DEPARTMENT OF HEALTH AND HUMAN SERVICES

DATE: 3/19

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TOTAL NUMBER OF PAGES SENT: 14
(including cover page)

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.

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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
Final–3/19/99 4:10 PM

- 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.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

AUG 3 0 1999

Dear State Secretary of Health and Human Services:

The Clinton Administration has a longstanding commitment to reducing the number of uninsured nationwide and providing health care to low-income working families. At the most recent National Governors Association's annual meeting in St. Louis, the President encouraged States to make the most of their flexibility under Medicaid and CHIP to provide affordable health insurance to low-income families. To assist states in these efforts, he directed the Department of Health and Human Services (HHS) to take new steps to ensure that low-income working families have access to the health insurance benefits for which they are eligible. To this end, for many states, HHS is extending the availability of the $500 million fund for Medicaid outreach and eligibility systems changes and conducting a national review of Medicaid eligibility and enrollment to eliminate barriers to enrollment.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provided states with $500 million to use for the costs of simplifying their Medicaid eligibility systems and conducting outreach related to the implementation of Section 1931 of the Social Security Act. The law specifies that states must use their entire allotment within 12 calendar quarters or lose access to the unspent portion of the funds. All funds must be spent by October 1, 2000.

Previously, the expiration date for this funding was interpreted to start the 12-quarter clock at the beginning of the quarter in which a state's TANF plan became effective. For many states, this meant that the funds would have expired at the end of September 1999. HHS has reconsidered this interpretation to maximize the availability of this funding. Therefore, for the purpose of accessing these funds, HHS has determined the clock started for each state at the beginning of the first full calendar quarter in which the State's TANF program was effective. As a result of this clarification, many states will essentially have 12 full quarters to spend these funds. (Please see enclosed chart.) Additional guidance on this issue will be forthcoming in an effort to help states take full advantage of these funds.

We encourage you to use these dollars to help improve Medicaid and CHIP enrollment in your state. Although this clarification represents the extent of our administrative flexibility, the President continues to support a proposal in his budget for the past two years that eliminates the 12-quarter clock and the legislative sunset date and broadens the use of the fund to include both general Medicaid and CHIP outreach activities. We will work with Congress in the hope that this proposal will be enacted.

As the next step in the Administration's effort to continue our work with States to ensure that low-income families have access to health insurance benefits, the President has directed HHS to work with states to review their Medicaid programs. During this comprehensive assessment, together we will review a range of issues related to States' eligibility and enrollment process, including those related to transitional Medicaid. Our Regional Office Staff, who will visit each state by this fall, will examine whether all states are complying with Federal requirements. In addition, we will ask to look at certain aspects of the eligibility determination process for the Children's Health Insurance Program (CHIP) in states with a separate CHIP program.

For states whose procedures conflict with applicable laws and regulations, HHS will work with that state and take all steps necessary to achieve compliance. In addition, as part of our education and technical assistance efforts, we will continue to gather and disseminate information on best practices with regard to outreach, enrollment, and eligibility determination processes for Medicaid and CHIP.

Regional Administrators for the Health Care Financing Administration (HCFA) and the Administration for Children and Families (ACF) will be sending letters to State Medicaid Directors and Human Services Directors that will provide more detail on the site visits. Some of you may already have been contacted by your respective Regional Offices. We want to minimize any possible burden posed by this site visit, so we will request that certain information be provided in advance. In general, we expect that the visit will last no longer than five days -- approximately two days at your central office and then three days in field offices.

We are committed to taking all necessary action to achieve our mutual goal of ensuring that all eligible children and families are enrolled in Medicaid. If you have any additional questions, please contact your HCFA Regional Administrator. Thank you for your time and attention to this critical effort that will safeguard the health of America's families and children.

Sincerely,

Michael Hash
Deputy Administrator
Health Care Financing Administration

Olivia A. Golden
Assistant Secretary
for Children and Families
Administration for Children and Families

Enclosure

UPDATED EXPIRATION DATES FOR THE $500 MILLION TANF-MEDICAID OUTREACH FUND

State	Total TANF-Medicaid Fund Allocation	Fund Expenditures as of 03/31/99	Percentage Expended	Expiration Date
AL	$6,504,897	$0	0.0%	**12/31/1999**
AK	$3,039,335	$7,500	0.2%	06/30/2000
AZ	$7,961,603	$17,901	0.2%	09/30/1999
AR	$5,095,513	$1,117,803	21.9%	06/30/2000
CA	$83,719,458	$4,453,468	5.3%	**12/31/1999**
CO	$5,166,316	$0	0.0%	06/30/2000
CT	$5,756,737	$0	0.0%	09/30/1999
DE	$2,801,757	$233	0.0%	**03/31/2000**
DC	$3,259,072	$0	0.0%	**03/31/2000**
FL	$22,262,239	$950,856	4.3%	09/30/1999
GA	$11,591,549	$0	0.0%	12/31/1999
HI	$3,435,742	$0	0.0%	06/30/2000
ID	$3,288,535	$541,328	16.5%	06/30/2000
IL	$19,363,894	$15,016	0.1%	06/30/2000
IN	$7,545,162	$452,521	6.0%	09/30/1999
IA	$4,782,362	$2,405,247	50.3%	12/31/1999
KS	$4,496,386	$389,409	8.7%	09/30/1999
KY	$7,269,014	$0	0.0%	**12/31/1999**
LA	$9,029,185	$0	0.0%	12/31/1999
ME	$3,569,238	$0	0.0%	**12/31/1999**
MD	$7,595,943	$0	0.0%	**12/31/1999**
MA	$9,463,490	$1,695,987	17.9%	09/30/1999
MI	$15,975,445	$2,606,516	16.3%	09/30/1999
MN	$7,708,769	$3,798,670	49.3%	06/30/2000
MO	$8,561,965	$3,298,443	38.5%	**12/31/1999**
MS	$6,617,604	$197,678	3.0%	09/30/1999
MT	$2,764,134	$7,653	0.3%	**03/31/2000**
NE	$3,308,247	$0	0.0%	**12/31/1999**
NV	$3,258,808	$3,258,808	100.0%	**12/31/1999**
NH	$2,875,952	$302,916	10.5%	09/30/1999
NJ	$11,012,253	$3,078,591	28.0%	**03/31/2000**
NM	$4,860,333	$0	0.0%	06/30/2000
NY	$37,034,556	$387,892	1.0%	**12/31/1999**
NC	$11,550,703	$0	0.0%	12/31/1999
ND	$2,537,922	$47,094	1.9%	06/30/2000
OH	$16,909,161	$2,915,724	17.2%	09/30/1999
OK	$5,938,082	$291,222	4.9%	09/30/1999

Continued

UPDATED EXPIRATION DATES FOR THE $500 MILLION TANF-MEDICAID OUTREACH FUND (Continued)

State	Total TANF-Medicaid Fund Allocation	Fund Expenditures as of 03/31/99	Percentage Expended	Expiration Date
OR	$5,740,656	$1,497,655	26.1%	09/30/1999
PA	$17,553,339	$2,854	0.0%	**03/31/2000**
RI	$3,459,771	$3,002	0.1%	**06/30/2000**
SC	$6,221,783	$0	0.0%	**12/31/1999**
SD	$2,642,597	$824,458	31.2%	**12/31/1999**
TN	$9,250,889	$0	0.0%	09/30/1999
TX	$27,523,806	$0	0.0%	**12/31/1999**
UT	$4,006,172	$0	0.0%	09/30/1999
VT	$2,891,672	$0	0.0%	09/30/1999
VA	$8,531,522	$2,020,109	23.7%	**03/31/2000**
WA	$10,443,170	$2,364,205	22.6%	**03/31/2000**
WV	$5,420,593	$121,629	2.2%	**03/31/2000**
WI	$7,023,766	$49,362	0.7%	09/30/1999
WY	$2,475,344	$212,028	8.6%	12/31/1999
GU	$270,439	$0	0.0%	06/30/2000
PR	$8,325,084	$0	0.0%	06/30/2000
VI	$308,045	$0	0.0%	06/30/2000
TOTAL	**$500,000,009**	**$39,333,778**	**7.9%**	

Bold indicates the expiration date has been extended to the last day of the quarter.

PROVIDING HEALTH CARE TO LOW INCOME WORKING FAMILIES MOVING FROM WELFARE TO WORK

In 1996, the President signed a bipartisan welfare reform plan that is dramatically changing the nation's welfare system into one that requires work in exchange for time-limited assistance. In passing welfare reform, the President insisted on maintaining the Medicaid entitlement; indeed, he vetoed two welfare bills that did not guarantee continued Medicaid coverage to all adults and children who were then eligible. Beyond preserving Medicaid eligibility, the welfare law created new health insurance options for families, providing states with broad flexibility under section 1931 to expand Medicaid to cover more low-income families at their option.

EXPANDING COVERAGE TO MORE FAMILIES. The Clinton Administration has taken action to ensure that low income families are able to access health insurance, including:

- **Creation of the Children's Health Insurance Program.** The President, with bipartisan support from the Congress, created the Children's Health Insurance Program (CHIP). The Balanced Budget Act of 1997 allocated $24 billion dollars over the next five years to extend health care coverage to uninsured children through State-designed programs. States project that they will ensure 2.5 million children when their new CHIP programs are fully implemented, and because states are currently planning to revise and expand their CHIP programs as well as work with us on Medicaid outreach activities, we are confident that we will be able to reach our goal of providing insurance up to 5 million children through a combination of Medicaid and CHIP.

- **Allowing states to expand Medicaid to cover families.** The welfare law allows states to expand Medicaid coverage under section 1931 to reach single and two-parent families who traditionally have earned too much to be eligible for Medicaid. These expansions present an opportunity for states to present Medicaid as a freestanding health insurance program for low-income families, an important step towards removing the welfare stigma associated with the program and enhancing its potential to reach families who do not come into contact with the TANF system.

- **Providing Medicaid coverage to two parent, low-income families who work.** In August 1998, the President eliminated a vestige of the old welfare system by allowing all states to provide Medicaid coverage to working, two-parent families who meet State income eligibility requirements. Under the old regulations, adults in two-parent families who worked more than 100 hours per month could not receive Medicaid regardless of their income level. Because the same restrictions did not apply to single-parent families, these regulations created disincentives to marriage and full-time work. The new regulation eliminates this requirement, providing health coverage for more than 130,000 working families to help them stay employed and off welfare.

ELIMINATING BARRIERS TO RECEIVING CRITICAL HEALTH INSURANCE COVERAGE. Since the passage of welfare reform, the Clinton Administration has taken additional steps to aggressively enforce the statute and maintain the Medicaid entitlement in order to ensure that low-income families have the health care they need in order to transition successfully from welfare to work, including:

- **Releasing new guidance to states to encourage them to reach out to children who are no longer eligible for cash assistance but are still eligible for Medicaid or CHIP.** The Administration released new guidance to all 50 states reiterating their responsibilities to establish and maintain Medicaid eligibility for families and children affected by welfare reform and establishing that states must provide Medicaid applications upon request and process them without delay. The guidance highlights the historic opportunity that the delinkage of Medicaid from welfare presents to promote Medicaid and CHIP coverage as a freestanding support for low income families with children.

- **Launching the Insure Kids Now Campaign.** This new campaign will engage a broad-based, bipartisan, public-private coalition to use a variety of means to educate and assist families in insuring their children. Initial activities include launching a nationwide, toll-free number set up by the National Governors' Association in partnership with the Administration and Bell Atlantic to provide families with essential information about Medicaid and CHIP; placing the toll-free number on corporate products; airing public service announcements on TV and radio; enlisting grass-roots organizations to get the word out; and stepping up activities by over 10 Federal agencies that interact with working families.

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

- **Eliminating burdensome reporting requirements for transitional medical assistance (TMA).** TMA provides time-limited Medicaid coverage to low-income households whose earnings or child support would otherwise make them ineligible for welfare-related Medicaid under state income eligibility standards. The President's FY 2000 budget would reduce burdensome reporting requirements, including TMA eligibility procedures in the current Medicaid eligibility redetermination process. The budget also exempts those states that have expanded Medicaid coverage to families with incomes up to 185 percent of the federal poverty level from burdensome TMA reporting requirements, providing states with additional incentives to provide critical health care services.

RESTORING FAIRNESS FOR LEGAL IMMIGRANTS. The President made a commitment to fix several provisions in the welfare reform law that had nothing to do with moving people from welfare to work. In 1997, the President fought for and ultimately was successful in ensuring that the Balanced Budget Act protects disabled legal immigrants. The Administration's FY 2000 budget would build on this progress by restoring important disability, health, and nutrition benefits to additional categories of legal immigrants, at a cost of $1.3 billion over five years.

- **Providing health insurance coverage to individuals with disabilities.** The Balanced Budget Act of 1997 and the Noncitizen Technical Amendment Act of 1998 invested $11.5 billion to restore disability and health benefits to 380,000 legal immigrants who were in this country before welfare reform became law. The President's FY 2000 Budget build on this progress and restore eligibility for SSI and Medicaid to legal immigrants who enter the country after that date if they have been in the United States for five years and become disabled after entering the United States. This proposal would cost approximately $930 million and assist an estimated 54,000 legal immigrants by 2004, about half of whom would be elderly.

- **Providing health care to children and pregnant women.** The President's FY 2000 Budget gives states the option to extend Medicaid or CHIP coverage to low-income legal immigrant children and Medicaid to pregnant women who entered the country after August 22, 1996. The proposal would cost $325 million and provide critical health insurance to approximately 55,000 children and 23,000 women by FY 2004. This proposal would reduce the number of high-risk pregnancies, ensure healthier children, and lower the cost of emergency Medicaid deliveries. Under current law, states have the option to provide health coverage to immigrant children and pregnant women who entered the country before August 22, 1996.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAR 2 2 1999

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

INTRODUCTION

In the aftermath of the 1996 welfare reform law, welfare rolls have dropped dramatically across the country. While welfare reform has been hailed for decreasing the welfare rolls and moving former recipients to jobs, little attention has been devoted to the health coverage of those who lose welfare benefits. As this report shows, one of the unintended consequences of welfare reform is that many people lose Medicaid coverage and become uninsured. This is the first study to show a direct connection between the loss of welfare benefits and the loss of health insurance coverage.

Using data from the U.S. Census Bureau's Current Population Survey and from the Health Care Financing Administration, we have found that *over two-thirds of a million low-income people—approximately 675,000—lost Medicaid coverage and became uninsured in 1997 due to welfare reform.* The majority (62 percent) of those who became uninsured due to welfare reform were children, and most of those children were, in all likelihood, still eligible for coverage under Medicaid. Moreover, the number of people who lose health coverage due to welfare reform is certain to grow rather substantially in the years ahead.

