DRAFT

SURVEY FOR

MEDICAID REGIONAL OFFICE

ON-SITE ASSESSMENT OF STATE MEDICAID

ENROLLMENT AND ELIGIBILITY PROCESSES

AUGUST 1999

INTRODUCTION

Through ongoing efforts to reform welfare, HCFA has developed a variety of approaches to support low-income families making the transition from welfare to work. A major goal is to increase the number of children and families with health insurance. One approach to obtaining this goal is to ensure that all States are complying with Federal requirements to quickly and efficiently provide Medicaid to eligible people and to assist States in coordinating the administration of the TANF and Medicaid programs.

We have planned for on-site visits to determine how well States are providing access to Medicaid during this time of welfare reform. The general focus of the review is to evaluate State compliance with specific Federal Medicaid eligibility and enrollment rules and optional policies for families who seek Medicaid, who leave Medicaid and for reaching families outside the Medicaid system. Although the review is not intended for assessing State performance in the general administration of its Medicaid program, there are some questions addressing other access and coverage requirements.

This survey is for regional office staff use during the on-site visits with States. Our research has shown that, through the administration of the TANF program, there are some problems with delays in the Medicaid application process and Medicaid cases being improperly denied or terminated. The survey focuses primarily on these two areas to ensure States are complying with Medicaid requirements and to identify State practices that result in eligible children and families not receiving Medicaid. In carrying out the on-site visits to States, place particular emphasis on the following program areas:

- improper delays in the Medicaid application process;
- improper Medicaid denials and terminations;
- providing transitional Medicaid;
- the effect of TANF application, denial and termination procedures on Medicaid applications, denials and terminations;
- improper systems terminations of Medicaid;
- promising State practices.

The survey is written to provide focus to the review and to promote an exchange of information between the regional office and its respective States while providing flexibility when conducting the on-site reviews. For example, reviews of State documents and Medicaid cases are limited to assessing compliance with Federal Medicaid requirements. However, regional offices may request from States additional documentation to further support compliance or for other purposes that meet the intent of the review. Also, the questions in this survey are to be used as a basis for discussion with a variety of State Medicaid and TANF officials and other relevant parties. The reviewer is not restricted to these questions and may ask additional questions in order to make a final determination of State performance. The information gathered through these State reviews will be instrumental in developing corrective actions and other initiatives to improve access to Medicaid on the State local level and to improve the health coverage of low-income children and families.

I. REACHING FAMILIES WHO SEEK MEDICAID

A. Eligibility Categories

1. Section 1931 Group - State Plan Amendment

Requirement: States must provide Medicaid to families who have a dependent child living with them and who meet certain financial and deprivation requirements under Section 1931 of the Act.

- o Does the State provide coverage to individuals eligible under section 1931 of the Social Security Act?

2. Section 4913 Group - State Procedures

Requirement: States must use current SSI income and resource standards and the definition of childhood disability in effect prior to the 1996 revised definition when verifying disability for purposes of determining Medicaid eligibility for disabled children who were receiving SSI benefits under Title XVI on August 22, 1996.

- o Does the State have a policy to wait at least 1 year after loss of SSI to conduct a financial redetermination. Does the policy provide a longer period to conduct a disability redetermination?

- o Does the State terminate these cases when SSI is lost?

- o Does the State have a manual or computer tracking system for individuals going on and off the rolls to redetermine eligibility based on their protected status?

B. Application and Enrollment

1. Opportunity to Apply for Medicaid

Requirement: States must provide the opportunity for families to apply for Medicaid without delay.

- o Where does an individual apply for Medicaid? (Check all applicable responses.)

_____ Job Centers
_____ County welfare office
_____ Other local district
_____ Outstationed workers
_____ Head Start
_____ TANF sites
_____ Medicaid-only sites
_____ Other (indicate where)

- Does the State use a joint TANF/Medicaid application or a separate Medicaid application?

  _____ Joint _____ Separate
  _____ Both Available _____ Other (explain)

- What is the system for reviewing the Medicaid portion of a joint application?

- What does the State do when an individual requests a Medicaid application?

_____ mailed to home _____ available at TANF office
_____ handed out in community _____ other (explain)

- How long does it take to get a Medicaid application? (Does the State impose a waiting period before providing an application?)

- Are Medicaid applications available in TANF offices? When a person at a TANF office applies for Medicaid, are they permitted to do so?

_____ yes, but referred to another office ____ not allowed/no referral made
_____ yes, apply at TANF office _____ other (explain)

- If an application for TANF is not made or is delayed because the applicant must fulfill job search requirements or is otherwise diverted; is the applicant given the opportunity to immediately apply for Medicaid?

_____ yes, but referred to another office ____ not informed/no referral made
_____ yes, apply at TANF office _____ other (explain)

- Are there any circumstances when an application for Medicaid could be made before all the TANF requirements are met?

- Describe the process used to discuss the Medicaid application process with those applying for TANF. What materials are given to TANF applicants with regard to Medicaid? What verbal information is given to applicants?

- Describe the process that a person would follow to apply for benefits. (Please note, different eligibility categories may have different processes.)

- Are individuals who have been terminated from TANF permitted to file Medicaid applications? How would they know of this opportunity?

- o Does the State require paternity information in cases where the parent is applying for Medicaid for the child only? Does noncooperation of the parent(s) affect the child's eligibility?

- o What has the State done to implement the policy on public charge?

- o Who makes the Medicaid eligibility determination? Is this State personnel authorized by the State to perform this function?

- o Which other programs does this worker have responsibility?

- o To what extent do workers rely on computers to make Medicaid eligibility determinations? Is there any supervisory review done prior to a denial?

- o How is the case file handled? Is there one file for TANF/Medicaid and all other benefits? Are the case files separated?

- o What is the size of the typical eligibility worker's caseload? Does the State have guidelines as to what the size of the caseload should be?

2. Timeframe for Eligibility Determinations

Requirement: Medicaid eligibility must be determined within 45 days from the date of application.

- o How long before Medicaid eligibility is determined once an application is filed?

- o What are the time frames for each step in evaluating the Medicaid application and the timeframes needed to complete each step on average?

- o Are these timeframes affected at all if it is a joint TANF/Medicaid application and TANF is denied?

II. MAINTAINING COVERAGE FOR FAMILIES WHO LEAVE MEDICAID

A. Provide Transitional Medicaid for Families

Requirement: States must provide transitional Medicaid to families under certain conditions. States must provide families a second 6 months of coverage to any family who received transitional Medicaid in the first 6-month period. NOTE: This second requirement was clarified on an errata page in the original publication of the Guide to Expanding Health Coverage.

1. Enrollment Process for Transitional Medicaid

- What is the overall process for enrolling families in transitional Medicaid? What are the steps in the process from the outreach phase to enrollment?
- How are families notified of their rights under Medicaid? Is enrollment in Transitional Medicaid automatically trigger by computer system?
- Does the State know to provide the required 6 months of transitional Medicaid (or 4 months if the child support income would cause Medicaid ineligibility) to all eligible individuals or only those persons who lose TANF? Is this done by the State?
- Does the State know to offer families the option to receive a second 6 months of transitional Medicaid? Is this done by the State?
- What documentation is a family required to present prior to receiving transitional Medicaid or as a condition of continuous eligibility?

2. Loss of Transitional Medicaid

- Following expiration of transitional Medicaid, are families/children re-screened for eligibility in Medicaid or the Children's Health Insurance Program (CHIP)?
- Is additional information required to complete this re-screening or does the State use information from existing data sources/internal records?
- Does the State terminate transitional Medicaid for individuals who fail to meet the reporting requirements?

o Does the State have a tracking, coding or other means for converting Medicaid eligible cases to transitional coverage automatically?

B. Procedures Related to Denial/Termination of Medicaid.

Requirement: States are prohibited from denying or terminating Medicaid until all possible avenues to eligibility have been exhausted.

1. Denial for Medicaid During TANF Application and Enrollment

o Is Medicaid eligibility denied if a family is ineligible for TANF?

o IF TANF eligibility is denied for failure to verify criteria, is Medicaid eligibility denied as well? Under what circumstances would Medicaid eligibility continue when a person denied TANF for failure to provide verification of eligibility?

2. Termination of Medicaid and the Medicaid Eligibility Redetermination Process

o What triggers an eligibility review for Medicaid, e.g. standard time frames, changes in TANF eligibility, changes in case circumstances?

o How often does the State require a redetermination for Medicaid-only cases versus for cases that also involve other public assistance, e.g., TANF?

o During an eligibility review, what is the overall process followed? What information, if any, does the agency require from the family in order to evaluate ongoing eligibility? Is a face-to-face interview required?

o If a family member is not eligible for or loses Medicaid under a certain category, does the State deny or terminate Medicaid to the entire family?

o When the State denies Medicaid, rather than exploring other possible categories of eligibility, does it advise the family to apply for Medicaid under another category?

o Ask the State to explain its process for analyzing changes in case circumstances and the impact on Medicaid eligibility for current recipients. Does the State determine if Medicaid eligibility is possible under a different category prior to termination?

o Is eligibility under alternate eligibility categories computerized or is it

done manually? If manually, is there any internal procedure to check the results of the review?

3. Termination of Medicaid and the Medicaid Eligibility Redetermination Process when TANF has been Terminated

- o When TANF is terminated for a family, does that termination affect Medicaid eligibility or enrollment?
- o When a TANF case is closed, does that fact trigger a review for eligibility in any other program?
- o If a TANF recipient requests that their case be closed, does that affect enrollment for another program?

III. REACHING FAMILIES OUTSIDE MEDICAID

Outstation Eligibility Workers

Requirement: States must have outstationing arrangements and provide an opportunity for pregnant women and children to apply for Medicaid at locations other than welfare offices.

- o Does the State provide an opportunity for children under age 19 and pregnant women to apply for Medicaid at locations other than welfare offices? Is such an opportunity provided to any other populations?
- o Where are these alternative application centers?

_____ Community centers _____ Job Centers
_____ Medicaid-only offices _____ Other (explain)

- o Does the State have outstationing arrangements at facilities designated as disproportionate share hospitals and Federally qualified health centers? Ask the State to provide evidence that it is complying with this requirement.
- o Does the State have outstationed workers, or alternative arrangements, specifically in health care for the homeless Federally qualified health centers?

IV. CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

- Please describe the State's method for screening CHIP applicants for Medicaid eligibility and enrolling Medicaid-eligible children into Medicaid. (it is helpful if they walk you through the process with the materials -- often it is enrollment brokers or local-level staff that are most knowledgeable.)

- How is the program coordinating between/among other children's health-related programs (e.g., Medicaid, MCH, title V, WIC, community and migrant health centers, etc.) to assure compliance with screen and enroll requirements?

- What follow-up occurs with families whose children have been identified as Medicaid eligible to see if they are actually enrolled in Medicaid?

- How are beneficiaries notified of hearing rights if eligibility is denied?

- Is there a person knowledgeable about the appeals process that is available to assist clients through this process?

OPTIONAL POLICIES FOR MEDICAID ELIGIBILITY

1. Maintaining Coverage for Families Who Leave TANF Assistance

Options: States may grant continuous coverage of children; States can terminate Medicaid for certain TANF recipients; States can pay certain premiums and cost-sharing for low-income workers.

- o Does the State provide continuous Medicaid eligibility to children under age 19 for up to 12 months?

- o Does the State pay the premium and cost-sharing for employer-sponsored health insurance when it is cost-effective to do so?

3. Reaching Families Outside Medicaid

Options: Expand coverage under Section 1931, cover children and/or families under CHIP; grant presumptive eligibility for pregnant women and children.

- o What types of expansions (if any) has the State adopted using the Section 1931 coverage group, e.g., expand coverage to two-parent families? Are any of the optional disregards used under Section 1931?

- o Has the State implemented CHIP through a Medicaid expansion?

- o Has the State used the option to cover families under CHIP?

- o Does the State grant presumptive eligibility to pregnant women and children?

- o Does the State allow for mail or phone-in applications for Medicaid and CHIP?

- o Is an interview required for enrollment in Medicaid or CHIP?

GENERAL QUESTIONS TO ENSURE ADMINISTRATIVE EFFICIENCY

I. MEDICAID QUALITY CONTROL - THE NEGATIVE CASE ACTION PROGRAM

- o Does the State operate a negative case action program as required under regulations at 42 CFR 431.812?
- o Has the State determined through this program if a high number of cases are being erroneously denied or terminated from Medicaid as a direct result of a TANF eligibility determination?
- o If so, what corrective actions has the State developed/taken to address this problem?
- o Does the State coordinate the findings from its negative case action program with Medicaid eligibility managers, systems managers and other appropriate staff?
- o Is the State aware that the regulations at 42 CFR 431.812 allow States to design an alternate negative case action program? Is the State aware that they can use this option to target problem areas such as erroneously denied and terminated Medicaid cases as a result of a TANF eligibility determination?

II. COORDINATION BETWEEN TANF AND MEDICAID

A. State Organization

- o Identify the single State agency for Medicaid in the State.
- o Is the single State agency the same agency for the TANF program?

_____ yes _____ no

- o Are local agencies or districts responsible for administering the TANF and Medicaid programs under State supervision?

_____ yes - Medicaid _____ yes - TANF
_____ no - Medicaid _____ no - TANF

B. Program Coordination

- Does the State have a system of coordinating program information for each case so that each Medicaid case indicates an eligibility determination for TANF or each TANF case indicates an eligibility determination for Medicaid?

- Does this coordination of case benefit information occur whether or not an application for both TANF and Medicaid is made at the same time or at different times?

  _____ only when benefits are applied for at the same time
  _____ when benefits are applied for on separate occasions
  _____ in both instances

- When an application for Medicaid taken at the TANF office and is denied or terminated, does the case become available for sampling as part of the universe of negative case actions?

  _____ yes _____ no

- If not, what happens to the case finding of ineligibility? Is there a process to ensure that data concerning Medicaid denials and terminations are captured?

C. Program Assurances

- Did the State provide training to caseworkers and other staff on welfare reform requirements?

- Did the State conduct any analyses or reviews on the issues of Medicaid participation levels and to identify where barriers to Medicaid exist?

- How does the State assure that Medicaid policies are accurately and consistently implemented at the local or caseworker level?

- Has the State developed any corrective actions to address identified problems with the administration of the TANF/Medicaid application and termination process at the local level?

  _____ yes _____ no

- o Does the State use a monitoring system to verify that the corrective actions were implemented at the local level?

  _____ yes _____ no

- o Does the State use any of the following accountability mechanisms to ensure that agency staff adhere to corrective actions or other error reduction initiatives addressing identified problems with Medicaid/TANF application and termination policies?

  - Does the State consider the accuracy and timely processing of Medicaid case actions when measuring employee performance and are these requirements reflected in employee appraisal forms?

    _____ yes _____ no

  - Does the State use a second-party case review process? Are these review results reported to higher level management as well as caseworkers?

    _____ yes _____ no

  - Does the State perform regular operational reviews of local offices to evaluate the effectiveness of corrective actions and that second-party case review recommendations have been implemented?

    _____ yes _____ no

III. COMPUTER SYSTEMS

- o Please confirm that the computer system functions in accordance with the policies described above.

- o Please describe the changes made to the computer system to reflect the new Section 1931 group.

- o Does the computer system allow for the Medicaid part of the application to stay open if TANF is denied?

- o Has the State separated the computers systems for TANF and Medicaid enrollment in order to protect against erroneous terminations when TANF is closed.

- o What intermediate steps are taken to override system functions that adversely impact Medicaid eligibility, including erroneous terminations, e.g., supervisory

reviews?

May 14, 1999

Study Links Medicaid Drop to Welfare Changes

Related Articles
- Issue in Depth: Welfare

By ROBERT PEAR

WASHINGTON -- A new study estimates that 675,000 people lost Medicaid coverage and were without health insurance in 1997 because of sweeping changes in Federal and state welfare programs.

The study was issued Thursday by Families USA, a consumer group that has worked closely with the White House on health policy for the last six years.

Ronald F. Pollack, executive director of Families USA, said most of those who became uninsured "as an unintended consequence of welfare reform" -- 420,000 of the 675,000 people in 1997 -- were children.

Pollack said the Clinton Administration was not enforcing Federal laws intended to guarantee Medicaid for people who lose cash assistance. In addition, he said, many states have apparently failed to comply with those laws.

The Federal Government has told states what they are required to do, but has not penalized them for failure to comply, preferring to coax and exhort state officials.

While advocacy groups and some local officials have complained about the loss of Medicaid coverage, the study by Families USA is the first that tries to paint a comprehensive national picture of the problem.

