115 Waiver	N		N		Y		N/A		4 pay stubs		Y		Y		Y	
New York	Y	N	N	N	Y	Y	N/A	N/A	4 pay stubs[11]	4 pay stubs [11]	Y	Y	Y	N	N[12]	Y
/1115 Waiver	Y		N		Y		N/A		4 pay stubs [11]		Y		Y		N[12]	
North Carolina	N	N	N	N	N	N	N/A	N/A	≤1 month	≤1 month	Y	Y	Y	Y	N	N
North Dakota	Y[13]	N	Y	N	Y	N	Y	N/A	≤ 1 month	≤ 1 month	Y	Y	Y	N	N	N
Ohio	N	-	N	-	N	-	N/A	-	≤ 1 month	-	Y	-	N	-	N	-
/1115 Waiver	N		N		N		N/A		≤ 1 month		Y		N		N	
Oklahoma	N	-	N	-	N	-	N/A	-	≤ 1 month	-	N	-	N	-	N	-
/1115 Waiver	N		N		N		N/A		≤ 1 month		N		N		N	
Oregon	N	N	Y	Y	N	N	N	N	≤3 months	≤3 months	Y	Y	N	N	N	N
/1115 Waiver	N		Y		N		N		≤ 3 months		Y		N		N	
Pennsylvania	N	N	N	N	N	N	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N	N	N
Puerto Rico	N	-	Y	-	Y	-	Y	-	1 pay stub	-	Y	-	N	-	N	-
Rhode Island	N	-	N	-	N	-	N/A	-	≤ 1 month	-	Y	-	N	-	N	-
/1115 Waiver	N		N		N		N/A		≤ 1 month		Y		N		N	

[8] Proof of unearned income needed only if no earned income.
[9] State reimburses qualified entities (Title V funded family and community health agencies, Title X family planning agencies, hospitals, agencies authorized to determine HeadStart eligibility, agencies authorized to determine eligibility under the Child Care and Development Block Grant, agencies participating in EIP, and WIC agencies) $11.81; for FQHCs, the state reimburses $23.83.
[10] NJKidCare Plan D does not have Presumptive Eligibility
[11] Paystubs must be consecutive and recent.
[12] New York adopted presumptive eligibility, but conditions necessary under State law to authorize implementation have not yet occurred.
[13] North Dakota has joint administration with the County and State governments. The State develops the policy and the counties carry it out.

State	ELIGIBILITY DETERMINATION															
	County-Specific Documentation Policies		Resource (Assets) Test		Documentation of Age or Identity		Documentation of Assets		Documentation of Earned Income		Documentation of Unearned Income		Documentation of Child Care Expenses		Presumptive Eligibility	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program
South Carolina	N	-	N	-	N	-	N/A	-	≤ 1 month	-	Y[14]	-	N	-	N	-
South Dakota	N	-	N	-	N	-	N/A	-	≤ 1 month	-	Y	-	Y	-	N	-
Tennessee[15] /1115 Medicaid	N	-	N	-	Y	-	N/A	-	≤ 1 month[16]	-	Y	-	Y	-	N	-
/1115 expansion	N		N		Y		N/A		≤ 3 months		Y		NA		N	
Texas	N	N	Y	N	Y	N	Y	N/A	≤ 3 months	≤ 3 months	Y	Y	Y	Y	N	N
Virgin Islands	N	-	Y	-	Y	-	Y	-	1 pay stub	-	Y	-	N	-	N	-
Utah	N	N	Y[17]	N	N	N	Y[17]	N/A	1 pay stub	1 pay stub	Y	Y	Y	Y	N	N
Vermont	N	N	N	N	N	N	N/A	N/A	N	N	N	N	N	N	N	N
/1115 Waiver	N		N		N		N/A		N		N		N		N	
Virginia	N	N	N	N	Y	Y	N/A	N/A	≤ 3 months	≤ 3 months	Y	Y	Y	Y	N	N
Washington	N	N	N	N	N	N	N/A	N/A	N	N	N	N	N	N	N	N
West Virginia	N	N	N	N	N	N	N/A	N/A	≤1 month	≤1 month	Y	Y	N/A	N/A	N	N
Wisconsin	N	-	N	-	Y	-	N/A	-	≤1 month	-	Y	-	Y	-	N	-
/1115 Badger Care Waiver	N		N		Y		N/A		≤ 1 month		Y		Y		N	
Wyoming	N	N	N	N	Y[18]	N	N/A	N/A	≤ 3[18] months	N	Y[18]	N	N	N	N	N