Because 1997 was the first year of welfare reform implementation, this study reports only the earliest consequences of welfare reform, before many of the time limits imposed by the new law take effect. This year, more people will be required to work in order to retain their welfare benefits. The vast majority of people moving from welfare into jobs wind up in entry-level positions with low salaries and no employer-subsidized health insurance. If, as required by law, they are granted 6- to 12-months of Medicaid coverage during the transition to work, they are then likely to join the ranks of the uninsured when their transitional coverage ends. Similarly, large numbers of people will be dropped from the welfare rolls in the future as they reach the 5-year lifetime limit on welfare benefits. When that happens, we can expect the number of uninsured to swell.

LOSING HEALTH INSURANCE:

5/13 RELEASE

KEY FINDINGS

- *Welfare reform has contributed to the increase in the number of low-income people without health insurance.* In 1997, an estimated 675,000 low-income people became uninsured as a result of welfare reform.
- *Welfare reform has contributed to declining Medicaid enrollment.* Approximately 1.25 million people with incomes under 200 percent of the federal poverty level lost their Medicaid coverage from 1995 to 1997 as a result of welfare reform.
- *Children under age 19 made up the majority of people who became uninsured as a result of welfare reform.* Of the 675,000 low-income people becoming uninsured in 1997 as a result of welfare reform, more than three out of five (62 percent) were children. Of the 1.25 million people who lost Medicaid between 1995 and 1997 as a result of welfare reform, almost two-thirds (65 percent) were children.
- *More than half of both children and adults became uninsured when they lost Medicaid.* Fifty-four percent of all people losing Medicaid as a result of welfare reform became uninsured.
- *Most of the children who lost Medicaid in 1997 as a result of welfare reform probably were still eligible for Medicaid and should not have lost that coverage.* Considerably more than half of the children who lost Medicaid between 1995 and 1997 as a result of welfare reform were eligible under federal requirements.
- *Poor people are more likely than those just above the poverty line to become uninsured when they lose Medicaid.* For people with income below the federal poverty, nearly two out of three adults (62 percent) and over half children (57 percent) became uninsured when they lost Medicaid. The impact on those with incomes just over poverty was significant as well: for people with incomes between the federal poverty level and 200 percent of poverty, 45 percent of adults and 42 percent of children became uninsured when they lost Medicaid.
- *Minority children are more likely to go uninsured than white children when they lose Medicaid.* When minority children lost Medicaid, about 58 percent

became uninsured, while 41 percent of white children became uninsured when they lost Medicaid.

- *The number of people becoming uninsured as a result of welfare reform is likely to increase considerably in the years following 1997.* These data show only the early-warning signs of welfare reform's impact on health insurance coverage for people with low incomes. As welfare reform is fully implemented over time, there will be large increases in the number of low-income uninsured people.

Breaking the Link Between Welfare and Medicaid

The 1996 welfare reform law(P.L.104-193, the Personal Responsibility and Work Opportunity Reconciliation Act) fundamentally altered our system of providing public assistance to poor families. Welfare reform eliminated the entitlement to cash assistance and ended the 60-year-old Aid to Families with Dependent Children (AFDC) program. Congress replaced the AFDC program with the Temporary Assistance to Needy Families (TANF) block grant program. TANF carries new requirements that recipients must meet in order to receive benefits and emphasizes moving welfare recipients off of the welfare rolls as quickly as possible.

While the welfare law established restrictions and limitations for the receipt of cash welfare benefits, Congress included provisions intended to insulate Medicaid participation from those restrictions and limitations. Prior to welfare reform, most low-income families qualified for Medicaid by first qualifying for welfare. The welfare reform law maintains the Medicaid entitlement and requires Medicaid eligibility to be determined independently from welfare. Despite the effort to ensure that low-income people continue to receive Medicaid benefits, hundreds of thousands of people, as of 1997, were stripped of health insurance as an unintended consequence of welfare reform.

How People Lose Health Coverage Because of Welfare Reform

There are three ways that low-income people lose health care coverage as a result of welfare reform. ***First, people lose health coverage when they or a family member successfully move from welfare to work.*** The vast majority of people moving from welfare to work wind up in jobs that provide no health care coverage *and*, after they leave welfare for a job, they often remain eligible for Medicaid only during a limited transition period. ***Second,*** *termination from welfare*

for any reason often results in wrongful losses of Medicaid coverage. Many people dropped from the welfare rolls remain eligible for Medicaid but, because Welfare administrators fail to inform people of their continuing eligibility, many people inappropriately lose their Medicaid coverage. ***Third,*** *state efforts to deter people from applying for welfare often result in people being denied the opportunity to apply for Medicaid.*

Losing Health Coverage When Moving from Welfare to Work

When families move from welfare to work, they are likely to find jobs that pay very low wages and do not offer benefits such as affordable health insurance. Evidence from a review of state "exit studies" (surveys of people who have left welfare) shows that, on average, only about 25 percent of people who got jobs after leaving welfare reported having employment-based health insurance.[1] (See box on pages 12-13 for more information about state exit studies.) A number of studies have shown that people moving from welfare to work tend to find jobs that pay less than $8 an hour and that do not provide benefits such as health insurance or paid sick leave.[2] Most welfare recipients who find jobs work less than full-time, full-year and earn less than the poverty level; however, even such a low-wage, part-time job will make a parent ineligible for Medicaid in most states.

Parents are eligible for Medicaid only if they earn very little money. In nine states, parents become ineligible for Medicaid when they earn more than 37 percent of the federal poverty level ($5,051 for a family of three in 1998). In half of the states, parents become ineligible if they earn more than 59 percent of the federal poverty level ($8,054 for a family of three in 1998). In all but nine states, parents become ineligible if they earn more than the federal poverty level ($13,650 for a family of three in 1998).[3] (See Figure 1 for state Medicaid eligibility levels for parents.)

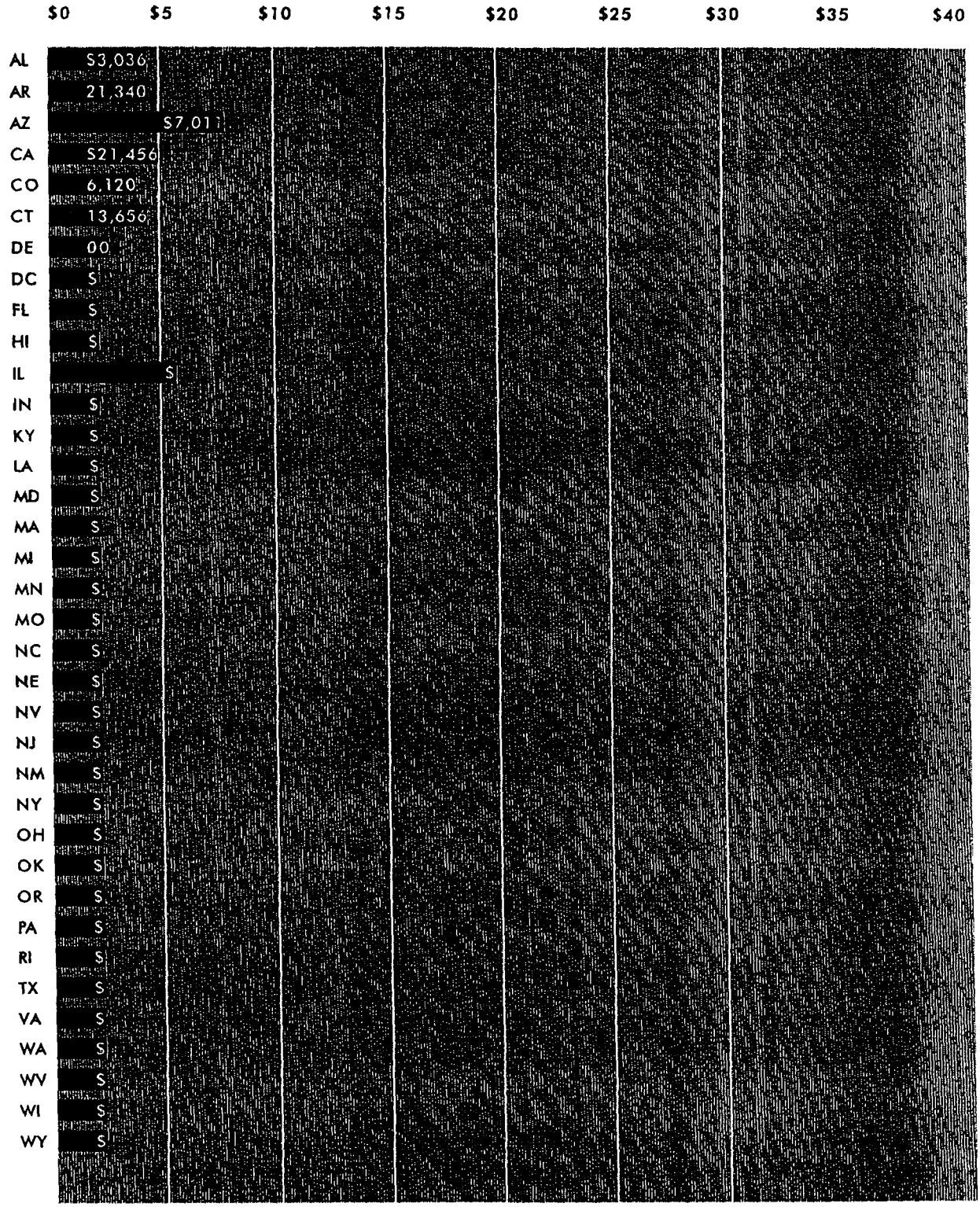
In many cases, children remain eligible for Medicaid even when their parents lose eligibility because children are eligible for Medicaid at higher income levels (see box on page 15). However, because families are unaware of this and states may fail to reassess the child's eligibility when parents are terminated, many children in working families are eligible but not enrolled in

THE UNINTENDED CONSEQUENCES

Figure 1

Income Eligibility Limits for Parents Receiving Medicaid

(Based on a family of three with one wage earner)

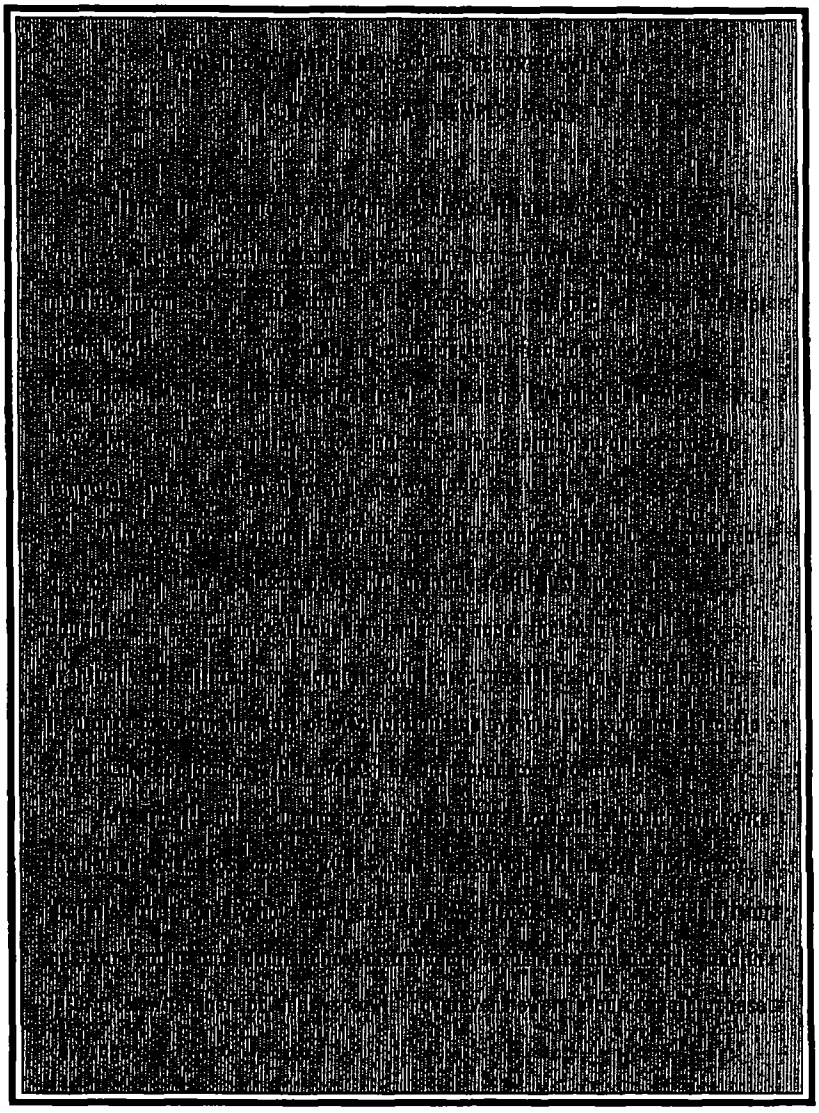


Source: 1998 Data Reported By Jocelyn Guyer and Cindy Mann, Employed But Not Insured, Center on Budget and Policy Priorities, March 1, 1999

*Information from a survey of state officials in late 1998/early 1999. These state income limits take into account earnings disregards for parents receiving Medicaid who have worked for 12 months or more. Income limits assume that earnings are the only source of income for the family. These income limits are for single-parent families; limits for two-parent families are lower in 18 states.

Medicaid.[4]

When low-income families become ineligible for Medicaid, they have very few places to turn for health insurance. The vast majority of insured people get their health coverage from their employers, but employer-sponsored coverage has declined significantly since 1987. This decline in employer-sponsored health insurance has hit low-wage workers the hardest: by 1997, only 42 percent of workers in jobs paying less than $7 per hour had employer-sponsored health insurance.[5] Over the past decade, the rising costs of health care led many employers to cut down on the scope of health insurance benefits they offer, to increase the percentage of health insurance costs that employees must pay, and to stop providing coverage for employees' spouses and children.[6]



Families who become ineligible for Medicaid because they have increased income from work are entitled to receive extended Medicaid benefits, called "Transitional Medicaid." Families receive six months of Transitional Medicaid

regardless of how much income they earn. They should get a second six months if their income (minus childcare expenses) is below 185 percent of the federal poverty level.[7] It is difficult to find data on the availability of Transitional Medicaid: states are not required to report such data to the federal government and most states do not track Transitional Medicaid in any systematic way. However, two studies have found that very few families who leave welfare actually receive Transitional Medicaid.[8] Those who do get transitional coverage will only have it for a limited time, whether or not they have access to affordable health insurance at their new jobs.

