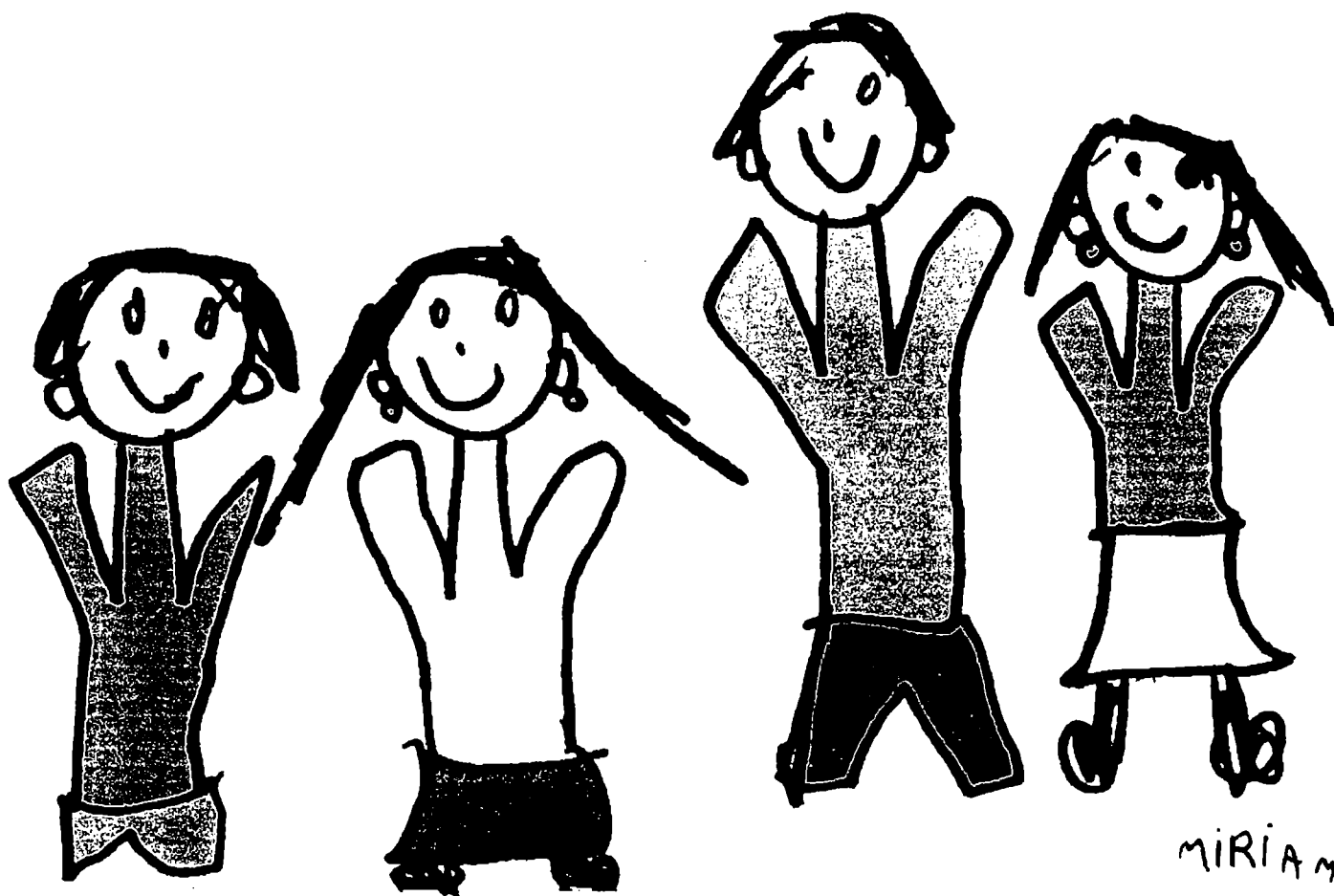




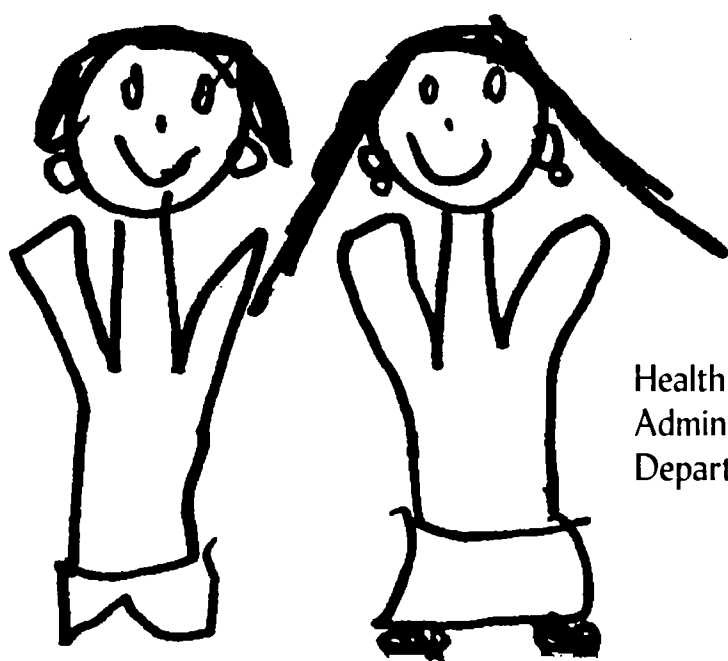
Supporting Families in Transition

A Guide to
Expanding Health Coverage in
the Post-Welfare Reform World



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the Post-Welfare Reform World



Health Care Financing Administration
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Department of Health and Human Services

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Introduction

The last two years have witnessed a profound transformation of the American welfare system. A booming national economy combined with innovative state policies and investments have helped millions of low-income Americans make the transition from dependency to work and self-sufficiency and resulted in steadily declining welfare caseloads. An essential pillar of family self-sufficiency is the ability to obtain and keep health insurance coverage.

Until recently, many low-income families obtained health insurance through their eligibility for cash assistance programs. Under the old Aid to Families with Dependent Children (AFDC) program, poor families automatically received Medicaid coverage when they qualified for cash assistance. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced AFDC with a new state-run Temporary Assistance for Needy Families (TANF) program and ended the automatic link between eligibility for cash assistance and eligibility for Medicaid.

To preserve Medicaid coverage for low-income families with children, the welfare reform law created a new Medicaid eligibility category. Under the new "Section 1931" group, families who would have qualified for Medicaid under a state's AFDC program are generally eligible for Medicaid now, regardless of whether they receive TANF assistance. The law also made available to states \$500 million in enhanced matching funds to support the systems changes and outreach necessary to address the effects of "delinking" Medicaid from welfare.

Beyond preserving Medicaid eligibility as it was prior to welfare reform, new options have been created. Specifically, Congress provided states with broad flexibility under Section 1931 to expand Medicaid to cover more low-income families at their option. Also, as a result of regulations published in August 1998, states can expand coverage to more two-parent working families through Section 1931. Finally, seeking to extend free or affordable health coverage to uninsured children in low-income families, President Clinton and Congress created the Children's Health Insurance Program (CHIP).

The dramatic changes in welfare laws and policies, and the challenges and opportunities they continue to present, require that states establish new strategies and procedures to ensure that as many children and families as possible retain or obtain health care coverage under Medicaid or CHIP. To achieve this result, we need to find new ways to reach children and families with these health programs—outside as well as through the welfare system.

This guide serves three major purposes:

- ✓ First, it assists state policymakers and others in understanding what the Medicaid statute and regulations require of states in terms of Medicaid eligibility, enrollment, redetermination, notice and appeal rights, and other program and policy areas. These requirements apply generally in Medicaid, and also specifically to Medicaid applications and eligibility determinations in the welfare context — that is, when families seek or leave TANF assistance. The guide includes information on the ways in which states can work within the statute to strengthen their outreach efforts, simplify their application processes, and broaden Medicaid coverage to reach low-income families with children, independent of TANF.
- ✓ Second, it discusses the Medicaid requirements and options that apply in three common scenarios: 1) when families seek TANF assistance; 2) when families leave TANF assistance; and 3) when families have no contact with the TANF program.
- ✓ Third, it points the reader to the various sources of funding that are available to states to pay for outreach, training, and other activities to help states bring their systems into compliance with the law and increase health insurance coverage for low-income families with children.

The guide is organized into four chapters:

Reaching Families Who Seek TANF Assistance. This chapter addresses the specific circumstances of families seeking TANF assistance. It outlines the Medicaid and CHIP requirements that states must meet when receiving and processing applications from these families, and identifies practices and techniques that states may wish to consider in designing their TANF programs and their application and enrollment processes to ensure maximum participation of families.

Maintaining Coverage for Families Who Leave TANF Assistance. This chapter focuses on the circumstances of families leaving the TANF system. It outlines applicable Medicaid legal requirements and options, and strategies and techniques that states may wish to consider in designing their Medicaid programs and the administration of their TANF programs to ensure maximum continued eligibility for Medicaid and CHIP.

Reaching Families Outside the TANF System. This chapter focuses on the ways in which states can help low-income families who are not seeking TANF assistance to obtain health insurance through Medicaid and/or CHIP. States have an opportunity here to capitalize on the delinkage of Medicaid from welfare eligibility by marketing

Medicaid as well as CHIP coverage as a freestanding support for working families — untied to TANF. This chapter also emphasizes the need to reach out to low-income families and inform them of the health coverage available to them under Medicaid and CHIP.

Funding Opportunities. The final chapter identifies sources of funds that are available to states to pay for outreach, training, and other activities critical to supporting compliance with Medicaid requirements and maximizing coverage of low-income families with children.

Reaching Families Who Seek TANF Assistance

Families seeking assistance under the Temporary Assistance for Needy Families (TANF) program typically first complete an application. All states currently report that they use joint applications for TANF and Medicaid. Therefore, the nature of coordination between the TANF and Medicaid agencies and their procedures has a critical impact on whether or not eligible low-income families obtain Medicaid coverage.

Not every person seeking TANF assistance actually completes the application process. In some states, for example, completion of an application is delayed until a parent conducts a job search. In other cases, an individual may decide not to apply for TANF after all because she secures employment, or for other reasons. Many parents do not realize that, regardless of their eligibility for or receipt of TANF assistance, they, or at least their children, may be eligible for Medicaid or CHIP. In such cases, TANF offices can be instrumental in ensuring that eligible families get enrolled in Medicaid or CHIP.

This chapter outlines the statutory and regulatory requirements under TANF and Medicaid that states must follow in establishing the eligibility rules for low-income families, as well as requirements concerning the Medicaid application and enrollment processes. To help state officials and others considering implementation issues, this chapter also identifies administrative steps and programmatic strategies designed to promote the maximum enrollment of families.

State Requirements and Options under Federal Medicaid Law

A. Mandatory Eligibility Policies

- ✓ **Section 1931 group.** Medicaid eligibility is no longer tied to or based on eligibility for welfare. Nor can states limit Medicaid eligibility only to families receiving TANF benefits. Section 1931 of the Social Security Act establishes rules for Medicaid eligibility for low-income families based on the income and resources of the family. Under Section 1931, states must provide Medicaid coverage to families who:

- ◆ have a dependent child living with them;
- ◆ have income and resources that would have qualified them for AFDC under the State plan in effect on July 16, 1996; and
- ◆ meet certain deprivation requirements (e.g., absent parent) that were in the state's AFDC plan as of July 16, 1996.

Most states have amended their Medicaid state plans to add the new Section 1931 eligibility group for low-income families to replace the former AFDC recipient eligibility group.

- ✓ **Comparable standards.** 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.
- ✓ **Statewide application.** Medicaid statute requires states to apply their policies through all subdivisions of the state. Accordingly, a state's Section 1931 eligibility rules must be the same throughout the state.

B. Optional Eligibility Policies

Under Section 1931, states have the option to modify their July 16, 1996 AFDC state plan requirements by using the flexibilities outlined below¹. To exercise any of these flexibilities under Section 1931, a state must submit a Medicaid state plan amendment.

- ✓ **Use less restrictive financial methodologies.** States can use less restrictive income and/or resource methodologies to determine Medicaid eligibility than those in effect under the July 16, 1996 AFDC state plan. By doing so, states can expand coverage to more low-income families with children without obtaining a Federal waiver. For example, a number of states have chosen to disregard a car of any value, as well as interest income, under their TANF programs. Some of these states have adopted the same disregards for their Section 1931 group under Medicaid as they have in their TANF programs. (These types of disregards must be applied equally to all applicants and recipients under the Section 1931 group.)

In addition, some states have chosen to apply more generous *earned income* disregards under TANF and have adopted the same disregards for the Medicaid Section 1931 group. States can apply these disregards to applicants and recipients or, without violating comparability requirements, they can apply such disregards to Medicaid recipients but not applicants, by replacing the "\$30 and 1/3" disregards, which applied only to recipients under the AFDC program.

¹Note that, consistent with the requirement for comparable standards described above, the policies states adopt under the Section 1931 group must apply equally to families receiving and applying for Medicaid. Earned income disregards (see under **Use less restrictive financial methodologies**) constitute the sole exception to the comparable standards rule; that is, states can apply earned income disregards differently for Medicaid applicants and recipients under Section 1931, because the AFDC rules that underlie Section 1931 eligibility allowed AFDC applicants and recipients to be treated differently in this respect.

- ✓ **Ease deprivation requirements (repeal of the "100-hour" rule).** Under regulations published August 7, 1998, states have increased flexibility to define the deprivation requirements for Medicaid eligibility. Prior regulations prohibited states from providing Medicaid eligibility to two-parent families if the principal wage-earner worked more than 100 hours per month. The new regulation removes the 100-hour definition of deprivation and instead allows states to set a reasonable standard based on hours of work and/or dollar amounts that may take into account family size and/or time elements. This new flexibility allows states to treat one-parent and two-parent families the same under Medicaid even if a distinction existed under the states' 1996 AFDC and Medicaid state plans.
- ✓ **Use less restrictive financial standards.** States can raise their income and resource standards by as much as the rise in the Consumer Price Index (CPI) since July 16, 1996. (Section 1931 also allows states to use income standards that are lower than the July 16, 1996 AFDC standard, but no lower than those in place on May 1, 1988.) Exercising this flexibility, a state may, for example, pass legislation indexing the income and asset standards for its Section 1931 families² — without obtaining a Federal waiver and without regard to its policies under TANF.
- ✓ **Continue certain AFDC waivers.** Finally, states are allowed to continue AFDC waivers that were in effect as of July 16, 1996 that relate to income and resource methodologies, deprivation, and the requirement that a child live with a specified relative. Section 1931 provides that these waivers may be continued permanently for Medicaid purposes even after the date the AFDC waiver expires. However, any AFDC provisions that were more restrictive than those in place for Medicaid cannot be continued for Medicaid purposes beyond their expiration.