[14] Documentation for child support, alimony, and interest is not required. Documentation for other unearned income is required.
[15] Tennessee operates a §1115 waiver with two separate populations that have somewhat different eligibility rules. The population referred to here as the §1115 expansion includes previously uninsured and uninsurable persons.
[16] If income fluctuates to the extent that a 30 day period alone cannot provide an accurate indicator of anticipated income, verification of a longer period of time may be required.
[17] Utah has no assets test for children under 6.
[18] Effective April 1, 2001, Wyoming will accept self-declaration of all eligibility factors for Medicaid.

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State	ONGOING ELIGIBILITY					
	Continuous Eligibility		Frequency of Eligibility Renewal		Monthly or Quarterly Reporting Cycle	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program
Alabama	12 months	12 months	12 months	12 months	N	N
Alaska	12 months	-	12 months	-	N	-
American Samoa[1]	-	-	-	-	-	-
Arizona /1115 Waiver	12 months 12 months	12 months	12 months 12 months	12 months	N N	N
Arkansas /1115 ArKids Waiver	N 12 months	-	12 months 12 months	-	N N	-
California	12 months[2]	12 months	12 months	12 months	N[3]	N
CNMI	N	-	12 months[4]	-	N	-
Colorado	N	12 months	12 months	12 months	N	N
Connecticut	12 months	12 months	12 months	12 months	N	N
Delaware /1115 Waiver	N N	12 months	12 months 12 months	12 months	N N	N
DC	N	-	12 months	-	N	-
Florida	12 months[5]	6 months[5]	12 months	6 months	N	N
Georgia	N	N	6 months	12 months	3 months	N
Guam	N	-	6 months	-	N	-
Hawaii /1115 Waiver	N N	-	12 months 12 months	-	N N	-
Idaho	12 months	-	12 months	-	N	-
Illinois	12 months	12 months	12 months	12 months	N	N
Indiana	12 months	12 months	12 months	12 months	N	N
Iowa	N	12 months	12 months	12 months	N	N
Kansas	12 months	12 months	12 months	12 months	N	N
Kentucky /1115 Waiver	N N	N	12 months 12 months	12 months	N N	N
Louisiana	12 months	-	12 months	-	N	-
Maine	6 months	6 months	6 months	6 months	N	N
Maryland /1115 Waiver	N[6] N[6]	-	12 months 12 months	-	N N	-
Massachusetts /1115 Waiver	N N	N	12 months 12 months	12 months	N N	N
Michigan	N	12 months	12 months	12 months	N	N
Minnesota /1115 MinnesotaCare Waiver	N N	-	12 months 12 months	-	N N	-
Mississippi	12 months	12 months	12 months	12 months	N	N

[1] American Samoa does not determine eligibility on an individual basis; a system of presumptive eligibility is utilized. HCFA pays expenditures for Medicaid based upon a yearly estimate of the percentage of the population below the poverty level. This estimate is approved by HCFA. For Federal Fiscal Year 2001, American Samoa had a total population of approximately 64,500, and the Census Bureau estimated that 58.6% of this population, minus an estimated 535 illegal aliens residing in American Samoa, is below the poverty level.

[2] Effective January 1, 2001

[3] Effective January 1, 2001

[4] Families who have fluctuating income due to the nature of their work, such as seasonal employment or overtime, are redetermined eligible every 3 or 6 months.

[5] Continuous eligibility is extended to children age 5 and under.

[6] Children who enroll in the State's managed care program will receive 6 months guaranteed coverage even if they become ineligible.