In 1997, the first year of federal welfare reform implementation in the states, only a small percentage of people moving from welfare to work reached the limits of their Transitional Medicaid coverage. As more and more people move from welfare to work, and as the six-month to one-year transition periods expire, increasing numbers of people are likely to lose health insurance coverage.

Losing Health Coverage Due to Termination of Welfare Assistance

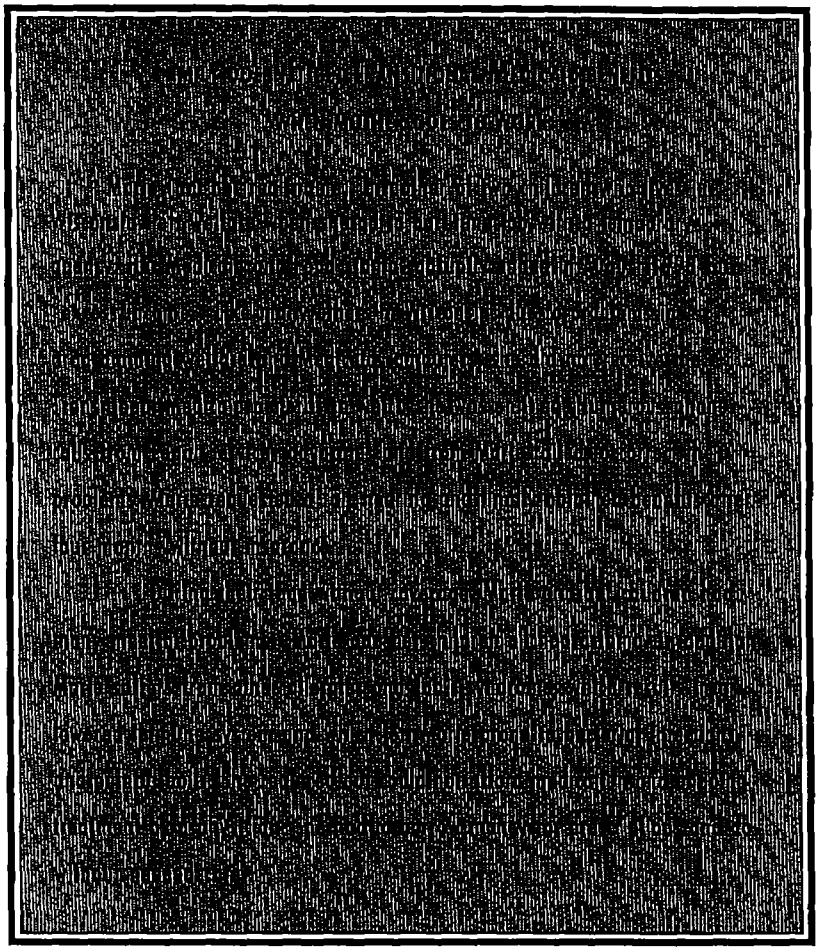
Historically, welfare has been the primary pathway to Medicaid for poor families. The two programs were linked so that people who qualified for welfare automatically received Medicaid as well. Although the law now requires Medicaid eligibility to be determined independently from welfare, state administrative systems often continue to treat Medicaid as an extra welfare benefit. This means that when a family is terminated from welfare, its Medicaid case is often closed at the same time. Because the two programs remain connected in the minds of caseworkers and recipients as well as in state computer eligibility systems, the new emphasis on closing welfare cases as quickly as possible is causing many families to be cut off Medicaid, even when they are still eligible.

A number of federal and/or state rules cause people to lose cash welfare assistance. These rules include the following:

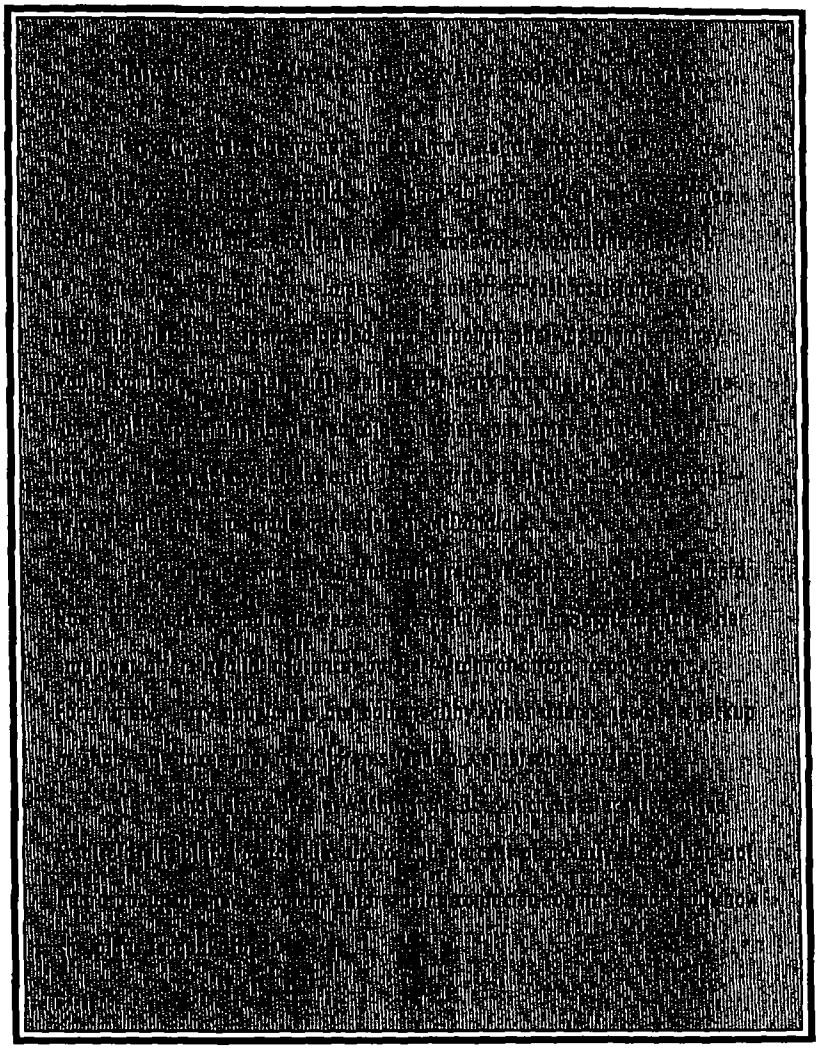
- Under federal law, families may only receive cash welfare assistance for a maximum of five years. Many states have established even shorter lifetime

caps for welfare.

- Federal law requires non-exempt[9] welfare recipients to be working in jobs after two years of receiving welfare benefits in order to continue receiving cash assistance.
- States may require welfare recipients to begin job search and work or other activities as soon as they are enrolled; failure to do so can result in termination of assistance.



While families may only receive cash welfare assistance for a specified number of years over their lifetime, there is no such time limit for Medicaid benefits. Similarly, none of the penalties for violating welfare rules can be applied to Medicaid participation except in one circumstance: states may opt to terminate an adult welfare recipient's Medicaid if the state cuts that person's welfare benefit for "refusal to work."[10] At no time, however, can a state terminate Medicaid for pregnant women or children because a member of their family has violated a welfare rule. Yet it appears that many people who are losing their cash welfare assistance are automatically losing their Medicaid coverage as well—either because of state administrative errors or because no one is informing low-



income families about their continued eligibility for Medicaid.

By July 1, 1999, current welfare recipients will have reached the two-year time limit when they must be working in order to keep their welfare benefits. Three years later, by July 1, 2002, individual families will have reached the lifetime limit on receipt of cash welfare. As these limits are reached, it is likely that many families losing welfare will lose their Medicaid coverage as well. Thus, the number of people losing health coverage due to welfare reform is likely to become considerably higher than the 1997 data depicted in this report.

Losses of Health Coverage Due to State Administrators' Diversion of Welfare Applications

Since cash welfare assistance is no longer an entitlement for eligible families, states are under no obligation to provide cash assistance to needy people. States are allowed to "divert" people from completing their welfare applications—by requiring them to undertake job search activities or to seek other forms of private help before applying for assistance, for example. In some

LOSING HEALTH INSURANCE:

WELFARE "DIVERSIONS" AND "SANCTIONS" DISCOURAGE MEDICAID APPLICANTS

New York City converted a number of its welfare offices to "Job Centers" following passage of welfare reform. At these Centers, people applied for Medicaid, cash assistance, and Food Stamps, but they were required to search for work before their applications were processed. In 1999, a federal court found that New York City's Job Center staff illegally discouraged and denied needy people from applying for Medicaid. The court barred the city from converting any more welfare offices to Job Centers until they corrected the problems.

PEOPLE AFFECTED BY NEW YORK'S DIVERSION AND SANCTION POLICIES INCLUDED THE FOLLOWING:

- In October 1998, Ms. Jenny Cuevas, a pregnant teen, applied for Medicaid and other assistance at a Job Center. She attended high school at night. Job Center personnel told her that she would have to search for work daily and participate in a "work experience" project, sweeping streets for the Department of Sanitation, in order to receive assistance. The next day, Ms. Cuevas was ill and went to an obstetric clinic instead of to the Job Center's orientation. Although she explained this to Job Center personnel, her Medicaid was still denied, along with her Food Stamps and cash assistance, for "failure to comply with Employment Center Orientation."
- Ms. G., a 39-year-old homeless woman, lost her Medicaid, cash assistance, and Food Stamps in August 1998 when New York's Office of Employment Services alleged that Ms. G. had not reported to a work experience assignment with the Department of Sanitation—an allegation that Ms. G. disputed. She was "sanctioned" for four months and could not receive any assistance during that time period. In mid-November, Ms. G. was pregnant with twins and had severe anemia and low blood pressure. She desperately needed blood pressure medication and attempted to reapply for benefits. The Job Center gave her a "Job Profile" form and collected documents that Ms. G. had brought, but did not permit her to file a Medicaid application until the following week. When Ms. G. returned the following week, the Job Center had lost her documents. Ms. G. completed application forms and was required to visit either the Job Center or another welfare office daily. When Ms. G. went to a doctor's appointment, the Job Center would not reschedule her Medicaid and welfare eligibility interview. In early December, for reasons that are not clear, the Job Center denied Ms. G.'s applications for Medicaid, cash assistance, and Food Stamps and told her that she would have to reapply for benefits.

Source: Reynolds v. Giuliani, 98-Civ-8877(WHP)(S.D.N.Y.)

instances, welfare administrators provide a lump-sum benefit to tide families over temporarily while they seek other help; if families accept this inducement, their welfare applications are put on hold.

As of August 1998, 31 states had implemented some form of "diversion" in the application process for cash welfare assistance.[11] Although such "diversion" processes are legal and are becoming routine in the context of cash welfare assistance, they can improperly divert people from applying for Medicaid as well. As a result, many families entitled to Medicaid are not receiving such coverage, and they remain uninformed about their right to complete Medicaid applications. Since many people cycle in and out of Medicaid each year, these diversionary practices may constitute a barrier to coverage for both new applicants and those who have left the Medicaid rolls but need coverage again.

What Exit Studies and Evaluations Tell Us about Employer-Sponsored Coverage

How do we know what is happening to people who leave welfare? Although there has been no national study tracking the health insurance status of people leaving welfare, there have been some state efforts to determine what happened to people who left welfare in their state. These studies all use different survey methods, ask different questions, interview different groups of people, and tend to have relatively low response rates. All of this makes it difficult to draw national conclusions based on the findings. However, despite these differences, the studies show consistently that people who leave welfare lose health insurance.

The surveys described here contained questions about employer-provided health insurance. One review of the exit study and evaluation literature available found that, on average, only one out of four welfare recipients who found jobs received employer-sponsored insurance.[13] A few of the studies only asked respondents whether their employer *offers* health insurance, not whether they could afford to take that insurance. Many low-income workers cannot afford the insurance offered by their employers, and therefore go uninsured.

- Mathematica Policy Research, Inc. studied families in IOWA temporarily cut off welfare for failing to comply with program rules. They found that only 10 percent of people who had jobs after being terminated from welfare had employer-sponsored insurance.[14]
- A SOUTH CAROLINA study, conducted by the state Department of Social Services Division of Program Quality Assurance, found that 11 percent of children and 36 percent of adults had private health coverage eight to twelve months after leaving welfare.[15]
- A survey of people who left welfare in NEW MEXICO found that 20 percent of respondents who were working were covered by employer-sponsored insurance. However, 50 percent of respondents who were working indicated that their employers *offered* health insurance. Most people who did not take their employer's insurance said that they could not afford it. The survey was conducted by the Bureau of Business and Economic Research at the University of New Mexico in September 1997. [16]
- A study of people in WASHINGTON state who had received welfare at any time between May and October 1996, found that, of respondents who had worked at any time since January 1996, 23 percent reported that their employer in their current or most recent job provided health insurance benefits. The study was conducted by the Social and Economics Sciences Research Center of Washington State University on behalf of the Washington State Department of Social and Health Services Economic Services Administration.[17]
- The Human Resources Administration (HRA) of the City of New York conducted a study of former

welfare recipients in NEW YORK CITY in 1998. They found that only 36 percent of respondents who had held jobs at any time sinceleaving welfare received health insurance from their employers.[18]

- The evaluation of FLORIDA's Family Transition Program (FTP), conducted by Manpower Demonstration Research Corporation, found that only 43 percent of recipients who found jobs were *offered* health insurance by their employer.[19] The data do not indicate how many people could afford and actually purchased such coverage.
- A study conducted by the Texas Department of Human Services (DHS) tracked people who left welfare and people who were diverted from applying for welfare in TEXAS. DHS found that, overall, 40 percent of respondents were *offered* health insurance by their employer, but it is unclear how many could actually afford that coverage. [20]

What Exit Studies and Evaluations Tell Us About Medicaid Participation after Welfare

Some people who leave welfare become ineligible for Medicaid because they have higher income levels. Many, however, remain eligible but lose coverage when states improperly terminate their Medicare coverage. The surveys described show that people lose Medicaid when they leave welfare, even if they remain eligible.

The previously mentioned study of former welfare recipients in NEW YORK CITY found that, of respondents working at the time of the survey (about six months after they left welfare), 46 percent were uninsured and only 14 percent were receiving Medicaid. Of those who were uninsured, all were eligible for Transitional Medicaid, but had not received it.[21]

A study of the employment and earnings of single parent families on welfare in Milwaukee, WISCONSIN looked at families that had left welfare in September 1996. The researchers found that, three months later, at least 45 percent were no longer receiving Medicaid.[22]

A recent study in WASHINGTON surveyed families who left welfare between December 1997 and March 1998 and families who left welfare between April and July 1998. The study shows that, for both groups, only about 60 percent of the children had received Medicaid after leaving welfare and only about 40 percent of adults had received Medicaid after leaving welfare.[23]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAR 2 2 1999

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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

DECLINING MEDICAID ROLLS

It is too early to tell whether welfare reform has affected Medicaid enrollment. State variation in the timing and nature of welfare reform programs, variation in state Medicaid policies, and improving national economic conditions make it difficult to generalize about the impact of welfare reform on Medicaid enrollment nationally. In addition, the state and national data necessary for such analysis are only gradually becoming available. While it is too early to tell whether welfare reform may have an indirect effect on Medicaid enrollment, we are doing everything possible to ensure it does not.