² Because of the CPI constraint, a state that has chosen to apply income standards under TANF that are significantly higher than those under its AFDC state plan in effect on July 16, 1996 may not be able to raise the standards for its Section 1931 group to the same level. However, such a state could effectively raise the income standard for its Section 1931 group by using the authority to liberalize its financial methodologies as explained above. For example, if a state raised the income standard under TANF from \$250 per month to \$500 per month and wanted to do the same under its Section 1931 group, the state could get the desired result by disregarding an additional \$250 of income (or disregarding "the difference between the AFDC standard and the TANF standard by family size") for purposes of Medicaid eligibility.

C. Mandatory Application and Enrollment Policies

- ✓ **Opportunity to apply.** Medicaid regulations (42 CFR 435.906) require states to provide the opportunity for families to apply for Medicaid *without delay*. When states use joint TANF-Medicaid applications or use the state TANF agency to make Medicaid eligibility determinations, the TANF office is considered a Medicaid office. Therefore, TANF offices in these states must furnish the joint application (or a separate Medicaid application) immediately upon request and may not impose a waiting period before providing the application for Medicaid or processing it. These Medicaid requirements also apply to CHIP programs that are Medicaid expansions, and states are encouraged to apply them in the same manner for non-Medicaid CHIP programs as well.

In states where the TANF application or eligibility is delayed (i.e., because families receive diversionary assistance, are required to conduct an up-front job search, or face any other initial administrative steps), the state must make a separate Medicaid application available immediately, or make the joint application available immediately for purposes of determining Medicaid eligibility. The evaluation of the Medicaid application and the Medicaid eligibility determination must be made by state personnel who are authorized to perform these functions.

- ✓ **Time frame for eligibility determination.** Federal regulations (42 CFR 435.911) require that Medicaid eligibility for most families and children must be determined within 45 days from the date of application. The date that a TANF-Medicaid application is filed begins the 45-day “clock” for Medicaid eligibility determination. While a few limited exceptions to the 45-day time frame are allowed, such as an administrative or other emergency beyond the state's control, a TANF requirement may not delay a Medicaid eligibility determination. For example, when a family applies for Medicaid and TANF through a joint application but does not qualify for TANF assistance because of a TANF requirement that does not relate to Medicaid (e.g., the living arrangements for teens), the state must make a timely determination of Medicaid eligibility based on the joint application.

States may grant Medicaid eligibility retroactive to the date of application, or to the first day of the month of application. Eligibility must be granted three months retroactive to the month of application if the applicant received services during that period and would have been eligible at the time the services were furnished.

- ✓ **Exhaust all avenues to eligibility before denial or termination.** Because Medicaid eligibility is not based on TANF eligibility, states may not deny Medicaid eligibility to a family or any family member simply because the family is ineligible for TANF due to employment, time limits, sanctions, or any other reason. Nor can a state deny Medicaid eligibility because a family member loses eligibility under a particular Medicaid eligibility category. Further, it is not acceptable for a state to deny joint applications and then advise families to reapply if they think they may be eligible under another Medicaid category. *States are prohibited from denying or terminating Medicaid eligibility unless all possible avenues to Medicaid eligibility have been affirmatively explored and exhausted.*

Since Medicaid eligibility for families no longer hinges on eligibility for welfare, and since Medicaid generally covers a broader group of children and families than may be eligible for TANF, some or all members of a family that fails to meet TANF eligibility criteria are likely to be eligible for Medicaid. There are many possible avenues to Medicaid eligibility for

family members denied or terminated from TANF assistance, including the Section 1931 group (depending on family income and other state eligibility rules for the group), poverty-level groups, and transitional Medicaid.

- ✓ **Medicaid denial notice and appeal rights.** Federal regulations (42 CFR, Part 431, Subpart E and 42 CFR 435.912) require that applicants who are denied Medicaid eligibility or individuals who are terminated from Medicaid receive timely notices informing them of the denial, the reasons for the denial, and their appeal rights. With very few exceptions Medicaid coverage for current recipients continues during an appeal. These rights apply to all Medicaid denials and terminations, including those that flow from joint TANF-Medicaid applications.

When a family applies for Medicaid and TANF through a joint application and the family does not qualify for TANF, the denial notice should inform the family that the TANF denial does not mean the family is ineligible for Medicaid.

D. Optional Application and Enrollment Policies

- ✓ **Facilitate Enrollment in Medicaid and CHIP.** Making both joint TANF-Medicaid applications and Medicaid-only applications available in TANF offices is an important step toward assuring that families get connected with Medicaid or CHIP, no matter what decision they ultimately make about seeking TANF assistance.

- ◆ ***Use joint applications.*** TANF offices are a critical site for reaching low-income families since, in most states, virtually all TANF recipients are likely to be eligible for Medicaid. In states that use a joint TANF-Medicaid application, the opportunity to apply for Medicaid must be provided without delay, whether the family applies for TANF or receives diversionary payments or any other assistance. The family cannot be told to come back another time or be sent elsewhere to obtain the application.

South Dakota uses a joint application for TANF and Medicaid. However, while both programs are supervised by the same operating division and the same case management staff administer the programs, the state's use of separate computer systems for TANF and Medicaid eligibility ensures that when a TANF case is denied, an independent Medicaid eligibility determination is made.

- ◆ ***Use separate applications.*** If a state does not use a joint application, it should ensure that Medicaid applications are available at all TANF sites. States with non-Medicaid CHIP programs should also ensure that CHIP applications are available at TANF sites.

- ◆ **Use both joint and separate applications.** An effective strategy for maximizing the Medicaid participation of families who come into TANF offices is for states to make both joint and Medicaid-only applications available. This way, no matter what course a family takes with regard to seeking TANF assistance, the family can apply for Medicaid easily.

Administrative Strategies and Considerations

Effective implementation of the new Medicaid rules requires procedures that ensure that eligibility for Medicaid is considered when TANF assistance is provided, denied, delayed, or terminated. State procedures should assure that caseworkers are proactive in offering families the opportunity to apply. Families should not be expected to take the initiative to ask about Medicaid. Rather, all those who come to TANF offices should be asked about their health coverage needs and informed of the process for applying for Medicaid and CHIP. Following are suggestions for how to assure such an outcome:

- ✓ **Provide Medicaid and CHIP outreach to families at TANF sites.** The key to any effort to identify and enroll eligible children and families is outreach. Success in outreach and enrollment requires the involvement of TANF offices and personnel. Families who inquire about or apply for TANF should also receive information about Medicaid and CHIP, including how to apply for these programs. TANF agency staff should be trained to conduct this outreach and education.
- ✓ **Place Medicaid/CHIP workers in TANF offices.** States are encouraged to place Medicaid and CHIP eligibility workers at TANF offices to take applications and assist in their preparation. This practice is especially important at sites where, by state or local policy, low-income people are often directed to job searches, receive diversion payments, or otherwise receive assistance that may result in their not filling out an application for TANF assistance.
- ✓ **Conduct staff training.** States can send a strong and clear message to their employees about the importance of Medicaid and CHIP eligibility through special staff training, supervisor reviews, and other mechanisms. Such efforts should call attention to the differences between the TANF rules and Medicaid and CHIP eligibility rules, and to the procedures necessary to ensure that Medicaid and CHIP eligibility are considered. States should consider offering similar training to hospitals, clinics, health providers, child care centers, Head Start programs, WIC offices, community-based organizations, and other programs that come into contact with low-income families and children.

- ✓ **Encourage Medicaid application when the TANF application process halts.** States should ensure that the Medicaid application process is completed when a family does not qualify for TANF-funded assistance or abandons the TANF application process. It is important to inform families early in the application process about the different eligibility rules for TANF and Medicaid. Otherwise, families may not understand that even if they don't qualify for TANF, their Medicaid application can and should be processed and could well be approved.

To give an example, a person who applies for TANF might be required to meet an up-front job search requirement before becoming eligible for cash assistance. Although that person's TANF application might be suspended, he or she should be guided to proceed with the application for Medicaid. As another illustration, a parent might not carry through with a joint application if he or she finds a job, thinking that the family is no longer eligible for Medicaid coverage. Rather than just accepting a withdrawal of a TANF-Medicaid application, a state should send a letter informing the family that all or some of its members might still be eligible for Medicaid, laying out the steps the family needs to take to complete the Medicaid aspects of the application, and urging them to pursue application.

- ✓ **Educate families.** Informing families early in the TANF application process and regularly thereafter about how the Medicaid and TANF rules differ, and reminding them that Medicaid eligibility is not tied to TANF receipt, can help encourage families to submit and complete Medicaid applications. One reason families may not sign up for Medicaid is that they are under the mistaken impression that Medicaid eligibility depends on welfare eligibility. Therefore, states should make clear in all of their informational materials about TANF that coverage under Medicaid and CHIP does not require welfare eligibility and that, no matter whether or not families apply for or receive TANF assistance, they are encouraged to apply for Medicaid and/or CHIP.

For individuals facing language barriers, states should consider developing culturally-appropriate materials in languages other than English.

- ✓ **Simplify application and enrollment.** States have considerable flexibility under Medicaid and CHIP to simplify the application and enrollment processes. HCFA has provided states with suggestions on how to do so in a letter to state health officials dated September 10, 1998, which can be found on the HCFA website (<http://www.hcfa.gov>).

Many states have simplified their application and enrollment processes for children under Medicaid and CHIP by shortening application forms, allowing the use of mail-in applications, reducing or eliminating verification and documentation requirements that go beyond Federal requirements, and speeding up processing of applications. States should consider taking similar steps to simplify the application process for low-income families.

- ✓ **Coordinate TANF and Medicaid Section 1931 eligibility.** The alignment of TANF and Medicaid eligibility requirements for low-income families can greatly facilitate families' participation in Medicaid. Medicaid and TANF requirements can be aligned by taking advantage of the flexibility to modify financial methodologies and standards under Section 1931, loosen the deprivation requirements for two-parent families, and continue certain AFDC waivers. By exercising these options, states can provide automatic Medicaid eligibility for TANF recipients as they did for AFDC recipients prior to the enactment of welfare reform.

States have begun to take advantage of the flexibility to harmonize TANF and Medicaid eligibility in several ways. For example, several states have adopted earnings disregards in their TANF programs that are more generous than the old AFDC earnings disregards. To ensure that TANF recipients also qualify for Medicaid, many of these states have adopted the same disregards under the Section 1931 eligibility group. With the exception of earned income disregards, the financial rules under the Section 1931 group must be applied to all members of the group, including those families who do not receive TANF benefits.

- ✓ **Eliminate or ease the Medicaid resource test.** Most states have dropped the Medicaid resource test for children and now, under Section 1931, states have the ability to drop or ease the resource test for parents as well. Taking this step makes it easier to establish Medicaid eligibility, and can also make Medicaid rules more compatible with welfare reform initiatives. Some states that have not dropped their resource requirements under Section 1931 have made their resource rules less restrictive, for example, by exempting the value of a car.

Maintaining Coverage for Families Who Leave TANF Assistance

This chapter focuses on the statutory and regulatory requirements with which states must comply in providing Medicaid to adults and children in families leaving the welfare rolls. This chapter also identifies administrative practices that can increase the likelihood that parents and children who leave welfare will continue to receive Medicaid and/or CHIP.

State Requirements and Options under Federal Medicaid Law

A. Mandatory Eligibility Policies

- ✓ **Exhaust all avenues to eligibility before denial or termination.** Because Medicaid eligibility is not based on TANF eligibility, states may not deny Medicaid eligibility to a family or any family member simply because the family is ineligible for TANF because of employment, time limits, sanctions, or for any other reason. Nor can a state deny Medicaid eligibility because a family member loses eligibility under a particular Medicaid eligibility category. Further, it is not acceptable for a state to deny a joint application and then advise families to reapply if they think they may be eligible under another Medicaid category. *States are prohibited from denying or terminating Medicaid eligibility unless all possible avenues to Medicaid eligibility have been affirmatively explored and exhausted.*

Since Medicaid eligibility for families no longer hinges on eligibility for welfare, and since Medicaid generally covers a broader group of children and families than may be eligible for TANF, some or all members of a family that fails to meet TANF eligibility criteria are likely to be eligible for Medicaid. There are many possible avenues to Medicaid eligibility for family members denied or terminated from TANF assistance, including the Section 1931 group (depending on family income and other state eligibility rules for the group), poverty-level groups, and transitional Medicaid.

- ✓ **Provide transitional Medicaid for families.** Under Section 1925 of the Social Security Act, states must provide extended Medicaid benefits ("transitional Medicaid") to families who, because of hours of work or income from employment (or loss of the earned income disregard), lose their

eligibility for Medicaid under the Section 1931 group. (States must also provide transitional Medicaid when eligibility would otherwise be lost due to child support income.) It is important to note that it is the loss of coverage under Section 1931 — not the loss of TANF assistance — that is now the trigger for transitional Medicaid.

States are required to provide an initial six-month period of transitional Medicaid and, subject to certain reporting requirements and the income limit explained below, can provide an additional six months of coverage. Some states provide a longer period of transitional Medicaid under Section 1115 waivers. (Four months of coverage are available when child support payments trigger eligibility.)

To be eligible for transitional Medicaid, a family must have received Medicaid under Section 1931 in three out of the preceding six months before becoming ineligible under this category. No income limit applies to families for the initial six-month period of transitional Medicaid. However, the optional second six-month period is limited to families whose earned income (less necessary child care expenses) does not exceed 185% of the Federal poverty level for the size of the family.

B. Optional Eligibility Policies

- ✓ **Provide continuous eligibility for children.** Under Section 1902(e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Such eligibility must end when the child reaches age 19. By granting children eligibility for up to one year without regard to changes in circumstances, states can minimize the burden on families seeking to maintain coverage for their children. Most importantly, continuous eligibility can minimize coverage losses among children that occur because families are in financial transition and because of the barriers to continued participation that recertification requirements impose. To adopt the continuous eligibility option, states must amend their Medicaid state plans. States may also grant continuous eligibility under CHIP.
- ✓ **Termination for failure to meet TANF work requirements.** States can terminate Medicaid coverage for a TANF recipient (excluding pregnant women and children eligible under a poverty-level group and minor children who are not heads-of-household under TANF) if the recipient's TANF assistance is terminated because of a refusal to cooperate with TANF work requirements. This sanction extends only to the person violating the TANF work requirement, in most cases the adult head-of-household. A state cannot terminate Medicaid benefits for other family members, including the chil-

dren of an adult who fails to meet a TANF work requirement. States that wish to adopt this option to terminate Medicaid for refusal to cooperate with work requirements must submit a Medicaid state plan amendment.