ONGOING ELIGIBILITY						
State	Continuous Eligibility		Frequency of Eligibility Renewal		Monthly or Quarterly Reporting Cycle	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program
Missouri /1115 MC+ Waiver	N N	-	12 months 12 months	-	N N	-
Montana	N	12 months	12 months	12 months	N	N
Nebraska	12 months	-	12 months	-	N	-
Nevada	N	12 months	12 months	12 months	N	N
New Hampshire	N[7]	N[8]	12 months	12 months	N	N
New Jersey	N	N	12 months	12 months	N	N
New Mexico /1115 Waiver	12 months 12 months	-	12 months 12 months	-	N N	-
New York /1115 Waiver	12 months 12 months	N	12 months 12 months	12 months	N N	N
North Carolina	12 months	12 months	12 months	12 months	N	N
North Dakota	N	12 months	12 months	12 months	1 month	N
Ohio /1115 Waiver	N N	-	12 months 12 months	-	N N	-
Oklahoma /1115 Waiver	N N	-	6 months 6 months	-	N N	-
Oregon /1115 Waiver	N N	N	6 months 6 months	6 months	N N	N
Pennsylvania	N	12 months	12 months	12 months	N	N
Puerto Rico	N	-	6 months	-	N	-
Rhode Island /1115 Waiver	N[9] N[9]	-	12 months 12 months	-	N N	-
South Carolina	12 months	-	12 months	-	N	-
South Dakota	12 months	-	12 months	-	N	-
Tennessee[10] /1115 Medicaid /1115 Expansion	12 months 12 months	-	12 months 12 months	-	N N	-
Texas	N	12 months	6 months	12 months	N	N
Virgin Islands	N	-	6 months	-	N	-
Utah	N	12 months	12 months	12 months	N	N
Vermont /1115 Waiver	N N	N	12 months 12 months	12 months	N N	N
Virginia	N	N	12 months	12 months	N	N
Washington	12 months	12 months	12 months	12 months	N	N
West Virginia	N	12 months	12 months	12 months	N	N
Wisconsin /1115 Badger Care Waiver	N N	-	12 months 12 months	-	N N	-
Wyoming	N[11]	12 months	6 months[11]	12 months	N	N

[7] Children who enroll in the State's voluntary managed care program will receive 6 months guaranteed coverage even if they become ineligible for Healthy Kids Gold (Medicaid).
[8] Children in Healthy Kids Silver (SCHIP) will receive 6 months guaranteed coverage even if they are become ineligible for Healthy Kids Silver except if they turn 19, are not longer resident of the State, or fail to pay the premium.
[9] Medicaid children are guaranteed 6-month coverage under managed care except if the child ages out or leaves the state.
[10] Tennessee operates a §1115 waiver with two separate populations that have somewhat different eligibility rules. The population referred to here as the §1115 expansion includes previously uninsured and uninsurable persons.
[11] Effective April 1, 2001, Wyoming will offer 12 months of continuous eligibility for Medicaid and move to annual renewals.

Application and Enrollment Simplification Profiles
Medicaid for Children and SCHIP
December 2000

State	RENEWAL													
	Separate Renewal Form		Pre-Printed Renewal Form		Mail-In Renewal Form		Documentation of Assets		Documentation of Earned Income		Documentation of Unearned Income		Documentation of Child Care Expenses	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program
Alabama	Y	Y	N	Y	Y	Y	N/A	N/A	≤ 1 month	N	Y	N	Y	N/A
Alaska	N	-	N	-	Y	-	N/A	-	≤1 month	-	Y	-	Y	-
American Samoa[1]	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Arizona	Y	Y	N	Y	Y	Y	N/A	N/A	≤ 3 months	≤ 1 [2]month	Y	Y	Y	N/A
/1115 Waiver	Y		N		Y		N/A		≤ 3 months		Y		Y	
Arkansas	Y	-	N	-	Y	-	N	-	N	-	N	-	N	-
/1115 ArKids Waiver	Y		N		Y		N/A		N		N		N	
California	Y	Y	N	Y	Y	Y	N/A	N/A	1 pay stub	1 pay stub	N	Y	Y	Y
CNMI	Y	-	N	-	Y	-	Y	-	2 pay stubs	-	Y	-	N	-
Colorado	Y	Y	N	N	Y	Y	N	N/A	≤ 3 months	≤ 3 months	N	N	N	N
Connecticut	N	N	N[3]	Y	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	Y	Y
Delaware	N	N	N	N	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N
/1115 Waiver	N		N		Y		N/A		≤ 1 month		Y		N	
DC	Y	-	Y	-	Y	-	N/A	-	≤ 1 month	-	N	-	Y	-
Florida	N	N	N	N	N	Y	Y	N/A	N	N	N	N	Y	N
Georgia[4]	Y	N/A	N	NA	N	N/A	N	N/A	N	N	N	N	N	N
Guam	N	-	N	-	Y	-	Y	-	≤ 3 months	-	Y	-	Y	-