Pollack predicted that the problem would get worse because more and more people are leaving the welfare rolls for low-wage jobs that do not provide health benefits.

Three million people left welfare in the year after President Clinton

signed the welfare bill in 1996. The Families USA study suggests that at least 1 in 5 former welfare recipients became uninsured.

These estimates are consistent with the findings of many studies by various experts who have examined the experience of individual states. The Clinton Administration, which in the past has embraced Families USA as an impeccable source of health policy research, said it had questions about the methodology of Pollack's new study.

In Congressional testimony just two weeks ago, Federal officials acknowledged that the loss of health insurance was a serious problem for many former welfare recipients.

But today Melissa T. Skolfield, a spokeswoman for the Department of Health and Human Services, said, "It's too early to know for sure if there is a cause-and-effect relationship" between the steep decline in welfare recipients and the increase in the number of uninsured.

In New York City, a Federal district judge has ruled that thousands of people were improperly denied Medicaid at city welfare offices.

Hillary Rodham Clinton, the First Lady, has suggested that Mayor Rudolph W. Giuliani is responsible, and White House officials said she would criticize him more harshly if she decided to run for the Senate from New York.

But Pollack said there had been "an abdication of responsibility" by the Federal Government as well. "There's much more the Federal Government could do to make sure states comply with clear and unequivocal Federal laws," he said.

In some states, Pollack said, computers automatically cut off Medicaid for people leaving welfare, and state employees have not been trained to override the computers.

Susan J. Golonka, a welfare expert at the National Governors' Association, said: "It's true that there are unintended consequences of the 1996 welfare law. We have heard concerns that some families who are eligible for Medicaid are not receiving it. States are working hard to address these issues, by reaching out to low-income families, simplifying eligibility procedures, expanding coverage for working parents and changing computers to make sure people can keep Medicaid when they go off welfare."

The study, done with assistance from the Lewin Group, estimated the number of people who would have had Medicaid in the absence of changes in welfare policy. It then compared this number with actual Medicaid enrollment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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COMMENTS:

Medicaid/TANF Q and As
Final--3/19/99

Q: What is the purpose of this guidebook?

A: As the cover letter says, our goal is to do everything possible to maximize both the number of people with health insurance and the number of people moving from welfare to work. The decoupling of Medicaid and TANF in the 1996 welfare reform law means that states need to pay careful attention to their eligibility and enrollment processes. It also provides a special opportunity for states to promote both Medicaid and CHIP as an independent support for low-income working families.

The guidebook released today 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 makes clear that states with a joint 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.

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.

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.

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.]

[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: 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: Beginning in July, HCFA began collecting information from city and state officials about Medicaid application procedures to ensure that New York City's Medicaid program was serving all qualified applicants, as required by law. In late January, a New York court issued a temporary restraining order against the city for failing to follow Medicaid enrollment requirements under law and regulation. The court required the city to submit a corrective action plan that includes procedure to address issues raised with the city's Medicaid enrollment process. That plan has now been submitted, and it is being reviewed by the court.

[BACKGROUND: The state of New York has asserted that they cannot provide any information to HCFA due to the court proceedings. HCFA is continuing to gather information from other sources. The plaintiff in the court case is the Legal Aid Society of New York.]

Q: What do you think of New York City's corrective action plan?

A: The court has not provided us with a copy of the plan and has not asked us for comment.

Q: Have there been similar violations in other states? Are you issuing the guidebook because you think this is a national problem?

A: We are certainly aware, as we say in the guidebook, that the de-linking of Medicaid and cash assistance creates both opportunities and challenges in the states. As we receive specific complaints, we will of course investigate them.

However, that is not the reason we released the guidebook. There is no evidence that this is a widespread problem. Our goal is to do everything possible to maximize both the number of people with health insurance and the number of people moving from welfare to work. State officials share those goals, and want to do the best job they can in administering TANF, Medicaid and CHIP.

In fact, significant resources exist for states to conduct Medicaid and CHIP outreach, including a $500 million Medicaid fund, enacted in the 1996 welfare law and aimed at outreach for children losing welfare; a provision in the CHIP law, allowing states to spend up to 10 percent of their CHIP allotment on administrative costs which can include outreach; and a provision in the welfare bill that allows states to use federal TANF funds and their state maintenance of effort funds for outreach and training activities for Medicaid and CHIP.

[BACKGROUND: Federal TANF funds can NOT be used for medical services or as Medicaid matching funds, however.]

Q: Why are the Medicaid rolls decreasing?

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 on Monday 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 Monday 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 that use a joint TANF-Medicaid application must furnish a Medicaid application upon request and may not impose a waiting period before providing it. 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, welfare reform has been successful in moving many families from welfare to work. Recent national data shows that the percentage of former welfare recipients who are working has tripled since 1992. 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. 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.

Third, 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.

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. 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. 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: Many steps are being taken. 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 on Monday 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 Monday 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.

Q: How can the Federal government ask States to do more work on Medicaid enrollment when the Administration has a proposal in place that will reduce the funds available for Medicaid?

A: With the repeal of the AFDC program and the enactment of TANF, states began to amend their public assistance cost allocation plans to charge activities to programs in the proportion to which the programs benefited from those activities, thereby increasing administrative costs for both Medicaid and Food Stamps. At the same time, these costs were already included in States' TANF block grants. The President's Budget proposes to reduce Medicaid administrative costs only to the extent that they would be increasing due to the changes in cost allocation plans - just as the Agriculture Research, Extension, and Education Reform Act reduced Food Stamps administrative costs last year. Unlike that Act, however, the Administration's proposal would allow States to use TANF funds to offset these cuts to the Medicaid program.

The Administration is committed to helping States to provide coverage to as many of the uninsured as possible. 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.

Q: Does the Administration oppose efforts in Congress to reduce or redirect unused TANF funds?

A: Yes. The Administration strongly opposes these proposals because they will undermine the decisions already made by the states regarding how they plan to use their TANF funds. We encourage states to continue to invest in all families to enable them to succeed at work. This means both helping hard-to-serve recipients overcome the barriers that prevent them from working and helping working families to sustain and improve their employment so that they can support themselves and their children. Innovative investment of the unspent funds is essential to the success of welfare reform.

[BACKGROUND: The proposal in the Senate Appropriations Committee's version of the Emergency Supplemental Bill to redirect TANF funds has now been dropped. The most recent data reported by the states to the Department show that in FY 1998, states also continued to make large investments in their work first welfare programs, spending or committing to spend 84 percent of their federal funds. Nineteen states spent 100 percent of their block grant. Although states can reserve funds from year to year without limitation, when FY 1997 and 1998 funds are combined, states left only 10 percent of the federal block grant unspent. We expect future data to show a substantial increase in spending commitments because 1) states will have had the opportunity to appropriate these additional funds, which they did not initially plan for because they did not expect such large caseload declines; 2) state policy decisions made in early 1998 will now be implemented, resulting in additional expenditures. We also expect states to leave some TANF funds unspent, leaving them in the federal treasury for a "rainy day" when additional funds may be needed due to population increases or a regional recession.]

Q: What is HHS doing about the "public charge" issue and why?

A: First, HHS sent out letters to the states last year reminding them that there are only limited circumstances when personal information on benefit receipt can be released and repayment sought. The Medicaid and the previous AFDC laws are clear about this, and DHHS is committed to following the letter of the law. Additionally, the INS has informed its field offices that they may not condition a person's visa on repayment of past benefits.

Second, HHS has been working closely with the INS, State Department and other agencies to develop guidance that will clarify the meaning of public charge and the effect of enrollment in benefit programs, such as Medicaid and CHIP on immigrants. We are hopeful that guidance will be issued shortly.

We also note that the INS *has* confirmed through several letters that use of Medicaid and CHIP by the children of immigrants, both U.S. citizens and lawful

permanent residents, will *not* have any effect on the child's public charge status or that of their immigrant family members. Nonetheless, we recognize that it is still critical to issue official guidance to settle the matter.

****Please note that within the next couple of weeks George Washington University will release a study on welfare diversion policies.**

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. We believe these strategies can be 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 on Monday 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).]

Talking Points—Medicaid/TANF
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- As the cover letter says, our goal is to do everything possible to maximize both the number of people with health insurance and the number of people moving from welfare to work. The decoupling of Medicaid and TANF in the 1996 welfare reform law means that states need to pay careful attention to their eligibility and enrollment processes. It also provides a special opportunity for states to promote both Medicaid and CHIP as an independent support for low-income working families.

- The guidebook released today 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 makes clear that states with a joint 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.

- 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.

- 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.

United States General Accounting Office

GAO

Report to Congressional Requesters

August 1999

MEDICAID ENROLLMENT

Amid Declines, State Efforts to Ensure Coverage after Welfare Reform Vary

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August xx, 1999

The Honorable William J. Coyne
Ranking Minority Member
Subcommittee on Oversight
Committee on House Ways and Means
United States House of Representatives

The Honorable Sander M. Levin
United States House of Representatives

Medicaid, a joint federal/state program, spent about $160 billion in federal fiscal year 1997 to finance health coverage for more than 40 million low-income individuals, including adults and children in families, aged, blind and disabled people.[1] States administer Medicaid within broad federal guidelines that specify which categories of individuals states must cover and which groups states have the option of covering. Prior to federal welfare reform, states were required to automatically provide Medicaid coverage to families enrolled in the Aid to Families with Dependent Children (AFDC) cash assistance program.

When federal welfare reform was enacted in August 1996, automatic eligibility for the federal-state Medicaid program was uncoupled from eligibility for cash assistance, and states implemented a variety of initiatives intended to move families from welfare to the workforce.[2] Some experts were concerned that despite federal protections to continue Medicaid coverage, about a third of the over 40 million low-income people that had been automatically eligible for Medicaid could lose coverage. Children unnecessarily losing coverage were of particular concern because, prior to welfare reform, more children gained access to Medicaid based on

[1] Fiscal year 1998 expenditures were $177 billion; data on the number of beneficiaries for 1998 are not yet available.
[2]The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193).

family receipt of cash assistance than via other avenues of eligibility, such as disability or other special medical needs. Moreover, recent reports of welfare and Medicaid enrollment declines have raised questions about the unintended consequences of welfare reform on Medicaid and the viability of the federal and state protections to ensure continued Medicaid eligibility for low-income families and children.

Given your concerns about apparent declines in Medicaid enrollment after welfare reform, you asked us to (1) analyze Medicaid enrollment changes for families and children following welfare reform and associated key federal protections established for Medicaid and (2) assess states' welfare-related policies and practices that can influence Medicaid enrollment. In conducting our work, we analyzed enrollment data from the 50 states and from the Health Care Financing Administration (HCFA) for 1995 and 1997.[3] To assess the procedures and protections that states used to enroll Medicaid-eligible individuals since welfare reform, we also contacted 21 states to review state policies and practices that influenced enrollment. Our work was performed between July 1998 and July 1999 in accordance with generally accepted government auditing standards. (For more detailed information on our study scope and methodology, see apps. I and II.)

RESULTS IN BRIEF

Between 1995 and 1997, Medicaid enrollment declined nationwide, but substantially less than the decline in welfare rolls. Overall, Medicaid enrollment among non-elderly, non-disabled adults and children declined by about 1.8 million, or 8 percent, compared to a 3.1 million, or a 23-percent decline in welfare participation. Shifts in individual states' Medicaid enrollment for these adults and

[3] For our analysis, 1995 provides a baseline for enrollment prior to the 1996 enactment of welfare reform and 1997 was the most current year for which HCFA enrollment data were

children during this period ranged from 19-percent declines in Ohio and Wisconsin to a 26-percent increase in Delaware. Some of the factors likely responsible for Medicaid and welfare enrollment declines include a strong economy, low unemployment rates, and new state welfare-to-work initiatives. The lesser declines in Medicaid enrollment may also be due to federal eligibility protections built into welfare reform and ongoing expansions of Medicaid coverage for low-income children that predated welfare reform. One eligibility protection that predates welfare reform is transitional Medicaid assistance, which provides an additional year of Medicaid coverage for individuals who lose eligibility due to employment or increased income. The extent to which transitional Medicaid affected national enrollment trends, however, is uncertain due to the lack of uniform reporting and tracking of this entitlement.

Our analysis also shows that changes in state-level welfare policies and practices may both positively and negatively influence Medicaid enrollment. In particular

- States we contacted are increasingly implementing welfare reform-related policies and programs designed to divert families from enrolling in cash assistance programs. A diversion strategy such as mandatory job searches prior to receiving cash assistance can result in delayed consideration of Medicaid eligibility, increased beneficiary reporting requirements, or both.
- The extent to which states we contacted provide transitional Medicaid for newly working families varied, ranging from 1-3 years of coverage. For families no longer receiving cash assistance, participation in transitional Medicaid ranged from about 4 percent to 94 percent of those leaving cash assistance among the several states that were able to provide such data. According to some states and beneficiary advocates, a key barrier to more extensive use of transitional

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available when we initiated our work.

Medicaid is the need for beneficiaries to report their income status as many as 4 times in 1 year. States taking advantage of the statutory authority to obtain HCFA waivers of these income-reporting requirements reported higher participation rates than others.

- Some states have initiated outreach and education campaigns to counter confusion among beneficiaries regarding Medicaid eligibility. In concert with the State Children's Health Insurance Program (SCHIP) enacted in 1997, some states have simplified Medicaid application and eligibility determination processes to facilitate enrollment. Officials in some states have noted increased Medicaid enrollment stemming from eligibility screening for SCHIP.

We identified one area where increased state flexibility could further ease the transition from welfare-to-work and make Medicaid more available to eligible individuals. The Congress may wish to consider allowing states, as a feature of their Medicaid program, to guarantee a full year of transitional Medicaid coverage to eligible beneficiaries without quarterly income reporting requirements. State options in this area would be similar to the flexibility granted under section 4731 of the Balanced Budget Act of 1997 (BBA), which allowed states to guarantee children a longer period of Medicaid coverage, regardless of changes in a family's financial status or size.

BACKGROUND

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 changed the relationship between receipt of cash assistance and Medicaid eligibility by delinking the two programs, potentially affecting about a third of the Medicaid population. The act replaced AFDC with fixed block grants to the states to provide Temporary Assistance for Needy Families (TANF) and ended the entitlement of families to cash assistance. Under TANF, states have flexibility to design their own

cash assistance programs, including developing strategies that may divert potential applicants from cash assistance entirely. In our 1998 report on TANF implementation, we noted that many states had begun implementing diversion strategies such as job search assistance or providing one-time, lump sum payments to divert potential applicants from cash assistance.[4] The act also established a 5-year lifetime limit on receipt of TANF benefits.[5] In an effort to safeguard access to health insurance for eligible low-income people, the welfare reform law also required that states implement a separate Medicaid eligibility category, which ensured that low-income families meeting a state's July 16, 1996, AFDC eligibility criteria could qualify for Medicaid without also receiving cash assistance.

The welfare reform law also provided states with new choices regarding how to administer Medicaid and determine applicants' eligibility for coverage.[6] Previously, states were required to use a single state agency to administer AFDC and Medicaid and a single application that could be used to determine eligibility for the two programs. Now states have the option of using separate state agencies, separate applications, separate eligibility criteria, and separate application procedures for TANF and Medicaid. While the law required that states use the July 16, 1996, AFDC eligibility income and resource (asset) criteria for determining Medicaid eligibility, states were free to apply different criteria for receipt of TANF including

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[4] States had the option of implementing their TANF programs as early as October 1996 or as late as July 1997. TANF implementation dates varied among the 21 states we contacted, from October 1996 in Connecticut, Florida, Utah and Wisconsin to January 1998 in California. For more information on TANF implementation, see Welfare Reform: States Are Restructuring Programs to Reduce Welfare Dependence (GAO/HEHS-98-109, June 17, 1998).

[5] For information on the states' efforts to track the impact of welfare reform on former cash assistance recipients, see Welfare Reform: Information on Former Recipients' Status (GAO/HEHS-99-48, April 28, 1999).

[6] See Medicaid: Early Implications of Welfare Reform for Beneficiaries and States (GAO/HEHS-98-62, February 24, 1998) for additional information on states' Medicaid-related choices following federal welfare reform.

work requirements and pre-application activities that people must satisfy before TANF applications are processed.