- ✓ **Medicaid payment of premiums and cost-sharing for employer-based health coverage.** Under Section 1906 of the Social Security Act, states have the option of paying a low-income worker's share of the premium for employer-sponsored health insurance along with any cost-sharing, if such action would be cost-effective relative to providing Medicaid for that person. That is, the cost to the state of the premiums and cost-sharing must not exceed the cost to the state of providing Medicaid benefits. The family or individual must be otherwise eligible for Medicaid and agree to enroll in the employer-based health insurance as a condition of Medicaid eligibility. Under Section 1925, states have the option of requiring that individuals receiving transitional Medicaid enroll in employer-sponsored insurance, whether or not it is cost-effective.

Administrative Strategies and Considerations

States may want to consider the following administrative strategies to maximize enrollment in Medicaid and CHIP:

- ✓ **Prevent inappropriate Medicaid denials and terminations.** The key to states ensuring that Medicaid-eligible families continue to receive Medicaid after their TANF benefits have been terminated is the set of procedures they use to prevent inappropriate Medicaid eligibility terminations. In no event should closure of a TANF case automatically result in closure of a Medicaid case.

In many situations in which a TANF case is closed, the state will have all the information it needs to determine whether Medicaid eligibility for a family should continue; in these cases, the state must make the Medicaid redetermination without seeking additional information from the family. In other situations, families will need to be informed that they must provide additional information to allow the state to evaluate their ongoing Medicaid eligibility. One way states can help families understand that their Medicaid benefits are not affected by the actions taken in their TANF case is to make sure that TANF case-closing notices state this fact very clearly.

- ✓ **Educate families about transitional Medicaid.** To maximize the participation of families in transitional Medicaid, it is critical that states educate families about this benefit and the steps they need to take — such as reporting earnings, rather than closing their cases — to safeguard and facilitate their Medicaid eligibility when they leave TANF assistance.

- ✓ **Delink Medicaid and TANF redeterminations.** To avoid inappropriate Medicaid termination, states can establish different redetermination periods for Medicaid and TANF, thereby delinking Medicaid and TANF eligibility reviews. Under Medicaid regulations, states must conduct redeterminations at least every 12 months, or promptly upon notification of a change in the family's or child's circumstances that may affect eligibility (unless the state has adopted the 12-month continuous eligibility option for children, as described next).
- ✓ **Adopt continuous eligibility for children.** Under Section 1902(e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Such eligibility must end when the child reaches age 19. By granting children eligibility for up to one year without regard to changes in circumstances, states can minimize the burden on families seeking to maintain coverage for their children. Most importantly, continuous eligibility can minimize coverage losses among children that occur because families are in financial transition and because recertification requirements impose barriers to continued participation.
- ✓ **Simplify redeterminations.** Eligibility reviews can be simplified. To avoid time-consuming face-to-face meetings and help working parents avoid missing work, states can be kept informed of changes in family circumstances by telephone or mail. States can respond to requests for eligibility reviews by simplifying the review process, much as they have simplified their Medicaid applications for children. Redetermination forms can be shortened, most of the necessary information can be filled in by the state based on the information on hand, and the family can be asked to send in the signed form with any changes noted.
- ✓ **Review closed TANF cases.** A state review of TANF cases that have been closed and in which Medicaid was not continued may identify families likely to be eligible for Medicaid. States have the authority to re-open erroneously closed cases on their own motion, and should, at a minimum, conduct aggressive outreach to families in this situation.
- ✓ **Expand Medicaid coverage for low-income working families.** States have the flexibility to use less restrictive financial methodologies and standards under the Section 1931 group, as well as authority to loosen deprivation requirements, in order to expand Medicaid to cover more working families (see pages 6-7 for a detailed discussion of state flexibility). States adopting such policies provide health security — a critical support — to families who have made or are making the transition to self-sufficiency. When states take this route to broadening eligibility for Medicaid, families at the higher income levels remain eligible as long as their income does not exceed the Medicaid income threshold and they continue to meet other applicable requirements.

- ✓ **Improve the reach of transitional Medicaid.** To be eligible for transitional Medicaid, a family must have received Medicaid under Section 1931 in three out of the preceding six months before becoming ineligible under this category. The same flexibility under Section 1931 that states can use to expand coverage quite broadly (e.g., via income and asset disregards) can also be used for the narrower purpose of increasing access to transitional Medicaid for working families who may be diverted from TANF or leave TANF assistance in less than the three months typically required to trigger transitional Medicaid.

For example, states that offer lump-sum "diversion" payments in lieu of recurring cash assistance can prevent these lump-sum payments from making the family ineligible for Medicaid by disregarding them as either income or resources when they determine eligibility under Section 1931. To give another example, a state can disregard all earnings below the poverty level for 12 months; this way, a low-income working family can obtain Medicaid eligibility under the Section 1931 group for 12 months, and subsequently qualify for transitional Medicaid for up to an additional 12 months. Alternatively, a state can adopt a more limited disregard of all earned income for three months, enabling families to obtain Medicaid eligibility under Section 1931 for the three-month period necessary for the family to qualify for transitional Medicaid.

As the illustrations make clear, limited changes in Medicaid rules can ensure that families in the earliest stages of their connection to the workforce do not lose their Medicaid coverage. Such programmatic coordination is key to the development of a coherent state strategy for supporting families in transition.

- ✓ **Pay private health insurance premiums and cost-sharing.** States' use of the option to cover Medicaid-eligible working families by paying the family's share of premiums for employer-sponsored health insurance, along with deductibles, coinsurance, and other cost-sharing, gives families an incentive not to drop employer-sponsored insurance, preserving continuity in their health coverage and supporting their employment. The approach also builds on the private insurance system, and may result in savings to the state.

Reaching Families Outside the TANF System

This chapter deals with ways to ensure coverage for low-income families who do not come in contact with the TANF system. As states succeed in helping families move to self-sufficiency, more families will remain outside the welfare system. Thus, it is critical that new strategies for reaching families outside the TANF system be developed and implemented.

The longstanding linkage between cash assistance and Medicaid was often seen as an inequitable and counter-productive feature of the old system. When families learn that they can receive Medicaid coverage without having to receive welfare, they may be less likely to turn to welfare in the first place or to return to the welfare system in the event that they have significant health care needs. This chapter highlights the historic opportunity that the delinkage of Medicaid from welfare presents to promote Medicaid and CHIP coverage as a freestanding support for low-income families with children, and outlines approaches states can take toward this goal.

This chapter also emphasizes the importance of information and outreach efforts, and of simplifying the application and enrollment processes, as means of identifying and enrolling low-income families and children in Medicaid and CHIP.

State Requirements and Options under Federal Medicaid Law

A. Mandatory Eligibility Policies

- ✓ **Outstation eligibility workers.** 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 welfare offices. States are required to have outstationing arrangements at facilities designated as "disproportionate share hospitals" and Federally Qualified Health Centers (FQHCs). HCFA regulations (42 CFR 435.904) permit alternative outstationing arrangements under certain limited conditions, and allow states to use additional sites where children and pregnant women receive services. States are free to station Medicaid eligibility workers at any location to take applications, provide assistance, and, if authorized, evaluate applications and make eligibility determinations.

B. Optional Eligibility Policies

- ✓ **Expand coverage for families under Section 1931.** Section 1931 authorizes states to use financial standards and methodologies for low-income families that are more generous than the standards and methodologies in AFDC state plans in effect on July 16, 1996. Together with the new flexibility to define deprivation (e.g., by substituting another definition of unemployment for the 100-hour rule), states can use Section 1931 to take two significant policy actions. (See pages 6-7 for a detailed discussion of state flexibility.) First, they can equalize their treatment of single- and two-parent families for Medicaid purposes. Second, they can expand coverage of families as far as state budget and policy preferences permit. States can accomplish these policy changes through amendments to their Medicaid state plan; they do not need to obtain Federal waivers.

Recognizing that Section 1931 coverage expansions will require additional state expenditures to draw down Federal matching payments (see under **Cover children under CHIP** regarding enhanced Federal match for uninsured children in families covered under a Section 1931 expansion), it should be noted that states' expansions of coverage to low-income families under Section 1931 can be as broad or as narrow as state resources and other considerations permit. For example, states can:

- ◆ ***Expand Medicaid to cover all families up to a specified income level.*** By using more generous financial methodologies and standards, states can expand coverage under Section 1931 to reach single- and two-parent families with more income than Medicaid has traditionally covered. Such expansions present an opportunity for states to recast and market Medicaid as a freestanding health insurance program for low-income families, improving the possibility of de-stigmatizing Medicaid and enhancing the potential of the program to reach families who do not come into contact with the TANF system. The law leaves states free to raise their effective income eligibility thresholds for Section 1931 to whatever level they wish.
- ◆ ***Phase in expansions.*** States can expand coverage under Section 1931 more narrowly initially and, based on their evaluation of the expansion and its success in meeting state welfare reform and health coverage objectives, consider broadening those expansions further to include families with more income and/or resources.
- ◆ ***Improve the reach of transitional Medicaid.*** The same flexibility under Section 1931 (e.g., income and asset disregards) that states can use to achieve a broad expansion of coverage can also be used for the narrower purpose of increasing access to transitional Medicaid for

families who do not come into contact with the TANF system. States can extend Medicaid to working families temporarily, by using income and asset disregards that permit families to obtain Medicaid eligibility for at least three months, and thus give them access to up to 12 months of transitional Medicaid as well. Such limited changes in Medicaid rules can ensure that families' success in attaining self-sufficiency does not preclude their qualifying for health coverage — a coherent result that supports the twin goals of reducing the numbers of people without insurance and supporting state welfare reform initiatives.

- ◆ ***Expand coverage to two-parent families.*** States can expand Medicaid to cover more two-parent families by replacing the 100-hour rule with a broader definition of unemployment.
- ✓ **Cover children under CHIP.** Under CHIP, enhanced matching funds are available to states to provide coverage for uninsured children who are not otherwise eligible for Medicaid. Coverage can be provided through a Medicaid expansion, a separate CHIP program, or a combination of both. Under Medicaid expansions, the usual Medicaid eligibility rules apply. Under a separate CHIP program, states have flexibility to establish eligibility requirements.

Nearly all states have approved CHIP plans and are implementing their programs. States should consider further expansions of coverage for uninsured children; such expansions promote both health care coverage and welfare reform goals by improving health security and providing needed support to low-income working families.

States implementing CHIP through a Medicaid expansion can claim enhanced Federal matching funds under Title XIX (section 1905(u)(2)(B)) for children who become eligible for coverage as a result of an expansion of family coverage under Section 1931. The enhanced match can be claimed only for uninsured children who would not have qualified for Medicaid coverage under the Medicaid state plan in effect on March 31, 1997. The funds claimed for CHIP-eligible children under Section 1931 would count against the state's CHIP allotment. To claim the enhanced match, states must have a means of identifying children who are uninsured and otherwise qualify for enhanced Federal matching payments for the medical assistance they receive. For children who do not meet the criteria for the enhanced match, the state may continue to claim its regular Medicaid match.

- ✓ **Cover families under CHIP.** CHIP also grants states the authority to obtain a "variance" to purchase family coverage that includes coverage of CHIP children if the state can demonstrate that the cost to the CHIP program of purchasing the family coverage does not exceed the cost of obtaining CHIP

coverage for the children alone, and that the family coverage will not otherwise substitute for other health insurance coverage for the children. While these statutory constraints limit use of the family coverage option under CHIP, a few states, including Massachusetts, have utilized this option to extend coverage to poor working families.

It should be noted that a CHIP family coverage program would not extend coverage to the parents of children who are eligible for Medicaid. To avoid an anomalous result in which higher income families are covered under CHIP, but the parents of lower-income children lack coverage, states would also need to implement a Medicaid expansion under Section 1931.

- ✓ **Presumptive eligibility for children and pregnant women.** States have the option to provide presumptive Medicaid eligibility to children and to pregnant women. Under Section 1920A of the Social Security Act, certain entities can determine, based on preliminary information, whether the family income of a child is within the state's income eligibility limits for Medicaid. If it is, the child (or, under Section 1920 the pregnant woman) can be granted temporary eligibility for Medicaid and has until the end of the following month to submit a full Medicaid application. A similar approach may be used under a separate CHIP program. It should be noted that states that use a simplified Medicaid application can also use this form to establish presumptive eligibility, eliminating the need for a two-step application. As always, however, an authorized state employee must make the Medicaid eligibility determination.

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 system because health care providers and others can grant temporary coverage on the spot when children and pregnant women go to receive health care services and other forms of assistance.

Under the law, the entities that can establish presumptive eligibility for children include: Medicaid providers, entities that determine eligibility for Head Start, WIC, and child care subsidies under the Child Care and Development Block Grant, and other entities designated by the state. Presumptive eligibility for pregnant women can be established by specified entities likely to have contact with pregnant women seeking pregnancy-related services. While TANF offices are not specifically mentioned in the statute, TANF offices can establish presumptive eligibility if they determine eligibility for one of the programs listed.

- ✓ **Continuous eligibility for children.** Under Section 1902(e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Such eligibility must end when the child reaches age 19. By granting children eligibility for up to one year without regard to changes in circumstances, states can minimize the burden on families seeking to maintain coverage for their children. Most importantly, continuous eligibility can minimize coverage losses among children that occur because families are in financial transition and because recertification requirements impose barriers to continued participation.

Administrative Strategies and Considerations

States may want to consider some or all of the following administrative strategies and other measures to improve outreach and increase coverage of low-income families with children:

- ✓ **Create application sites outside the welfare office.** States may make Medicaid applications regularly available at sites outside of welfare offices. For example, sites can be established at state or county offices that handle child care subsidies or at "Medicaid-only" offices. States may also place eligibility workers at locations that provide services to low-income families (see just below) subject to the regulations on outstationing cited on page 19. Federal law does not limit states' options along these lines as long as all final eligibility determinations are performed by state personnel who are authorized by the state to perform these functions. This approach can help promote the program as one that offers health insurance coverage to low-income families, generally, and not just to families receiving TANF.
- ✓ **Place Medicaid and CHIP eligibility workers in communities.** The opportunity to apply for Medicaid or CHIP can be enhanced by placing outreach and eligibility workers in locations where they are likely to interact with low-income families who are eligible for those programs (e.g., hospitals, community and migrant health centers, community action agencies, schools, community colleges, Head Start programs, and one-stop career centers).

Medicaid permits only authorized state eligibility workers to evaluate the information on the application and supporting documentation and to make eligibility determinations. But other individuals, including volunteers, provider and contractor employees and TANF workers may take applications at the outstation locations described on page 19, and perform initial processing activities, including interactions with applicants. The regulations on outstationing do not prohibit the use of volunteers to help appli-

cants complete applications at sites other than outstation locations. Therefore, states can work with a very broad range of public and private organizations to identify eligible families, educate them about Medicaid and CHIP, and have them complete applications for health insurance. Again, the evaluation of Medicaid application information and the eligibility determination itself must be performed by state personnel who are authorized by the state to perform these functions.

States have greater flexibility to determine the sites where non-Medicaid CHIP applications may be taken and who may conduct initial application processing activities and make eligibility determinations.