[1] American Samoa does not determine eligibility on an individual basis; a system of presumptive eligibility is utilized. HCFA pays expenditures for Medicaid based upon a yearly estimate of the percentage of the population below the poverty level. This estimate is approved by HCFA. For Federal Fiscal Year 2001, American Samoa had a total population of approximately 64,500, and the Census Bureau estimated that 58.6% of this population, minus an estimated 535 illegal aliens residing in American Samoa, is below the poverty level.
[2] Coverage may still be renewed if the beneficiary fails to provide documentation of income.
[3] Connecticut is developing a pre-printed renewal form.
[4] Children who apply for SCHIP and are found to be eligible for Medicaid or SCHIP through this application process receive a renewal letter in the mail from the third party administrator. This letter asks for current income information, which families may submit over the phone, and a renewal form is not used. Children who apply for Medicaid through the local offices have a separate renewal process.

State	RENEWAL													
	Separate Renewal Form		Pre-Printed Renewal Form		Mail-In Renewal Form		Documentation of Assets		Documentation of Earned Income		Documentation of Unearned Income		Documentation of Child Care Expenses	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program
Hawaii	N	-	N	-	Y	-	N/A	-	≤ 3 months	-	Y	-	N	-
/1115 Waiver	N		N		Y		N/A		≤ 3 months		Y		N	
Idaho	Y	-	Y	-	Y	-	N	-	N	-	N	-	N	-
Illinois	Y	Y	N	Y	Y	Y	N/A	N/A	≤1 month	≤1 month	Y	Y	Y	Y
Indiana	Y	Y	N	N	Y	Y	N/A	N/A	≤1 month	≤1 month	Y	Y	N	N
Iowa	N	N	N	Y	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N
Kansas	Y	Y	N	N	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N
Kentucky	Y	Y	Y	Y	Y	Y	N/A	N/A	N	N	N	N	N	N
/1115 Waiver	Y		Y		Y		N/A		N		N		N	
Louisiana	N	-	N	-	Y	-	N	-	≤ 1 month	-	Y	-	Y	-
Maine	Y	Y	N	N	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N
Maryland	N	-	N	-	Y	-	N/A	-	N	-	N	-	N	-
/1115 Waiver	N		N		Y		N/A		N		N		N	
Massachusetts	Y	Y	N[5]	N[5]	Y	N	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N
/1115 Waiver	Y		N[5]		Y		N/A		≤ 1 month		Y		N	
Michigan	N	Y	N	Y	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	N	Y	N
Minnesota	Y	-	N	-	Y	-	Y	-	≤ 1 month	-	Y	-	N	-
/1115 MinnesotaCare Waiver	Y		N		Y		Y		≤ 1 month		N		N	
Mississippi	Y	Y	N	N	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N
Missouri	Y	-	N	-	Y	-	N/A	-	1 pay stub	-	Y	-	N	-
/1115 MC+ Waiver	Y		N		Y		N/A		1 pay stub		Y		N	
Montana	Y	N	N	N	Y	Y	Y	N/A	2 pay stubs	2 pay stubs	Y	N	Y	Y
Nebraska	Y	-	N	-	Y	-	N/A	-	≤ 1 month	-	Y	-	Y	-
Nevada	N	Y	N	Y	Y	Y	Y	N/A	≤1 month	≤1 month	Y	N[6]	Y	NA

[5] The State is piloting a preprinted renewal process.