In addition, the welfare reform law extended the life of the transitional Medicaid assistance program through the year 2001. The transitional Medicaid assistance program, established in 1988 and specified by section 1925 of the Social Security Act and subsequent amendments, entitles certain families losing Medicaid due to employment or increased income to an additional year of Medicaid coverage. Families moving from welfare-to-work are entitled to an initial 6 months of Medicaid coverage without regard to the amount of earned income and an additional 6 months of coverage if family earnings, less childcare costs, do not exceed 185 percent of the federal poverty level.[7]

The welfare reform law, however, did not change the time limits that states must meet in processing Medicaid applications, nor did it change federal oversight responsibility for Medicaid and cash assistance. States are still required to provide Medicaid applications upon request and to determine applicant eligibility for Medicaid coverage within 45 days from the date of application.[8] In addition, the Department of Health and Human Services (HHS) continues to have oversight responsibility for both HCFA—the federal agency that administers Medicaid—and for the Administration for Children and Families (ACF), which administered AFDC and now oversees the TANF block grant program.

The federal welfare reform law also did not alter Medicaid coverage for the so-called 'expansion population'—pregnant women, and infants and children under age 19 born after September 30, 1983 whose family income falls below states' poverty-level

[7] In 1999, the federal poverty level for a family of three was $13,880 or about $1,157 per month.

[8] States have 90 days to determine eligibility for disability-related coverage.

standards.[9] The Medicaid statute requires that states annually expand Medicaid coverage to children living in low-income families until children through age 18 are eligible by October 2002.[10] Currently, the law only requires that children up to age 15 be covered; however, over 20 states accelerated the expansion by allowing older children to qualify for Medicaid coverage sooner than prescribed by the law. By August 1996 when federal welfare reform legislation was passed, 16 states, including 6 states in our sample—were already covering children up to age 19.[11]

One year after passage of welfare reform, as part of BBA, the Congress established SCHIP—an optional health insurance program for children in families with incomes up to 200 percent of the federal poverty level who do not qualify for Medicaid.[12] Beginning in October 1997, SCHIP provides about $40 billion over 10 years in federal matching funds for states to expand health care coverage to uninsured low-income children. States have the choice of 1) expanding Medicaid coverage; 2) establishing a separate, stand-alone health insurance program; or 3) combining these two approaches. Because the percentage federal contribution is higher for SCHIP than for Medicaid, the Congress was concerned that states would have some incentive to enroll Medicaid-eligible children in SCHIP rather than

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[9]The Omnibus Budget Reconciliation Act of 1989 (OBRA '89, P.L. 101-239) required states to provide Medicaid coverage for pregnant women and children up to age 6 with family incomes below 133 percent of the federal poverty level. OBRA 89 also froze eligibility standards at December 19, 1989 levels for 17 states that had chosen to provide coverage for pregnant women and infants in families with incomes above 133 percent and up to 185 percent of the federal poverty level.

[10]Section 4601 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) mandated the annual expansion for children living in families with incomes below 100 percent of the federal poverty level.

[11] Some states have continued to expand eligibility above the required level; by September 1997, 35 states' standards exceeded 133 percent for pregnant women and infants and 14 states exceeded that level for children up to age 6 as well.

[12] For states with Medicaid income levels that already approach or exceed 200 percent of the federal poverty level, SCHIP allows states to expand eligibility up to 50 percentage points above its existing Medicaid eligibility standard. For additional information on SCHIP, see Children's Health Insurance Program: State Implementation Approaches Are

Medicaid. To ensure that Medicaid-eligible children are not enrolled in SCHIP, HCFA requires that states first screen all SCHIP applicants for Medicaid eligibility. Therefore, states have recently been implementing welfare reform and SCHIP concurrently -- both of which have potential implications for Medicaid enrollment.

MEDICAID ENROLLMENT DECLINE INFLUENCED BY VARIOUS FACTORS AND KEY FEDERAL PROTECTIONS

From 1995 to 1997, national enrollment in Medicaid among adults and children declined by about 1.8 million or 8 percent and ranged from a decrease of 19 percent in Ohio and Wisconsin to an increase of 26 percent in Delaware. In contrast, welfare participation declined an average of about 23 percent, or 3.1 million recipients from 1995 to 1997—from a 7 percent decline in Alaska to a nearly 56 percent decline in Wisconsin.[13] In several states for which data were available, child enrollment for Medicaid showed a much smaller decline compared to adults.

Factors that states cited as affecting declines in Medicaid and welfare enrollment—a strong economy, low unemployment rates, and new welfare-to-work initiatives—may have had a more limited effect on Medicaid enrollment than on welfare. In particular, employment in lower wage positions, many of which do not offer health insurance coverage, is not likely to make families losing cash assistance ineligible for Medicaid. Families may continue to be eligible for Medicaid because of federal requirements to disregard certain types of income in calculating Medicaid eligibility. Additionally, differences in the rates of decline between welfare and Medicaid enrollment may also be due to federal health coverage protections for low-income families and Medicaid eligibility expansions for low-income children.

Evolving (GAO/HEHS-99-65, May 14, 1999).

[13] Only one state—Hawaii—had an increase in welfare participation during this time period.

However, data on transitional Medicaid—designed to preserve coverage for families on a temporary basis—are not available nationwide, and its effect on Medicaid enrollment remains uncertain.

Welfare Declines Outpaced Medicaid Declines

Nationally, welfare participation declined three times as much as Medicaid enrollment from 1995 to 1997—23 percent compared to nearly 8 percent. As table 1 shows, for our sample of 21 states, welfare enrollment consistently declined more than Medicaid.

Table 1: Comparison of Changes in GAO State Sample for Medicaid Enrollment and Welfare Participation for Adults and Children, 1995 to 1997

State[a]	Percentage Change in Medicaid Enrollment	Percentage Change in Welfare Enrollment
National [b]	-7.5	-23.4
GAO Sample [c]	-9.3	-23.4
California	-7.6	-13.5
Colorado	-9.6	-32.2
Connecticut	-1.0	-11.5
Delaware	+26.2	-15.8
Florida	-13.4	-35.2
Georgia	-4.6	-30.4
Idaho	-10.8	-49.0
Indiana	-9.0	-36.8
Kansas	-10.5	-37.0
Kentucky	-10.1	-20.3
Maryland	-7.2	-31.2
Michigan	-8.9	-26.9
Nevada	-13.1	-29.3
North Dakota	-8.0	-27.0
Ohio	-19.0	-23.5
Oklahoma	-9.3	-34.0
Oregon	-13.0	-42.2
South Carolina	+2.4	-32.9
Utah	-5.0	-26.2
Vermont	+2.6	-16.8
Wisconsin	-19.0	-55.6

[a] States had varying amount of Medicaid enrollment data available for analysis. For a state-by-state discussion of available data, see Appendix II, table II.1.

[b] We were unable to obtain comparable enrollment data for the District of Columbia, Rhode Island and West Virginia.
[c] We over-sampled states with Medicaid declines in order to focus our analysis on state policy and practices that may contribute to declines in enrollment.

Source: GAO analysis of the states' Medicaid monthly enrollment data and of welfare data from the U.S. Department of Health and Human Services' Administration for Children and Families.

On a national level, the declines in welfare enrollment did not explain the declines in Medicaid enrollment; moreover, the ratios of declines for both programs were not closely related.[14] Differences in state policy and practices may also help explain some of the variation. For example, South Carolina's Medicaid enrollment increased by 2.4 percent, in part due to state expansions of eligibility for Medicaid and significant outreach efforts. During this same time period, welfare enrollment dropped by 32.9 percent. Ohio and Wisconsin had the largest declines in Medicaid enrollment nationally —19 percent—but very different declines in welfare. Ohio's decline in welfare enrollment was about the same as the decline in Medicaid enrollment, while Wisconsin's decline in welfare enrollment was almost three times as great as its Medicaid enrollment decline. Both states reported that an improved economy and successful welfare-to-work strategies might have accounted for some of the declines in Medicaid enrollment. However, they also expressed concern that beneficiaries and state caseworkers were confused about the change in relationship between welfare and Medicaid.

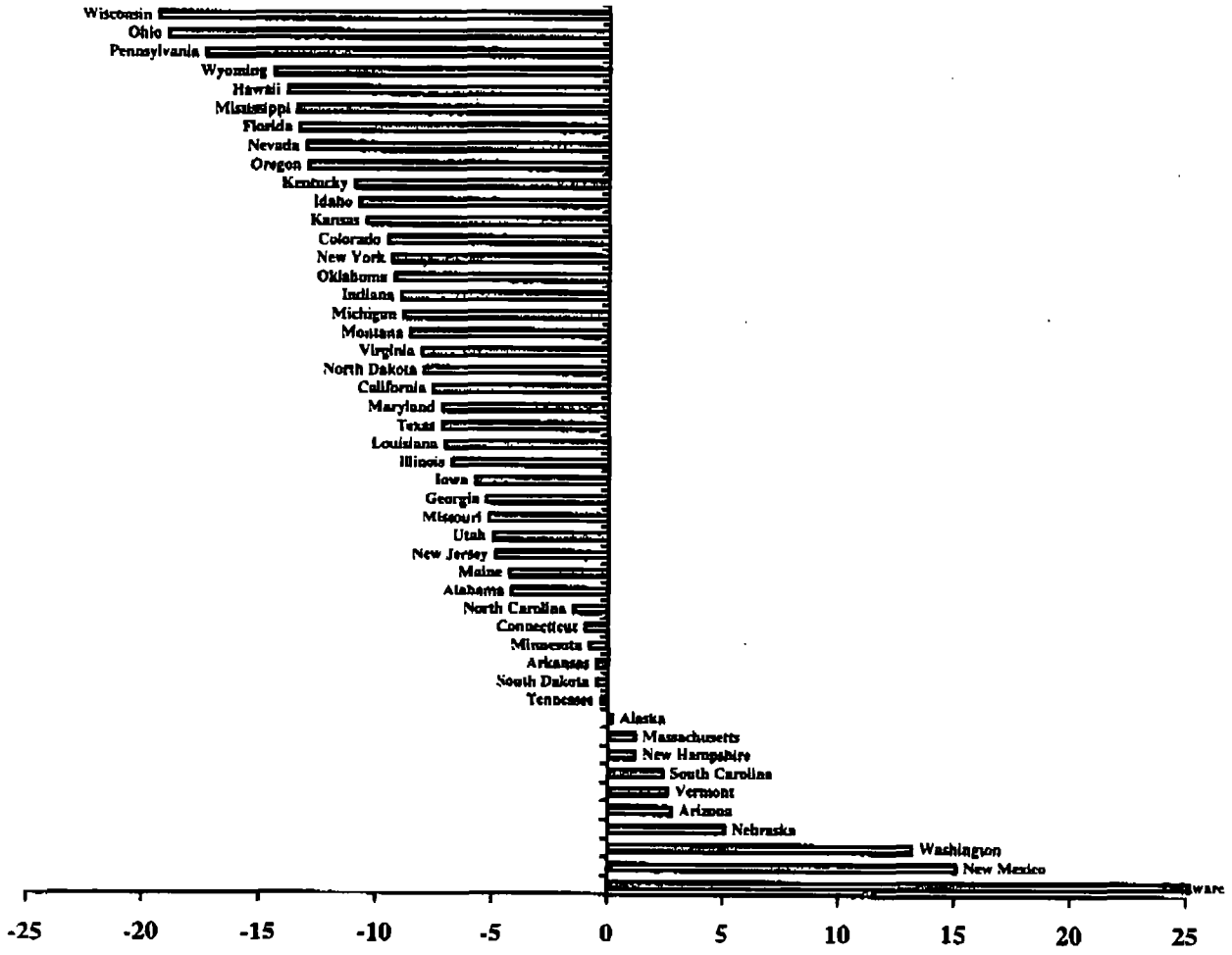
Magnitude of Medicaid Declines Varied Across the States

Within the overall 8-percent decline in Medicaid enrollment nationally, there was considerable variation among the states. As illustrated by figure 1, 12 states experienced declines of 10 percent or more, while 4 states saw Medicaid enrollment

[14] We found a statistically significant relationship between welfare and Medicaid enrollment ($p < .01$ level for a correlation coefficient of .38); however, declines in welfare

increase by 5 percent or more. Twelve states had relatively stable enrollment with changes of less than 3 percent. (See Appendix II for more detail.)

Figure 1: Changes in State' Medicaid Enrollment, 1995-97 [a]



[a] We were unable to obtain comparable Medicaid enrollment data for the District of Columbia, Rhode Island and West Virginia.

Source: GAO analysis of the states' monthly Medicaid enrollment data.

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explained 15 percent of the decline in Medicaid enrollment (r2= .15).

For Families Leaving Cash Assistance, Medicaid Eligibility Remains Likely Despite Strong State Economies

While a strong economy helps explain the decreases in welfare participation, it may have had a more limited effect on Medicaid enrollment. Officials in most of the 21 states we contacted attributed their declines in enrollment to successful welfare-to-work strategies and strong state economies. They said that low unemployment rates have aided their efforts to help welfare recipients quickly find jobs. Nationally, the unemployment rate averaged about 4.9 percent in 1997, down from about 5.6 percent in 1995 and almost all states in our sample experienced declines in the unemployment rates between 1995 and 1997. In comparison, in 1994 when welfare enrollment was at its peak at 14.2 million, the unemployment rate was 6.1 percent. Over the same period the federal minimum wage increased from $4.25 in 1995 to $4.75 in 1997.[15]

Despite strong state economies, families may continue to be eligible for Medicaid while working because of federal requirements and state flexibility to disregard certain types of income in calculating Medicaid eligibility. For example, states are required to exclude or "disregard," the first $30 of monthly family earnings for one year and one-third of remaining income for the first 4 months of employment.[16] Additionally, optional income disregards include $90 per month for work-related expenses, such as clothing and transportation, and $175 to $200 per child, based on age, in monthly childcare expenses. Eight of our sample states—California, Connecticut, Delaware, Maryland, Ohio, South Carolina, Utah and Vermont—had

[15] The national unemployment rate for the first 4 months of 1999 was 4.5 percent with a $5.15 minimum wage.

[16] After 4 months, states must still disregard the first $30 of earnings for one year, but may alter any other income disregards.

federal waivers in place that allowed them to continue to use more generous income disregards in determining eligibility for Medicaid.[17]

Applying the option available under federal welfare reform to continue waiver criteria as well as the income disregards noted above, many former cash recipients working in minimum wage jobs may remain eligible for Medicaid, at least for the first 4 months.[18] Data on former cash recipients in California, Indiana, Maryland, and Wisconsin also showed former welfare recipients generally held low-wage jobs—such as in retail stores, hotels, restaurant and health care—and worked less than full-time. For example, an Indiana survey of nearly 1,600 former welfare recipients found that in addition to working in low-wage jobs, heads of households often worked less than 32 hours per week and did not have health insurance. Over half of those surveyed were offered employer-provided health insurance; of these, about 60 percent declined coverage because it was too expensive or for other reasons. Only 8 percent of those declining coverage were enrolled in Medicaid.[19] Although state monthly income eligibility standards varied greatly—from $200 in South Carolina to $663 in California—it appears that in every state in our sample, heads of three member households could work full-time at the 1997 minimum wage and be Medicaid-eligible.

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[17] Prior to the 1996 enactment of the welfare reform law, many states had received waivers from the federal rules applicable to the AFDC program. These waivers allowed states to experiment with various welfare policies, including the use of more generous income disregards for working families. Federal welfare reform law allowed the states to continue applying welfare waiver provisions to Medicaid eligibility when such provisions involved income and resource methodologies and certain other criteria involving family composition. Provisions such as time limits, sanctions (withholding coverage) and more restrictive eligibility criteria could not be continued beyond the expiration of the waiver. Under TANF, states determine their own eligibility criteria, including any amounts of income to be disregarded.

[18] See app. 1 for additional information on our methodology for this analysis.

Additionally, an analysis by the Center on Budget and Policy Priorities shows that in 6 of the 21 states in our sample—California, Connecticut, Delaware, Ohio, Oregon and Vermont—heads of three-member households could work full time, earning as much as $5.15 per hour and continue their Medicaid eligibility.[20] Among the remaining 15 states, the number of hours per week heads of three-member households could work and continue to be income-eligible for Medicaid ranged from 17 in Indiana to 36 in Florida.[21]

Federal Protections for Low-Income Families May Have Tempered Welfare-Related Medicaid Declines

Federal health coverage protections for low-income families, expansions of coverage for low-income children and the availability of transitional Medicaid coverage for families moving from welfare-to-work may have also prevented greater declines in Medicaid enrollment. These protections, however, often appeared to have different outcomes for children and adults. Of the 11 states in our sample that were able to readily provide separate Medicaid enrollment data for children and for adults, declines in child enrollment were significantly less than among adults in 10 states, as shown in table 2. Delaware was an exception to this trend; its nearly 94-percent increase in adult enrollment occurred after the state implemented a Medicaid waiver expanding eligibility to adults with incomes up to the federal poverty level.