- ✓ **Improve the availability of application sites.** It is important that states make it easy for low-income families, including working families, to apply for Medicaid and CHIP. Keeping application sites open during evening hours and on weekends makes it more convenient for working families to apply.
- ✓ **Simplify the application and enrollment processes.** Application and enrollment processes should not be a barrier to low-income families applying for Medicaid. As noted earlier, states have taken several steps to simplify the application and enrollment process for children under Medicaid and CHIP, including simplifying application forms, reducing documentation requirements, allowing mail-in applications, and expediting processing of applications. States also should consider allowing families who are not applying for TANF to use simplified Medicaid and CHIP applications and application processes. This approach would facilitate Medicaid and CHIP participation among these families. (HCFA's guidance on simplifying the Medicaid and CHIP application and enrollment processes was provided in a letter to state health officials dated September 10, 1998, which can be found on the HCFA website (<http://www.hcfa.gov>).)
- ✓ **Educate families.** It is important that low-income families understand that the coverage available under Medicaid and CHIP for families and children is not linked to receipt of TANF assistance. The misconception that Medicaid eligibility is linked to TANF is widespread. Vigorous educational efforts are needed to correct this belief so that enrollment in Medicaid and CHIP can be maximized.
- ✓ **Conduct outreach.** It is critical that aggressive outreach be conducted to provide Medicaid and CHIP information to low-income families. States have used a variety of valuable approaches to help them locate children and facilitate their enrollment in Medicaid and CHIP, which should also be used to reach out to low-income families as a whole. They include:

- ◆ implementing a toll-free telephone hotline for enrollment information;
- ◆ placing billboards and posters in places frequented by low-income families;
- ◆ producing public service announcements for radio and television;
- ◆ distributing information through other public and private programs designed for low-income families (e.g., child care, Head Start, food pantries, one-stop centers, and community-based organizations);
- ◆ stationing state eligibility workers in places frequented by low-income families, such as TANF offices, WIC offices, hospitals, and one-stop centers); and,
- ◆ working with local community-based organizations to develop creative outreach programs.

States should also maximize publication of the national toll-free number that automatically connects callers with the CHIP program in their state. The number is 1-877-KIDS-NOW.

- ✓ **Integrate health and social service systems.** States should aim to integrate their programs to ensure that low-income families receiving any of an array of services learn about and apply for Medicaid and CHIP. The recently enacted Workforce Investment Act (WIA) promoted this concept by establishing an innovative "one-stop" system designed to provide a comprehensive array of job training, education, and employment services at a single neighborhood center. The WIA specifies several Federal programs and activities that must participate in each local one-stop system. Although not required partners, the TANF and Medicaid programs can link up with one-stop systems as optional partners, enhancing the support available to low-income working families and families making the transition from welfare to self-sufficiency.

Several states have taken advantage of this new opportunity. For example, the Kenosha County Job Center in Wisconsin has combined services, including Medicaid, at its job center. Although the one-stop center was initially designed to include services fairly directly related to job training, job-seeking, and education, it evolved to include Medicaid, child support, child care, and Head Start.

Funding Opportunities

This chapter sets out the funding sources available under Medicaid, CHIP, and TANF for outreach activities, systems changes, training, and other investments critical to supporting compliance with Medicaid requirements in the new welfare context and to maximizing health care coverage of low-income families with children. States have several options for claiming Federal matching funds for their spending on efforts to find and enroll families and children in Medicaid and CHIP. The Medicaid and CHIP funds for outreach were described in detail in a January 23, 1998 letter to state health officials (available at <http://www.hcfa.gov>) highlighting new and existing opportunities for outreach to uninsured children. In addition, options to receive Federal funds for outreach spending are available under TANF. These options are described below.

Medicaid Funds

Medicaid law does not limit the amount of money a state can spend on outreach efforts to enroll people in Medicaid. The Federal government will match such spending dollar for dollar. In addition, a special \$500 million Medicaid fund was created under the welfare reform law to help states with the additional administrative costs of eligibility determinations resulting from the delinkage of Medicaid from welfare eligibility and the establishment of Section 1931. These funds are available for matching certain allowable administrative expenditures incurred by states during the first three years in which the states' TANF programs are in effect. State spending is matched by the Federal government at either a 90 percent or a 75 percent rate. (For more details, see the notice published in the Federal Register on May 14, 1997, Vol. 62, No. 93, pages 26545-26550.)

Each state has an allocation from the \$500 million fund from which it can claim matching funds. Each state's allocation is composed of a "base allocation" and a "secondary allocation." The base allocation for each state is \$2 million; the secondary allocation varies by state based on state-specific factors. Federal matching funds are available from the base allocation at the enhanced matching rate of 90 percent for allowable administrative activities (including outreach), regardless of the type of activity. Federal matching funds are available from the secondary allocation at enhanced matching rates of either 90 percent or 75 percent, depending on the type of activity. Activities whose costs are claimable from the secondary allocation at the enhanced rate of 90 percent include: educational activities, public service announcements, outstationing of eligibility workers, training, outreach, developing and disseminating new publications, and local community activities. Activities whose costs

are claimable from the secondary allocation at the enhanced rate of 75 percent include: hiring new eligibility workers, designing new eligibility forms, identifying at-risk TANF recipients, intergovernmental activities, and eligibility systems changes.

In order to be allowable, activities must be attributable to administrative costs of eligibility determinations that are incurred due to the enactment of Section 1931. However, it is clear that outreach efforts conducted by states to implement the provisions of Section 1931 may also result in Medicaid eligibility determination activities for individuals covered under other groups. It is neither administratively efficient nor practical, with respect to claims for Section 1931 outreach activities, to distinguish between activities resulting in eligibility determination under Section 1931 and activities related to Medicaid eligibility under other statutory authorities. Therefore, so long as the outreach activities are designed principally to address the eligibility determinations related to Section 1931, states may claim the costs of such activities at the enhanced Federal matching rate.

CHIP Funds

State spending on CHIP-related outreach activities is matched from the state's CHIP allotment. States may spend up to 10 percent of their total CHIP expenditures (Federal and state) on non-benefit activities, including outreach. These expenditures are matched at the enhanced CHIP matching rate. At state option, outreach activities related to a CHIP Medicaid expansion can be matched either from the state's CHIP allotment (at the CHIP enhanced matching rate) or at the regular Medicaid administrative matching rate. If a state elects to claim the CHIP match rate for outreach expenditures related to the CHIP Medicaid expansion, then the Federal matching payments count against 10 percent limit and the CHIP allotment. If the state exceeds either limit, it may claim matching for the additional costs of these activities at the regular administrative matching rate under the Medicaid program.

TANF Funds

States can also use their Federal TANF or state maintenance-of-effort (MOE) funds for outreach and training activities for Medicaid and CHIP. However, MOE funds cannot be used as state Medicaid matching funds. While Section 408(a)(6) of the Social Security Act prohibits the use of Federal TANF funds to provide medical services (except for pre-pregnancy family planning services), TANF funds can be used for non-medical services, such as outreach to ensure medical coverage.



Health Care Financing Administration
Administration for Children and Families
Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Total number of pages sent:

Comments:

NOTE TO: Jeanne Lambrew
Cynthia Rice

FROM: Melissa Skolfield

Can you all please review the attached and let me know if you have any suggestions? I'm not familiar with the report's methodology, and I've decided to handle any press inquiries myself.

Note almost all of this language has been previously cleared by Bruce and Chris.
Thanks.

DRAFT Q and As
Families USA

Q: Do you agree with Families USA that 675,000 people lost Medicaid coverage and became uninsured in 1997 because of welfare reform?

A: No. While the latest Medicaid enrollment figures show that there was a decline in the Medicaid rolls from 1996 to 1997, it is too early to say with confidence what has caused the decline. There are a number of factors, such as fewer people in poverty, lower rates of unemployment, and the rise in number of businesses offering health insurance to their employees that contribute to any change in enrollment numbers. It's also important to note that while Medicaid enrollment has declined since 1996, the number of people under the poverty level who are uninsured has not increased in that period.

This report simply restates what studies we've funded have already shown – that the decoupling of cash assistance and Medicaid provides both challenges and opportunities for states. It is a positive development that single parents are moving off the welfare rolls into jobs. But states can and should do more to ensure that they retain access to important work supports such as health insurance.

[BACKGROUND: The overall enrollment figures are 41.4 million in 1995, 41.2 million in 1996, and 40.3 million in 1997. The number of children enrolled went from 20.4 million in 1995 to 20.5 million in 1996 to 19.6 million in 1997. In addition to adults and children receiving cash assistance, Medicaid also covers disabled individuals who receive SSI, low-income elderly Americans, low income parents who would have qualified for cash assistance under the rules in effect prior to the enactment of welfare reform; their children; other children of working parents who meet certain income guidelines; and some working adults in states that have received waivers to continue Medicaid eligibility to low-income working families.]

[BACKGROUND: The numbers shown in HCFA's Congressional Justification are in person years (or, average enrollment). The latest Medicaid enrollment figures in person years indicate that, on average in 1997, about 33 million Americans were enrolled in Medicaid, down from 33.2 million the year before. In FY 1997, there were 16.4 million children enrolled in Medicaid, down from about 16.9 million in 1996.]

Q: Why are the Medicaid rolls decreasing?

A: This is a complex question with no easy answer. There are a number of factors, such as fewer people in poverty, lower rates of unemployment, and the rise in number of businesses offering health insurance to their employees that contribute to any change in enrollment numbers. Individuals also may not realize they are still eligible for the Medicaid program after leaving welfare for work.

Irrespective of these complicated questions, the Administration maintains its long-standing belief that the best approach is for states to move families from welfare to work, while preserving Medicaid eligibility and improving outreach strategies. A new guidebook for states released last month is just the latest of our efforts to work with states to ensure that people moving off cash assistance programs, and working families who may not realize they are eligible for assistance, still get Medicaid benefits. The guidebook also makes clear that states' TANF-Medicaid application must furnish a Medicaid application upon request and may not impose a waiting period. States must also process Medicaid applications without delay.

Q: How is welfare reform going?

A: First, welfare reform has been successful in moving many families from welfare to work. In fact, the Census Bureau data shows that the percentage of people on welfare in one year who were working the following year has almost tripled since 1996. An estimated 1.5 million people who were on welfare in 1997 were working in 1998, and all states met the first overall work participation rates required under the welfare reform law.

Second, we have learned a fair amount about the effects of welfare reform on employment and earnings, and the early news is very encouraging. In fact, TANF administrative data from 39 states show a 30 percent increase in employment among TANF recipients in the fourth quarter of FY 1997, compared to the first three quarters. Over the same period, the average earnings of those employed increased by 17 percent, from \$506 to \$592 per month.

Third, caseloads are down dramatically. The number of welfare recipients has dropped by more than 45 percent since August 1996, and the percentage of the U.S. population receiving assistance is the lowest since 1969.

Fourth, there has been NO race to the bottom in state welfare spending-states are spending more per recipient now than they did in 1994. In 1998, all states met the minimum spending requirements and 13 states exceeded them.

Fifth, a majority of states are increasing their "earnings disregards." That means they're raising the amount of earnings that are not counted when determining a recipient's benefits. This will not only help pull families out of poverty, it will send the message to low wage earners that going to work is a better deal than staying home.

This is clearly not the end of welfare reform, it is only the beginning. And that's why this Administration has challenged all Americans to help make this historic law work even better. The President has spoken forcefully about the need for the business community to hire people coming off welfare. The 10,000 companies that have joined the Welfare to Work Partnership have hired 410,000 welfare recipients. The federal government has done its fair share too, hiring 10,000 welfare recipients.

Q: Do you agree with Families USA that the problem of Medicaid eligibility loss will only get worse as welfare reform continues and time limits begin to kick in?

A: No. While it is too early to tell what caused the 1996-1997 decline in the Medicaid rolls, we are doing everything possible to help states extend Medicaid to everyone who qualifies. For example, HHS recently issued guidance to states explicitly underscoring that states with joint applications for TANF and Medicaid must provide Medicaid applications upon request and must process Medicaid applications without delay, regardless of state rules governing TANF applications. The document also provides examples of successful state outreach activities for both Medicaid and CHIP, the new Children's Health Insurance Program. CHIP has already enrolled almost 1 million children whose parents earn too much to qualify for Medicaid, and we expect it to provide health insurance for many children whose parents leave welfare for work.

As for time limits, as the Families USA report itself points out, most children whose parents reach the five-year time limit will retain their eligibility for Medicaid, or will be eligible for CHIP. It is also important to remember that states have great flexibility in designing their time limit policy, and that the law allows states to exempt up to 20 percent of families receiving TANF from the five-year time limit.

Congress can also do more to address this issue. The President's Fiscal Year 2000 budget outlines some additional initiatives that would improve Medicaid awareness and potentially enroll thousands more children in Medicaid as well as CHIP. For example, HHS is proposing to broaden states' ability to use a special \$500 million Medicaid fund, enacted in the 1996 welfare reform law and aimed at the costs incurred by states because of the decoupling of AFDC and Medicaid, including outreach costs. In addition, we are proposing to remove outreach costs from the 10 percent cap states have on administrative costs for the CHIP program. Instead, states could spend up to 3 percent of their total allotment on outreach. This initiative, which is scored at \$875 million, would give states more flexibility in designing outreach campaigns to reach families.

WELFARE REFORM QUESTIONS AND ANSWERS

Q: Is it true that welfare reform has resulted in families to lose their Medicaid benefits unfairly?

A: When welfare reform was passed in 1996, the President insisted that the new law preserve the Medicaid entitlement for low income families. The Administration is doing everything possible to maximize the number of people with health insurance who are moving from welfare to work, and we will continue to work with States to design model outreach strategies. The new Insure Kids Now effort will augment our current efforts.

Q: Today's NYT article blames welfare reform for causing individuals to lose Medicaid benefits, even though the welfare law does not formally change the Medicaid entitlement. What is your response?

A: In passing welfare reform, the President insisted on maintaining the Medicaid entitlement; indeed, he vetoed two welfare bills that did not guarantee continued Medicaid coverage to all adults and children who were then eligible. A number of factors are likely to be the source of reductions in Medicaid enrollment, including the strong economy, which may have made it possible for many low income people enrolled in the Medicaid program with incomes high enough to disqualify them for Medicaid.

While it is too early to tell whether welfare reform may have an indirect effect on Medicaid enrollment, we are doing everything possible to ensure it does not. The Administration is taking aggressive steps to ensure that states and communities do not undermine the Medicaid guarantee of coverage in implementing their welfare programs.

For example, just last month, HHS issued guidance to states explicitly underscoring that states with joint applications for TANF and Medicaid must provide Medicaid applications upon request and must process Medicaid applications without delay, regardless of the state rules governing the TANF application. This document also provides examples of successful outreach and enrollment activities for families moving from welfare to work. This commitment to outreach builds on four national public awareness events in which the President, the Vice President, the First Lady and Mrs. Gore have highlighted the importance of these efforts.