The number of people in poverty is steadily decreasing. Between 1995 and 1997, the total population in poverty has fallen by 800,000 (2.3 percent). A drop of 600,000 in the number of poor children made up a significant share of the decline. These declines continue a downward trend in poverty numbers that began with this Administration. Since 1993, the number of poor adults has fallen by almost 4 million (9 percent) and the number of poor children has fallen by 1.6 million (10.3 percent).

The availability of Medicaid through non-welfare related routes preserves current coverage. Although the number of adults and children receiving welfare related Medicaid fell by about 25 percent, the number who receive non-welfare related Medicaid rose by approximately 23 percent. This preliminary data indicates that the President has kept his promise to maintain the Medicaid entitlement and guarantee continued Medicaid coverage to all adults and children who were then eligible for the program before the passage of welfare reform.

The number of poor people with private health insurance coverage has increased. In addition to the overall drop in the number of poor people since 1995, the number of poor adults and children has increased since the advent of welfare reform by 200,000 and 100,000 respectively.

Table 1: S ▸ Allocations and Expenditures from $500 lion Fund, of 3-99

STATE	Total (Base and Secondary) State Allocation from $500 million TANF fund	Expenditures from $500 million TANF fund, as of 3-99	%Spent of Total Allocation	Amount Remaining of Allocation, as of 3-99	Date by which funds must be used (no later than 9/30/00)
ALABAMA	$ 6,504,897	$ 0	0%	$ 6,504,897	11/15/99 •
ALASKA	$ 3,039,335	$ 7,500	0%	$ 3,031,835	07/01/00
ARIZONA	$ 7,691,603	$ 17,901	0%	$ 7,673,702	10/01/99 •
ARKANSAS	$ 5,095,513	$ 1,117,803	22%	$ 3,977,710	07/01/00
CALIFORNIA	$ 83,719,458	$ 4,453,468	5%	$ 79,265,990	11/26/99 •
COLORADO	$ 5,166,316	$ 0	0%	$ 5,166,316	07/01/00
CONNECTICUT	$ 5,756,737	$ 0	0%	$ 5,756,737	10/01/99 •
DELAWARE	$ 2,801,757	$ 233	0%	$ 2,801,524	03/10/00
DISTRICT OF COLUMBIA	$ 3,259,072	$ 0	0%	$ 3,259,072	03/01/00
FLORIDA	$ 22,262,239	$ 950,856	4%	$ 21,311,383	10/01/99 •
GEORGIA	$ 11,591,549	$ 0	0%	$ 11,591,549	01/01/00 •
HAWAII	$ 3,435,742	$ 0	0%	$ 3,435,742	07/01/00
IDAHO	$ 3,288,535	$ 541,328	16%	$ 2,747,207	07/01/00
ILLINOIS	$ 19,363,894	$ 15,016	0%	$ 19,348,878	07/01/00
INDIANA	$ 7,545,162	$ 452,521	6%	$ 7,092,641	10/01/99 •
IOWA	$ 4,782,362	$ 2,405,247	50%	$ 2,377,115	01/01/00
KANSAS	$ 4,496,386	$ 389,409	9%	$ 4,106,977	10/01/99 •
KENTUCKY	$ 7,269,014	$ 0	0%	$ 7,269,014	10/18/99 •
LOUISIANA	$ 9,029,185	$ 0	0%	$ 9,029,185	01/01/00
MAINE	$ 3,569,238	$ 0	0%	$ 3,569,238	11/01/99 •
MARYLAND	$ 7,595,943	$ 0	0%	$ 7,595,943	12/09/99 •
MASSACHUSETTS	$ 9,463,490	$ 1,696,987	18%	$ 7,767,503	09/30/99 •
MICHIGAN	$ 16,975,445	$ 2,606,516	16%	$ 13,368,929	09/30/99 •
MINNESOTA	$ 7,708,788	$ 3,798,670	49%	$ 3,910,099	07/01/00
MISSISSIPPI	$ 6,617,604	$ 197,678	3%	$ 6,419,926	10/01/99 •
MISSOURI	$ 8,561,965	$ 3,298,443	39%	$ 5,263,522	12/01/99 •
MONTANA	$ 2,764,134	$ 7,653	0%	$ 2,756,481	02/01/00
NEBRASKA	$ 3,308,247	$ 0	0%	$ 3,308,247	12/01/99 •
NEVADA	$ 3,258,808	$ 3,258,808	100%	$ 0	12/03/99 •
NEW HAMPSHIRE	$ 2,875,952	$ 302,916	11%	$ 2,573,036	10/01/99 •
NEW JERSEY	$ 11,012,253	$ 3,078,591	28%	$ 7,933,662	02/01/00
NEW MEXICO	$ 4,860,333		0%	$ 4,860,333	07/01/00
NEW YORK	$ 37,034,556	$ 387,892	1%	$ 36,646,664	12/02/99 •
NORTH CAROLINA	$ 11,550,703	$ 0	0%	$ 11,550,703	01/01/00
NORTH DAKOTA	$ 2,537,922	$ 47,094	2%	$ 2,490,828	07/01/00
OHIO	$ 16,909,161	$ 2,915,724	17%	$ 13,993,437	10/01/99 •
OKLAHOMA	$ 5,938,082	$ 291,222	5%	$ 5,646,860	10/01/99 •
OREGON	$ 5,740,656	$ 1,497,655	26%	$ 4,243,001	10/01/99 •
PENNSYLVANIA	$ 17,553,339	$ 2,854	0%	$ 17,550,485	03/03/00
RHODE ISLAND	$ 3,459,771	$ 3,002	0%	$ 3,456,769	05/01/00
SOUTH CAROLINA	$ 6,221,783	$ 0	0%	$ 6,221,783	10/12/99 •
SOUTH DAKOTA	$ 2,642,597	$ 824,458	31%	$ 1,818,139	12/01/99 •
TENNESSEE	$ 9,250,889	$ 0	0%	$ 9,250,889	10/01/99 •
TEXAS	$ 27,523,806	$ 0	0%	$ 27,523,806	11/05/99 •
UTAH	$ 4,006,172	$ 0	0%	$ 4,006,172	10/01/99 •
VERMONT	$ 2,891,672	$ 0	0%	$ 2,891,672	09/20/99 •
VIRGINIA	$ 8,531,522	$ 2,020,109	24%	$ 6,511,413	02/01/00
WASHINGTON	$ 10,443,170	$ 2,364,205	23%	$ 8,078,965	01/10/00
WEST VIRGINIA	$ 5,420,593	$ 121,629	2%	$ 5,298,964	01/11/00
WISCONSIN	$ 7,023,766	$ 49,362	1%	$ 6,974,404	09/30/99 •
WYOMING	$ 2,475,344	$ 212,028	9%	$ 2,263,316	01/01/00
TOTAL	$ 490,826,441	$ 39,333,778	8%	$ 451,492,663	

Source: Health Care Financing Administration, financial information; Agency for Children and Families, dates of fund expiration.

18 by 10/31/9

28 by 12/31/9

Administration for Children and Families
U.S. Department of Health and Human Services

STATUS OF TANF PLANS
as of 9/29/97 10:00AM

Source: U.S. Dept. of Health & Human Services/Administration for Children & Families

States/D.C./Territories submitted: 51	Tribes submitted: 11
States/D.C./Territories certified: 51	Tribes certified: 10*
States/D.C. pending: 0	Tribes pending: 1
*NOTE: Tribal plans are approved, unlike state and territory plans which are certified.	

In effect
Latest

Subm Date Certified Approval Effective Later of A

Wisconsin	8/22/96	9/30/96	09/30/96
Michigan	8/27/96	9/30/96	09/30/96
Ohio	9/19/96	11/1/96	10/01/96 ✓
Florida	9/20/96	10/8/96	10/01/96 ✓
Vermont	9/20/96	11/18/96	09/20/96
Massachusetts	9/23/96	1/28/97	09/30/96 ✓
Maryland	9/27/96	1/10/97	12/09/96 ✓
Oregon	9/27/96	11/1/96	10/01/96
Arizona	9/30/96	11/1/96	10/01/96
Kentucky	9/30/96	11/18/96	10/18/96
Maine	9/30/96	12/27/96	11/01/96
Oklahoma	9/30/96	11/1/96	10/01/96
Tennessee	9/30/96	12/20/96	10/01/96
Utah	9/30/96	12/13/96	10/01/96
Alabama	10/1/96	12/7/96	11/15/96
Connecticut	10/1/96	1/22/97	10/01/96 ✓
Indiana	10/1/96	11/1/96	10/01/96

Kansas	10/1/96	11/27/96	10/01/96
Louisiana	10/1/96	1/10/97	01/01/97
Mississippi	10/1/96	11/27/96	10/01/96
Missouri	10/1/96	12/23/96	12/01/96
Nebraska	10/1/96	12/7/96	12/01/96
New Hampshire	10/1/96	11/12/96	10/01/96
South Dakota	10/1/96	12/7/96	12/01/96
Texas	10/1/96	11/26/96	11/05/96
Red Cliff Band of Lake Superior Chippewas (WI)	10/2/96	9/29/97	10/1/97
California	10/9/96	12/7/96	11/26/96
New Jersey	10/15/96	1/29/97	02/01/97
South Carolina	10/12/96	1/3/97	10/12/96
New York	10/17/96	12/13/96	12/02/96
Wyoming	10/17/96	12/23/96	01/01/97
Nevada	10/18/96	12/24/96	12/03/96
North Carolina	10/18/96	1/10/97	01/01/97
Montana	11/1/96	2/13/97	2/1/97
Georgia	11/15/96	1/21/97	01/01/97
Iowa	11/15/96	1/21/97	01/01/97
West Virginia	11/26/96	2/13/97	01/11/97
District of Columbia	12/4/96	4/2/97	03/01/97
Virginia	12/6/96	2/21/97	02/01/97
Washington	12/12/96	1/14/97	01/10/97
Guam	1/9/97	6/27/97	07/01/97
Delaware	1/22/97	4/11/97	03/10/97
Pennsylvania	1/22/97	4/23/97	03/03/97
Osage Tribe (OK)	2/21/98		
Forest County Potawatomi (WI)	3/4/97	6/30/97	7/1/97
Rhode Island	3/13/97	6/9/97	05/01/97
Klamath Tribe (OR)	3/20/97	5/15/97	7/1/97

New Mexico	4/4/97	6/5/97	07/01/97
Hawaii	4/7/97	6/27/97	07/01/97
Minnesota	5/1/97	7/1/97	07/01/97
North Dakota	5/1/97	6/26/97	07/01/97
Colorado	5/13/97	6/27/97	07/01/97
Sokaogon Chippewa (WI)	5/14/97	9/29/97	10/1/97
Idaho	5/15/97	6/27/97	07/01/97
Illinois	5/19/97	7/1/97	07/01/97
Arkansas	5/21/97	6/26/97	07/01/97
Stockbridge-Munsee (WI)	5/22/97	9/29/97	10/1/97
Virgin Islands	5/22/97	6/30/97	07/01/97
Alaska	5/30/97	6/27/97	07/01/97
Sisseton-Wahpeton (SD)	6/3/97	9/29/97	10/1/97
Puerto Rico	6/12/97	6/30/97	07/01/97
Confederated Tribes of Siletz Indians	6/26/97	9/29/97	10/1/97
Pascua Yaqui (AZ)	6/27/97	10/21/97	11/1/97
White Mountain Apache	6/30/97	10/24/97	11/1/97
Southern Callifornia Tribal Chairman's Association	1/30/98	2/25/98	3/1/98

Department of Health and Human Services
Welfare Reform
Administration for Children and Families
Return to the ACF Welfare Reform Information Main Page

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Questions? Contact: ACF Public Affairs: 202-401-9215 or e-mail us.

OPTIONS TO EXTEND THE LIFE OF THE $500 MILLION FUND FOR TANF-MEDICAID OUTREACH

BACKGROUND

(h) TRANSITIONAL INCREASED FEDERAL MATCHING RATE FOR INCREASED ADMINISTRATIVE
COSTS.--

(1) IN GENERAL.--Subject to the succeeding provisions of this subsection, the Secretary shall
provide that with respect to administrative expenditures described in paragraph (2) the per centum specified in section 1903(a)(7) shall be increased to such percentage as the Secretary specifies.
(2) ADMINISTRATIVE EXPENDITURES DESCRIBED.--The administrative expenditures described
in this paragraph are expenditures described in section 1903(a)(7) that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs of eligibility determinations that (but for the enactment of this section) would not be incurred.
(3) LIMITATION.--The total amount of additional Federal funds that are expended as a result of the application of this subsection for the period beginning with fiscal year 1997 and ending with fiscal year 2000 shall not exceed $500,000,000. In applying this paragraph, the Secretary shall ensure the equitable distribution of additional funds among the States.
(4) TIME LIMITATION.--This subsection shall only apply with respect to a State for expenditures incurred during the first 12 calendar quarters in which the State program funded under part A of title IV (as in effect on and after the welfare reform effective date) is in effect.

(i) WELFARE REFORM EFFECTIVE DATE.--In this section, the term "welfare reform date" means the
effective date, with respect to a State, of title I of the Personal Responsibility and Work Opportunity
Reconciliation Act of 1996 (as specified in section 116 of such Act)[328].

Availability and use of 1931(b) outreach funds

Background:

- Section 1931(h) of the Personal Responsibility and Work Opportunity Act provided for a $500 million fund available to States at enhanced Federal matching rates for certain administrative expenditures. This provision was implemented in a Federal Register notice (MB-110-NC) and an All-State Medicaid Director Letter from the Medicaid Bureau, both dated May 14, 1997. Section 1931(h)(3) of the Act established a $500 million fund and provided the authority for DHHS to establish a basis for allocating the fund among States.
- Section 1931(h)(3) of the Act further stipulates that these funds must be used within "the period beginning with fiscal year 1997 and ending with fiscal year 2000."
- Section 1931(h)(4) of the Act stipulates that States' allocations of the $500 million fund are available for expenditures "incurred during the first 12 calendar quarters in which the State program funded under part A of title IV (as in effect on and after the welfare reform effective date) is in effect." [Part A of title IV refers to pre-reform provisions-- the regulations state that these outreach funds are "available ... only during the first 12 calendar quarters in which the State's Temporary Assistance to Needy Families program ... is in effect after August 21, 1996."]