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[19] See Abt Associates, Inc. and The Urban Institute, The Indiana Welfare Reform Evaluation: Program Implementation and Economic Impacts After Two Years (Washington, D.C.: November 1998).

[20] The Center on Budget and Policy Priorities, Employed But Not Insured (Washington, DC: March 1, 1999). This analysis used state-specific deductions applicable after the initial 4 months of employment.

[21] Other GAO work found that 4 states in our sample—Indiana, Oklahoma, South Carolina, and Wisconsin—former cash assistance recipients are likely to earn an average hourly wage above the federal minimum wage. See Welfare Reform: Information on Former Recipients' Status, (GAO/HEHS-99-48, April 28, 1999).

Table 2: Percentage Change Between 1995-97 in Child and Adult Medicaid Enrollment in GAO State Sample

State [a]	Percentage Change for Medicaid, Adults and Children	Percentage Change for Children [b]	Percentage Change for Adults
California	-7.6	-6.5	-10.5
Colorado	-9.6	-5.0	-21.9
Connecticut	-1.0	-0.2	-2.8
Delaware [c]	+26.2	+3.7	+93.8 [d]
Georgia	-4.6	+.1	-18.7
Idaho	-10.8	-6.5	-24.7
Kentucky	-10.1	-7.2	-17.2
Maryland	-7.2	-4.6	-14.2
Nevada	-13.1	-6.5	-33.4
North Dakota	-8.0	-5.0	-15.8
Utah	-5.0	-4.8	-5.3

[a]We were unable to readily obtain separate enrollment data for children and adults from Florida, Indiana, Kansas, Michigan, Ohio, Oklahoma, Oregon, South Carolina, Vermont, and Wisconsin.
[b]The upper age each state uses to define children varies, ranging from age 18 to age 21.
[c]In calculating the percentage of change for children and adults in Delaware, we excluded less than 5 percent of total adult/child enrollment because state officials were unable to allocate the data between the two categories.
[d]In 1995, Delaware expanded adult eligibility to 100 percent of the federal poverty level. The state reported that the effect of this expansion was that 16, 000 more adults became eligible for Medicaid.

Source: GAO analysis of states' Medicaid monthly enrollment data.

Protections for Adults in Low-Income Families

The welfare reform act provided a mandatory Medicaid coverage protection for adults in low-income families and also allowed states to apply additional protections on a voluntary basis. In the absence of these protections, even larger declines in adult Medicaid enrollment could have resulted as welfare recipients moved into the workforce. A section of the Social Security Act (Section 1931) establishes a separate Medicaid eligibility category to protect adults—primarily women and their older teenaged children—previously eligible under their states' former AFDC programs.

Specifically, the law requires that states use standards no more stringent than the former AFDC standards in effect on July 16, 1996 as the criteria for determining Medicaid eligibility. Of the 21 states we contacted, only Maryland had not established a section 1931-eligibility category.[22]

Welfare reform also included several exceptions to the July 16, 1996 standards—two that allowed states to voluntarily expand Medicaid eligibility and one that allowed states to impose more restrictive standards.[23] Of the 21 states in our sample, 7—California, Delaware, Florida, North Dakota, Ohio, South Carolina and Vermont—expanded Medicaid eligibility by increasing their resource and income standards or liberalizing their determination methodologies. None of the 21 states applied more restrictive eligibility policies to Medicaid.[24]

Other health coverage protections for adults include provisions of the Medicaid statute that predated federal welfare reform and allow states to use higher income standards and more liberal methodologies for determining Medicaid eligibility than used for determining applicant eligibility for cash assistance. For example, section 1902(r)(2) of the Social Security Act provides that states may eliminate resource tests for certain individuals—such as pregnant women and children and persons

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[22] Maryland officials asserted that because the state did not delink its cash assistance and Medicaid programs – (i.e., families receiving cash still automatically receive Medicaid) and has a medically needy program for families, they did not believe that another category was needed as well. HCFA disagreed with Maryland's position. HCFA guidance does not indicate that the existence of a medically needy program for families would satisfy the section 1931 requirement.

[23] States were permitted to expand Medicaid eligibility by (1) using less restrictive methodologies for calculating family income and resources than used on July 16, 1996, or (2) increasing their AFDC July 16, 1996, income and resource standards by as much as the year's consumer price index. States could restrict eligibility by lowering their AFDC July 16, 1996 income standards (not below May 1, 1988 levels).

[24] States could not impose additional restrictions on Medicaid eligibility without jeopardizing access to SCHIP funds. In particular, BBA stipulated that states participating in the SCHIP could not use more restrictive income or resource standards than the standards used for Medicaid on June 1, 1997.

only applying for Medicaid—or use more liberal income and resource standards for people enrolled than for new applicants.[25] States such as California, Connecticut, Delaware and Vermont expanded Medicaid eligibility for adults in low-income families by disregarding more than the standard amounts for resources.[26] California and Connecticut allow families to have more than the former AFDC-standard amount of $1,000 in liquid assets, while both Delaware and Vermont have eliminated asset tests for families only applying for Medicaid coverage.

Protections and Mandated Program Expansions for Children

In addition to mandatory protections for low-income families imposed by welfare reform, lesser declines in Medicaid enrollment for children can also be attributed to program expansions for children mandated by the Medicaid statute. As table 3 shows, as of September 30, 1997, 11 of the 21 states we contacted provided Medicaid coverage to children older than 14 years of age, with family incomes at or above the federal poverty level. Such coverage will soon become a legal requirement for all low-income children up to age 19.[27]

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[25] Prior to welfare reform, when cash assistance and Medicaid eligibility were still linked, states disregarded additional amounts of earned income as incentives to encourage cash assistance recipients to work.

[26] Under the former AFDC program, cash recipients were limited to $1,000 in total resources (assets). However, in calculating family assets, states were required to disregard (not include in the calculation) certain assets such as a personal residence and its contents, burial plots, educational grants and scholarships, and to discount the value of other assets. For example, in calculating total resources states were required to discount vehicle equity by $1,500 and pre-paid funeral or burial arrangements by $1,500 per person.

[27] Per the Omnibus Budget Reconciliation Act of 1989, OBRA '89 (P.L. 101-239), States must annually phase-in Medicaid eligibility to children born after September 30, 1983, until all children up to age 19 in families with incomes below 100 percent of the federal poverty level are covered. By October 1, 1999, all children up to age 16 will be covered.

Table 3: State Medicaid Coverage of Pregnant Women, Infants and Children, GAO State Sample, as of September 30, 1997

State	Percent poverty level			Upper Age Limit
	Pregnant Women and Infants	Below Age 6	Ages 6 and Older	
Minimum mandatory coverage	133[a]	133	100	14
California	200	133	100	14
Colorado	133	133	100	14
Connecticut	185	185	185	16
Delaware	185	133	100	18
Florida	185	133	100	14
Georgia	185	133	100	19
Idaho	133	133	100	14
Indiana	150	133	100	18
Kansas	150	133	100	17
Kentucky	185	133	100	14
Maryland	185	185	185	14
Michigan	185	150	150	16
Nevada	133	133	100	14
North Dakota	133	133	100	18
Ohio	133	133	100	14
Oklahoma	150	133	100	14
Oregon	133	133	100	19
South Carolina	185	150	150	18
Utah	133	133	100	18
Vermont [b]	200/225	225	225	17
Wisconsin	185	185	100	14

[a] The minimum mandatory requirement for pregnant women and infants may be higher than 133 for states that—as of 12/19/89—had opted to set eligibility for this category between 133 percent and 185 percent of the federal poverty level.

[b] Vermont provides Medicaid coverage for pregnant women with family incomes up to 200 percent of the federal poverty level and coverage for infants up to 225 percent of poverty.

Source: National Governors' Association

Since 1990, children have been able to qualify for Medicaid when living in families with substantially higher incomes than cash assistance recipients. States' cash assistance programs typically limited eligibility to families with incomes well below the federal poverty level—ranging from a high of about 81 percent of the federal poverty level in Connecticut to low of 15 percent in Alabama. In 1997, 5 of the states in our study—Connecticut, Maryland, Michigan, South Carolina, and Vermont—covered children between ages 6 and 14 in families with incomes of 150 percent or more of the federal poverty level. Four of these five states—Connecticut, Michigan, South Carolina and Vermont—also covered older children at 150 percent or more of poverty. The remaining states are still phasing-in coverage for older children, or are using SCHIP funds to accelerate coverage.[28]

Transitional Medicaid Assistance Is Designed to Protect Families Moving From Welfare to Work

In addition to the protections in the welfare law and state efforts to expand coverage, transitional Medicaid assistance is another avenue that should prevent the immediate loss of Medicaid coverage for families who transition from welfare-to-work. Section 1925 of the Social Security Act requires that states provide transitional Medicaid coverage to families losing Medicaid eligibility due to employment or other financial circumstances.[29] Under this provision, states are specifically required to provide two sequential 6-month periods of transitional Medicaid for families when certain conditions are met.[30] Nationwide, the extent to

[28] Florida and Wisconsin are using SCHIP funds to extend coverage to older children.
[29] Other circumstances include increased hours of work or changes in income disregards, which states can choose to disallow after 4 months of employment. Families who lost Medicaid eligibility based on the former AFDC standards due to increased child or spousal support are entitled to 4 months of transitional coverage.
[30] For instance, in order to qualify for transitional Medicaid, a family must have received Medicaid under the former AFDC standards in 3 of the previous 6 months before becoming ineligible due to increased income for this category. The initial 6-month period of

which eligible families receive and keep coverage under transitional Medicaid is unknown. HCFA does not require state reporting and does not monitor state compliance with providing this program benefit, nor do states separately identify families receiving transitional Medicaid in reporting enrollment data to HCFA.

HCFA proposed regulations on transitional Medicaid on December 14, 1993, but did not finalize them due to staff constraints.[31] The proposed regulations essentially reiterated the statute but did not provide states with additional structure or guidance regarding implementation or ways to consistently monitor that beneficiaries receive and retain coverage under this benefit. On March 22, 1999, however, the agency sent guidance to TANF Administrators and state Medicaid and SCHIP directors on expanding health coverage to families making the transition from cash assistance to work. While the March 1999 guide provides that states must not deny or terminate Medicaid eligibility unless all possible avenues to such eligibility have been exhausted, HCFA does not address transitional Medicaid in any detail.

CHANGES IN STATE WELFARE POLICIES AND PRACTICES HAVE MIXED INFLUENCES ON MEDICAID ENROLLMENT

Changes in state welfare policies and practices have had both positive and negative influences on Medicaid enrollment. We identified four aspects of states' welfare reform programs that may influence Medicaid enrollment: (1) diversionary programs, which are intended to help families avoid the need to enroll in TANF; (2)

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transitional Medicaid does not impose an income limit on eligibility. During the second 6-month period, however, a family's gross monthly earnings, less childcare expenses, cannot exceed 185 percent of the federal poverty level.

[31] 58 Fed. Reg. 65,312. Currently, HCFA officials are working on an updated version of the proposal—linking transitional Medicaid to enrollment in the new section 1931 Medicaid eligibility category instead of receipt of AFDC. The states did not strongly oppose the proposed regulation and HCFA only received 6 comments on it.

eligibility policies and procedures, which states use to determine who is qualified for coverage; (3) transitional Medicaid assistance, which assists families moving from welfare-to-work; and (4) educational and outreach efforts, which are aimed at minimizing confusion about Medicaid eligibility following welfare reform. These program approaches vary by state, and can affect Medicaid enrollment levels. Finally, our contacts with states showed that SCHIP outreach efforts have had a positive impact on Medicaid enrollment, particularly for children.

States' Welfare Diversion Policies Can Influence Medicaid Enrollment

States are increasingly implementing policies and programs—such as mandatory, up-front job searches and offers of a one time lump-sum payment—that are designed to divert families from enrolling in welfare. As table 4 shows, 18 of the 21 states in our sample either require that applicants spend some period of time searching for employment or offer welfare-eligible applicants one-time payments in lieu of ongoing cash assistance. Although state officials told us that their diversion policies do not apply to Medicaid applicants, the imposition of these TANF requirements may confuse applicants about eligibility requirements or dissuade them from completing a separate Medicaid application. In the states we contacted, up-front job searches may be more of an issue than lump-sum payments, which were available at the beneficiaries' discretion.

Table 4: Comparison of 21 States' Welfare Diversion Policies, as of April 1999

State	Up-Front Job Search	Lump-Sum Payment
California [a]		X
Colorado [a]		X
Connecticut		X
Delaware [b]		X
Florida		X

Georgia	X	
Idaho	X	X
Indiana [b]	X	X
Kansas	X	
Kentucky	X	X
Maryland [a]	X	X
Michigan		
Nevada [b]	X	X
North Dakota		
Ohio [a]	X	X
Oklahoma	X	
Oregon	X	
South Carolina	X	
Utah		X
Vermont [c]		
Wisconsin [d]	X	
Total	12	12

[a] Lump-sum payments and job search requirements may differ by county in these states.
[b] State has not yet implemented its program.
[c] Vermont requires two-parent families to participate in employment training as a condition for cash assistance.
[d] Although Wisconsin has a job access loan program for its cash assistance clients, we did not consider it a diversion strategy; unlike lump-sum payments offered in other states, clients must repay job access loans in cash or in-kind.

Mandatory up-front job search policies

To encourage work over welfare, 12 of the states in our sample have established mandatory, up-front job search requirements that families must satisfy to be eligible for cash assistance. States' requirements varied greatly, from joining a job registry—as in Kentucky, Utah and Wisconsin—to spending time (ranging from 2 weeks in Maryland to 45 days in Oregon) pursuing various state-provided job leads.

In states that have combined welfare and Medicaid applications—such as Maryland, Oklahoma, Oregon and South Carolina—mandatory job search policies

can delay determination of Medicaid eligibility until job search requirements are satisfied. For example, South Carolina officials told us that they hold combined applications until the job search requirements—10 verified employer contacts—are satisfied. After 30 days, if a job search is not completed, the welfare portion of the application is denied while the Medicaid portion is forwarded to a separate unit for an eligibility determination. Approved Medicaid applications are retroactive to the initial date of application. Maryland officials similarly explained that they have a 14-day hold on cash assistance applications and after that period, the state will determine family eligibility for cash assistance and Medicaid.[32] Officials in the other two states did not indicate that the Medicaid portions of the combined applications are held pending a job search; however, we did not independently verify this.

Lump-sum payments

Officials in nine states reported offering welfare applicants one-time, lump-sum diversion assistance and officials in three other states indicated that they will soon implement such a program statewide.[33] Of the nine states with operational programs, Utah's and Maryland's programs appear somewhat more active than those in the other seven states where relatively few families have accepted lump-sum payments. According to Utah officials, between 190 to 200 families applying for cash assistance each month—less than 1 percent of the state's 1997 average monthly welfare enrollment—accept lump-sum diversion payments in lieu of

[32] States are required to determine applicant eligibility for Medicaid coverage within 45 days from the date of application (90 days when a disability determination is involved).
[33] For example, Delaware plans to implement its lump-sum payment program in October 1999. Indiana is piloting both a lump sum payment program and up-front job search requirements in several of its counties. Indiana officials indicated that if the pilots were successful, they would be implemented in additional counties during the year. Nevada officials said that their legislature approved a lump-sum payment program and state

ongoing assistance. Utah began offering diversion assistance statewide in July 1996 under a welfare waiver that was approved before the federal reform law was enacted. State officials explained that families accepting diversion payments must be eligible for ongoing cash assistance; furthermore, they are also enrolled in Medicaid and offered childcare and job placement assistance. Families can receive the lump-sum equivalent of 3 months of cash assistance, $1,353 for a family of three, and 3 months of Medicaid coverage. Utah allocates its diversion payments over a 3-month period so that the payment does not make them automatically ineligible for Medicaid.[34] At the end of the 3-month period, eligibility workers determine whether the families are eligible for any additional months of Medicaid coverage.

Maryland welfare officials said that about 1,600 welfare avoidance grants—for items such as car repair and dental services—have been awarded statewide over the first 2 years of welfare reform. In Maryland, as is the case in California, Colorado and Ohio, counties have broad authority to implement state programs based on their own priorities. Thus, welfare avoidance grants are optional benefits that caseworkers may offer welfare-eligible families. Baltimore city welfare officials, who manage over 50 percent of the state's welfare caseload, have defined welfare avoidance grants as one-time payments, the equivalent of up to 3 months of cash assistance (ranging between $1,050 to $1,197 for three-member household) that caseworkers may offer welfare-eligible families so that the head of a household can continue working or accept a bona fide job offer. Baltimore city officials said, because very few of their cash assistance applicants have jobs or genuine job offers, very few have met the local criteria for caseworkers to offer these welfare avoidance grants. In fact, few welfare avoidance grants have been given to families in large

officials are considering the software and eligibility system changes needed before implementing the program.