BACKGROUND ON OUTREACH EFFORTS:

The Administration has also launched "Insure Kids Now", a new campaign to reach out to uninsured children who are potentially eligible for Medicaid or CHIP. Efforts include: unveiling a new national toll free number for children's health

insurance outreach, "1-877-KIDS NOW"; running public service announcements on national television and radio about Insure Kids Now; and printing the Insure Kids Now toll free number on commonly used products, such as grocery bags, toothbrushes, diaper boxes, pharmaceutical products, child safety seats, and schoolbuses.

In addition, the President has included a \$1 billion, 5-year initiative to fund outreach to enroll uninsured children in Medicaid and the new Children's Health Insurance Program (CHIP) in his FY 2000 budget. These new funds will enable States to simplify enrollment systems, launch ad campaigns, educate community volunteers, outstation eligibility workers, and conduct outreach campaigns to identify and enroll uninsured children in both Medicaid and CHIP.

Q: Wasn't the Administration investigating New York City for violating Federal rules about immediate processing of Medicaid applications? What is the status of that investigation?

A: HHS has been working with New York City for several months to ensure that its Medicaid program is serving all qualified applicants, as required by law. In late January, a New York district court issued a temporary restraining order against the city for failing to follow federal Medicaid enrollment requirements; this order requires the city to develop a plan for coming into compliance with current statute. We are following this case closely, and will continue to work with New York to ensure that people moving from welfare to work retain their Medicaid benefits as long as they are eligible.

THE WHITE HOUSE



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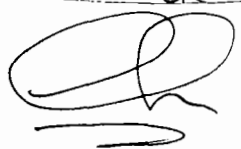
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Comments: Found the 1st Lady's comment
from the New York speech. You can
of course use it as you see fit. However,
as we discussed, I don't want be on the
record on this issue. Thanks 

I remember a woman I met at the White House. She and her husband both work, but for three years, they were unable to afford health insurance for their two boys. She told me that she felt like she was "walking on eggshells" that entire time, especially when the boys started playing sports. And she talked about how grateful she was, and how much more relaxed she feels now -- because since July 1998, her children have been covered through CHIP. And they are not alone. **I am pleased to announce today that, after its first full year, almost one million more children in America have health insurance, thanks to the new CHIP program.**

And that's in large part because a number of states are finding innovative ways to reach them. When I was in Chicago last week, I heard that when parents picked up report cards at their public schools, an army of volunteers are making sure they also pick up forms to get their children enrolled right on the spot. In Florida, they've developed an easy-to-read fact sheet that helps immigrant families find out about the issue -- and whether their children are eligible. And right here in New York, Child Health Plus has radio spots in many languages, including Greek, Russian, Albanian, Creole, and Chinese. More than 250,000 children have now been enrolled here.

We need every state to follow these examples. And we need some states, quite frankly, to do more and do better -- if we are to fulfill our goal of enrolling millions of children.

[And as we do this, we must also ensure that Medicaid is there for all who are eligible for it, especially as we succeed in moving people from welfare to work. Recently, we've heard disturbing stories -- stories about people who are automatically dropped by the computer from Medicaid when they go off welfare. People who are told they must search for work to get their health benefits -- or left to believe they are no longer eligible or otherwise discouraged from applying for Medicaid.

If these stories are true, they violate the provisions and purpose of the welfare law. How can people become independent when their families don't have health care? Twice different welfare bills crossed the President's desk. And twice he vetoed them -- in large part because they took away the guarantee of Medicaid. His Administration has recently written to the states clarifying the welfare law -- and saying that its letter and spirit must be followed.

So, who are the rest of the uninsured? The fastest growing group is between the ages of 55 and 65. And they are the ones most likely to have health problems. Think about the woman who is covered by her husband's plan. If he is older, she often loses her coverage when he becomes eligible for Medicare. Or the person whose retiree coverage is dropped by the company he spent his life working for. Or all the older Americans who are increasingly losing their jobs -- often because of plant closings or downsizing -- just when they need them most.

For Americans 55 and older, the President's plan says you should be able to buy into Medicare. And if your company reneges on their commitment to provide you with retiree benefits, you should be able to get COBRA coverage until you're 65. He proposed this in last year's budget. And he was proud to have Senator Moynihan as its lead sponsor. He proposed it again this year. And I hope Congress passes it.

But, we also know that more than 50 percent of the uninsured are young people between the ages of 18-34. Now, I remember when I was 25. I thought I'd live forever. Of course, now that I'm over 50, I wake up and know I'm alive -- because I ache somewhere.

L

842-0427

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION



PHONE: (202)690-6102 FAX: (202)690-6167

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From: Rob Stewart

To: Devorah Adler

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Division: _____

City & State: _____

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Office Number: _____

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Number of Pages + cover 7

REMARKS: _____

DRAFT Ver. 3

Draft Under Internal Review
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HOW WELFARE REFORM AND ECONOMIC FACTORS AFFECTED MEDICAID PARTICIPATION

Leighton Ku

Bowen Garrett

The Urban Institute
2100 M. Street NW
Washington, DC 20037

June 1, 1999

This paper was supported by the Assessing the New Federalism Project. Brian Bruen, Johnny Kim, Matthew Schirmer, Linda Giannarelli, Margaret Weant, Alberto Martini, and Jerome Gallagher kindly provided data or helped us find the data used in these analyses. Several colleagues offered helpful advice, including John Holahan, Steve Zuckerman, Sharon Long, Michael Wiseman, and Tim Waidmann.

EXECUTIVE SUMMARY

Despite longstanding efforts to reduce the number of uninsured people in the United States, between 1995 and 1996 the number of children and parents who got health insurance through the Medicaid program fell by about 750,000. Recent research indicates that the reduction in Medicaid coverage helped fuel a rise in the number of uninsured Americans. The major factor leading to the Medicaid caseload reduction has been the sharp decline in the number of people receiving welfare, which traditionally conveyed Medicaid coverage. These changes occurred before the 1996 federal welfare reform law, but were related to the numerous state welfare reform waivers which formed the basis of the policies under the subsequent federal law.

An important question, which this report addresses, is how much the recent reduction in Medicaid participation was caused by welfare reform policies or by broader economic and demographic forces, particularly the strong economy of the mid-1990s. If the economy is the principal reason, then these changes would have occurred regardless of states' policies and there may simply have been less "need" for Medicaid. If welfare reform policies are the main factor, this signals that caseload reductions were negative consequences of state and federal policies and implies that governments have a greater obligation to fix the problems.

Methodology

To answer this question, we conducted analyses of factors related to each state's Medicaid caseload from 1984 to 1996, particularly nondisabled, nonelderly adults and children who are the great majority of Medicaid beneficiaries. Three categories of factors were examined:

- **Welfare policies.** These are state policies for the Aid to Families with Dependent Children (AFDC) program, including maximum benefit levels, presence of an AFDC-UP (Unemployed Parent) program, earnings disregards, family caps, and work-related time limits. Since AFDC recipients were automatically eligible for Medicaid (through 1996), these policies inherently affected Medicaid eligibility also.

- *Medicaid policies.* These are state policies that expand eligibility for adults and children beyond welfare, including the extent of poverty-related expansions for pregnant women and children (as well as those of Section 1115 waiver expansions) and Medically Needy programs.
- *Economic and demographic factors.* These included state-specific measures of unemployment, earnings, health care prices, and the level of female-headed households. We also included the federal Medicaid matching rate, which is based on per capita incomes in each state.

Data come from a variety of sources, including state reports of Medicaid participation, state welfare and Medicaid policies, and economic and demographic variables drawn from Census, Bureau of Labor Statistics, and American Hospital Association data.

We examined six measures of participation: the number of Medicaid recipients who were “cash adults” (adults who also received welfare benefits), “noncash adults” (who got Medicaid only), and total adults (cash and noncash combined), as well as cash, noncash and total children on Medicaid. These finer measures are particularly useful since the cash Medicaid caseload ought to be directly affected by welfare caseload changes, but the noncash caseloads could grow if people shift out of welfare-related participation to noncash eligibility groups. To compare across states, we computed participation rates in which the caseload levels were divided by each state’s population.

Key Findings

Our analysis had two main parts. First, we estimate fixed effects regression models for the 1984 to 1996 period. Second, we use these model results to assess the relative influence of welfare, Medicaid and economic/demographic factors in the caseload reduction from 1995-96.

Findings for the 1984-96 Period

- Welfare policies, Medicaid policies and economic factors all affect Medicaid participation rates to at least some extent, although they may affect different portions of the caseloads at different times.
- Among welfare policies, the presence of an AFDC-UP program, which provides benefits to unemployed two-parent families, was associated with increases in cash and total participation by adults and by children. This suggests the importance of policies that include two-parent families as having the potential to expand coverage.
- Family cap programs, which prohibit providing additional welfare benefits when a new baby is born to a recipient family, were correlated with reductions in cash and total participation by adults and children. *- how?*
- Higher earnings disregards, which let welfare recipients keep more of their earnings, are related to higher cash Medicaid participation, but lower noncash participation. The net effect on caseloads is not significant. *- isn't this obvious?*
- The approval of a statewide welfare reform waiver, independent of the specific policies adopted or the date of implementation, led to reductions in Medicaid cash assistance participation by adults and children. This indicates that participation shifts occur because of changes in the perceptions of the low-income population or operational and office culture changes in the welfare agencies, regardless of the specific policies adopted.
- Poverty-related Medicaid expansions led to caseload increases, particularly in the noncash category, but also in the cash and total participation of adults and children. The increases in noncash participation is not surprising, since that was the intent of these policies. The related increase in cash Medicaid recipients suggests that the Medicaid eligibility expansions led more people to apply for benefits, also increasing participation in cash assistance.
- The effect of Medicaid expansions was larger in states with no AFDC-UP programs. Since these states had fewer ways of providing assistance to two-parent families, it is not surprising that AFDC-UP and poverty-related expansions are interrelated.
- Medically Needy programs significantly increased noncash participation by adults, but did not significantly affect child participation. Since adults have fewer Medicaid eligibility options than children, the Medically Needy program is more influential for them.
- Some aspects of the business cycle affect Medicaid caseloads, particularly the cash assistance component. Higher earnings levels per capita (adjusted for inflation) are associated with lower cash and total adult and child caseloads. Higher unemployment rates in one year lead to higher cash Medicaid participation in the following year, for both adults and children.
- The level of female-headed households in a state was positively related to increased cash and total Medicaid caseloads for adults and children, as well as to noncash receipt by children.

why would medical prices affect Non-cash participation

- Higher medical prices, as measured by the average cost of inpatient hospital care per day (adjusted for inflation), were correlated with higher noncash participation by adults and children and higher cash and total participation of adults.

Findings for the 1995-96 Period

- We grouped the welfare policies, Medicaid policies and economic/demographic factors and looked at the actual changes in those policies and the models' predictions of caseload changes from 1995 to 1996.
- The main factor related to the net reduction in total Medicaid participation from 1995 to 1996 was the welfare reform policies. Changes in welfare policies were associated with a reduction in cash, noncash and total Medicaid participation rates for adults and children.
- By contrast, changes in economic and demographic factors were associated with declining cash Medicaid caseloads, but increases in noncash and total levels for adults and children. For those on both Medicaid and cash assistance, the strong economy was lowering participation rates. However, from the perspective of total participation, including the noncash recipients, the economic and demographic changes should have led to somewhat higher caseloads. This is because forces like rising female-headed household rates and medical care prices were exerting upward forces on participation.
- Changes in Medicaid eligibility policies had very small positive effects on caseloads. Since there were few Medicaid expansions in this period (mainly the ongoing phase-in of poverty-related child eligibility), this is not surprising.
- *is always* Our models do not predict all of the actual reduction in caseloads, which suggests that certain variables were omitted. Other possible factors which might have depressed Medicaid participation rates include people's perceptions of the availability of benefits, stigma associated with welfare or Medicaid, and operational changes made in welfare offices. Regrettably, there are not good data to help us analyze how these might affect caseloads.
- Although our data are for the period before the federal welfare reform legislation was implemented, preliminary data suggest that Medicaid caseloads have continued to fall. It is reasonable to presume that the factors which shaped participation in this period continue to act in more recent time periods.

Conclusions

The main reason that Medicaid participation fell after 1995 was because of welfare reform policies adopted in that period, not because of the economy. This finding is consistent

with other recent research that suggests that welfare reform led to reductions in Medicaid participation and increases in uninsurance levels. In turn, this means that state and federal policy choices led to unanticipated consequences in reducing insurance coverage among low-income families.

In part, this is a result of disjointed welfare and health coverage policies at both state and federal levels. Although local welfare agencies are responsible for eligibility intake for both welfare and Medicaid in most states, decision making has not always been well coordinated for the two programs. States adopted policies to shrink welfare caseloads without taking full stock of the consequences for Medicaid coverage. Similarly, Medicaid agencies were not always fully aware of the welfare policies and operational changes and were not making adequate efforts to keep people on Medicaid. For example, although the 1996 federal welfare reform law provided \$500 million in extra federal funds to help states upgrade eligibility operations in light of the decoupling of welfare and Medicaid eligibility, only 4 percent of these funds had been requested by states by the end of Fiscal Year 1998.

A broader lesson is the interrelated and sometimes unanticipated effects of policy changes. Policies designed to change welfare caseloads also affect Medicaid participation; policies to increase poverty-related Medicaid coverage may lead the number of cash assistance recipients to increase, and so on. Those who design and implement policies need to consider possible secondary effects of those policies, monitor the consequences and make necessary adjustments. The policy and administrative adjustments that are needed to protect Medicaid coverage are complex and may require restructuring day-to-day operations in thousands of local agencies across the nation. But given the importance of the problem and the number of people affected, these issues should be seriously addressed by federal, state and local administrators.

The logo consists of three vertical bars of increasing height from left to right, resembling a stylized bar chart.

CENTER ON BUDGET AND POLICY PRIORITIES

HIGH-PERFORMANCE BONUS NEEDS TO INCLUDE FOOD STAMPS AND MEDICAL INSURANCE

The "high-performance bonus" is awarded to states under the provisions of the 1996 welfare law. The law sets aside \$1 billion to be awarded to high-performing states over a five-year period using a formula based on performance in achieving the goals of the TANF program. The Secretary of HHS is to develop the formula after consulting with the states.

The Administration will soon release regulations describing the formula for the bonus to be based on state performance in fiscal years 2000 through 2002. If this formula is identical to the one used to measure state performance in 1998 and 1999, important TANF program goals will not be taken into account and the Administration will miss an opportunity to send an important message.