California's timeline for TANF implementation:

- The "effective date" for California's TANF program was 11/26/96. This is the date when ACF "certified as complete" California's TANF program, notifying the State that their TANF program met statutory requirements. The approval was not retroactive. HCFA has interpreted this to mean that the TANF program was in effect during the first quarter of FY 1997. Hence, the 12 quarter period for California was established as 10/1/96 through 9/30/99.
- California began expending TANF funds in December 1996.
- California later changed their TANF program by enacting CalWORKS. AB 1542, the bill that enacted CalWORKS, was signed on August 11, 1997.
- The effective date for CalWORKS was January 1998. The 58 counties began enrolling eligible recipients into CalWORKS throughout 1998.
- California implemented its 1931 group under its Medi-Cal program in January 1998.

California's allocation of funds:

- California's allotment of the Federal outreach funds is $83,719,458. To date, they have allocated $17.9 million of these funds through contracts with counties. Many counties have in turn subcontracted with community organizations to carry out outreach activities.
- California began claiming the enhanced administrative funds in the quarter ending 9/30/98. Through the quarter ending 3/31/99, California has claimed $13.1 million.
- The State and advocates are concerned that the September 1999 end date for use of the State's outreach allocation will occur around the same time that TANF benefits will be discontinued for many recipient, and when outreach efforts would be particularly useful. Further, some of the community organizations that have contracted with the State for use of a portion of these outreach funds have remaining funds available for outreach, should the State's end date for use of the funds be extended.

May 14, 1997

Dear State Medicaid Director:

This letter and attachments provides guidance on how State Medicaid Agencies must report, and the Health Care Financing Administration (HCFA) will track, certain Medicaid administrative expenditures and budget projections relating to the provision of the Welfare Reform legislation (Public Law 104-193, enacted August 22, 1996), the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which established a special $500 million fund available to States for enhanced Federal matching for such expenditures.

In consultation with State intergovernmental groups, HCFA allocated two amounts from the $500 million fund to each State Agency, to be used for allowable expenditures. The first allocation is a minimum amount and is generally the same for all States ($2 million). States may make claims for any allowable expenditures against this allocation at the enhanced Federal matching rate of 90 percent. The second amount differs among States and was based on State specific factors such as caseload and Medicaid administrative expenditures. States may make claims for allowable expenditures against this allocation at two rates, 90 or 75 percent, relating to the category of expenditure.

The allocated funds are available to each State for certain administrative expenditures attributable to the costs of Medicaid eligibility determinations related to this Welfare Reform provision and incurred during the first three years the State's Temporary Assistance for Needy Families (TANF) program is in effect, but no earlier than October 1, 1996 and no later than September 30, 2000.

There are 3 attachments to this letter. The first attachment contains more detailed guidance describing this provision and the reporting requirements that States must follow in order to claim for allowable expenditures at the enhanced Federal matching rates. The second attachment is a chart showing the States' allocations from the $500 million enhanced Federal matching Fund. The third attachment is the Federal Register notice (MB-103-NC) implementing this provision.

If you have any questions or require further information, please contact your HCFA Regional Office.

Sincerely,

/s/

Judith D. Moore
Acting Director
Medicaid Bureau

ATTACHMENT

STATE REPORTING OF EXPENDITURES AND BUDGET PROJECTIONS RELATING TO $500 MILLION ENHANCED FEDERAL MATCHING FUND

Background - Repeal of the AFDC Program. Title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) replaced the open-end funded Aid to Families with Dependent Children (AFDC) cash assistance program with the block grant funded Temporary Assistance for Needy Families (TANF) program. Previously, receipt by a family of cash assistance under the AFDC program conferred automatic Medicaid eligibility. Under section 1931 of the Social Security Act (the Act), as amended by section 114(a) of PRWORA, in general State agencies must provide Medicaid eligibility to those low-income families meeting the eligibility requirements for AFDC under the States' AFDC State plans in effect as of July 16, 1996.

$500 Million Fund Established. To assist State Medicaid agencies with the additional Medicaid administrative expenditures that they will incur as a result of determining AFDC-related Medicaid eligibility, section 1931(h) of the Act, established a $500 million enhanced Federal matching fund and directed the Secretary of the Department of Health and Human Services to ensure the equitable distribution of the fund among the States and territories.

Two Allocations Of The Fund For Each State. In consultation with State intergovernmental groups, the Health Care Financing Administration (HCFA) allocated two amounts to each State agency from the $500 million fund: a minimum (Base) Allocation which is generally the same for all States ($2,000,000); and an additional amount (Secondary Allocation), which differs among States and was allocated in accordance with a formula based on State specific factors such as caseload and Medicaid administrative expenditures. State agencies may claim Federal funding for allowable activities against the Base Allocation at a 90-percent enhanced Federal matching rate. States may claim Federal funding for allowable activities against the Secondary Allocation at two rates: a 90-percent enhanced Federal matching rate for specified activities considered critical to protecting recipients; and a 75-percent enhanced Federal matching rate for other allowable activities.

Period for Which Enhanced Funds Are Available. A State agency may claim enhanced Federal matching funds for allowable expenditures incurred during the first 12 calendar quarters (3 years) in which the State's TANF program is in effect. Furthermore, the enhanced Federal matching funds are only available for allowable expenditures for the period beginning with Federal fiscal year 1997 (that is October 1, 1996) and ending with Federal fiscal year 2000 (that is, September 30, 2000).

One Enhanced Federal Matching Rate for the Base Allocation. We established the higher 90-percent enhanced Federal matching rate associated with the Base Allocation to recognize the pressing startup and other common costs among States related to the transition from AFDC to the TANF program. The higher Federal matching rate for the Base Allocation will help expedite funds to States for such costs.

Two Enhanced Federal Matching Rates for the Secondary Allocation. We established the two enhanced Federal matching rates associated with the Secondary Allocation to recognize two priorities of activities related to this provision. Items of the highest priority are indicated in the Allowable Activities section below by an asterisk (*) and are claimed at the higher 90-percent Federal matching rate. These items are associated with beneficiary oriented activities such as outreach, public service announcements, and education. The higher 90 percent enhanced rate encourages such activities and recognizes the importance of ensuring that individuals do not lose their eligibility inappropriately, are correctly determined (or redetermined) eligible, and understand program requirements during the critical period of transition to TANF. The lower 75-percent enhanced Federal matching rate addresses the other activities performed during the transition period.

Allowable Activities. Expenditures for activities allowable for enhanced Federal matching funds under this provision include only those that would otherwise be Federally matched as Medicaid administrative expenditures at a 50 percent rate under section 1903(a)(7) of the Act. These are expenditures attributable to the increased administrative costs of Medicaid eligibility determinations and directly related activities incurred because of the transition from AFDC to TANF, and resulting from the enactment of section 1931 of the Act. For example, expenditures related to new Medicaid eligibility workers (including outstationed eligibility workers) hired by a State to implement the provisions of section 1931 of the Act would be allowable at the enhanced Federal matching rates. In addition, PRWORA activities performed by current eligibility workers would be allowable at the enhanced Federal matching rates. On the other hand, expenditures related to activities of outstationed eligibility workers who determine Medicaid eligibility for Supplemental Security Income (SSI) related individuals, such as the aged and disabled, or other non-PRWORA activities would not be allowable at the enhanced Federal matching rates.

With respect to the Base Allocation all of the allowable activities on the following list would be claimable at the 90 percent enhanced Federal matching. With respect to the Secondary Allocation, those allowable activities indicated with an asterisk (*) would be claimable at the 90 percent enhanced Federal matching rate. The other allowable activities with no asterisk would be claimable against the Secondary Allocation at the 75 percent enhanced Federal matching rate.

- Educational activities (relating to current or potential beneficiaries).*
- Public service announcements (PSAs).*
- Outstationing of eligibility workers (more workers or new locations, for example, churches, day care centers, WIC offices, health care providers).*
- Training related to the section 1931 provisions--*
    - Eligibility workers
    - Providers
    - Outstationed eligibility workers and other individuals
    - Community

- Outreach activities (for example, general or targeted mailing campaigns, contracts to assist beneficiaries with the redetermination process).*
- Developing and disseminating new publications (targeted to at-risk populations).*
- Local community activities (for example, meetings with community leaders and speeches to community groups).*
- Hiring new Medicaid eligibility workers (related to section 1931 determinations).
- Designing new eligibility forms, for example, a single application for TANF and Medicaid whether eligibility is linked or not.
- Identification of "at-risk" TANF recipients (in this context, at-risk refers to vulnerability to losing Medicaid eligibility as a result of the TANF provisions).
- State and local government organizational changes related to the section 1931 provisions.
- Intergovernmental activities.
- Eligibility systems related changes.
- Other activities identified by States and approved by the Secretary as applicable to the enhanced matching fund provisions.

In order for State agencies to claim Federal funds for these allowable activities at the appropriate enhanced Federal matching rates associated with the two allocations, and for HCFA to properly track State expenditures against the allocations, States will need to report the expenditures on the Form HCFA-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance program) and Form HCFA-37 (Medicaid Program Budget Report), as described in the sections below.

REPORTING EXPENDITURES FOR STATE AND LOCAL ADMINISTRATION - FORM HCFA-64.10 AND 64.10P

Waiver Schedules of the Forms HCFA-64.10/10p). In order for State agencies to claim Federal funds for allowable administrative activities at the correct enhanced Federal matching rates associated with the Base and Secondary Allocations, and for HCFA to track State expenditures against the two allocations, States must create two separate waiver schedules for the Form HCFA-64.10, one for each of the two allocations. Note, line 14 of the Form HCFA-64.10 has previously allowed Federal share entries to be reported only in column (d) at the 50 percent rate. In order to allow the reporting of expenditures at the enhanced Federal matching rates of 90 and 75 percent, the Medicaid Budget and Expenditure System (MBES) has been modified to

allow entries to be reported on the Form HCFA-64.10 in columns (b) at 90 percent, and (c) at 75 percent.

Base Allocation. In order to report and claim expenditures against the Base Allocation at the associated 90 percent Federal matching rate, the State must create a waiver schedule of the Form HCFA-64.10, indicating "TANF" in the "TYPE OF WAIVER" block and "BASE ALLOC" in the "WAIVER NUMBER" block. All allowable expenditures for which States are claiming against the Base allocation must be reported on line 14 (OTHER FINANCIAL PARTICIPATION) of this waiver schedule of the Form HCFA-64.10. The total computable amounts must be reported in column (a) and the (90 percent) Federal share amounts must be reported in columns (b) and (f).

Secondary Allocation. In order to report and claim expenditures against the Secondary Allocation at the associated 90 and 75 percent Federal matching rates, the State must create a waiver schedule of the Form HCFA-64.10, indicating "TANF" in the "TYPE OF WAIVER" block and "SECONDARY ALLOC" in the "WAIVER NUMBER" block. All allowable expenditures for which States are claiming against the Secondary allocation must be reported on line 14 (OTHER FINANCIAL PARTICIPATION) of this waiver schedule of the Form HCFA-64.10. The sum of all the total computable amounts for both the 75 percent and the 90 percent activities must be reported in column (a). The 90 percent Federal share amounts must be reported in column (b) and the 75 percent Federal share amounts must be reported in column (c). The sum of the Federal share amounts reported in columns (b) and (c) must be reported in column (f).

Base Form of the Form HCFA-64.10. Line 14 of the base form of the Form HCFA-64.10 must include the combined totals in each of the columns from all the "TANF" waiver forms, as well as the usual current administrative expenditures reported by the States on this form. Note, any entries on the base form of the Form HCFA-64.10 in columns (b) at 90 percent and (c) at 75 percent must reflect only the TANF expenditures related to the Base and Secondary Allocations.

The following example illustrates how to complete the Form HCFA-64.10/10p.

> **Example.** For the third quarter of FY 1999 the State has the following current quarter total computable "Other Financial Participation" administrative expenditures:
>
> - $100,000,000 in regular Medicaid administrative expenditures
> - $6,500,000 in total administrative expenditures for allowable TANF related activities:
>   - $1,000,000 in expenditures for TANF activities to be applied towards the Base Allocation at 90 percent.
>   - $3,000,000 in expenditures for TANF activities to be applied towards the Secondary Allocation at 90 percent.
>   - $2,500,000 in expenditures for TANF activities to be applied towards the

Secondary Allocation at 75 percent.

- $50,000 in prior period expenses. In addition to the above current quarter expenditures, in the third quarter of FY 1999 the State has $50,000 of total computable allowable TANF related expenditures related to a prior period, FY 1998, to be reported against the Secondary Allocation at 75 percent.

In order to report the above regular and TANF related administrative expenditures, the State will need to do the following:

- For the Base Allocation current quarter expenditures, create a Form HCFA-64.10 waiver schedule for the third quarter of FY 1999, indicating on line 14 $1,000,000 in Column (a) and $1,000,000 in column (b). The system will calculate the federal share of $900,000 (90 percent of $1,000,000) for column (b) and report $900,000 in column (f). Indicate "TANF" as the Type of Waiver and "BASE ALLOC" as the Waiver Number. Indicate June 30, 1999 in the Quarter Ended block.

- For the Secondary Allocation current quarter expenditures, create a Form HCFA-64.10 waiver schedule for the third quarter of FY 1999, indicating on line 14 $5,500,000 ($3,000,000 plus $2,500,000) in column (a), $ 3,000,000 in column (b), and $2,500,000 in column (c). The system will compute $2,700,000 in column (b) (90 percent of $3,000,000), $1,875,000 in column (c) (75 percent of $2,500,000) , and $4,575,000 in column (f) ($2,700,000 plus $1875,000). Indicate "TANF" as the Type of Waiver and "SECONDARY ALLOC" as the Waiver Number. Indicate June 30, 1999 in the Quarter Ended block.

- Base Form HCFA-64.10. For line 14 of the third quarter FY 1999 current quarter expenditures base Form HCFA-64.10, indicate $106,500,000 total computable in column (a), $4,0000,000 in column (b), $2,500,000 in column (c), and $100,000,000 in column(d). The system will compute $3,600,000 (Federal share at 90 percent) in column (b), $1,875,000 (Federal share at 75 percent) in column (c), $50,000,000 (Federal share at 50 percent) in column (d), and $55,475,000 total Federal share in column f). Indicate June 30, 1999 in the Quarter Ended block.