[34] Under the former AFDC program, families were limited to $1,000 in liquid assets.

urban areas in Maryland. One point of difference between Baltimore city and other counties in Maryland is with regard to car repairs. Baltimore city officials do not consider car repairs as valid reasons for offering avoidance grants because the area has a public transportation system, while other areas in the state include car repair as an acceptable need.

Officials in the remaining seven states attributed low participation in their voluntary diversion programs to both the small amounts of money that families are offered and to other benefits they might forego in accepting the lump-sum payment. For example, only 12 families in Florida have accepted lump-sum payments since the state implemented the program in November 1997. Florida officials hypothesized the reason more families have not found the program an acceptable alternative to cash assistance is because the payment is small in comparison to the benefits they could receive as cash assistance recipients. A family of three, for instance, is limited to a single payment of $606—the equivalent of 2 months of cash assistance. To receive that payment, the family must prove eligibility by completing the standard welfare application and possibly forego food stamps and Medicaid coverage if the payment raises family resources above the state's $2,000 cash limit; the family must also agree not to apply for more cash assistance for 3 months.

States' Eligibility Redetermination Processes Have Added Complexities for Workers

States must annually redetermine whether individuals remain eligible for Medicaid. As part of the redetermination process, eligibility workers verify that family incomes are within state standards and that families still meet any additional criteria, such as family composition and resource limits applicable for their particular Medicaid eligibility category. Welfare reform and state welfare-to-work strategies have introduced added complexities to the Medicaid

redetermination process that appear to have affected workers and, as a result, have a potential impact on beneficiaries. For example, families who do not satisfy state redetermination requirements are terminated from the Medicaid program. We found that 10 of the 21 states in our sample still require that heads of household meet in-person with eligibility workers for eligibility redeterminations—a practice that can be problematic for working families.

State and local welfare officials reported three reasons why welfare reform has made the redetermination process more burdensome for eligibility workers. First, eligibility workloads per worker have increased in three of the four states we visited—California, Florida, and Maryland—since welfare reform.[35] Second, in those states where TANF and Medicaid redeterminations are still linked, workers often reported added complexities such as monitoring beneficiary compliance with state job-search, work and vocational training requirements. Third, because families can now apply for Medicaid separately from cash assistance, workers need to become more familiar with Medicaid eligibility rules as many states' eligibility systems are not fully automated. Officials in California, Colorado, Florida, Maryland and Ohio told us that they are seeing an increase in the number of Medicaid-only cases relative to the number of cash assistance cases.

Advocates we spoke to in Florida, Maryland, and California indicated that the added pressures on eligibility workers can strain worker-beneficiary relations and, in some cases, make communications between the parties so difficult that eligible families do not get the information they need to apply for or retain Medicaid

[35] Although Medicaid enrollment had declined in these states, it does not appear that the declines occurred in major urban areas that we visited. For example, workers in Los Angeles County attributed their increased per-worker caseload to the increasing number of mixed status households, stating that a single family may have as many as four separate cases representing different categories of Medicaid eligibility, such as those based on citizenship status, income, and medical need. Florida workers attributed their increased caseloads to staff reductions and turnover.

coverage. The growing number of Medicaid-only cases concerns eligibility workers who previously handled very few of these cases and consider Medicaid as too complex given the many eligibility categories with differing income, resource, and family composition criteria. The addition of the section 1931 eligibility category adds to this. Officials in the 21 states we contacted reported having almost 30 to over100 different Medicaid eligibility categories for non-disabled, non-elderly adults and children. According to state officials and workers, the proliferation of eligibility categories is challenging for workers in most states and is particularly troublesome for workers in states with computer systems that have not kept up with welfare policy changes. For example, we were told that workers in Florida must manually determine Medicaid eligibility or understand the policies well enough to verify the accuracy of the state's computerized eligibility determinations. California officials told us that workers must manually determine Medicaid eligibility for the section 1931 eligibility category. Most of the state's programming expertise has been devoted to assuring that more vital state systems are 'Year 2000' compliant.

Wide Variation in Beneficiary Access to Transitional Medicaid Exists Across States

Although the Medicaid statute entitles families moving from welfare-to-work to as much as 12 months of transitional Medicaid coverage, the extent to which families receive the benefit and the length of coverage varies considerably by state. Among the states with data that we contacted, transitional Medicaid participation rates ranged from about 4 percent of the families losing cash assistance in Idaho to 94 percent of such cases in Connecticut. Within our 21-state sample, 6 states—California, Connecticut, Delaware, South Carolina, Vermont and Utah—have pre-welfare reform waivers to provide 24 months or more of coverage.[36] Officials from

[36] California has a waiver to provide 12 months of transitional Medicaid to people losing eligibility due to marriage or reunification of spouses. Additionally California provides 12

some states identified several barriers to beneficiaries fully using transitional Medicaid benefits, such as periodic income-reporting requirements for beneficiaries and a lack of program knowledge among eligibility workers. Several states have found ways to overcome these barriers and make enhanced use of the benefits afforded by transitional Medicaid for individuals moving from welfare-to-work. Moreover, HCFA has recommended via a legislative proposal that beneficiary income reporting requirements be eliminated from transitional Medicaid.

Receipt of Transitional Medicaid Varies By State

Receipt of transitional Medicaid varied considerably among the states we contacted, and we were unable to obtain consistent data on program participation for all 21 states in our sample.[37] Furthermore, among the 16 states that could provide us information on transitional Medicaid, there was little consistency in tracking and interpreting data on program participation. For example, an Idaho survey of 14,772 cash assistance cases closed during state fiscal year 1998 showed that 636 families (4 percent) received transitional Medicaid. Idaho officials said they were not alarmed by this low participation rate because in their estimation most of the families losing cash assistance were still enrolled in Medicaid either under the new section 1931 eligibility category for low-income families or as children in the state's Medicaid expansion program.[38] A Connecticut survey of the 2,190 families leaving cash assistance and scheduled for exit interviews in January 1998, showed that 2,050 families (94 percent) received transitional Medicaid. Maryland officials were not able to determine comparable transitional Medicaid participation rates for

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months of state-funded coverage to adults 19 years or older who have exhausted the 12 months of federal/state-funded coverage.

[37] Lack of data has been a consistent problem in understanding the availability and use of transitional Medicaid. See Welfare to Work: Implementation and Evaluation of Transitional Benefits Need HHS Action, (GAO/HRD-92-118, September 29, 1992).

[38] As shown in table 1, between 1995 and 1997, Idaho's Medicaid enrollment decline was 10.8 percent compared to 49.0 percent for welfare.

families but noted that in federal fiscal year 1998, 7,206 individuals received transitional Medicaid and 7,227 were enrolled in 1997.[39]

Although officials in Delaware and Vermont did not provide specific information on transitional Medicaid participation rates, they surmised that most families losing cash assistance in their states receive the additional months of coverage. Both states received waivers to provide more than 12 months of transitional Medicaid even prior to federal welfare reform. Delaware provides 24 months of transitional Medicaid coverage, and the state's eligibility determination system showed that 80 percent of the families enrolled in transitional Medicaid kept coverage for the full 24-month period. Vermont officials similarly believe that participation in their state's 36-month transitional Medicaid program was high. In addition to an almost 3-percent increase in adult and child Medicaid enrollment between 1995 and 1997, Vermont officials estimate that about 18 percent of the state's population received some form of publicly subsidized health insurance coverage.

Income Reporting Requirements Can Limit Transitional Medicaid Participation

HCFA and state officials noted that quarterly beneficiary income reporting requirements can pose barriers to family receipt of transitional Medicaid benefits. Transitional Medicaid begins when families lose cash assistance—and therefore Medicaid eligibility based upon receipt of such assistance—due to increased earnings. Reporting requirements can pose barriers for families leaving cash assistance at two points: (1) entering transitional Medicaid and (2) maintaining this entitlement for the full period of eligibility. In the first case, the failure to notify eligibility workers of employment can prevent families from being enrolled in transitional Medicaid. Theoretically, a head of household would report increased

[39] According to data from the Administration for Children and Families, 61,096 individuals

earnings, be removed from cash assistance, and placed on transitional Medicaid. However, many heads of households do not notify their eligibility workers that they have obtained employment and thus, once disqualified from cash assistance, they are not rolled over into transitional Medicaid eligibility. Thus, the eligible family never receives transitional Medicaid.

In the second case, families participating in transitional Medicaid can have their benefits terminated if they fail to meet statutory reporting requirements established under section 1925 of the Social Security Act. Although the Medicaid statute entitles families to 12 months of transitional Medicaid assistance—in two 6-month segments—each 6-month period of coverage has its own eligibility criteria and income reporting requirements. In all but 3 of the 21 states we contacted beneficiaries must comply with the following statutory requirements to obtain and receive a full year of transitional Medicaid coverage.[40]

- To receive the first 6 months of transitional Medicaid, families must notify the state—typically through the family's eligibility worker—of their employment status. Although there is no income eligibility limit during this period, families must also submit quarterly income reports to the state by the 21st day of the 4th month of transitional Medicaid coverage.

- To receive the second 6 months of transitional Medicaid coverage, family income less childcare expenses may not exceed 185 percent of the federal poverty level. Families must submit quarterly income reports by the 21st day of the 1st and 4th

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lost cash assistance in Maryland between January 1997 and September 1998.

[40] Prior to welfare reform, Connecticut, Delaware and Oregon obtained welfare and Medicaid waivers to eliminate the requirement for quarterly income reporting—thus assuring an uninterrupted period of transitional Medicaid coverage. The BBA also permits states, as part of their HCFA approved state Medicaid or SCHIP plan, to guarantee 12 months of continuous Medicaid/SCHIP eligibility for low-income children, without

months of the second 6-month period. During this period, families may also be required to pay premiums and the state can reduce the level of Medicaid benefits and services to which they are entitled.

In both instances, failure to report beneficiary income status can result in the termination of transitional Medicaid benefits, unless the family can show good cause for their failure to report on a timely basis.

Our review of states shows that beneficiary income reporting requirements can affect whether families receive transitional Medicaid coverage for the full period for which they may be entitled. Some state officials said that although eligibility workers explain the availability and conditions for receiving transitional Medicaid and provide new beneficiaries with program information, few families comply with the reporting requirements and do not respond to termination notices alerting them to loss of coverage. For example, Colorado, Florida and Oklahoma officials told us that families typically receive only 6 months of transitional Medicaid, generally because of families' failure to submit the required quarterly income reports.

A study of closed cash assistance cases in Maryland between October 1996 and September 1997, showed that 19 percent of the cases were closed due to increased income, making them eligible for transitional Medicaid. Over 50 percent of the closed cases were coded by eligibility workers as administrative closures, such as failing to submit required reports or not completing the redetermination process. Wisconsin advocates similarly became concerned that the state's automated eligibility determination system was not appropriately shifting closed cash cases into transitional Medicaid following increased complaints from beneficiaries that their cases had been improperly terminated. In previous work, we noted that 14 states did not have policies for informing families about transitional Medicaid at

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additional family income reporting requirements.

either application for or redetermination of cash assistance.[41] Advocates also noted that state cash assistance termination notices can be difficult to understand and beneficiaries may fail to see how such notices affect their Medicaid eligibility.

Our contacts with the 21 states indicated that while many states expect eligibility workers to provide beneficiaries with information on transitional Medicaid, only six states—California, Georgia, Florida, Indiana, Maryland and South Carolina—reported having developed specific materials in easy to read language for workers and beneficiaries. Four of these six states—Georgia, Florida, Maryland and South Carolina—use consistent materials developed by the Southern Institute on Children and Families, while the other two developed worker training or educational materials in response to concerns raised by their legislatures and beneficiary advocates.[42]

Several States Have Strategies And Incentives To Increase Use of Transitional Medicaid

Several states have initiatives in place to facilitate beneficiaries' eligibility for transitional Medicaid. As found in an earlier report, difficult trade-offs exist between the need for program integrity and ease of enrollment for beneficiaries.[43] In this regard, states—and HCFA in its oversight capacity—must balance efforts to simplify and streamline eligibility processes against efforts to ensure that benefits go only to qualified individuals.

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[41] See Welfare to Work: Implementation and Evaluation of Transitional Benefits Need HHS Action, (GAO/HRD-92-118, September 29, 1992).

[42] The Southern Institute on Children and Families is an independent nonprofit public policy organization founded in 1990. The Southern Institute endeavors to improve opportunities for disadvantaged children and families in the South.

[43] See Medicaid: Demographics of Nonenrolled Chidlren Suggest State Outreach Strategies, (GAO/HEHS-98-93, March 20,1998).

Transitional Medicaid, which occurs for a limited period of time after an individual moves from welfare-to-work, has been the focus of some states' strategies to increase family receipt of Medicaid. Connecticut, which has an approved waiver from HCFA to provide 24 months of transitional Medicaid, also has waiver authority to eliminate quarterly income reporting.[44] The state cross-matches closed cash cases with state labor department records and, if records reveal family earnings within 6 months of case closures, Connecticut initiates transitional Medicaid coverage. Kansas revised its computer systems so that eligible families leaving cash assistance or Medicaid are automatically transferred into an alternative health program, such as transitional Medicaid, one of the expansion categories for children, or into HealthWave—the state's SCHIP program. In addition, Kansas workers randomly contact families leaving cash assistance to determine their health insurance status and to verify that they obtained the additional months of Medicaid coverage they were eligible to receive. As a result, they estimate that about 70 percent of the families leaving cash or Medicaid receive transitional coverage.

Indiana and Michigan officials also informed us that they have taken steps to improve participation in transitional Medicaid. Indiana instituted a statewide training campaign for eligibility workers to explain the importance of entering earnings information in the state's eligibility system. As of November 1998, Indiana officials reported that 13,126 families were receiving transitional Medicaid, which was an increase of 117 percent from family participation since May 1998. Michigan officials also reported a significant improvement. Since October 1992 when the state began its present welfare reform initiative, program participation in transitional Medicaid has increased more than four-fold—from 28,301 to 125,493

[44]Oregon also provides the required 12 months of transitional Medicaid coverage, and obtained a waiver prior to welfare reform to eliminate quarterly income reporting for transitional Medicaid beneficiaries.

individuals in November 1998. Because the state uses a prospective budgeting system (projecting expenditures for purposes of developing a budget) for determining cash assistance benefits and Medicaid eligibility, eligibility workers will trigger transitional coverage for families whose earnings are likely to make them ineligible for this category of Medicaid in the upcoming quarter.

Officials in South Carolina, Utah and North Dakota encourage increased participation in transitional Medicaid by contacting families with closed cash assistance cases to determine whether they obtained the additional months of Medicaid coverage they may be entitled to receive. Both South Carolina and Utah have pre-welfare reform waivers to provide 24 months of transitional Medicaid. South Carolina officials told us that they have used county-level goal setting and surveys of closed cash cases to increase enrollment in their state's transitional Medicaid program. The results of a February 1999 survey showed that the percent of families receiving transitional Medicaid had increased from about 75 percent between October to December 1996, to about 77 percent between October to December 1997. As a quality-control measure, Utah officials use system-generated monthly lists of closed Medicaid cases to contact families and verify whether they received their 24 months of coverage. North Dakota eligibility workers prefer that families leaving cash assistance receive transitional Medicaid because, if those families were to leave Medicaid and reapply, they would likely be in an eligibility category that would require more burdensome monthly income reporting and monitoring.

HCFA Initiative Seeks to Eliminate Beneficiary Income Reporting Requirements for Transitional Medicaid

In view of concerns that beneficiary reporting requirements are limiting the use of the transitional Medicaid benefit, HCFA has proposed legislation aimed at simplifying transitional Medicaid. In particular, this proposal eliminates recipient

reporting requirements for transitional Medicaid benefits for the full period of eligibility (up to 1 year). Essentially, the failure to report income on a quarterly basis would no longer result in a beneficiary's removal from Medicaid enrollment. To date, no action has been taken on this proposal, which has been submitted as a part of the President's fiscal year 2000 budget.