The high-performance bonuses based upon state performance in fiscal years 1998 and 1999 (awarded in fiscal years 1999 and 2000) use a formula that consists exclusively of data on state effectiveness in increasing work effort among TANF recipients. This is an important criterion, but it does not capture all the goals of the legislation. In addition to recognizing states that increase work effort by recipients, the Administration should allocate a portion of the bonus funds to reward states that are most successful in providing food stamps and Medicaid coverage to low-income working families with children.

Recent work done by the Center on Budget and Policy Priorities shows that in spite of strong economic growth, the average disposable income (including food stamps and housing assistance) of the poorest single-mother families was lower in 1997 than the average disposable income of similar families in 1995, before the passage of the federal welfare law. This was a reversal of the trend over the previous two years, from 1993 to 1995, during which average disposable incomes increased among these families. The data show that from 1995 to 1997, gains in earnings and increases in the EITC were entirely offset by declines in means-tested assistance for the poorest single-mother families.

This suggests that while states have been successful in moving families from welfare to work, they have been less successful in providing support for families that have gone to work but remain poor. It also suggests that some of the families with the most severe barriers are losing food stamp benefits and Medicaid protection when they

no longer receive TANF. This has most affected the poorest single-parent families with children. With much of their initial work to implement welfare reform now completed, states can devote more attention to making sure that needed supportive services, such as food stamps and health insurance, are available to those families that have left welfare but remain poor.

The high-performance bonus formula currently is based on job entries, job retention, and earnings gains among TANF recipients. In addition to these factors, we would like to see half of the current bonus amount distributed to states on the basis of changes in food stamp participation among children in working poor families and the proportion of individuals in families leaving TANF who are covered under the state Medicaid or child health insurance programs. Because of problems with the data on food stamp and Medicaid participation in the Current Population Survey, the formula should be based on administrative data for these two factors.

Specifically, the formula should include:

- The change since 1994 or 1995 in the number of children in working poor families (receiving TANF or not) who receive food stamps relative to the total number of children in the state. Working poor families are defined as those with earnings equal to at least a half-time job at the minimum wage. The number of children in working poor families who receive food stamps would be obtained from food stamp administrative data. The ten to fifteen states with the largest increase in the ratio for the year being evaluated relative to the base year of 1994 or 1995 would be awarded the bonus.
- The percentage of parents and children in those families who left TANF six months earlier who currently receive Medicaid or child health insurance. This information would be obtained by states doing a match between their TANF and Medicaid/CHIP computer systems. Again, the ten to fifteen states with the greatest percentage of parents and children leaving TANF who are enrolled in Medicaid or CHIP should be awarded the bonus.
- As an alternative to the food stamp measure outlined above, the same method used for health insurance could be used to determine the percentage of individuals in those families who left TANF six months earlier who currently receive food stamps.

Perhaps these formulations can be improved, but there are several important considerations behind the recommendations described here. The first is that these

measures are almost entirely dependent upon administrative data and therefore can be measured accurately at the state level. The only part of the measure not dependent upon administrative data is the total number of children in the state. Second, by concentrating on working poor families in the food stamp program, there is a recognition that participation is lowest among this group and that if there is to be greater poverty reduction among children, food stamp benefits as well as the earned income tax credit are important additions to low-wage employment. Third, every effort was made to level the playing field among states so all states could compete on an equal basis for the bonus. For example, that is why this performance measure does not include the percentage of children covered by health insurance, but focuses on the percentage of welfare leavers (both parents and children) with Medicaid or CHIP health insurance protection.

Including food stamps and health insurance in the formula, and giving them equal weight with work effort factors, would go a long way toward rewarding states that not only move families from welfare into work but also provide the supports these families need to attain economic self-sufficiency and to make work pay.

JUN 28 1999 16:01 FR SENATOR ROCKEFELLER 202 244 7665 TO 94567431 P.02/03

United States Senate

WASHINGTON, DC 20510

June 28, 1999

Donna E. Shalala
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

We are writing to urge that pending regulations regarding the "high-performance bonus" awarded to states under the provisions of the 1996 welfare law take into account important aspects of the program that have been left out of the current bonus formula.

The high-performance bonuses awarded in fiscal years 1999 and 2000 (based upon state performance in fiscal years 1998 and 1999) uses a formula that consists exclusively of data on state performance in increasing work effort among TANF recipients. This is a very important criterion, but does not provide a complete measure of state performance. In fact, the first goal of the TANF program is to "... provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives...." We believe the access to health care and adequate nutrition are vital aspects of such care. Therefore, in addition to recognizing states that increase work effort by recipients, we believe the Department should allocate a portion of the bonus funds to reward states that are most successful in providing Medicaid coverage and food stamps to low-income working families with children.

A recent GAO review of studies on the status of former TANF recipients suggests that many who have found employment are making relatively modest wages, often at or below the poverty line. As you well know, the Chafee-Breaux amendment that passed the Senate by a 97 to 2 vote ensured that poor families with children would retain their eligibility for Medicaid and food stamps even if they were not on the TANF rolls. The goal was to ease the transition from welfare to work by retaining access to health care and food stamps. We believe an important element of the state's welfare performance is seeing that families move to work and get the benefits promised in the law. The same GAO study suggests mixed success by states in ensuring continued eligibility for Medicaid and food stamps.

The high-performance bonus formula currently is based solely on job entries, job retention, and earnings gains among TANF recipients. In addition to these factors, we believe it is important to give states an incentive to ensure that Medicaid coverage and food stamp

JUN 28 1999 16:01 FR SENATOR ROCKEFELLER 202 244 7665 TO 94567431 P.03/03

The Honorable Donna E. Shalala
June 28, 1999
Page 2

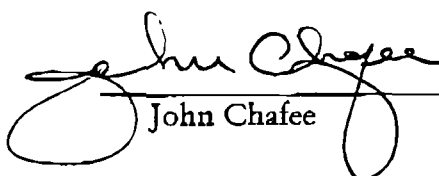
participation is encouraged, as required in the law. As we watch the change in the administration and culture of local welfare offices, it seems that such incentives are important. We believe it would be appropriate to target half of the current bonus amount distributed to states on: 1) the proportion of individuals in families leaving TANF who are covered under the state Medicaid or child health insurance programs; and 2) food stamp participation among children in working poor families. Because of problems with the data on food stamp and Medicaid participation in the Current Population Survey, the formula should be based on administrative data for these two factors.

Specifically, the formula could include the change since 1994 or 1995 in the number of children in families with earnings equal to at least a half-time job at the minimum wage who receive food stamps relative to the total number of children in the state. The ten to fifteen states with the largest increase in the ratio for the year being evaluated relative to the base year of 1994 or 1995 could be awarded the bonus. In addition, the formula could include the percentage of parents and children in those families who left TANF six months earlier who currently receive Medicaid or child health insurance. Again, the ten to fifteen states with the greatest percentage of parents and children leaving TANF who are enrolled in Medicaid or CHIP could be awarded the bonus. The same formula could be used to determine the percentage of individuals in families who left TANF six months earlier who currently receive food stamps.

Including food stamp and health insurance in the formula, and giving them equal weight with work effort factors, will go a long way toward rewarding states that not only move families from welfare into work, but also provide the support necessary for these families to attain economic self-sufficiency.

If you have any questions, please contact our staffs. We appreciate your attention to this important issue.

Sincerely,


John Chafee


John Breau


John D. Rockefeller IV

cc: Jack Lew
Bruce Reed

THE WHITE HOUSE

WASHINGTON

July 9, 1999

copied
Reed
Podesta
Berkhardt -
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99 JUL 9 PM 7:15

MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed

SUBJECT: DPC Weekly Report

1. Education - Class Size: As you know, the House Education and Workforce Committee recently reported legislation which we have threatened to veto because it would significantly undermine our class size program. The House bill would include class size funding in a broader teacher quality bill and allow it as an eligible purpose. However, it would not require a dedicated stream of funding for class size nor the achievement of any class size goals or targets. In other words, under the provisions of the bill, a state could spend virtually nothing on class size and still receive funding. This bill is expected to move to the House floor within the next two weeks.

House Committee Democrats are split on the issue. Some -- led by Congressman Roemer, possibly Miller and others -- do not share the Administration's view on the need for a dedicated funding stream for class size, nor do they seem to agree with us as to the importance of the class size goal. Others -- Representatives Clay, Kildee, Martinez -- strongly support us from a policy perspective but seem doubtful about our ability to hold Democrats on this issue. To broaden support for the Democratic substitute we plan to amend our proposal to give more flexibility to states and school districts that have a preexisting class size reduction plan in effect, and to districts that need to spend more on recruiting and training in order to attract qualified teachers to reduce class size.

DPC, OMB, the Department of Education, and Legislative Affairs recommend a legislative strategy to unite as many Democrats as possible on a class size Democratic amendment and to attempt to achieve a veto sustaining margin against final passage. Our conversations with staff this week suggest that it may be possible to achieve a good Democratic vote on the amendment but it will be difficult to ask members to vote against the bill. They believe that many Democrats will not want to oppose a bill which purports to promote teacher quality. However, we believe that it will also be very hard to explain away an overwhelming vote for the final bill as anything other than a defeat for class size since the Goodling bill clearly kills our program.

Democratic Leader Gephardt's staff has given a reluctant blessing to our approach but has conveyed concern about whether or not Democrats can remain united on this issue. It is our sense that the Democratic leadership's willingness to take on this issue will depend in part on our aggressive leadership and our ability to demonstrate that it has a reasonable chance of success. We will press Representative Gephardt to provide more leadership on the issue of class size,

which was a critical victory for all Democrats last Fall.

AFT and NEA as well as the Great City Schools are highly supportive of our approach and have indicated that they will work members at the grassroots level. The Senate Democrats (as represented by their staff) are extremely firm on this issue and have already demonstrated their willingness to take this issue to the mat by agreeing to sustain a veto of the ED Flex bill if it had eliminated class size as it did in the Senate bill.

2. Welfare – Food Stamp Announcements: Earlier this year, we promised that we would prepare a package of executive actions you could take to make the food stamp program more accessible for working families. These actions are now ready, and you may want to announce them in your DLC speech next week to highlight your record of requiring work and ensuring work pays better than welfare. Like child care, EITC, and Medicaid, food stamps are an important support for working families – a family of three with a full-time worker earning the minimum wage can get \$220 a month in food stamps. While families are eligible for food stamps up to 130 percent of the poverty line -- about \$8.50 an hour or \$17,748 for a family of three -- participation among working families is low. Presently, only 39 percent of individuals with earnings who are eligible for food stamps benefits receive them, compared to 71 percent of all eligibles and 97 percent of those on cash assistance. The package includes: 1) new policy guidance making it easier for working families to own a car and still receive food stamps; 2) new regulations making it easier for families to report income and ensure states serving working families won't be penalized for small errors in estimating families' future earnings; and 3) a new outreach campaign to inform low-income families of their food stamp eligibility.

3. Welfare – Welfare-to-Work Update: Our \$1 billion Welfare-to-Work reauthorization proposal is beginning to gain some momentum in Congress, though it will take a concerted effort from the White House to ensure that new funding is achieved this year. Our proposal -- including funds to help recipients with the greatest challenges to employment as well as fathers who need jobs to pay child support -- has been introduced by Democrats in both the House and Senate. Republican Ways and Means subcommittee chair Nancy Johnson has expressed some interest in working on a bipartisan basis on a fatherhood bill, but there are indications that she and her Republican colleagues are hesitant to move a bill with new funding. Meanwhile, Senator Bayh is developing a broad-based fatherhood proposal with Senator Domenici; we expect him to include elements of our Welfare-to-Work proposal, including an expanded focus on fathers using existing funds, but no new funding.

Since state and local grantees have up to three years to spend current funds, some resources will continue to be available even if we do not enact new funding this year. However, there is overwhelming demand for Welfare-to-Work funds: the Department of Labor received 1,400 applications for competitive grants last year totaling \$5 billion and only had funds to award grants of \$468 million.

On a more personal note, we thought you would be interested in news from Carlos

Rosas, the young father who introduced you at the January 25th event unveiling your Welfare-to-Work budget proposal. Carlos reports that he has now graduated from the technical college he was attending as part of the responsible fatherhood program in St. Paul, and has gotten a new job as a technician servicing business machines which will enable him to pay even more child support.

4. **Crime - Guns:** We have tentatively planned for about 80 Denver-area high school students to attend a White House event on Thursday to highlight the gun issue. The students, many of whom are from Littleton, are affiliated with S.A.F.E. (Sane Alternatives to the Firearms Epidemic) Colorado and will be in town to urge Congress to move quickly to pass gun legislation. At the event, we hope to release a brief report on the first six months of the National Instant Criminal Background Check System (NICS). The report will contain information detailing the types and number of gun sales blocked by the NICS. On a related note, on Wednesday, the D.C. district court dismissed a case filed by the NRA challenging the ability of the FBI to retain records for up to 6 months under the NICS.

✓ 5. **Health Care - Upcoming Activity on Medicare and Patients Bill of Rights:** Your advisors have developed a coordinated White House strategy to highlight your priorities on both Medicare and the Patients Bill of Rights over the next few weeks. On Sunday, Larry Summers and John Podesta are appearing respectively on *This Week* and *Meet the Press* to discuss your Medicare reform package and contrast your effort to strengthen and modernize the program with the proposed Republican tax cuts. On Monday, you are meeting with the bipartisan Congressional leadership to discuss Medicare reform within the context of the current negotiations on the budget. Before departing for Florida, where you will speak to the Communication Workers of America on Medicare reform, you will give a departure statement on the floor debate on the Patients Bill of Rights. Finally, early next week, you will hold an event promoting your proposed Medicare prescription drug benefit.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Melissa T. Skolfield

Assistant Secretary for Public Affairs

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Date:

3/16

Total number of pages sent:

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Comments:

3/16/99

NOTE TO CHRIS JENNINGS AND CYNTHIA RICE –

I've attached the draft of the GWU press release, and some Q and As on the topic for your review. Please note that:

- The press release should not be shared with anyone else. I'm going to try to negotiate the language and a release date with them.
- The Q and As borrow heavily from material you've already cleared – the guidebook and the Q and As Bruce and Chris ok'd some time ago in response to a NYT Week in Review piece. But I'd very much like your thoughts as I clear them within the department.
- I believe John Monahan is right that we need to talk to a few members of Congress and intergovernmental groups before this guidebook is in the press.

Can you all call me, fax me, or maybe set up a conference call with John and me before we make any further decision? Thanks.