- For the FY 1998 prior period expenditures applicable to the Secondary Allocation, create a Form HCFA-64.10p waiver schedule for FY 1998, indicating on line 14 $50,000 in columns (a) and (c). The system will compute $37,300 (75 percent of $50,000) in columns (c) and (f). Indicate "TANF" as the Type of Waiver and "SECONDARY ALLOC" as the Waiver Number. Indicate June 30, 1999 in the Quarter Ended block. Indicate 1998 in the Fiscal Year block.

- Summary Form HCFA-64. Finally, the total computable amounts of $106,500,000, and the associated Federal shares of $55,475,000, for the current third quarter of FY 1999 (which were reported on the base Form HCFA-64.10),

will be included on line 6 in columns (c) and (d) of the summary Form HCFA-64.

The total computable amount of $50,000, and the associated Federal shares of $37,300 for the prior period FY 1998, will be included on line 7 in columns (c) and (d) of the summary Form HCFA-64.

TRACKING ALLOWABLE EXPENDITURES AGAINST THE STATE ALLOCATIONS

Section 1931(h) of the Act provides for enhanced Federal matching for States' claims against the Base and Secondary Allocations. These enhanced Federal matching rates are in addition to Federal funds that would ordinarily be available for such expenditures at the 50 percent matching rate available under section 1903(a)(7) of the Act. Therefore States' claims for allowable administrative activities will reduce their Base and Secondary Allocations only by the amounts that are in excess of the usual 50 percent Federal matching rate, and not by the entire Federal matching amount. Specifically, States' allocations will be reduced by the amount of the claim multiplied by the difference between the enhanced Federal matching rate percentage and the (usual) 50 percent rate.

Using the example above, the State's allocations would be reduced by the following:

- The Base Allocation would be reduced by $400,000 (900,000 - $500,000) with respect to the total computable expenditure of $1,000,000, which received 90 percent Federal matching.

- The Secondary Allocation would be reduced by $1,200,000 ($2,700,000 - $1,500,000) with respect to the total computable expenditure of $3,000,000, which received 90 percent Federal matching.

- The Secondary Allocation would be reduced by $625,000 ($1,875,000 - $1,250,000) with respect to the total computable expenditure of $2,500,000, which received 75 percent Federal matching.

- The Secondary Allocation would be reduced by $12,500 ($37,500 - $25,000) with respect to the prior period total computable expenditure of $50,000, which received 75 percent Federal matching.

The above amounts will be tracked against the States' respective Base and Secondary Allocations by the grants analysts in the HCFA's Medicaid Bureau and reflected in the quarterly grant awards for each State.

POSSIBLE REALLOCATION OF FUNDS: TRACKING ALLOWABLE EXPENDITURES AFTER THE ALLOCATIONS ARE MET

Once a State's has claimed up to its Base and Secondary allocations (that is, the State's

allocations have been reduced to $0) Federal funds will only be available for allowable expenditures at the usual 50 percent matching rate. However, it is possible that certain States may never reach their allocations; that is, they may not incur sufficient expenditures during the applicable period to use up their entire allocations. If there are such unused funds, HCFA would reallocate the unused Federal funds to those other States that may have incurred allowable expenditures in excess of their allocations during the applicable period, if the excess allowable expenditures have been reported appropriately.

In order for HCFA to reallocate any potential unused amounts from the $500 million fund to those States that may be able to use them, and for such States to claim the reallocated fund at the enhanced Federal matching rates, the States will need to continue to report and HCFA will need to continue to track the amounts of allowable expenditures incurred by such States during the applicable period under these provisions. This would need to be done even after the States have reached their allocations in order for HCFA at the time of reallocation to identify and match the expenditures at the appropriate enhanced Federal matching rate. Therefore, States that want to be eligible for any potential reallocation will need to continue to report allowable expenditures, even after they have reached their allocations.

However, after a State has claimed up to its allocations, but prior to the availability of any reallocation, HCFA would have to defer or disallow claims for allowable expenditures at the enhanced Federal matching rates, if the State were to continue to report and claim the expenditures at the 90/75 percent enhanced Federal matching rate on line 14 columns (b) and (c) of the waiver schedule of Form HCFA-64.10/10p. That is, prior to the availability of any reallocated amounts, Federal funds would not yet be available for States' claims which are in excess of their State allocations at other than the 50 percent rate and amounts of claims in excess of 50 percent would have to be deferred or disallowed.

In order to avoid the need for deferral or disallowance actions yet still provide information that would be used by HCFA to pay claims against potential reallocated funds, States should continue to report the allowable expenditures in excess of its allocations, but only at the 50 percent rate, on line 14 in column (d) of the Secondary Allocation waiver schedule of Form HCFA-64.10/10p. Since these amounts will only be reported in the 50 percent column (d) on line 14, the State will also need to distinguish between amounts of the allowable expenditure that would be claimed at 90 or 75 percent. In order to properly distinguish these expenditures, States should use the narrative sheet of the Form HCFA-64 to indicate and separately identify the amounts of the expenditures that would have been claimed at 90 percent and at 75 percent.

> Example. A State has claimed up to its Base Allocation and Secondary Allocation by the end of FY 1998 (September 30, 1998). In the first quarter of FY 1999 the State has allowable TANF related expenditures which otherwise could have been claimed at the enhanced Federal Matching rates of 90 percent and 75 percent in the total computable amounts of $1 million and $2 million, respectively. On line 14 of the Secondary Allocation waiver schedule of the Form HCFA-64.10, the State should report $3 million ($1 million plus $2 million) in the total computable column (a) and $1.5 million (50 percent of $3 million) in the 50 percent Federal matching rate column (d). On the

narrative sheet of the HCFA-64, the State should indicate to the effect: "The $3 million total computable TANF related expenditures reported on line 14 in column (a) of the Secondary Allocation waiver schedule of the Form 64.10, represents $1 million in allowable expenditures for activities that could otherwise have been claimed at an enhanced Federal matching rate of 90 percent, and $2 million at 75 percent, except that the State has already claimed up to its TANF allocation."

MEDICAID PROGRAM BUDGET REPORT FORM HCFA-37.10

States must include and report all allowable TANF expenditures on line 14, Other Financial Services, of the Form HCFA-37.10. Include and enter the total computable portion in column A and the Federal share in column B. This line will no longer automatically calculate the Federal share in column B. After entering the total computable amount you must calculate the Federal share in order to receive reimbursement since line 14 will now reflect the multiple Federal matching rates. In order for HCFA to relate the amounts indicated on line 14 to the TANF provisions, the State must indicate in the narrative section of the Form HCFA-37.12 the amount of TANF expenditures they are requesting for both the Base and Secondary allocation. The example below illustrates the completion of the Form HCFA-37.

Example. For FY 1999 the State projects the following (dollars are in thousands):

- $100,000 in total computable regular line 14 Other Financial Participation administrative expenditures, to be Federally matched at 50 percent. The projected Federal share of this amount would be $50,000.
- $1,000 in total computable expenditures to be applied against the base allocation at the 90 percent Federal matching rate. The projected Federal share of this amount would be $900.
- $3,000 in total computable expenditures to be applied against the secondary allocation at the 90 percent Federal matching rate. The projected Federal Share of this amount would be $2,700.
- $2,550 in total computable expenditures to be applied against the secondary allocation at the 75 percent Federal matching rate. The projected Federal share of this amount would be $1,913.

In accordance with this information the State must complete the Form HCFA-37 as follows:

- On the Form HCFA-37.10, the State must report the following for budget year FY 1999:
  - $106,550 ($100,000 + $1,000 + $3,000 + $2,550) on line 14 column A.

- $55,513 ($50,000 + $900 + $2,700 + $1,913) on line 14 in column B.

- In the narrative section of the Form HCFA-37.12 the State must indicate language to the effect for FY 1999:

  - "Explanation of Line 14 of the Form HCFA-37.10. The $106,550 Other Financial Participation total computable expenditure amounts includes $100,000 in regular expenditures Federally matchable at 50 percent, and "Section 1931 related TANF expenditures" as follows: $1,000 applicable towards the Base Allocation and Federally matchable at 90 percent, $3,000 applicable to the Secondary Allocation and Federally matchable at 90 percent, and $2,550 applicable to the Secondary Allocation and Federally matchable at 75 percent. The $55,513 Other Financial Participation Federal Share expenditure amounts reflects the above total computable expenditures at the respective Federal Matching rates: $50,000, $900, $2,700, and $1913."

$500 MILLION ENHANCED MATCH ALLOCATION PERIOD		
ALABAMA	11/15/96	10/1/96 - 9/30/99
ALASKA	7/1/97	7/1/97 - 6/30/2000
ARIZONA	10/1/96	10/1/96 - 9/30/99
ARKANSAS	7/1/97	7/1/97 - 6/30/2000
CALIFORNIA	11/26/96	10/1/96 - 9/30/99
COLORADO	7/1/97	7/1/97 - 6/30/2000
CONNECTICUT	10/1/96	10/1/96 - 9/30/99
DELAWARE	3/10/97	1/1/97 - 12/31/99
DISTRICT OF COLUMBIA	3/1/97	1/1/97 - 12/31/99
FLORIDA	10/1/96	10/1/96 - 9/30/99
GEORGIA	1/1/97	1/1/97 - 12/31/99
GUAM	7/1/97	7/1/97 - 6/30/2000
HAWAII	7/1/97	7/1/97 - 6/30/2000
IDAHO	7/1/97	7/1/97 - 6/30/2000
ILLINOIS	7/1/97	7/1/97 - 6/30/2000
INDIANA	10/1/96	10/1/96 - 9/30/99
IOWA	1/1/97	1/1/97 - 12/31/99
KANSAS	10/1/96	10/1/96 - 9/30/99
KENTUCKY	10/16/96	10/1/96 - 9/30/99
LOUISIANA	1/1/97	1/1/97 - 12/31/99
MAINE	11/1/96	10/1/96 - 9/30/99
MARYLAND	12/9/96	10/1/96 - 9/30/99
MASSACHUSETTS	9/30/96	10/1/96 - 9/30/99
MICHIGAN	9/30/96	10/1/96 - 9/30/99
MINNESOTA	7/1/97	7/1/97 - 6/30/2000
MISSISSIPPI	10/1/96	10/1/96 - 9/30/99
MISSOURI	12/1/96	10/1/96 - 9/30/99
MONTANA	12/16/96	10/1/96 - 9/30/99
NEBRASKA	12/1/96	10/1/96 - 9/30/99
NEVADA	12/3/96	10/1/96 - 9/30/99
NEW HAMPSHIRE	10/1/96	10/1/96 - 9/30/99
NEW JERSEY	2/1/97	1/1/97 - 12/31/99
NEW MEXICO	7/1/97	7/1/97 - 6/30/2000
NEW YORK	12/2/96	10/1/96 - 9/30/99
NORTH CAROLINA	1/1/97	1/1/97 - 12/31/99
NORTH DAKOTA	7/1/97	7/1/97 - 6/30/2000
OHIO	10/1/96	10/1/96 - 9/30/99
OKLAHOMA	10/1/96	10/1/96 - 9/30/99
OREGON	10/1/96	10/1/96 - 9/30/99
PENNSYLVANIA	3/3/97	1/1/97 - 12/31/99
PUERTO RICO	7/1/97	7/1/97 - 6/30/2000
RHODE ISLAND	5/1/97	4/1/97 - 3/31/2000
SOUTH CAROLINA	10/12/96	10/1/96 - 9/30/99
SOUTH DAKOTA	12/1/96	10/1/96 - 9/30/99
TENNESSEE	10/1/96	10/1/96 - 9/30/99
TEXAS	11/6/96	10/1/96 - 9/30/99
UTAH	10/1/96	10/1/96 - 9/30/99
VERMONT	9/20/96	10/1/96 - 9/30/99
VIRGINIA	2/1/97	1/1/97 - 12/31/99
VIRGIN ISLANDS	7/1/97	7/1/97 - 6/30/2000
WASHINGTON	1/10/97	1/1/97 - 12/31/99
WEST VIRGINIA	1/11/97	1/1/97 - 12/31/99
WISCONSIN	9/30/96	10/1/96 - 9/30/99

Declining Medicaid Rolls

Introduction

This memo presents preliminary findings concerning welfare reform and dynamics in both welfare caseload and Medicaid enrollment. The findings are based on analyses of program data and the Current Population Survey (CPS) from 1995 through 1997, and on research on the subject and reports from the field.

Attachment 1 is a table that displays the data used for the analysis presented here. Attachment 2 outlines research that is underway or planned, and describes the efforts the Department and other parties are making to improve Medicaid outreach and increase participation among eligible children and families.

Background

Until passage of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA), eligibility for Medicaid was automatic for those receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program. PRWORA replaced AFDC with a new program of block grants to the states – Temporary Aid to Needy Families (TANF) – and severed the historical linkage between welfare and Medicaid eligibility for families. Also, together with sweeping changes in immigration law, PRWORA restricted the eligibility of new immigrants for Medicaid and welfare.

In a specific effort to preserve Medicaid coverage for those affected by welfare reform, PRWORA required states, under a new *section 1931*, to continue to provide Medicaid to families who meet the AFDC eligibility criteria that were in effect on July 16, 1996[1] – regardless of whether they are eligible for cash under their states' new TANF programs. Thus, states must, at a minimum, maintain their old AFDC eligibility criteria for purposes of determining Medicaid eligibility, even though they apply different eligibility criteria for TANF. However, under section 1931, states also have flexibility to expand Medicaid coverage beyond previous levels.

Acknowledging the new administrative burden on states that resulted from delinking Medicaid from cash receipt, PRWORA provided $500 million in enhanced matching funds to help states cover the increased costs associated with outreach and Medicaid eligibility determinations in the new environment. The law also gave states two new Medicaid options -- presumptive eligibility for children and 12-month continuous eligibility -- to improve coverage among poor families. Since PRWORA passed, HCFA, the Department, and others have undertaken substantial efforts to improve Medicaid outreach and increase the participation of eligible children and families at risk of losing Medicaid -- or never enrolling -- as a consequence of welfare changes. Further, the Children's Health Insurance Program (CHIP) provides a new mechanism for finding Medicaid-eligible children.

Current Findings

State variation in the timing and character of welfare reform, and variation in Medicaid policies and economic conditions, pose a formidable challenge to research aimed at defining or modeling the impact of welfare reform on Medicaid enrollment dynamics. Also, the state and national data necessary for such analysis are only gradually becoming available. For all these reasons, research is still at an early stage. Nonetheless, the following important preliminary findings can be drawn from data on poverty, welfare, and Medicaid (see Attachment 1).

* *Raw Poverty Numbers are Down* -- Between 1995 and 1997, the total population in poverty fell by 800,000 (2.3%). A drop of 600,000 in the number of poor children made up a significant share of the decline. These declines continued a downward trend in poverty numbers that began with this Administration. Since 1993, the number of poor adults has fallen by almost 4 million (9%) and the number of poor children has fallen by 1.6 million (10.3%).