Some States Initiated Outreach and Beneficiary Education Campaigns to Lessen Confusion Over Welfare Reform

Six states we contacted—California, Florida, Georgia, South Carolina, Utah and Wisconsin—have initiated or adapted their Medicaid outreach and educational programs to specifically address any confusion among beneficiaries following welfare reform. Aside from eligibility-related issues involving non-citizens, confusion about Medicaid counting against the 5-year limit for welfare benefits and the impact of TANF sanctions on Medicaid, beneficiary advocates were concerned that welfare reform would deter eligible low-income families from seeking coverage. To address these issues, the welfare reform law set-aside $500 million in Medicaid funds that states could use for a variety of Medicaid-related administrative costs following welfare reform and offered an enhanced Medicaid matching rate for outreach and beneficiary education activities. However, as of December 31, 1998—the most recent data available—HCFA documents show that the states had only claimed $25.4 million from the fund; the 21 states we contacted accounted for $7.4 million of the expenditures.[45]

Individually, some states have initiated efforts to counter any confusion that may have resulted from welfare reform. For instance, South Carolina contracted with the Southern Institute for Children and Families to produce educational and

[45] According to HCFA officials, the agency does not track the state's specific uses of the set-aside funds because a variety of administrative and outreach purposes are permissible.

outreach materials for distribution to beneficiaries and employers on post-welfare-reform benefits, such as Medicaid, that low-income working families might be eligible to receive. This effort was the result of an outreach project among several of the state's larger counties. In addition, each quarter South Carolina randomly surveys 500 families after their welfare cases are closed, to determine if they have health insurance or are Medicaid eligible. State officials use the survey results to provide feedback to the counties and monitor their compliance with state performance goals. South Carolina officials believe that these performance goals give county officials an added incentive to follow-up with families and ensure that eligible families do not lose Medicaid coverage.

States with large immigrant populations, such as California and Florida, face additional challenges for education and outreach efforts. State and local officials in California told us that citizenship and residency concerns within the state's immigrant communities have had a significant chilling effect on new applications. For example, in February 1998, Los Angeles County initiated a project to enroll 100,000 of the area's estimated 300,000 uninsured low-income children in Medicaid by September 1999. By December 1998, only 35,000 to 40,000 additional children had been enrolled, despite expanded community-based outreach. Both beneficiary advocates and county officials attributed the low enrollment to the immigrant communities' concerns that receipt of Medicaid, even for citizen-children, might jeopardize pending applications for citizenship or change in residence status. Florida officials noted a similar effect in their state, where immigrant families decline to apply for Medicaid due to concerns about jeopardizing their immigration status. Florida officials have been working with numerous community-based organizations and housing projects to counteract the misunderstanding or mistrust that remains within immigrant communities.

In light of the fears and confusion among immigrants regarding this issue, the Administration has recently published a proposed rule to clarify the circumstances in which individuals can accept certain public benefits without fear of negative immigration consequences.[46] The proposed rule specifies a list of benefits, prepared by HHS, the Immigration and Naturalization Service (INS) and the State Department, that immigrants can receive without affecting their admission to the United States or their resident status. Under current law, before admitting someone as a legal permanent resident, the INS or State Department must conclude that the individual is not likely to become a "public charge," – that is, a person who largely relies on the government for subsistence. Among the benefits specified in the proposed rule, Medicaid and SCHIP would be exempt from the "public charge" test for immigrant admission, adjustment or deportation.[47]

Some states have put a significant amount of effort into developing enrollment outreach programs, and increasing the number of locations to facilitate enrollment and inform beneficiaries and providers that Medicaid eligibility is no longer tied to cash assistance. For instance:

- Georgia used its nearly 150 "Right From the Start" Medicaid outreach eligibility workers to enroll Medicaid-eligible children and to act as intermediaries for families who are only seeking Medicaid coverage and do not wish to go to a local welfare office to apply.

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[46] 64 Fed. Reg. 28,675 (May 26, 1999).

[47] While Medicaid will not be considered in public charge determinations, the proposed rule specifies an exception to this. Medicaid or a similar state program will be considered in limited circumstances when it is needed to pay for long-term care, in the form of nursing home or institutionalized care for the individual. The proposed rule provides, however, that the need for long-term care alone does not automatically result in a public charge determination. INS and State Department officials must consider other factors required by

- Utah was able to reach beyond the traditional "outstation" locations by placing additional workers in schools, Indian reservations and larger medical clinics.[48] The state also allowed families to apply for Medicaid by telephone and the mail. Additionally, the Utah's Department of Workforce Services, which oversees the TANF program, also accepts Medicaid applications by telephone.

- In Wisconsin, the welfare and Medicaid programs are separately administered. Therefore, officials were particularly concerned about the confusion this could cause beneficiaries and providers. In an effort to avoid such confusion, Wisconsin has increased the number of outstationed locations in Milwaukee—one of the state's larger urban areas—and contracted with advocates to assist beneficiaries in navigating the new system.

SCHIP Outreach and Related Simplifications May Increase Future Medicaid Enrollment

While officials in most of the 21 states we contacted reported that outreach for SCHIP has had a positive spillover effect on Medicaid enrollment among children, 6 specifically suggested that such efforts may have directly contributed to enrollment increases or stabilization in their Medicaid programs. Although firm data are not yet available, officials in our state sample estimate that perhaps as many as an additional 125,000 children have recently been enrolled in Medicaid due to SCHIP outreach and the requirement that states screen all SCHIP applicants for Medicaid eligibility and enroll those who qualify. For instance, Massachusetts and Michigan officials reported that they enrolled two children in Medicaid for each SCHIP

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law (such as age, health, family status, assets, etc.), and determinations are made on a case-by-case basis.

[48]Section 4602 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) added the requirement that states "outstation" eligibility workers at locations other than local welfare offices, allowing mothers and children to apply for Medicaid at the sites where they

enrollee. However, since SCHIP was enacted in 1997 and program implementation was just getting underway in 1998 and 1999 for most states, these spillover enrollment effects are not reflected in our 1997 Medicaid data.

While state officials did not report a similar spillover effect on adult participation, SCHIP has resulted in simplified Medicaid applications and redetermination processes for children that may also facilitate enrollment among adults. For instance, states such as California, Kansas, and Utah have begun to simplify their Medicaid enrollment and application processes in the following ways:

- California shortened its 28-page joint Medicaid/SCHIP application to 4 pages.
- In Kansas, since January 1999, low-income families can submit Medicaid redetermination information by mail and are no longer required to meet in-person with an eligibility worker.
- Utah instituted several innovative procedures even prior to SCHIP, including allowing family application by mail or telephone, and redetermination by mail, telephone, or facsimile.

SCHIP has also sparked states to consider or implement a variety of ways to make their enrollment and application processes less burdensome, including offering applications at alternative locations such as schools, Head Start centers, and community action agencies. Other states have adopted alternative application methods for SCHIP, such as mail-in applications, community-based worker assistance, and one state is considering the feasibility of accepting applications over the Internet.

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receive health care.

CONCLUSIONS

Despite federal protections to ensure that low-income families retain health insurance regardless of their receipt of cash assistance, establishing and keeping Medicaid coverage for eligible low-income families has become more complicated with the advent of welfare reform. States are challenged with identifying and enrolling families that no longer qualify for cash assistance—yet retain Medicaid eligibility. Some states have taken advantage of the flexibility under welfare reform by using protections provided by the law to ensure that Medicaid coverage is sustained for low-income families' transitioning to work. Others have found it more difficult to communicate to both beneficiaries and workers that Medicaid coverage can be maintained even though changes in welfare policies may limit or deny cash assistance. National declines in Medicaid enrollment raise questions as to whether states have been able to "delink" welfare and Medicaid policies in a manner that consistently provides Medicaid coverage to eligible individuals.

Transitional Medicaid is a protection offered to families at a critical juncture in their efforts to move from welfare-to-work. Employment into low wage positions frequently does not provide adequate access to affordable health insurance, making Medicaid coverage an important benefit. However, there are indications that procedural difficulties with income reporting, coupled with a lack of national data and the apparent disparate use of this benefit by the states, are limiting the extent to which beneficiaries are receiving and maintaining eligibility for transitional Medicaid. Prior to the advent of welfare reform, states were able to obtain authority from HCFA to waive certain beneficiary reporting requirements. Presently, however, states without waivers must comply with section 1925 of the Social Security Act, which requires beneficiary income reporting even though such reports do not affect eligibility for the first 6 months of transitional Medicaid. As a

result, families can be terminated from transitional Medicaid, despite their income eligibility for this entitlement.

There is precedent for a less burdensome approach, by which states could be allowed to adopt or eliminate beneficiary income reporting requirements. For example, the BBA allowed states to guarantee a longer period of coverage for children, regardless of changes in a family's financial status or size. Similarly, the Congress could—as proposed by HCFA—eliminate beneficiary income reporting, provided that sufficient safeguards remain in place to assure that only those qualified receive the benefits.

Information on the extent to which transitional Medicaid is implemented across the states is scarce. In this regard, HCFA has the responsibility to oversee the states' implementation of this entitlement, and is in the position to serve as a conduit of technical assistance and dissemination of states' best practices in implementing transitional Medicaid. Doing so can serve to heighten understanding of systemic barriers and provide states with strategies to foster and maintain transitional Medicaid coverage for eligible families.

MATTER FOR CONGRESSIONAL CONSIDERATION

To further facilitate families' making the transition from welfare-to work and to prevent income eligible families from being terminated from Medicaid for procedural reasons, the Congress may wish to consider revising section 1925 of the Social Security Act. Specifically, the Congress may wish to allow states to lessen or eliminate periodic income reporting requirements for families receiving transitional Medicaid coverage, provided that states offer adequate assurances that the benefits are reserved to those eligible. Actions in this regard may facilitate uninterrupted health insurance coverage for families' transitioning from cash assistance to the workforce.

RECOMMENDATION TO ADMINISTRATOR

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 and
- 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 for eligible beneficiaries.

AGENCY AND OTHER COMMENTS

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies to The Honorable Donna Shalala, Secretary of HHS; Nancy-Ann Min DeParle, HCFA Administrator; Olivia Golden, Administrator, Administration for Children and Families; the directors of the programs in our 21 states; and, interested congressional committees. Copies of this report will also be made available to others upon request.

Sincerely yours,

Richard L. Hembra
Assistant Comptroller General,
Health, Education and Human Services Division

CONTENTS

Abbreviations

ACF	Administration for Children and Families
AFDC	Aid to Families With Dependent Children
BBA	Balanced Budget Act of 1997
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
INS	Immigration and Naturalization Service
OBRA	Omnibus Budget Reconciliation Act
SCHIP	State Children's Health Insurance Program
TANF	Temporary Assistance for Needy Families

SCOPE AND METHODOLOGY

To analyze Medicaid enrollment for families and children following welfare reform, we examined state-level data from two sources: (1) state-provided monthly enrollment data and (2) HCFA's federal fiscal year data on the states' annual enrollment.[49] We chose 1995 and 1997 for our analysis because 1995 provided a baseline for enrollment before the 1996 enactment of welfare reform. Additionally, 1997 was the most current year for which HCFA enrollment data was available when we initiated our work. We limited our analysis to non-elderly, non-disabled adult and child enrollment because this segment of the Medicaid population was the most likely to have been enrolled in the states' cash assistance programs that were affected by welfare reform.

To report the change in Medicaid enrollment, between 1995 and 1997, we used state-provided data because average monthly data provided a better indicator of changes in states' Medicaid enrollment than the cumulative, annual count of enrollees that HCFA reports. Moreover, we found significant inconsistencies in the HCFA data for federal fiscal years 1995 and 1997, which are described in greater detail at the end of this appendix. We analyzed average monthly enrollment data for January 1995 through June 1997 that we collected by contacting the 50 states.[50] When states did not provide 12 months of data for each year, we extrapolated the data provided to derive annual averages. Finally, we obtained state-specific welfare participation data from the Administration for Children and Families.

To review the effects of minimum wage employment on Medicaid eligibility, we used

[49] HCFA collects and publishes annual Medicaid enrollment on a state-by-state basis as part of the agency's '2082' reporting format.

[50] We were unable to obtain comparable monthly data for the District of Columbia, Rhode Island and West Virginia.

the U.S. Department of Labor's 1997 minimum wage data and the minimum income disregards required by the former AFDC program, applicable to the first 4 months of employment. This allowed us to determine the extent to which heads of three-member households might work and continue to qualify for Medicaid coverage. Working 52 weeks at 40 hours per week, at the 1997 minimum wage of $4.75 per hour, we estimated that family income would be approximately $823 per month. After deducting the standard disregards required by the former AFDC program and still applicable in determining Medicaid eligibility ($30 plus one-third of $793), family income would be approximately $529. If states also exercised their option to disregard a portion of work- and childcare-related expenses, family income could be even less. According to the most recent data available on the optional disregards, states disregarded an average of $102 per month for work-related expenses and $137 for childcare in 1995. Applying those averages to $529 results in a net income of $290 per month.

With countable family income of $290 per month, in all but 3 of the 21 states included in the GAO sample, heads of three-member households could work full-time at the minimum wage and continue to qualify for Medicaid coverage. Even in these three states—South Carolina, Indiana and Kentucky—families can be considered Medicaid eligible even if their income is above the standard used to determine eligibility for cash assistance. Under the former AFDC program states determined the amount of income families of varying sizes need for a minimal standard of living and set payments standards which represented the maximum AFDC cash assistance payment families were entitled to receive. Nationally, most states' AFDC payments were below the state's need standards.[51]

[51] For example, in South Carolina, a family of three may have monthly 'countable' income up to $667 and remain Medicaid eligible because the state's need standard is $668.

To identify the procedures and protections states used to enroll Medicaid-eligibles, we judgmentally selected 21 states to contact for additional review, over-sampling for states with declines in Medicaid enrollment to focus our analysis on those policies and practices that may have contributed to declines in enrollment. We initially selected 15 states with the largest declines in Medicaid enrollment, based on a preliminary analysis of HCFA data and subsequently expanded the sample by adding states with relatively stable or increased enrollment. The 21 states represented about 46 and 45 percent of Medicaid enrollment in 1995 and 1997, respectively, as well as approximately 39 percent of total program expenditures for fiscal year 1997. In addition to geographic diversity, the states had varying degrees of experiences and approaches to welfare reform. We visited four states and several locales within the states—California (Sacramento, Los Angeles), Florida (Tallahassee, Miami), Maryland (Baltimore, Prince George's County), and Wisconsin (Madison, Milwaukee). We interviewed by telephone, collecting and analyzing documentation on Medicaid eligibility and application processes from officials in the 17 remaining states—Colorado, Connecticut, Delaware, Georgia, Idaho, Indiana, Kansas, Kentucky, Michigan, Nevada, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Utah and Vermont.

Using structured interview protocols in each of the four site-visit states, we interviewed knowledgeable state and local Medicaid and welfare officials, beneficiary advocates, and eligibility workers. From state-level officials we obtained and analyzed information and documentation on state pre-application policies, such as diversion assistance and up-front job search requirements; Medicaid application procedures and locations; eligibility determination policies; transitional Medicaid and former welfare recipients' health insurance status; TANF sanctions that may affect Medicaid coverage; and, state outreach strategies. Our local welfare office interview protocol covered office organization and eligibility worker training, outreach, initial applicant contact, pre-application activities (diversion assistance

and up-front job search requirements), and Medicaid application procedures and eligibility determination policies.

For the other 17 states, we obtained information on state Medicaid eligibility criteria, eligibility determination processes and computer systems, transitional Medicaid, outreach strategies, state pre-application activities (diversion and up-front job search requirements), application procedures, and health insurance status of former welfare recipients.

Also, we obtained and reviewed various reports, studies and/or interviewed officials representing the American Public Human Services Association (formerly known as the American Public Welfare Association), the Center on Budget and Policy Priorities, the Children's Defense Fund, the George Washington University's Center for Health Policy Research, the National Eligibility Workers Association, the National Governors' Association, the National Health Law Program, the Southern Institute on Children and Families, and The Urban Institute.

Limitations of HCFA Enrollment Data

HCFA data attempts to provide an unduplicated annual count of Medicaid enrollees, whereas state monthly enrollment data shows, by month, the number of individuals enrolled in the program. For our analysis of changes in Medicaid enrollment, we relied primarily on the average monthly Medicaid enrollment data that we obtained directly from the states because of significant inconsistencies that we found in HCFA's enrollment data for federal fiscal years 1995 and 1997. State officials explained that although HCFA obtains the data it uses to arrive at the unduplicated annual counts from the states, it might not be as reliable as the monthly enrollment data that states use for their own analysis. For example, HCFA's annual enrollment data for Georgia showed that enrollment had slightly

increased by about 1 percent while the state's monthly enrollment data showed about 5 percent fewer adults and children enrolled in Medicaid in 1997 than in 1995.