Melissa

DRAFT KAM 3/9/99

*GWU's just draft.**they're open on timing. next 2 weeks.**Ann McCormick in*For Immediate Release
March 1999Contact: ????
202/496-8499

ASPE

*turning
contact
over
to
us.***WORK-ORIENTED WELFARE REFORM STRATEGIES MAY HAVE
POTENTIAL TO DIVERT FAMILIES FROM MEDICAID****GWU Researchers Say Emphasis on Steering Families Away From Cash Assistance
and Requiring Work-Related Activities Likely to Increase**

Formal strategies to divert families from welfare are an increasingly common aspect of states' efforts to shift to a work-oriented assistance system according to a study released today by the Center for Health Policy Research ("CHPR") at The George Washington University School of Public Health and Health Services. More than half of the nation's states have instituted formal programs to avoid enrolling families in welfare programs by finding other ways to assist them or by requiring work-related activities at a much earlier point in the application process. These efforts to emphasize work instead of welfare on the "front end" can also result in informal diversion. Diversion, both formal and informal, has substantial potential to reduce initial access to Medicaid, particularly as families increasingly bypass welfare or go to work quickly.

There is increasing awareness and concern that the implementation of aggressive state welfare reform efforts can lead to decreased access to other public benefits such as Food Stamps and Medicaid. The 18-month CHPR study examined the emergence of diversion programs as a welfare reform strategy and the potential for diversion to reduce access to Medicaid. The first study, released in September 1998, reported on a nationwide study of the different types of state diversion programs. This second study examined the experiences of five local communities in five states (GA, MD, MO, MT, OH) in establishing diversion programs.

"Design and implementation of diversion programs reflect state and/or local goals and philosophies," noted Kathleen A. Maloy, JD, PhD, principal investigator on the study and Associate Research Professor at the GWU School of Public Health, "these five states represent a range of diversion strategies that illustrate the importance of understanding key design and implementation choices in each state and, in some cases, each local office within a state." Of the three types of formal diversion programs, mandatory applicant job search represents the fastest growing program with the greatest potential to divert large number of families.

"One of the most striking findings from these case studies is how little we know about the outcomes of diversion for families," commented LaDonna A. Pavetti, PhD, co-principal investigator and Senior Research at Mathematica Policy Research, "for example, how many families are being diverted and what their circumstances are once they are diverted." Without such information, reports on the success or failure of state welfare reform efforts are incomplete.

Delinking Medicaid and cash assistance creates both opportunities to ensure and/or enhance access to Medicaid and circumstances that can result in reduced access. States' early experiences suggest that delinking Medicaid from cash assistance is a complex undertaking. The advent of diversion programs adds to this complexity. This study focuses on the frequently overlooked issue regarding whether certain families (such as diverted families) not receiving or forgoing cash assistance are still considered for their eligibility for Medicaid. "We found the potential for these potentially Medicaid-eligible families to fall through the cracks" noted Dr. Maloy, "and in light of preliminary evidence suggesting declining Medicaid enrollment generally among eligible groups, this issue requires serious attention."

She commented that "the study results suggest two reasons for state diversion programs to affect Medicaid eligibility. First, it is challenging for states to implement two eligibility procedures, one for welfare and one for Medicaid. Second, many states have not considered how to make their Medicaid policies support the goals of diversion programs for families to bypass welfare and pursue work. Eligible families that never enter the welfare system because they 'play by the rules' and find work quickly, however, may forgo the Medicaid eligibility that they otherwise might have had — Medicaid eligibility that could support maintaining work — unless states make changes in their Medicaid policies."

Study findings suggest that the compelling Medicaid and welfare reform policy challenge posed by diversion is how to use Medicaid effectively to support the welfare reform goal to promote work. Because PRWORA fundamentally changed the nature of the welfare system, states can and should consider whether it is a desirable consequence of their Medicaid and welfare policies that access to Medicaid for diverted families is limited or unavailable. State officials can ameliorate this effect on Medicaid by improving implementation efforts and taking advantage of policy options under Section 1931 to focus attention on Medicaid as a stand-alone health insurance program for low-income families.

The study was funded by The Administration for Children and Families and The Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services. Basic support for this study, as well as support for ongoing analyses of welfare reform and health, was also provided by The Robert Wood Johnson Foundation as part of the Foundation's commitment to funding research examining the impact of welfare reform on access to Medicaid and health care services.

Copies of the report titled "*Diversion As A Work-Oriented Welfare Reform Strategy and Its Effect on Access to Medicaid: An Examination of the Experiences of Five Local Communities*" can be ordered by calling 202-530-2346.

Version in clearance

W Diversion Report Q and As
3/16/99 am

Q: This study suggests that state welfare diversion policies like one-time cash assistance, mandatory job search, and encouraging alternative sources of support may have negative consequences for poor families -- and may especially be discouraging people from enrolling in Medicaid. Is this true, and how does the Administration feel about these efforts by the states?

A: Our goal is to continue to do everything possible to maximize both the number of individuals with health insurance and the number of people moving from welfare to work. Under the welfare reform bill, states have the flexibility to provide families with enough cash to solve an immediate problem and stay off welfare, or to require an up-front job search before cash assistance is provided. These strategies appear to be both well-intentioned and effective.

As for the effect of diversion strategies on Medicaid, the report itself notes that the "de-linking" of Medicaid and cash assistance creates both opportunities and challenges in ensuring access to Medicaid. We agree. When families learn that they can receive Medicaid coverage without having to receive welfare, they may be less likely to turn to welfare in the first place, or to return to the welfare system if they have unmet health care needs. "De-linkage" also provides a special opportunity for states to promote both Medicaid and CHIP as an independent support for low-income working families.

The decoupling of Medicaid and TANF also means that states need to pay careful attention to their eligibility and enrollment processes. That's why we have worked with states to ensure that people moving off cash assistance programs, as well as low-income working families who may not realize they are eligible for assistance, get Medicaid benefits. We agree with the authors of this report that diversion problems can be averted if states adequately inform families of their ability to apply for Medicaid separately from cash assistance; put procedures in place to be sure Medicaid applications are processed promptly; and exercise new options under the law to make more working families eligible for Medicaid.

HHS has repeatedly urged states in many different ways to pay attention to their eligibility and enrollment processes to ensure that those eligible for Medicaid - particularly children - are enrolled. In fact, all state Medicaid and TANF administrators received a letter in June of last year explaining actions states should take to ensure that all those eligible for Medicaid receive it - including making Medicaid and CHIP applications available at sites where TANF eligibility is evaluated, and where "diversionary" assistance is provided.

The guidebook released **date TBD** is just the latest of our efforts to work with states to ensure that people moving off cash assistance programs, and working families who may not realize they are eligible for assistance, still get Medicaid benefits. The guidebook also

makes clear that states TANF-Medicaid application must furnish a Medicaid application upon request and may not impose a waiting period. States must also process Medicaid applications without delay.

We will continue to work with states to identify model outreach strategies, program operations, coverage expansions and Medicaid policies designed to increase the number of people eligible for Medicaid who actually receive it.

BACKGROUND: Beginning in 1993, President Clinton led the effort to reform welfare by granting waivers to 43 states allowing them to move families from welfare to work. In each waiver, the Administration insisted that states ensure continued Medicaid coverage for all eligible people at the same time they were promoting work. This reflected our commitment to expanding health coverage and our belief that health insurance is a crucial work support. Consistent with this conviction, the President insisted that the welfare reform law guarantee Medicaid coverage to all adults and children who would have been eligible prior to the law's passage (except for those adults who refuse to meet their work obligations).

Q: What are the current figures available for the number of Medicaid recipients nationwide? Are they declining?

A: The latest Medicaid enrollment figures, for 1997, show that there are 40.3 million Americans enrolled in Medicaid, down from 41.2 million enrolled in 1996. It is too early to say with confidence what has caused this decline, however. There are a number of factors, such as fewer people in poverty, lower rates of unemployment, and the rise in number of businesses offering health insurance to their employees that contribute to any change in enrollment numbers. It's also important to note that while Medicaid enrollment has declined since 1996, the number of people under the poverty level who are uninsured has not increased in that period.

BACKGROUND: The overall enrollment figures are 41.4 million in 1995, 41.2 million in 1996, and 40.3 million in 1997. The number of children enrolled went from 20.4 million in 1995 to 20.5 million in 1996 to 19.6 million in 1997. In addition to adults and children receiving cash assistance, Medicaid also covers disabled individuals who receive SSI, low-income elderly Americans, low income parents who would have qualified for cash assistance under the rules in effect prior to the enactment of welfare reform; their children; other children of working parents who meet certain income guidelines; and some working adults in states that have received waivers to continue Medicaid eligibility to low-income working families.

Q: Why are the Medicaid rolls decreasing?

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here

A: This is a complex question with no easy answer. A possible answer is that the improving economy has made it possible for many low income people enrolled in the Medicaid program to find jobs that offer health insurance benefits. Another answer is that

individuals may not realize they are still eligible for the Medicaid program even if their income increases slightly.

Irrespective of these complicated questions, the Administration maintains its long-standing belief that the best approach is for states to move families from welfare to work, while preserving Medicaid eligibility and improving outreach strategies. The guidebook released **date TBD** is just the latest of our efforts to work with states to ensure that people moving off cash assistance programs, and working families who may not realize they are eligible for assistance, still get Medicaid benefits. The guidebook also makes clear that states' TANF-Medicaid application must furnish a Medicaid application upon request and may not impose a waiting period. States must also process Medicaid applications without delay.

Q: Isn't welfare reform responsible for the drop in Medicaid enrollment?

A: This Administration has demonstrated an unprecedented commitment to reducing the numbers of the uninsured and would not take any action that would reduce access to health insurance for low-income people. National welfare reform legislation was enacted in August 1996 and phased in by the states during 1997, so the numbers currently available say little about the effect of welfare reform on Medicaid coverage.

Beginning in 1993, President Clinton led the effort to reform welfare by granting waivers to 43 states allowing them to move families from welfare to work. In each waiver, the Administration insisted that states ensure continued Medicaid coverage for all eligible people at the same time they were promoting work. This reflected our commitment to expanding health coverage and our belief that health insurance is a crucial work support.

Consistent with this conviction, the President insisted that the welfare reform law guarantee Medicaid coverage to all adults and children who would have been eligible prior to the law's passage (except for those adults who refuse to meet their work obligations). Recently, the Department revised its regulations to help families work their way off welfare by permitting states to extend Medicaid to low income two-parent families even if the principal wage earner worked more than 100 hours per month.

The guidebook released **date TBD** is just the latest of our efforts to work with states to ensure that people moving off cash assistance programs, and working families who may not realize they are eligible for assistance, still get Medicaid benefits. The guidebook also makes clear that states TANF-Medicaid application must furnish a Medicaid application upon request and may not impose a waiting period. States must also process Medicaid applications without delay.

Again, the precise reason for declining Medicaid rolls is a complex question with no easy answer. A possible answer is that the improving economy has made it possible for many low income people enrolled in the Medicaid program to find jobs that offer health insurance benefits. Another answer is that individuals may not realize they are still eligible for the Medicaid program even if their income increases slightly.

Q: How is welfare reform going?

A: First, caseloads are down dramatically. The number of welfare recipients has dropped by more than 30 percent since August 1996, and the percentage of the U.S. population receiving assistance is the lowest since 1969.

Second, welfare recipients are moving into jobs as a result of welfare reform. Preliminary state data show that 50 to 60 percent of the people leaving welfare under TANF are working a short time later. Early national data show that 1 in 3 families who received welfare in 1996 -- 1.7 million people -- were working in 1997, just one year later. This is a dramatic increase from the 19 percent of families in this category in 1992.

Third, there has been NO race to the bottom in state welfare spending, and states are spending somewhat more per recipient than they did in 1994. In fact, 22 states report spending above the required maintenance of effort level.

Fourth, a majority of states are increasing their earnings disregards. That means they're raising the amount of earnings that are not counted when determining a recipient's benefits. This will not only help pull families out of poverty, it will send the message to low wage earners that going to work is a better deal than staying home.

This is clearly not the end of welfare reform, it is only the beginning. That's why the President has spoken forcefully about the need for the business community to hire people coming off welfare - and has backed up his words with deeds by offering tax incentives to businesses that hire welfare recipients. And that's why this Administration has challenged all Americans to help make this historic law work even better.

[Background: In 1998, 225,000 legal immigrant children, elderly and disabled persons who were in the country as of enactment of the welfare reform law had their Food Stamp eligibility restored. In raw numbers, citizen households receiving welfare declined by 857,000 from 1994-1997, and immigrant households declined by only 249,000 according to CPS estimates.]

Q: What other steps are being taken to get Medicaid eligibles enrolled?

A: The Administration is committed to improving awareness of both Medicaid and CHIP. For example, we recently announced the Insure Kids Now campaign, a toll-free number and media campaign to help families get access to both Medicaid and CHIP. Last year, we revised our regulations to permit states to extend Medicaid to low income two-parent working families even if the principal wage earner worked more than 100 hours per month. We've issued a guidebook **date TBD** to help state welfare, Medicaid, and CHIP directors find and use effective options to enroll more eligible people. And we are also working with states to identify model outreach strategies, program operations,

coverage expansions and Medicaid policies. Louisiana, for example, is replacing its 14 page Medicaid application with a 2 page application for both Medicaid and its CHIP program.

The President's Fiscal Year 2000 budget outlines some additional initiatives that would improve Medicaid awareness and potentially enroll thousands more children in Medicaid as well as CHIP:

- HHS is proposing to broaden states' ability to use a special \$500 million Medicaid fund, enacted in the 1996 welfare reform law and aimed at outreach for children losing welfare, to fund outreach to other children eligible for CHIP. [This is expected to increase Medicaid spending by \$345 million over the next five years, including both administrative expenses and benefits.]
- The President's budget proposes allowing states to extend Medicaid to low-income children up to age 21 who were in foster care but who 'age out' of that system at age 18. This would help assure health care for this vulnerable population as they continue to prepare for adulthood, just as older children living in their own families can be covered under a parent's insurance policy. Each year, about 16,000 youths age out of foster care and 9,000 more leave the foster care system and run away.
- In addition, we are proposing to remove outreach costs from the 10 percent cap states have on administrative costs for the CHIP program. Instead, states could spend up to 3 percent of their total allotment on outreach. This initiative, which is scored at \$875 million, would give states more flexibility in designing outreach campaigns to reach families.

Q. In light of the Administration's commitment to maximizing health insurance coverage for low-income working families, why does your budget not include a proposal to remove the sunset on the transitional Medicaid benefit, which will expire at the end of FY 2001 under current law?

A. The Administration has always supported health care coverage for families moving from welfare to work. That is why the budget includes two proposals to simplify and improve transitional Medicaid--it removes certain burdensome reporting requirements, and it encourages States to serve more low-income working families. Since transitional Medicaid is authorized throughout both the coming fiscal year and the fiscal year after that, the program does not need to be reauthorized at this point and is therefore not included in budget projections through FY2002-2004. We will continue our efforts to ensure that people making the transition from welfare to work have the necessary health care supports to keep them successfully on the job and off of welfare.