* *But Poverty Rates Have Changed Little* -- Although the number of poor fell between 1995 and 1997, the poverty rate among adults fell only from 13.8% to 13.3% in this period, and the poverty rate among children fell by just under one point, from 20.8% to 19.9%. Nonetheless, these declines in the poverty rate continue a trend that began under this Administration: in 1993, the poverty rate among adults was 15.1% and the poverty rate among children was 22.7%.

* *Welfare Rolls Are Falling Much Faster than Poverty* -- From 1995 to 1997, when the population in poverty fell by 800,000, the average monthly welfare caseload dropped by 3 million -- a 23% decrease. The data show that the drop in welfare caseload appears to be accelerating rapidly: from 1995 to 1996, caseload fell by about 1 million; from 1996 to1997 caseload fell by an additional 2 million; and the newest available data, from 1997 to June 1998, show that the welfare caseload fell by another 2 million.

* *Medicaid Enrollment Is Dropping Much Less than Welfare Caseload* -- In contrast to the 3 million (23%) drop in welfare caseload from 1995 to 1997, the number of people enrolled in Medicaid fell by 1.1 million (2.7%) over this period. Although the number of adults and children receiving welfare-related Medicaid fell by about 25%, the number who receive non-welfare-related Medicaid rose by 23%. Because the increase in non-welfare-related Medicaid was not large enough to completely offset the decrease in welfare-related Medicaid, there were 600,000 fewer adults and 700,000 fewer children on Medicaid in 1997 than in 1995.

* *The Uninsured Rate and the Private Coverage Rate Among the Poor Have Both Increased* -- Despite the overall drop in the number of poor people since 1995, the number of poor adults and children who have private coverage rose by 200,000 and 100,000 respectively. At the same time, the number of poor adults and children who are

uninsured increased by about 250,000 each.

Discussion

It appears from the data that many low-income families -- especially children -- who can qualify for Medicaid through eligibility groups that are not tied to welfare are now being covered under such other categories. However, the net loss of 1.1 million people enrolled in Medicaid still warrants attention to ensure that those whose economic status has not improved, but who have been affected by welfare reform, make the transition from welfare-related to non-welfare-related Medicaid coverage.

It is unlikely that the 1.1 million-person decrease in the Medicaid rolls translated strictly into coverage losses among the poor. While the number of poor adults and children who were uninsured did indeed rise over this period (by 250,000 each), so did the number with private coverage (by 200,000 and 100,000, respectively). In addition, some of those no longer covered by welfare-related Medicaid could have been among the 800,000 people lifted out of poverty altogether; in that case, we can only speculate about whether they obtained private coverage or became uninsured as a result.

In short, the data suggest that despite the changes in welfare, the availability of Medicaid through non-welfare-related routes preserved coverage to a substantial extent. The Medicaid caseload drop in the poorest group bears watching, and closer study of the transitions experienced by this population since welfare reform is critical to better identification of gaps and better targeting of outreach. The 2.7% drop in total Medicaid enrollment also warrants notice, as net increases in Medicaid caseload might have been expected over this period if the phase-in of poverty-level children continued to add children to the rolls, and if section 1931 maintained enrollment of families, as intended.

The apparent acceleration of welfare caseload declines -- the rolls dropped by 1 million between January 1997 and June 1998 alone -- argues for careful monitoring with regard to Medicaid enrollment dynamics. Because the availability of Medicaid data lags behind welfare data, it remains to be seen whether non-welfare-related Medicaid eligibility continued to preserve coverage for the increasing numbers of people not on welfare, as well as it appeared to between 1995 and 1997.

Other Study Findings

The data findings of Medicaid coverage declines and rising uninsurance among the poor are consistent with the results of various studies that have specifically examined Medicaid enrollment and participation in relation to changes in welfare and immigration policy, as follows.

Medicaid caseload analysis

* In an analysis for the Urban Institute's *Assessing the New Federalism* (ANF) project, Ellwood and Ku analyzed Medicaid caseload changes between 1995 and 1996. They found a net decline of nearly 2 percent in Medicaid enrollment of children and non-disabled adults – the first downturn in nearly a decade of eligibility expansions and rising Medicaid participation rates.[2]

* Analyzing state Medicaid enrollment data from five states, Ellwood found enrollment drops from January 1995 to January 1998 of 12 to18 percent in New York, California, and Florida, and 29 percent in Wisconsin. Only Minnesota showed an increase, of 1 percent. However, this study did not track the insurance status of those who left Medicaid to determine what proportion found private coverage and what proportion became uninsured.

* An analysis of administrative data from Los Angeles County generated important findings regarding immigrants. Applications for Medicaid and welfare benefits by non-citizen-headed families declined sharply following enactment of PRWORA, while approvals of citizen cases did not change. Approvals of non-citizen-headed cases fell by 52% between January of 1996 and 1998, explaining the entire 23% drop in total approvals over the period. Non-citizen applications for Medicaid-only benefits also declined. Finally, the number of citizen children of non-citizen parents applying for Medicaid and welfare declined sharply -- approved applications dropped by 48% between January of 1996 and 1998, compared to a 6% increase for citizen children of citizen parents during the period.

Studies of welfare "leavers"

* Preliminary 1997 results from the National Evaluation of Welfare-to-Work Strategies (formerly the JOBS evaluation) indicate that as members of both experimental and control groups left AFDC in increasing numbers, health coverage among both groups declined. Evaluation sites that experienced greater impacts on employment and welfare receipt typically also had greater reductions in health coverage among the treatment group, despite increasing rates of employer sponsored insurance (ESI), because more families lost Medicaid than gained ESI. These findings will be addressed in greater detail in a forthcoming report.

* In a widely cited 1989-92 analysis of families leaving welfare, uninsurance among mothers exiting welfare was found to rise over the three years they were followed, from 23 to 45 percent. The study findings highlight the particular exposure of mothers, who are not protected by poverty-related Medicaid eligibility, and also the importance of Medicaid during the early period following exit, when low-wage work without ESI is typical.[3]

* A May 1997 GAO study of three states showed that, despite continued eligibility for Medicaid, participation plummeted in households where welfare benefits were

terminated. Before termination, Medicaid participation ranged from 84 to 100 percent across the three states; after termination, the rates ranged from 26 to 61 percent.[4]

* The finding of decreased Medicaid enrollment is also typical of states' own studies of their welfare "leavers." ESI increases have not offset these reductions in Medicaid enrollment.[5]

Effects of Re-engineering Welfare

Welfare reform profoundly changed both the administration of welfare and welfare "culture" in the states. The major restructuring of the welfare system and related operational challenges, and transformation in public attitudes toward welfare, may cause reduced participation in Medicaid as well as welfare during this period of fundamental transitions.

* As welfare offices are transformed into "job centers" and former caseworkers are re-trained as "job counselors," the new emphasis on job placement and reducing dependency may be eclipsing any focus on determining eligibility for medical (and food) assistance, despite their importance as work supports.

* Former welfare caseworkers, who in their new role, become front line Medicaid eligibility workers, may actually have little or no training or experience making Medicaid eligibility determinations. They may not understand that, unlike before, Medicaid eligibility for applicants does not flow strictly from receipt of cash benefits, and that applicants who do not qualify for TANF must be evaluated separately for Medicaid eligibility under section 1931.

* The profound changes in public attitudes toward welfare and in welfare itself (e.g., time limits) may result in fewer people entering welfare/job offices. Non-participation in welfare may cause non-participation in Medicaid as well if those who decline to apply for TANF do not make contact with the Medicaid program otherwise.

* Reports from the field provide mounting evidence that misinformation, confusion, and discouraging messages also contribute to suppressed Medicaid enrollment among eligible children and families, including immigrants.

* The New York Times recently reported that welfare offices in New York City, which are actively discouraging application for welfare, are also systematically failing to provide and process applications for Medicaid (and Food Stamps) promptly, despite clear federal policy guidance that they do so. City statistics show that while 53 percent of the people who asked to apply for welfare, food stamps and Medicaid were successful in the past, about 25 percent receive benefits at the city's new "job centers."

Conclusion

The net results of the latest data and research in this area counsel both concern and optimism. Medicaid enrollment is down overall during a period when increases might have been expected. Moreover, the fact that the net drop results from the decline in enrollment in the poorest Medicaid coverage group implies a need for more outreach to those who have dropped from the welfare caseload but remain eligible for Medicaid.

At the same time, the data indicate that the drop in Medicaid enrollment is nowhere near the level that many worried would result from welfare reform. A significant number of those no longer qualifying for welfare-related Medicaid appear to be finding their way into Medicaid through other eligibility pathways. Some of those who do not show up on the Medicaid rolls are families whom the economy has boosted out of poverty and/or into jobs with insurance. Some, like many young adults, do not realize the importance of having health insurance for themselves and their children. But clearly, some leaving the welfare-related Medicaid rolls, and some who do not show up in Medicaid as a result of the immigrant policy changes, are becoming uninsured.

The data findings should be considered preliminary and tentative and some caveats should be noted. The data sets analyzed measure different periods of time and they measure in substantially different ways. Furthermore, the data instruments are not sensitive to volatility in income, employment, and coverage within a year that undoubtedly complicate the results. Finally, the data cover only two years; as data from subsequent years become available, the longer series will provide a more reliable picture of trends in poverty and program participation.

Especially given reservations about the data currently available for analysis, other research and reports from the field are important sources of information and insight, and should help guide future study and monitoring efforts. It is clear from a mounting body of such work that confusion about eligibility, both in the public and among eligibility workers in state and local offices, is a consequence of the delinkage of Medicaid from welfare. The separate processing of Medicaid applications for those who are denied welfare benefits may not occur promptly or automatically. Formal and informal welfare diversion programs probably produce diversion from Medicaid as well, because while the programs are decoupled, many continue to believe that eligibility for them remains linked. If eligible families fail to become enrolled in Medicaid for any of these reasons, then the work support offered by transitional Medicaid will also remain unrealized. Finally, the welfare and immigration changes that have transformed the program have also changed the larger "culture," sending new messages that discourage participation, not only in welfare but also in other public benefits. Those who decline to apply for welfare may either decline to apply separately for Medicaid, or simply fail to.

The importance of health insurance for low-income families and children, and its importance as a work support, both suggest that dynamics in coverage among this population should be a critical focus of monitoring for the Department. In particular, we need to monitor states' implementation of welfare reform as it affects Medicaid, and their implementation of section 1931, so that we can more narrowly identify the obstacles to Medicaid participation and better design outreach efforts.

ATTACHMENT 1

Changes in Poverty and Program Caseload Between 1995 and 1997				
	1995	1997	Difference	Percent Change
CPS Poverty Data				
Total Population in Poverty	36.4 m	35.6 m	-800,000	-2.3%
Adults	21.8 m	21.5 m	-300,000	-1.4%
Children	14.7 m	14.1 m	-600,000	-3.8%
ACF Welfare Data				
Total AFDC/TANF Caseload	13.4 m	10.4 m	-3 m	-22.6%
HCFA Medicaid Data				
Total Medicaid Enrollment	41.4 m	40.3 m	-1.1 m	-2.7%
Non-Disabled Adults	9 m	8.4 m	-600,000	-6.3%
Welfare Related	5.4 m	4.0 m	-1.4 m	-26.0%
Non-Welfare Related	3.6 m	4.5 m	+800,000	+23.0%
Non-Disabled Children	20.4 m	19.6 m	-700,000	-3.5%
Welfare Related	11.2 m	8.4 m	-2.8 m	-25.0%
Non-Welfare Related	9.2 m	11.3 m	+2.1 m	+22.6%
CPS Insurance Data				
Poor Uninsured Adults	11 m	11.2 m	+250,000	+2.2%
Poor Uninsured Children	3.1 m	3.4 m	+250,000	+7.4%
Poor Adults w/ Private Coverage	8.1 m	8.3 m	+200,000	+1.8%
Poor Children w/ Private Coverage	2.7 m	2.8 m	+100,000	+4.1%

Note: Non-Disabled Adults + Non-Disabled Children do not add to Total Medicaid enrollment because Total Medicaid Enrollment includes SSI groups and the elderly.

Devorah R. Adler
03/18/99 02:55:00 PM

Record Type: Record

To: Laura Emmett/WHO/EOP

cc: Karin Kullman/OPD/EOP
Subject: nursing home guidance

apparently the press office was asking for this -- pls call with questions -- Courtney, can you have Elena clear this, please? thanks -- Devorah

Q: The GAO released several reports on Thursday that criticize HHS for lax oversight of state nursing home complaint investigations and insufficient penalties for facilities that are out of compliance. What is your response?

A: I have always demanded that states investigate all serious complaints promptly to ensure that residents are safe and well-cared for. Last July, I initiated a new nursing home quality initative that ensures swift and strong penalties for nursing homes failing to comply with standards, strengthened oversight of state enforcement mechanisms, and implemented unprecedented efforts to improve nutrition and prevent bed sores. I also invested over $60 million in his FY 2000 budget to support these new efforts.

However, we know that some states haven't taken their oversight responsibility seriously enough. On Thursday, I took strong new steps to address this problem, requiring States to investigate any complaint that alleges harm to a nursing home resident within 10 working days, requiring states to report all of these complaints to HHS' national database, creating a $1,000 minimum fine for facilities violating quality standards, and making it easier for states to impose fines of up to $10,000 for quality violations.

CURRENTS
of the
NEW YORK CITY CHAPTER
NATIONAL ASSOCIATION OF SOCIAL WORKERS
NASW

50 BROADWAY · 10TH FLOOR · NEW YORK, N.Y. 10004 · (212) 668-0050 JANUARY 1999 VOLUME XLI No. 4

Focus on Welfare Reform

Job Centers: NYC's diversion from aid = loss of human rights

As part of its plan to keep social workers informed of and involved in the latest developments in welfare reform, especially at the local level, the New York City Chapter's Task Force on Welfare Reform will run a series of articles in Currents, beginning with this one by Julie Carlson, a social work intern with the Urban Justice Center. Ms. Carlson, a student at the Hunter College School of Social Work, is helping to coordinate the Center's Human Rights Documentation Project. The Chapter's Task Force is doing cooperative work with the Center as well as with other area welfare advocacy groups as part of its effort to educate and activate social workers. This information was included in a recent presentation to the Chapter's Board of Directors.

The nation's punitive welfare reforms have spurred a new movement that defines the violation of welfare rights as a loss of human rights. As part of this effort, the Human Rights Documentation Project organized by the Urban Justice Center has been surveying applicants as they leave New York City's Income Maintenance Centers, now called "Job Centers."