Furthermore, we found duplicate counts in some states' HCFA data and inconsistencies in the use of reporting categories. For example, West Virginia officials told us that the fiscal year 1995 data may have double counted adult and child enrollees, thus substantially overstating the extent of Medicaid declines between 1995 and 1997. Similarly, HCFA's data for Oregon showed about an 18 percent increase in adult and child enrollment, due to over-counting the number of infants and children in 1997, while the monthly data reflected a 13-percent decline. The state Medicaid Director agreed that enrollment had declined between 1995 and 1997. Louisiana officials told us that HCFA's 1997 data inappropriately categorized most of the state's adult and child enrollees as aged, indicating a nearly 50 percent decline in adult and child enrollment rather than the 7 percent decline reflected by the state's average monthly enrollment for the same period. HCFA officials acknowledged that comparing the 2 years' data could be problematic because in fiscal year 1997 the agency changed the reporting format and categories.

HCFA officials noted that steps were being taken to improve the overall reliability of the future years' enrollment data. HCFA officials believe that the BBA of 1997 requirement that states use the Medicaid Statistical Information System reporting format to electronically submit all Medicaid claims and enrollment information on or after January 1999, as well as outside contractor assistance in screening state data, will improve categorical consistency among the states.

Appendix II

ANALYSIS OF STATES' MEDICAID ENROLLMENT AND WELFARE PARTICIPATION DATA

Using 1995 and 1997 data to compute states' average annual monthly enrollment, the aggregate national decline for the adult and children portion of Medicaid enrollment was 7.5 percent. The median decline was about 7 percent. States' changes in Medicaid enrollment ranged from a 19-percent decline in Ohio and Wisconsin to an approximate 26-percent increase in Delaware. Medicaid enrollment among non-elderly, non-disabled adults and children declined by 10 percent or more in 12 states, declined between 3 and 10 percent in 20 states, had declines or increases of 3 percent or less in 12 other states, and increased by 5 percent or more in 4 states.

Table II.1: Changes in Adult/Child Medicaid Enrollment Between 1995 and 1997

State	Enrollment Change 1995-97	Average Monthly Enrollment	
		1995	1997
Alabama	-4.2	289,333	277,041
Alaska	0.2	52,197	52,306
Arizona [a]	2.8	322,904	331,908
Arkansas [a]	-0.5	139,175	138,472
California	**-7.6**	**4,189,509**	**3,869,454**
Colorado	**-9.6**	**169,957**	**153,592**
Connecticut	**-1.0**	**224,128**	**221,935**
Delaware	**26.2**	**49,085**	**61,953**
District of Columbia [b]	N/A	N/A	N/A
Florida [c]	**-13.4**	**988,805**	**855,888**
Georgia [a]	**-4.6**	**674,374**	**643,301**
Hawaii [d]	-13.9	153,103	131,834
Idaho [a]	**-10.8**	**55,746**	**49,745**
Illinois	-6.8	1,083,802	1,010,397
Indiana [a]	**-9.0**	**337,791**	**307,429**
Iowa	-5.8	230,139	216,742
Kansas	**-10.5**	**133,295**	**119,265**
Kentucky [a]	**-10.1**	**828,403**	**744,418**
Louisiana [d]	-7.1	499,265	463,999
Maine [d]	-4.2	107,791	103,297
Maryland	**-7.2**	**319,799**	**296,843**
Massachusetts	1.2	409,713	414,639

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Michigan [c]	**-8.9**	**688,646**	**627,561**
Minnesota	-0.8	340,330	337,529
Mississippi	-13.4	254,801	220,536
Missouri [a]	-5.2	436,945	414,276
Montana [a]	-8.6	76,518	69,947
Nebraska	5.1	99,977	105,047
Nevada	-13.1	57,863	50,301
New Hampshire [c]	1.2	60,296	61,034
New Jersey	-4.9	489,753	465,959
New Mexico	13.7	182,543	207,507
New York	-9.4	2,248,274	2,037,802
North Carolina	-1.5	526,780	518,650
North Dakota	**-8.0**	**31,110**	**28,628**
Ohio [b]	**-19.0**	**947,568**	**767,408**
Oklahoma	**-9.3**	**199,383**	**180,838**
Oregon	**-13.0**	**329,786**	**286,779**
Pennsylvania	-17.4	1,253,478	1,035,142
Rhode Island [b]	N/A	N/A	N/A
South Carolina	**2.4**	**231,882**	**237,338**
South Dakota	-0.5	39,264	39,081
Tennessee [a]	-0.3	910,494	907,485
Texas	-8.6	1,592,553	1,455,059
Utah [a]	**-5.0**	**97,733**	**92,881**
Vermont	**2.6**	**61,950**	**63,548**
Virginia	-8.1	362,383	333,092
Washington	13.2	489,427	554,030
West Virginia [b]	N/A	N/A	N/A
Wisconsin	**-19.0**	**316,419**	**256,449**
Wyoming	-14.5	29,694	25,400
Total all States	-7.5	23,614,161	21,843,764
GAO Sample states	-9.3	10,933,232	9,915,553
Percentage National Medicaid adult/child enrollment		46.3	45.4

Notes: States in boldface were part of the GAO sample.

[a] The average monthly enrollment for these states was calculated using less than a full year of monthly data.

[b] We were unable to obtain comparable monthly enrollment data for District of Columbia, Rhode Island and West Virginia.

[c] Data for Florida and Hawaii may reflect only a portion—approximately 70 percent and 80 percent, respectively--of the state's non-elderly, non-disabled adult/child enrollment.

[d] Louisiana and Maine officials were not able to provide separate data on adult child enrollment. As a result, we derived the figures by applying the ratio of adult/child versus total Medicaid enrollment from each state's 2082 data submissions to HCFA.

[e] Michigan and New Hampshire provided a yearly enrollment figure that reflected the state's fiscal year—July 1st to June 30th. As a result, the monthly enrollment data calculation represents July 1994 to June 1995 and July 1996 to June 1997 enrollment.

Source: GAO analysis of state monthly enrollment data.

We calculated changes in welfare participation by using the average of January 1995 and 1996 recipient data to arrive at the figure for 1995 and the average of January 1997 and 1998 recipient data for 1997 figure. Over this period, welfare participation declined on average by about 23 percent, ranging from as much as nearly 56 percent in Wisconsin to less than 7 percent in Alaska. Hawaii was the only state to experience an increase in welfare participation between 1995 and 1997.

Table II.2: Changes in Welfare Participation Between 1995 and 1997

State	Percent of Welfare Decline	Average Annual Welfare Participation	
		1995	1997
Alabama	-33.3	115,053	76,766
Alaska	-6.6	36,348	33,939
Arizona	-27.8	183,350	132,368
Arkansas	-26.5	62,274	45,792
California	**-13.5**	**2,670,487**	**2,310,530**
Colorado	**-32.2**	**105,241**	**71,393**
Connecticut	**-11.5**	**166,228**	**147,184**
Delaware	**-15.8**	**24,734**	**20,823**
District of Columbia	-12.9	71,206	62,000
Florida	**-35.2**	**616,433**	**399,608**
Georgia	**-30.4**	**378,285**	**263,348**
Hawaii	7.0	65,949	70,565
Idaho	**-49.0**	**23,799**	**12,129**
Illinois	-17.8	686,622	564,353
Indiana	**-36.8**	**172,154**	**108,820**
Iowa	-24.2	97,418	73,890
Kansas	**-37.0**	**76,131**	**47,995**

Kentucky	**-20.3**	**185,162**	**147,559**
Louisiana	-34.7	248,714	162,493
Maine	-21.2	58,646	46,222
Maryland	**-31.2**	**217,844**	**149,960**
Massachusetts	-25.2	264,374	197,872
Michigan	**-26.9**	**573,964**	**419,638**
Minnesota	-14.5	176,203	150,616
Mississippi	-37.3	139,674	87,564
Missouri	-25.4	248,824	185,541
Montana	-27.8	33,435	24,138
Nebraska	-7.5	40,346	37,313
Nevada	-29.3	41,169	29,118
New Hampshire	-31.2	26,595	18,287
New Jersey	-23.0	307,492	236,692
New Mexico	-25.6	103,881	77,287
New York	-18.3	1,233,599	1,007,952
North Carolina	-25.7	299,961	222,729
North Dakota	**-27.0**	**14,286**	**10,424**
Ohio	**-23.5**	**591,012**	**452,417**
Oklahoma	**-34.0**	**118,917**	**78,471**
Oregon	**-42.2**	**99,896**	**57,740**
Pennsylvania	-24.5	582,182	439,714
Rhode Island	-11.1	61,531	54,673
South Carolina	**-32.9**	**127,635**	**85,628**
South Dakota	-28.6	17,237	12,303
Tennessee	-38.8	273,651	167,457
Texas	-27.9	739,992	533,221
Utah	**-26.2**	**44,309**	**32,681**
Vermont	**-16.8**	**26,791**	**22,292**
Virginia	-31.6	177,753	121,623
Washington	-13.1	283,479	246,258
West Virginia	-27.2	103,054	75,019
Wisconsin	**-55.6**	**199,307**	**88,507**
Wyoming	-54.3	14,483	6,613
Total all States	-23.4	13,227,097	10,127,210
GAO Sample states			
Percentage Decline			

Notes: States in boldface were part of the GAO sample.

Source: Administration for Children and Families' AFDC/TANF recipient data.

Appendix II

Analyzing state-provided monthly Medicaid enrollment (for non-elderly, non-disabled adults and children) between January 1995 and December 1997 and comparable years' welfare data from the Administration for Children and Families, we found that nationally welfare participation declined 1.2 times more than Medicaid enrollment. State-by-state analysis showed some variance in the states' experiences, as shown in Table II.3. State ratios ranged from 1.9 in Wyoming—where welfare participation declined by over 54 percent and Medicaid declined by 14.5 percent—to a ratio of .8 in Hawaii—where welfare participation increased 7 percent while Medicaid declined by nearly 14 percent. However, 38 states were within (+/-) .2 of the national ratio. In addition, a correlation analysis of the data showed a statistically significant relationship between changes in welfare enrollment and changes in Medicaid enrollment between the 2 years ($r = .38$, $p. < .01$). In general, states that experienced a decline in welfare enrollment also had a decline in Medicaid enrollment. While the relationship is statistically significant, only 15 percent of the change in Medicaid enrollment may be explained by its relationship to the change in welfare enrollment ($r^2 = .15$). Consequently, there are factors in addition to welfare reform that influenced Medicaid enrollment between 1995 and 1997.

Table II:1: Comparison of Changes in States' Medicaid and Welfare Enrollment Between 1995 and 1997

State	1997 Enrollment as a Proportion of 1995 Enrollment		Ratio of Welfare-to-Medicaid Change *
	Medicaid Enrollment	Welfare Enrollment	
Alabama	.96	.67	1.4
Alaska	1.00	.93	1.1
Arizona	1.03	.72	1.4
Arkansas	.99	.74	1.4
California	.92	.87	1.1
Colorado	.90	.68	1.3
Connecticut	.99	.89	1.1
Delaware	1.26	.84	1.5
Florida	.87	.65	1.3
Georgia	.95	.70	1.4
Hawaii	.86	1.07	.8
Idaho	.89	.51	1.8
Illinois	.93	.82	1.1

Appendix II

Indiana	**.91**	**.63**	**1.4**
Iowa	.94	.76	1.2
Kansas	**.89**	**.63**	**1.4**
Kentucky	**.89**	**.80**	**1.1**
Louisiana	.93	.65	1.4
Maine	.96	.79	1.2
Maryland	**.93**	**.69**	**1.3**
Massachusetts	1.01	.75	1.4
Michigan	**.91**	**.73**	**1.2**
Minnesota	.99	.85	1.2
Mississippi	.87	.63	1.4
Missouri	.95	.75	1.3
Montana	.91	.72	1.3
Nebraska	1.05	.92	1.1
Nevada	.87	.71	1.2
New Hampshire	1.01	.69	1.5
New Jersey	.95	.77	1.2
New Mexico	1.15	.74	1.5
New York	.91	.82	1.1
North Carolina	.98	.74	1.3
North Dakota	**.92**	**.73**	**1.3**
Ohio	**.81**	**.77**	**1.1**
Oklahoma	**.91**	**.66**	**1.4**
Oregon	.87	.58	1.5
Pennsylvania	.83	.76	1.1
South Carolina	**1.02**	**.67**	**1.5**
South Dakota	1.00	.71	1.4
Tennessee	1.00	.61	1.6
Texas	.93	.72	1.3
Utah	**.95**	**.74**	**1.3**
Vermont	**1.03**	**.83**	**1.2**
Virginia	.92	.68	1.3
Washington	1.13	.87	1.3
Wisconsin	**.81**	**.44**	**1.8**
Total [b]	.93	.77	1.2
GAO Sample	.91	.77	1.2

Notes: States in boldface were part of the GAO sample.

[a] We derived these ratios by dividing 1997 average monthly Medicaid and welfare enrollment by 1995 average monthly Medicaid and welfare enrollment.

[b] We were unable to obtain comparable enrollment data for the District of Columbia, Rhode Island and West Virginia.

GAO CONTACTS AND STAFF ACKNOWLEDGEMENTS

GAO Contact	Kathryn Allen, (202) 512-7118
Acknowledgements	In addition to the person named above, Carol Carter, Carolyn Yocom, Enchelle Bolden, Christine DeMars, JoAnn Martinez and Craig Winslow made key contributions to this report.

RELATED GAO PRODUCTS

Food Stamp Program: A Strong Economy and Legislative Reforms Are the Main Reasons for Declining Participation (GAO/RCED-99-185, July 2, 1999).

Children's Health Insurance Program: State Implementation Approaches Are Evolving (GAO/HEHS-99-65, May 14, 1999).

Welfare Reform: Information on Former Recipients' Status (GAO/HEHS-99-48, April 28, 1999).

Welfare Reform: States' Experiences in Providing Employment Assistance to TANF Clients (GAO/HEHS-99-22, Feb. 26, 1999).

Welfare Reform: Status of Awards and Selected States' Use of Welfare-to-Work Grants (GAO/HEHS-99-40, Feb. 5, 1999).

Welfare Reform: Few States Are Likely to Use the Simplified Food Stamp Program (GAO/RCED-99-43, Jan. 29, 1999).

Year 2000 Computing Crisis: Readiness of State Automated Systems to Support Federal Welfare Programs (GAO/AIMD-99-28, Nov. 6, 1998).

Welfare Reform: Early Fiscal Effects of the TANF Block Grant (GAO/AIMD-98-137, Aug. 18, 1998).

Welfare Reform: Child Support an Uncertain Income Supplement for Families Leaving Welfare (GAO/HEHS-98-168, Aug. 3, 1998).

Welfare Reform: Many States Continue Some Federal or State Benefits for Immigrants (GAO/HEHS-98-132, July 31, 1998).

Welfare Reform: States Are Restructuring Programs to Reduce Welfare Dependence (GAO/HEHS-98-109, June 17, 1998).

Medicaid: Early Implications of Welfare Reform for Beneficiaries and States (GAO/HEHS-98-62, Feb. 24, 1998).

(101762)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Melissa T. Skolfield

Assistant Secretary for Public Affairs

Phone: (202)690-7850 **Fax: (202)690-5673**

To: Chris Jennings

Fax: 456-5557 Phone: 456-5560

Date: 3/17/99 Total number of pages sent: 2

Comments:

200 Independence Avenue, S.W., Bldg. HHH, Room 647-D, Washington, D.C. 20201

3/17/99

NOTE TO CYNTHIA RICE ---

As promised, here's the missing "Q" on what HCFA is currently doing in New York. Please let me know if you have any edits on the previous set of Q and As, and give me a call when you can. Thanks.

Melissa

Q: Wasn't HCFA investigating the city of New York for not providing Medicaid applications promptly? What is the status of that investigation?

Beginning in November (?) HCFA began collecting information from city and state officials about Medicaid application procedures to ensure that New York City's Medicaid program was serving all qualified applicants, as required by law. In late January, a New York court issued a temporary restraining order against the city for failing to follow Medicaid enrollment requirements under law and regulation. The court required the city to submit a corrective action plan that includes procedures to address issues raised with the city's Medicaid enrollment process. That plan has now been submitted, and it is being reviewed both by HCFA and by the court.

[BACKGROUND: The state of New York has asserted that they cannot provide any information to HCFA due to the court proceedings. HCFA is continuing to gather information from other sources, even as they review the corrective action plan. The plaintiff in the court case is the Legal Aid Society of New York.]

cc: Chris Jennings

65557

FS + Medicaid TO: Devorah

either in the State plan or in the data it reports under §265.9(b)(6), it would not have to duplicate this information.