State	RENEWAL													
	Separate Renewal Form		Pre-Printed Renewal Form		Mail-In Renewal Form		Documentation of Assets		Documentation of Earned Income		Documentation of Unearned Income		Documentation of Child Care Expenses	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program
New Hampshire	N	N	N	N	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	Y	Y
New Jersey	Y	Y	Y	Y	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N
New Mexico	N	-	N	-	N	-	N/A	-	4 pay stubs	-	Y	-	Y	-
/1115 Waiver	N		N		N		N/A		4 pay stubs		Y		Y	
New York	N	N	N	N	N	Y	N/A	N/A	4 pay stubs	4 pay stubs	Y	Y	Y	N
/1115 Waiver	N		N		N		N/A		4 pay stubs		Y		Y	
North Carolina	Y	Y	N	N	Y	Y	N/A	N/A	≤1 month	≤1 month	Y	Y	Y	Y
North Dakota	Y	Y	N	Y	Y	Y	Y	N/A	≤ 1 month	≤ 1 month	Y	Y	Y	N
Ohio	N	-	N	-	Y	-	N/A	-	≤ 1 month	-	Y	-	N	-
/1115 Waiver	N		N		Y		N/A		≤ 1 month		Y		N	
Oklahoma	Y	-	N	-	Y	-	N/A	-	N	-	N	-	N	-
/1115 Waiver	Y		N		Y		N/A		N		N		N	
Oregon	N	N	N	N	Y	Y	N	N	≤ 3 months	≤ 3 months	Y	Y	N/A	N/A
/1115 Waiver	N		N		Y		N		≤ 3 months		Y		N/A	
Pennsylvania	Y	Y	N	N	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N	N
Puerto Rico	N	-	N	-	N	-	N	-	1 pay stub	-	Y	-	N	-
Rhode Island	Y	-	N	-	Y	-	N	-	≤ 1 month	-	N	-	N	-
/1115 Waiver	Y		N		Y		N		≤ 1 month		N		N	
South Carolina	Y	-	N	-	Y	-	N/A	-	≤ 1 month	-	Y[7]	-	N	-
South Dakota	N	-	N	-	Y	-	N/A	-	≤ 1 month	-	Y	-	Y	-
Tennessee[8] /1115 Medicaid	N	-	N	-	N	-	N/A	-	≤ 1 month[9]	-	Y	-	Y	-
/1115 Expansion	Y		N		N		N/A		≤ 3 months		Y		N	

[6] Proof of unearned income needed only if no earned income

[7] Documentation for child support, alimony, and interest is not required. Documentation for other unearned income is required.

State	RENEWAL													
	Separate Renewal Form		Pre-Printed Renewal Form		Mail-In Renewal Form		Documentation of Assets		Documentation of Earned Income		Documentation of Unearned Income		Documentation of Child Care Expenses	
	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program	Medicaid	Separate Program
Texas	N	N	N	Y	N	Y	Y	N/A	≤ 3 months	N[10]	Y	N[10]	Y	N[10]
Virgin Islands	N	-	N	-	N	-	N	-	1 pay stub	-	Y	-	N	-
Utah	Y	Y	Y	Y	Y[11]	Y	Y	N/A	1 pay stub	1 pay stub	Y	Y	Y	N
Vermont	N	N	N	N	Y	Y	N/A	N/A	N	N	N	N	N	N
/1115 Waiver	N		N		Y		N/A		N		N		N	
Virginia	Y	Y	N	N	Y	Y	N/A	N/A	≤ 3 months	≤ 3 months	Y	Y	Y	Y
Washington	N	N	N	N	Y	Y	N/A	N/A	N	N	N	N	N/A	N/A
West Virginia	N	N	N	N	Y	Y	N/A	N/A	≤ 1 month	≤ 1 month	Y	Y	N/A	N/A
Wisconsin	N	-	Y	-	Y	-	N	-	≤ 1 month	-	Y	-	Y	-
/1115 Badger Care Waiver	N		Y		Y		N		≤ 1 month		Y		Y	
Wyoming	Y	Y	Y	Y	Y	Y	N/A	N/A	2 pay stubs[12]	N	Y[12]	N	N	N

[8] Tennessee operates a §1115 waiver with two separate populations that have somewhat different eligibility rules. The population referred to here as the §1115 expansion includes previously uninsured and uninsurable persons.

[9] If income fluctuates to the extent that a 30 day period alone cannot provide an accurate indicator of anticipated income, verification of a longer period of time may be required.

[10] Documentation may be requested if earned income, unearned income, or child care expenses have changed since the initial application.

[11] Utah allows beneficiaries to report changes over the phone without returning the pre-printed form.

[12] Effective April 1, 2001, Wyoming will accept self-declaration of all eligibility factors for Medicaid.

CONCLUSION

This guide is intended to help States ensure that low-income families and individuals are properly considered for Medicaid, whether or not they have applied for or ever received cash assistance, and to improve Medicaid access and retention for all applicants and beneficiaries. Medicaid coverage provides critical health care to families who are entering the workplace, as well as to families who work at jobs that do not offer affordable health care. Medicaid is no longer an adjunct to cash assistance; it is a health care program offering coverage, largely through the purchase of managed care, to a broad group of low-income children and an expanding group of low-income families. Together, Federal, State and local Medicaid agencies must adapt to these changes, overcome public misperceptions about Medicaid, and, in some cases, reorient their way of doing business in order to promote participation among eligible children and families.

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