BACKGROUND: The Administration has always supported health care coverage for families moving from welfare to work. The President's FY2000 budget baseline for Medicaid reflects the fact that the requirement for TMA expires on September 30, 2001

under current law. As a general matter, the budget projections 2001-2004 regarding Medicaid do not reflect potential legislative proposals. The FY2000 budget does include a proposal to remove burdensome reporting requirements that have posed an obstacle to families' participation in transitional Medicaid. The budget also includes a provision that states that extend Medicaid to individuals up to 185% of poverty have the option not to do TMA.

Q: Why aren't HCFA and ACF issuing guidance to states specifically about diversion programs in general or lump sum payment programs in particular?

A: HHS has repeatedly urged states in many different ways to pay attention to their eligibility and enrollment processes to ensure that those eligible for Medicaid - particularly children - are enrolled. In fact, all state Medicaid and TANF administrators received a letter in June of last year explaining actions states should take to ensure that all those eligible for Medicaid receive it - including making Medicaid and CHIP applications available at sites where TANF eligibility is evaluated, and particularly where "diversionary" assistance is provided. The guidebook released **date TBD** is just the latest of our efforts to work with states to ensure that people moving off cash assistance programs, and working families who may not realize they are eligible for assistance, still get Medicaid benefits. The guidebook also makes clear that states TANF-Medicaid application must furnish a Medicaid application upon request and may not impose a waiting period. States must also process Medicaid applications without delay.

Q: You've bragged about welfare caseload declines since 1994, but recent reports say the declines are disproportionately in the immigrant community. Isn't that a terrible consequence of your policies?

A: Not at all. Findings in the recent Urban Institute study are based on data that was collected prior to the implementation of welfare reform eligibility changes. The President has always been clear that welfare reform is about moving people who can work to work -- not punishing children and the elderly who are here legally. With the President's leadership, a significant number of legal immigrants who lost their benefits under the welfare reform act have already had their eligibility restored. As the report itself states, immigrants represented only 9 percent of households receiving welfare in 1994 -- most of the decline was not in the immigrant community. In his 2000 budget, the President has proposed to restore Medicaid and the Children's Health Insurance Program (CHIP) to legal immigrant children who have entered the country after the welfare law's enactment, and to restore Medicaid to pregnant women who enter the country after enactment.

~~XXXXXXXXXX~~ need comments today —

Comments of the Health Care Financing Administration (HCFA)
on the General Accounting Office (GAO) Report:
"Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage
After Welfare Reform Vary"

Medicaid is a critical part of supporting families so that they can successfully transition from welfare to work. We appreciate the research that the General Accounting Office has done on the decline in Medicaid enrollment from 1996 to 1997. We also agree with the GAO's conclusion that it is too early to say with confidence what has specifically caused the decline. In your report you describe a number of possible factors, such as fewer people in poverty, lower rates of unemployment, and the decline in the number of employees participating in employer-sponsored health insurance that may contribute to any change in enrollment numbers. It's important to note that, while Medicaid enrollment has declined since 1996, the number of people under the poverty level who are uninsured has not increased in that period. And, in addition to the approach the GAO used, there are several, equally valid methodologies for quantifying the drop in Medicaid, including some that would show a decline as small as 3%.

What is clear is that the decoupling of cash assistance and Medicaid provides both challenges and opportunities for states. Certainly it is a positive development that people are moving off the welfare rolls into jobs. It is also clear that states can and should do more to ensure that they retain access to important work supports such as health insurance. And, in fact, states have more options now than ever before to provide health insurance to low-income families, including the ability under section 1931 to make more families eligible for Medicaid, and the option to waive the "100 hour rule" to expand Medicaid eligibility to working, two-parent families.

While it is too early to tell what caused the 1996-1997 decline in Medicaid enrollment, HCFA has been aggressive in ensuring that states extend Medicaid to everyone who qualifies. Since the beginning of 1997, HCFA has issued numerous letters to inform and educate the states concerning their responsibilities under Medicaid. A new guidebook for states released in April of 1999 is just the latest of our efforts to work with states to ensure that people moving off cash assistance programs, and working families who may not realize they are eligible for assistance, still get Medicaid benefits. [The guidebook also makes clear that states' TANF-Medicaid application must furnish a Medicaid application upon request and may not impose a waiting period. States must also process Medicaid applications without delay.]

statute should go before guidebook.

We will continue to work with states directly to ensure that programs are using their flexibility appropriately and to ensure compliance with the law. If a state is not in compliance with Medicaid law and regulations, then the Department of Health and Human Services (HHS) will take all steps necessary to achieve compliance. As part of our education and technical assistance efforts, HHS will be reviewing and addressing all aspects of a particular state's eligibility and enrollment policies and processes, including those related to transitional Medicaid.

The President's Fiscal Year 2000 budget outlines some additional initiatives that would improve Medicaid awareness and potentially enroll thousands more children in Medicaid as well as CHIP. For example, HHS is proposing to broaden states' ability to use a special \$500 million Medicaid fund, enacted in the 1996 welfare reform law and aimed at the costs incurred by states because of the decoupling of AFDC and Medicaid, including outreach costs.

GAO Recommendation

1) In order to ensure that eligible individuals leaving cash assistance do not lose Medicaid coverage, we recommend that the Administrator of HCFA determine the extent to which transitional Medicaid is reaching the eligible population.

Response

We agree with the recommendation. The HHS, through the Office of the Assistant Secretary of Planning and Evaluation (ASPE) and HCFA, has already initiated research to study the trends in Medicaid enrollment, including transitional Medicaid. [We believe that this research is critical for improving our understanding of the issues surrounding welfare to work. We also believe that this research will allow us to improve the effectiveness of our activities with the states.]

contracted with
~~Specifically~~, ASPE has ~~sponsored~~ Mathematica Policy Research (MPR) to study longitudinal Medicaid enrollment patterns in 1995 in six states. HCFA will follow up on this research (with MPR) and study eligibility patterns in eight to ten states for the time periods 1993-1994 and 1996-1997. In each state, data for children and adults will be analyzed so that the Medicaid eligibility status of individuals can be studied over time. Of particular interest are the dynamics in maintaining eligibility of families and individuals leaving welfare. For all states in the study, all of the relevant eligibility groups will be analyzed. In states that have specific codes for transitional Medicaid, a report on transitional Medicaid eligibility will be developed *Am*

Also, in the fall of 1998, HCFA issued a contract to MPR and its subcontractor, the Urban Institute, to study the changes in the Medicaid program that have resulted from recent changes in welfare policy. HCFA is interested in knowing how the changes in welfare eligibility rules have affected the Medicaid population. Using existing HCFA and Social Security Administration (SSA) data sets to quantify the population of affected individuals, MPR and the Urban Institute will study the impact of new welfare reform laws on enrollment in the Medicaid program. For various enrolled groups, the study will also examine Medicaid utilization and expenditures before and after welfare reform. *A*

To accomplish this research agenda, the following seven studies have been designed. The HHS will study:

- National trends in Medicaid enrollment and in expenditures for the groups affected by welfare reform in all states using 1991-1998 HCFA 2082 data.

- Changes in the characteristics of Medicaid child and parent enrollees and of their utilization and expenditures before and after welfare reform in selected states using 1994 and 1997 State Medicaid Person Summary Research Files (SMRF).
- Changes in longitudinal Medicaid enrollment patterns for children and parents in selected states, including the characteristics of transitional, continuous and discontinuous enrollment using 1993-1994 and 1996 and 1997 SMRF files.
- SSI immigrants subject to redetermination in selected states using 1996-1998 SSA Eligibility Extract files and HCFA SMRF files.
- SSI children in selected states using SSA Eligibility Extract files and HCFA SMRF files.
- SSI drug addicts and alcoholics subject to redetermination in selected states using SSA Eligibility Extract files and HCFA SMRF files.
- Low-income populations that have or have not enrolled in Medicaid before and after welfare reform, using the NCHS National Health Interview Survey.

2) In order to ensure that eligible individuals leaving cash assistance do not lose Medicaid coverage, we recommend that the Administrator of HCFA provide states with guidance or other appropriate technical assistance regarding best approaches to implementing transitional Medicaid in a manner that facilitates the full and appropriate use of this entitlement (transitional Medicaid) for eligible beneficiaries.

Response

We agree with the recommendation. HHS is committed to ensuring that all beneficiaries receive their full entitlement under the law. To that end, the HHS developed a multifaceted approach to make sure that states understand all their opportunities and responsibilities under Medicaid law, especially with relation to transitional Medicaid. This approach includes: 1) following up on guidance that has already been issued on transitional Medicaid, 2) providing technical assistance to state programs, 3) conducting outreach to beneficiaries, 4) developing legislative proposals where appropriate, and 5) following-up on earlier regulatory activity.

Developing Further Guidance to States on Transitional Medicaid

HCFA has already provided guidance materials to the states on Medicaid and transitional Medicaid. With respect to transitional Medicaid, HCFA has provided fact sheets, letters, and Medicaid Manual guidance, including:

- In 1994, HCFA issued State Medicaid Manual guidance on transitional Medicaid in March.
- In February 1997, HCFA amended the State Medicaid Manual guidance to reflect changes to the law made by the welfare reform.
- HCFA and ACF issued a joint letter to states on June 5, 1998, urging states to seek out innovative ways to coordinate the administration of TANF and Medicaid. The letter

emphasized the importance of transitional Medicaid as a way of supporting families making the transition from welfare to work.

- HCFA and ACF issued a comprehensive guide on March 22, 1999, entitled *Supporting Families in Transition*. The Guide provides a number of strategies for the states to consider in improving TANF/Medicaid coordination and in improving Medicaid participation rates by eligible low-income working families. It also sets out the requirements for transitional Medicaid and suggests ways for states to improve the reach of transitional Medicaid.

As you point out, more work is needed to supplement the information and guidance that we have already provided on this topic. The HHS already has plans to follow up on the release of the Guide with the development of additional guidance regarding successful implementation practices for transitional Medicaid. This letter should be ready for release in September 1999. We will gather information about promising and successful models, and collect best practices from the states. These models and best practices will be distributed as widely as possible through letters, direct contact with the states, and at eligibility conferences.

Providing Technical Assistance

In addition, HCFA is currently preparing to conduct an extensive on-site review in every state. As mentioned earlier, the purpose of the review is to ensure that states are taking full advantage of their opportunities and to make certain that states are meeting the challenges posed by changes in the Balanced Budget Act of 1997 and PROWRA. The states must comply with federal requirements to provide Medicaid to all eligible people. To achieve that goal, HCFA's review will assist the states in coordinating the administration of the TANF and Medicaid programs. A major component of this review will be providing technical assistance to the states, including strategies on how to implement transitional Medicaid in a manner that facilitates full and appropriate use of this benefit. Where shortcomings are identified, HCFA will assist states in improving performance through professional or technical consultation, corrective action plans, or other appropriate actions.

Conducting Outreach Activities

Outreach to low-income families is an important critical aspect of HCFA's efforts in working with the states. HCFA has undertaken a number of outreach-related activities focused on outreach to children. HCFA, in conjunction with ACF, is planning an aggressive campaign to extend these efforts to low income families. The HHS will build on efforts already begun under the Children's Health Insurance Program and expand those efforts to Medicaid. This effort will include the provision of technical assistance, the identification and sharing of best practices, and direct contact with beneficiaries. An important emphasis of this outreach will be stressing that Medicaid is not linked to TANF and that the states should continue Medicaid after cash benefits are lost because of the transition from welfare to work.

Requesting Legislative Changes

HHS believes that legislative improvements are needed to expand the use of transitional Medicaid. Therefore, in our FY 2000 budget, we proposed important changes in the law that will help people to receive their full Medicaid benefit.

- **Improvements in Transitional Medicaid** -- the HHS has proposed legislation to eliminate the burdensome reporting requirements for transitional Medicaid that are currently required by law. States and advocates have expressed concern that these reporting requirements are a major barrier to participation in transitional Medicaid.
- **Flexibility for Outreach** -- The HHS has several proposals to improve outreach. For example, the HHS has proposed legislation that would remove the sunset of the special \$500 million in enhanced matching funds. These funds were provided as part of welfare reform to defray state costs associated with implementing the new eligibility group (section 1931) for low income families. They are necessary because of the delinkage of Medicaid from welfare eligibility. The proposed legislation would both broaden the array of permissible uses of the funds and increase the amount a..

Increasing Regulatory Activity

As you point out, HCFA has not finalized the regulations surrounding transitional Medicaid. HCFA intends to publish a final rule on transitional Medicaid by the end of 1999.

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

COMMITTEES:
WAYS AND MEANS
JOINT ECONOMIC

CR/AK/CJ-

June 14, 1999

From my
favorite
Congressman
BR

Bruce Reed
Assistant to the President for Domestic Policy
The White House
Washington, D.C.

Dear Mr. Reed,

Your response of May 26 to the letter that I sent on Feb. 1 with Reps. Bob Matsui (D-Calif.) and William Coyne (D-Penn.) is disappointing. It ignores numerous published analyses that highlight 1) unexplained, precipitous declines in food stamp participation and 2) a disturbing drop in Medicaid enrollment in the face of program eligibility expansions and enactment of the State Children's Health Insurance Program.

A summary of some of these analyses is enclosed. Also attached is a sample of relevant newspaper articles and columns outlining the struggles of individuals who have left TANF, or who have merely been diverted from cash assistance.

Those studies and articles suggest that low-income families are struggling, not prospering, in the wake of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. While it is true that fewer low-income families are receiving cash assistance -- which many states are counting as a major victory -- it is also clear that very few are escaping poverty after they return to the workforce. Indeed, the average annual income of very poor families dropped from 1995 to 1997, and only a tiny minority of those leaving welfare are finding jobs that come with private health insurance.

Unless the Administration takes a proactive stance in instructing states to do a far better job at implementing PRWORA, these dismal trends will only accelerate as statutory time limits on cash assistance begin to take effect. Already, it is plain that welfare "job centers" are failing to instruct case workers to enroll TANF applicants, recipients and leavers in other federal and state programs to which they are legally entitled. The ignoble result is that despite increases in employment, the childhood poverty rate remains unchanged at 20%.



As for enforcement, I do not agree with the premise of your argument that an HHS letter of "guidance" to states on Medicaid enrollment in March of 1999 constitutes an adequate response to the New York City fiasco that occurred in the fall of 1998. USDA's response to the illegal denial of food stamps in New York City was quicker and more aggressive, which is commendable.

But a critical question remains: What *additional* steps is the Administration prepared to take to *prevent* states and localities from putting in place policies that effectively deny or curb enrollment in Medicaid, CHIP, food stamps and other programs that can boost working low-income families out of poverty? I suggest that the alternative – to condone programs like Wisconsin's "light touch" model – in which eligibility workers are trained to offer welfare applicants no services other than those that they know enough about to explicitly request – is inhumane.

I await a response at your earliest convenience.

Sincerely,

A handwritten signature in black ink, appearing to read "Pete Stark". The signature is fluid and cursive, with the first name "Pete" and last name "Stark" clearly distinguishable.

Pete Stark
Member of Congress