Since the proposed rules were published and the comment period ended, we have heard concerns that, in some places, families served by TANF diversion programs are being inadvertently diverted from other programs. In addition, we have seen declines in food stamp and Medicaid enrollments, which could be related at least in part to the treatment of families in TANF diversion programs. While there is no specific requirement in the TANF statute for referrals to other programs, we strongly encourage States to maintain critical linkages among these programs because accessing these other program benefits could further the goals of TANF. In addition, diverting individuals from programs where they have an entitlement to benefits or to prompt action on a request for assistance could represent a violation of rules in the other programs.

3/8 fax pg. 17

3/11 conf. call

According to the Health Care Financing Administration (HCFA), 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 at least to families with a dependent child living with them whose income and resources would have qualified them for AFDC benefits under the State plan in effect on July 16, 1996. Therefore, Medicaid eligibility is not tied to or based on eligibility for TANF-financed assistance. Also,

States cannot limit Medicaid eligibility to families receiving TANF.

Medicaid regulations (at 42 CFR 435.906) require States to provide the opportunity for families to apply for Medicaid without delay.

In States that use joint TANF-Medicaid applications or utilize the State TANF agency to make Medicaid eligibility determinations, the TANF office is considered a Medicaid office. Therefore, in this situation, a TANF agency, like any Medicaid agency, must immediately furnish a Medicaid application (joint or separate) upon request and act upon that application promptly. If there is a delay in accepting or filing an application for TANF assistance (e.g., because the family is served through a diversion program, is subject to up-front job search requirements, or faces other behavioral or administrative requirements that delay assistance), the agency must make a Medicaid application available immediately. If there is a delay in processing the TANF portion of a joint application, the agency must process the Medicaid portion of the application immediately.

According to the Food and Nutrition Service (FNS), at the Department of Agriculture, in enacting PRWORA, Congress thoroughly reviewed the Food Stamp Act of 1977, as amended, and made changes to many of its provisions. However, it made clear that the Food Stamp Program continued to have a distinct set of

nationwide application rights and responsibilities. Section 11(e) of the Food Stamp Act sets forth requirements that a State agency administering the Food Stamp Program must follow. Among other things, it requires that the agency: (1) provide timely, accurate, and fair service for applicants for, and participants in, the Food Stamp Program; (2) develop an application containing the information necessary to comply with the Act; (3) permit an applicant household to apply to participate in the program on the same day the household first contacts the food stamp office in person during office hours; and (4) consider an application that contains the name, address, and signature of the applicant to be filed on the date the applicant submits the application.

Where PRWORA did not amend the Food Stamp Act, current food stamp regulations remained in effect. The regulations at 7 CFR 273.2(c) provide that: (1) each household has the right to file an application on the same day that it contacts the food stamp office during office hours; (2) the State agency must advise the household that it does not have to be interviewed before filing an application, and it may file an incomplete application as long as the applicant's name and address are recorded on an appropriately signed form; (3) State agencies shall encourage households to file an application form the same day the household contacts the food stamp office and expresses interest in obtaining food stamp assistance. If individuals express interest in the Food Stamp Program, or have concerns about food security, States have a responsibility to inform them about the Food Stamp

This Facsimile is from the

Administration for Children and Families
370 L'Enfant Promenade S.W.
Washington, D.C. 20447-0001

Date: 3/18/99

This transmission consists of this cover plus 1 pages

To: Deborah Adler

From: Kristin Sieverding

Phone:

Phone:

Fax:

Messages: Re: TANF/Medicaid Guide

Administration for Children and Families
Phone: 401-9200 Fax: 401-5770

Ex. Sec.: 401-9211 Fax: 205-4891

DRAFT
INTERNAL HHS ROLLOUT PLAN

Here is a summary of the rollout plan as discussed in yesterday's meeting:

THURSDAY 3/18

1) There is a briefing for the regions at 2:30PM. ACF, ASPE, and HCFA staff will participate on the call with IGA.
2) ASPA will recirculate the Qs and As and draft a set of TPs for the head's up calls tomorrow and future external calls. Peter will get Ellen the Q and A on cost allocation. ACF gave Ellen the Q and A on the $350 deferral of TANF funds.
3) HCFA will produce the joint cover letter for the guide (OG signed; awaiting Nancy Ann's signature). ACF will give HCFA labels for the TANF directors.
4) ASPE is producing 500 copies for Monday.

FRIDAY 3/19

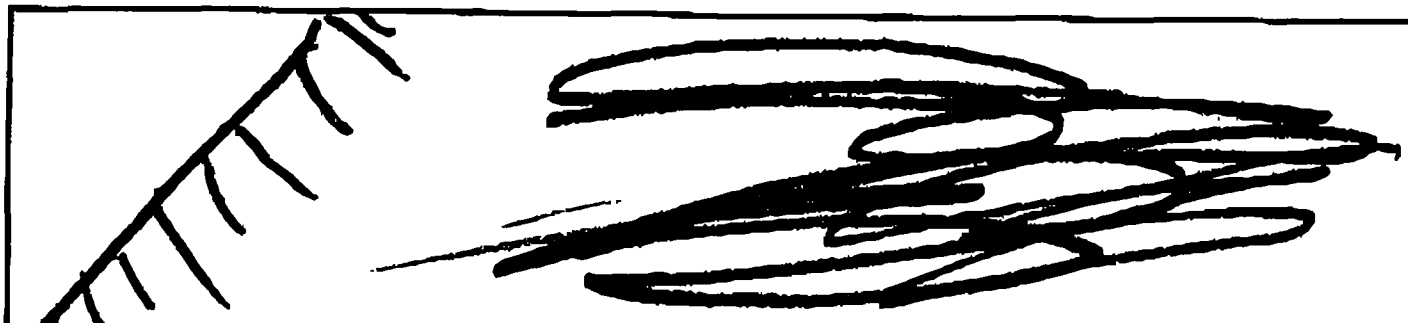
1) Final Qs and As and TPs will be circulated by ASPA.
2) After 3:00PM: IGA, IGA/HCFA, and IGA/ACF will make head's up calls to the list of IG groups (approx. 15 calls). Will offer to do a briefing.
3) After 3:00PM: ASL will make head's up calls to the list of hill folks. ASL will offer to do a briefing.
4) After 3:00PM: Patricia, BJ and Peter will make head's up calls to select interest/advocacy organizations. Will offer to do a briefing.

MONDAY 3/22

1) In the morning, ASPE will deliver copies to ACF, HCFA, IGA and ASL for distribution.
2) Hard copies will go out to the hill and ig groups.
3) HCFA will mail the guide/letter to State TANF, Medicaid and CHIP directors.
4) IGA will mail copies to the Washington Governors' offices' with a cover letter from Andy
5) ACF, ASPE, and HCFA will put the guide on the web

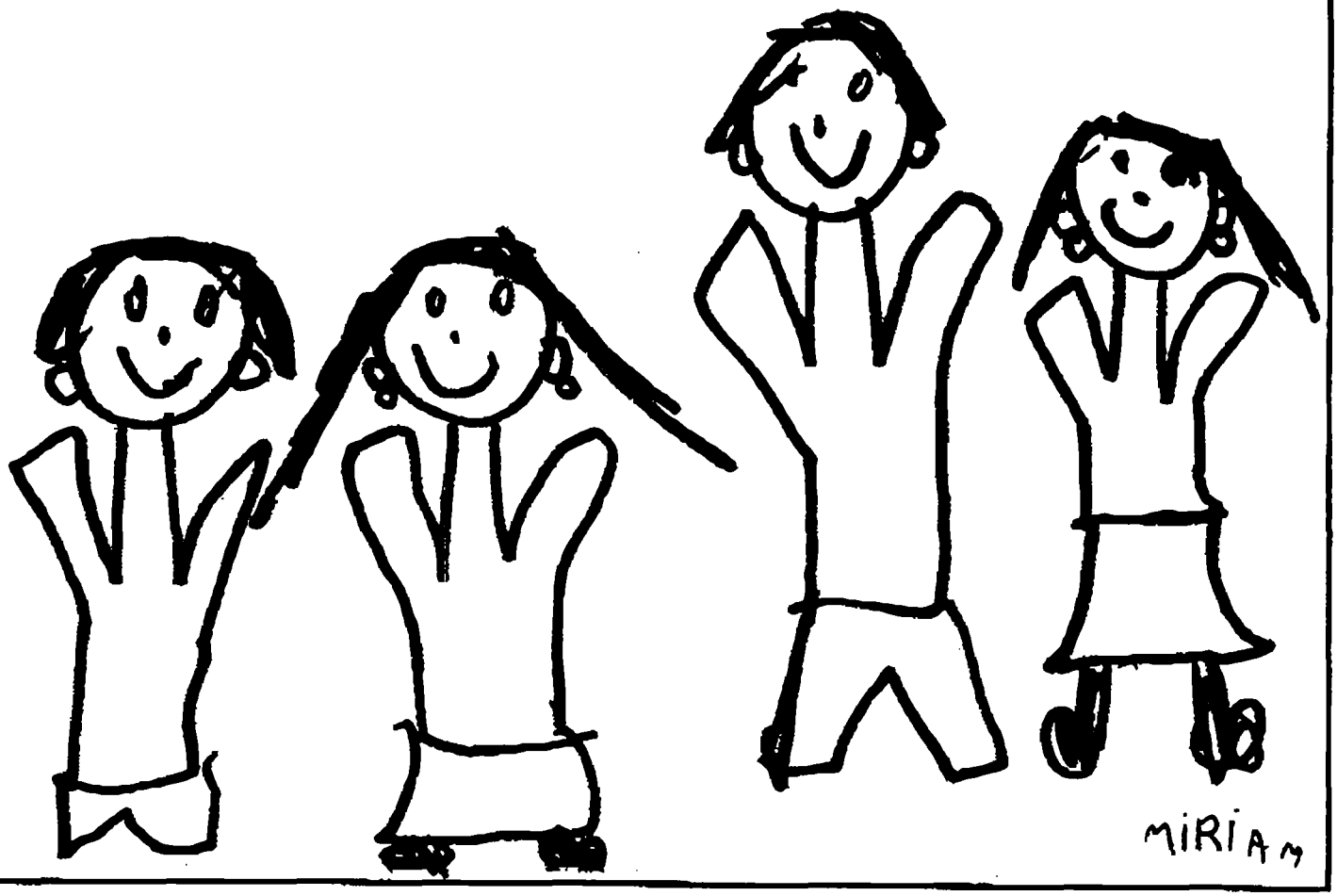
WEEK OF 3/22 and 3/29

1) ASL will schedule a hill briefing if required.
2) IGA, IGA/ACF, and IGA/HCFA have tentatively scheduled a briefing for IG groups on Monday March 29
3) Peter and Patricia will schedule a briefing with the interest groups at which HCFA and ACF principals (and staff) shall talk. 100 hard copies will be provided for this briefing from the first round of production (the first 500). Please inform us of date/time asap so that attendance by principals is secured.
4) HCFA is producing the second round of hard copies (2,000-3,000?) for distribution (late yesterday HCFA indicated ability to do this instead of ASPE)--hopefully by next Friday or the following Monday.
5) There will be an internal meeting to begin discussions about the TA strategy for the regions.



Supporting Families in Transition

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



HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE: Devorah **PHONE:** _____	**FROM:** Peter **OFFICE OF THE ADMINISTRATOR** **200 INDEPENDENCE AVE., S.W.** **ROOM 314G** **WASHINGTON, DC 20201** **PHONE: 202-690-6726** **FAX : 202-690-6262**

TOTAL PAGES:	**ADDRESSEE'S FAX MACHINE NUMBER:**	**DATE:**

REMARKS:

Final Letter

Dear TANF Administrators, State Medicaid Directors, and CHIP Directors:

Through an ongoing strategy to reform welfare, the Administration has fought to continue efforts to support low-income families, especially those trying to make the transition from welfare to self-sufficiency. As part of these efforts, it is critical that progress is made towards increasing the number of Americans with health insurance. The delinkage of Medicaid from cash assistance and declining welfare caseloads have created both challenges and opportunities for providing this support for working families. It important that we use effective strategies and find new ways to reach children and families outside, as well as through, the welfare system.

In order to help policy makers overcome these challenges, and to realize the potential of these opportunities, we have developed the enclosed guide, "Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World." This guide contains information regarding processes and procedures that will help ensure as many children and families as possible obtain health insurance.

In a letter we sent you on June 5, 1998 (http://www.hcfa.gov/medicaid/wrdl605.htm), we encouraged you to coordinate both the administration of and eligibility for your TANF and Medicaid programs. In that letter, we highlighted states' responsibilities to establish and maintain Medicaid eligibility for families and children affected by welfare reform, and we also outlined the broad flexibility the statute affords you to expand eligibility. Through the enclosed guide, we are providing additional information to help you accomplish these important goals.

In addition to explaining state options and suggesting appropriate strategies, the guide summarizes the application and enrollment requirements for the Medicaid program. Two of the most critical requirements are that States must:

- **Provide Medicaid applications upon request.** Based on Medicaid regulations (42 CFR 435.906), the Department of Health and Human Services (DHHS) has determined that states using joint TANF-Medicaid applications must furnish a Medicaid application immediately upon request and may not impose a waiting period before providing the application for Medicaid.

- **Process Medicaid applications without delay.** States must assure that an application for Medicaid is processed quickly and not delayed by any TANF requirement. In states where TANF application or eligibility is delayed (i.e., families receive diversionary assistance or face any other initial administrative steps), the state must process the joint application immediately to determine Medicaid eligibility.

In addition to issuing the guide, we will be expanding our technical assistance efforts to states to ensure that TANF programs are designed and implemented so that children and their families are informed about Medicaid and CHIP and enrolled when eligible. To focus our efforts more effectively, we will work with states to review their welfare and Medicaid eligibility and enrollment procedures. This process will help us assist state agencies in improving their practices, it will further help us by identifying successful models of coordination that can be shared with other states.

We recognize the new needs for outreach, accessibility, and coordination that have arisen from the delinkage of Medicaid from the welfare system, and the growing number of working families unlikely to enter the welfare office but likely to be eligible for Medicaid. In light of these new challenges, we are committed to working with you to establish the most effective Medicaid application and enrollment procedures for low-income families with children.

We look forward to continuing this very important work with you and to charting the gains we make together in improving the health coverage of all low-income children and families, and in supporting the transitions of families from welfare to self-sufficiency. In the meantime, please contact your HCFA or ACF Regional Administrator or your Regional Director with any questions or for additional information.

Sincerely,

Olivia Golden
Assistant Secretary
Administration for Children and Families

Nancy Ann Min DeParle
Administrator
Health Care Financing Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DATE: 5/12

TO: Deborah Adler
fax: 456-5557

FROM: Ellen Dahl
Office of the Assistant Secretary for Public Affairs
Tel: 202/690-7578, Fax: 202/690-5673

TOTAL NUMBER OF PAGES SENT: 5
(including cover page)

COMMENTS:

Deborah –
These are in final Dept. review -- Melissa wanted you to know we took almost all of your edits. Could you pls. make sure Bruce, Jeanne, and Cynthia see these?

Thanks!
- Ellen

Suite 647-D 200 Independence Ave SW Washington, DC 20201

DRAFT Q and As - 2
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 decline in the number of employees participating in employer-sponsored health insurance 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. 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.

HCFA also intends to be aggressive in ensuring that states carry out their responsibilities under Medicaid law. 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.

[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.

[The Families USA study, done by the Lewin group, compares estimates of who would have been insured in the absence of welfare reform with actual coverage data from 1997.

No matter how sophisticated the methodology, no such model can take all the trends affecting coverage into account; thus, their report is inherently flawed.

[Also note that the numbers shown in HCFA's Congressional Justification for Medicaid enrollment are in person years (or, average enrollment) and are slightly different. 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 a decline in the number of employees participating in employer-sponsored health insurance 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.

The document also provides examples of successful state 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.

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 12,000 welfare recipients.

Congress can also do more. The Administration's budget requests $1 billion to extend the Welfare-to-Work program; $430 million for welfare-to-work housing vouchers; doubles Access to Jobs transportation funding; extends tax credits to businesses to encourage the hiring and retention of welfare recipients; and proposes significant new funding for child care to help working families meet the cost of child care.

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.

Again, Congress can and should 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.

[BACKGROUND: 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. What has HCFA been doing to ensure that States have been following the law and enrolling people into the Medicaid program? Has HCFA been lax in its enforcement of the law?

A. HCFA has been working hard with states to ensure that people who should be enrolled in Medicaid are, in fact, enrolled.

Medicaid is a joint partnership between HCFA and the states. States have primary responsibility for operating their programs. Nevertheless, HCFA continues to provide technical assistance to states and intends to be aggressive in ensuring that states follow all federal rules involved with Medicaid eligibility determinations.

Since the beginning of 1997, HCFA has issued numerous letters designed to inform and educate States of their responsibilities under Medicaid. 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.