As part of the new "work first" philosophy embodied in the latest welfare reform, the Human Resources Administration began converting its welfare of-

(Continued on page 8)

The Chapter's Welfare Reform Task Force reports to the Board of Directors: from left, Task Force members Dr. Mimi Abramovitz, Eri Noguchi, and Co-chair Diane Borko.

Managed Care Companies Reduce Social Work Fees

Two major managed care organizations have lowered the fees being paid to social workers for mental health services. NASW leaders are meeting with representatives of Magellen and Value Options to address this; political and legal strategies are being explored.

See page 3.

Focus on Welfare Reform

(Continued from page 1)

fices into Job Centers. Nine of the city's 33 welfare offices have already been converted and all 33 will be changed over within the next year. The stated goal of the Job Center is to help persons applying for public assistance, many of whom are women with children, find employment. Many observers agree, however, that the new policy's real purpose is to divert people from using the welfare program altogether. Unlike the former Income Maintenance Centers, which brought people, however begrudgingly, into the system, the Job Centers try to keep people out.

One of the most significant changes within the new Job Centers is that applicants are required to complete a complicated 35-50 day application process before they become eligible for welfare. Day One of this process begins with a five page form. Since these forms are only distributed before 9:30 am, many who arrive after that time are told to come back the next day. After completing the first form, most applicants must then wait all day to interview with a "financial planner" whose job it is to "help" applicants tap into financial resources other than welfare. That is, applicants are "encouraged" to turn to family, food pantries, soup kitchens-- anything but welfare--for help. Applicants who make it past the interview may apply for benefits. But to prove they are "truly needy," they must come back the next day to file a public assistance application form and continue meeting with a variety of other welfare officials.

While the public assistance application is being processed, the applicant must participate in mandated job search activities for seven hours a day. This consists of making calls to want ads listed in the paper and to employers in the phone book, even though these methods are well-known to be the least effective ways to find a job. If at any point during this process a person misses a Job Center appointment, s/he must start all over again. It is especially difficult to complete the Job Center requirements for those who are physically or mentally unable to maneuver through the confusing and demanding process. If no job is found within 35-50 days, the applicant is automatically placed in the Work Experience Program (WEP). WEP is New York City's version of "workfare" which requires welfare recipients to "work off" their benefits.

The Job Center may sound effective to some. However, experience shows that its main purpose is to make the process of applying for welfare so unpleasant and punitive that only the "most desperate" people will try. Prior to the Job Center conversions, the majority of welfare, Food Stamps and Medicaid applicants received benefits. Now only 25 percent do.

HRA would like us to believe that the tremendous drop in the welfare roles proves that people with dire economic needs do not want to work or aren't really in need of public assistance. However, the growing number of people utilizing food pantries, soup kitchens and shelters suggest otherwise. So do the realities of New York City's 9 percent unemployment rate, shrinking number of entry-level jobs, and lack of affordable child care.

Our data as part of the Human Rights Documentation Project remains preliminary. However, we have met many people who report they are not receiving emergency assistance (even though they qualify), child care, and other resources necessary to comply with mandated Job Center activities, such as carfare. The Center's diversion tactics have left so many without Food Stamps, Medicaid, and welfare, that federal Food Stamp and Medicaid authorities are investigating the Center process. Locally, the General Welfare Committee of the NYC Council is considering "right to apply" legislation to ensure that the Giuliani Administration obeys the law regarding the provision of social services.

Social workers see and understand first hand the devastating impact of such punitive welfare "reforms." The Human Rights Documentation Project would like to distribute our short survey to social workers. If you have contact with Job Center applicants and would like to join the effort to make the City honor its commitment to the poor, please call Tracy Morgan, CSW, Urban Justice Center, 212-533-0540 x343.

NASW's Welfare Reform Task Force welcomes new participants. For more information, call the Chapter office at (212) 668-0050.

Community Food Resource Center publishes advocates' guide to welfare rules

The Community Food Resource Center (CFRC) has just published "An Advocate's Guide to the Welfare Work Rules." This Guide is a valuable resource in enhancing advocacy work and will contribute to the protection and assertion of the legal rights of low-income New Yorkers in this critical arena.

The 60 page Guide, which costs $10, features:

- a clear, detailed description of the law concerning the work rules in New York.
- footnotes citing the relevant state statutes and regulations.
- sections providing advice, called "Advocacy Tips".
- appendices that cover, among other topics:
  - procedures HRA is beginning to implement on a pilot basis.
  - useful contacts.
  - a listing of litigation involving the work rules and fair hearing issues.
  - a checklist of potential fair hearing issues.

For ordering information, call CFRC at (212) 344-0195, ext. 312.

U.S. Audit Is Said to Criticize Giuliani's Strict Welfare Plan

NEW YORK TIMES 1/20/99

By RACHEL L. SWARNS

A two-month Federal inquiry into New York City's welfare program has found that city officials routinely violate the law by denying poor people the right to apply promptly for food stamps, according to two officials who have read a draft report prepared by the United States Department of Agriculture.

The officials said Federal auditors, who reviewed 600 cases at two welfare offices in Queens, had found that city workers failed to make applications immediately available as required by law. The workers also failed to screen families for emergency food needs, required the poor to search for jobs before receiving help and cut off food stamps to needy families who were still eligible for those benefits, the officials said, speaking on the condition that neither they nor their agencies be identified.

The Federal investigators, the officials said, also sharply criticized the state for failing to properly monitor the city's welfare program, which the Giuliani administration has said was intended to discourage people from applying for public benefits, including food stamps. Advocates for the poor — not state officials — alerted the Federal Government to the problems at city welfare offices.

"Substantial noncompliance with the food stamp act and regulations has gone undetected and unaddressed at the local level," the report said, according to the two officials who described its findings to The New York Times.

The Federal report offered the sharpest criticism yet of Mayor Rudolph W. Giuliani's tough welfare policies, which Mr. Giuliani has repeatedly described as one of his biggest accomplishments. Federal officials are also reviewing the city's Medicaid policies to determine whether the city is improperly preventing the poor from applying for medical assistance.

Officials from the Department of Agriculture, who presented the draft report to the city and state last week, told the local officials that they must act immediately to correct the deficiencies and gave them until yesterday evening to respond.

City officials declined to discuss the report or to describe the changes they were making in response to it. Instead, they accused the investigators of trying to sabotage their efforts to push people to rely more on themselves and less on government.

"The review being conducted by

U.S. Audit Is Said to Fault Giuliani's Welfare Program

Continued From Page A1

U.S.D.A. is a misguided effort intended to derail the state and city's progress in transforming welfare, which includes food stamps, into one where work and self-sufficiency are the foremost objectives of the program," said Debra Sproles, a spokeswoman for the city's Human Resources Administration, which runs the city's welfare programs.

State officials said they had responded in writing, telling the Federal auditors that the city had agreed to develop a new application form, to improve the screening process for emergency food needs and to allow food stamp applicants with children under 6 to forgo the work requirement. But the state officials vigorously defended their oversight of the city, saying the problems were minor and already being addressed.

"We have spent unprecedented amounts of time working on various food stamp issues," said Daniel D. Hogan, a Deputy Commissioner of the state's Office of Temporary and Disability Assistance, which oversees welfare programs in New York City.

"We have asked the Federal Government to withdraw this review," Mr. Hogan said. "There's no basis for it. A conference call could have taken care of these issues. The city's only intention here is to run a fair, efficient operation that works."

Federal officials, who have the power to withhold financing from states that fail to address legal violations, plan to issue a final report in several weeks once they review New York's comments on their findings. But the inquiry has already spawned a Federal class-action lawsuit, filed by lawyers for the poor last month, as well as some soul searching in welfare offices and state capitals across the country.

The situation in New York highlights the conundrum confronted by welfare officials across the country, who find themselves struggling to juggle two very different Federal mandates. On one hand, the Federal welfare law allows states and municipalities to discourage people from applying for cash benefits, and offers financial incentives for those with declines in their caseloads.

On the other, the law requires states to encourage the needy to apply for food stamps and Medicaid, two benefits described as critical by Federal officials hoping to keep the working poor off welfare and the newly employed from returning.

While the law allows food stamp applicants who are denied benefits to appeal those decisions, it was unclear last night whether people who have been improperly discouraged from applying for food stamps have any recourse, beyond reapplying. An official familiar with the Federal report said it did not address that issue.

New York City began its new application process in April when it started converting welfare offices into "job centers," where caseworkers encourage people to seek child support payments, unemployment benefits or help from food pantries instead of cash benefits. The workers offer applications only if a person returns for a second appointment.

About a third of the city's welfare offices currently operate under those rules. When the Federal investigators examined the two Queens offices, they were among only 9 of the roughly 30 offices citywide that had been converted.

The welfare issue is important to Mayor Giuliani, who may be contemplating national office and often mentions his tougher approach to welfare when he travels across the country testing the political waters. And when the Federal inquiry became public in November, Mr. Giuliani began a vigorous attack on the Federal investigators and advocates for the poor.

At first, Jason Turner, the city's welfare Commissioner, told The Times that he would speed up the distribution of applications to the poor as a precaution while the Government conducted its inquiry.

But the next day, city officials said they would not speed up the distribution. They said agriculture officials had determined that their policies complied with Federal law, an assertion the officials promptly denied.

Later that week, Mr. Giuliani said that The Times had not reported Mr. Turner's remarks accurately, adding, "Sometimes, things aren't reported exactly the way somebody says something because there is an emotional or ideological bias." Mr. Turner did not complain of being misquoted, but he was no longer available to comment.

Congress of the United States
House of Representatives
Washington, DC 20515

February 1, 1999

President William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President,

Continuing media reports and an initial HHS analysis of state data on TANF work participation rates show that there has been a significant drop in the number of families nationwide receiving cash assistance. While some attribute the decline to implementation of the Temporary Assistance to Needy Families (TANF) program, there is strong evidence that our healthy economy is playing a large role.

In our view, the jury is still out on whether TANF will prove to be a success in helping to meet the needs of vulnerable, low-income people. But there are worrisome signs that some TANF applicants, recipients and leavers are not always receiving vital support services that can help ensure the transition to work is a permanent one.

For example, average monthly food stamp participation fell by 4.4 million between 1995 and 1997, or five times more than the decline in poverty during that period, according to the Center on Budget and Policy Priorities. This means that millions living in poverty, although eligible, are not receiving food stamps. In another analysis, a 1998 study prepared for the Commonwealth Fund estimates that five million uninsured children – out of a total of 11 million – are potentially eligible for health benefits under Medicaid.

We believe it is important to look at the story behind these numbers. An October 1998 report published by the Kaiser Family Foundation suggests that some states are failing to inform TANF recipients and applicants about their potential eligibility for Medicaid -- despite a letter sent out by the Health Care Financing Administration that directs states to coordinate their TANF and Medicaid eligibility. And until a Federal judge intervened in New York City last week, eligible families were being denied the

opportunity to apply for food stamp and Medicaid assistance *to which they are legally entitled.*

The Kaiser report suggests that "those who administer the work programs were believed to know little of Medicaid or health programs and to be focused solely on the objective of getting people into the first possible job." Based on interviews with welfare and Medicaid program administrators and researchers, the Kaiser report also finds that "people do not know they are eligible for Medicaid because both they and state workers lack information or are confused about eligibility rules, given all the recent policy changes."

The fact that Americans are being denied access to food stamps and Medicaid because of the implementation of the TANF program is clearly in violation of federal law. The 1996 welfare law (section 835) reiterated a long-standing food stamp rule that "a state agency...shall permit an applicant household to apply to participate in the program on the same day the household first contacts a food stamp office in person."

Medicaid law is equally clear. The Medicaid statute and subsequent regulations refer to the right of an individual to receive benefits on a timely and fair basis. Furthermore, the welfare reform law took specific precautions to ensure that changes in cash welfare eligibility did not affect a family's right to medical assistance under the Medicaid program. Under the Personal Responsibility and Work Opportunity Reconciliation Act, states are required to provide coverage to families that would have been eligible under program income and resource standards in effect on July 16, 1996.

We believe the Administration must not stand by and watch as these practices to delay or deny health benefits and food stamps become more widespread. Overt actions to deprive people of the health benefits or food assistance for which they are eligible simply must not be tolerated. Likewise, operational practices that have a similar, albeit inadvertent, effect must be corrected immediately. Otherwise, welfare "reform" will wind up wrongly depriving many Americans who are struggling to make a living in low-wage jobs of the critical support services that they need to keep working and on the road to self-sufficiency.

We hope you will agree that states and local jurisdictions cannot be allowed to ignore federal Medicaid and food stamp laws. The well-being of millions of low-income TANF families demands that state rules and practices *support* families as they transition from welfare to work. In addition, we

hope that the Administration will play a more active role in promoting the value of both these programs to low-income families.

We thank you for your attention to these important issues, and we look forward to hearing about the actions your Administration is taking to address alarming declines in Medicaid and food stamp participation.

Sincerely,

Pete Stark	Robert Matsui	William J. Coyne
Member of Congress	Member of Congress	Member of Congress

CC: CK
Eric
Gene
DeNash
Jeanne

Executive Office of the President of the United States
Office of Management and Budget

Office of Information and Regulatory Affairs
Human Resources and Housing Branch
New Executive Office Building
Room 10235
Washington, DC 20503

FAX TRANSMITTAL

HPB Change Pages

FAX: 202-395-6974

DATE: _____

TO: Jeff Farkas, ANIL KAKANI, ANDREA KANE Lori will be setting up an EOP staff discussion for wed afternoon or Thursda

FROM: Lori SCHACK

Total number of pages (Including Transmittal Sheet): 28

Recipient's Fax Number: _____

Recipient's Telephone Number: _____

Comments:

ANDREA - PLEASE DISTRIBUTE TO DPC FOLKS

- THANKS -

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of Legislative Affairs and Budget (OLAB)

Madeline Mocko, Director
370 L'Enfant Promenade SW
7th Floor West - Aerospace Building
Washington DC 20447
Tel: (202)401-9223
Fax: (202)401-4562

TO: Lori Schack DATE: 10/8/99

FAX: (___) _____

SUBJECT: High Performance Bonus NPRM

☐ AS REQUESTED ☐ COMMENT ☑ CLEARANCE ☐ FYI

In response to OMB/DPC comments on our proposed high performance bonus reg, we are forwarding the attached page:

1) Child Poverty – deletes the child poverty measure from the regulation and includes a preamble discussion regarding the measure (pg 51-54)

2) Reallocation of bonus award funds gives final decision on measures to be included (pg 118-119)

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of Legislative Affairs and Budget (OLAB)

Ps. 2

Madeline Mocko, Director
370 L'Enfant Promenade SW
7th Floor West - Aerospace Building
Washington DC 20447
Tel: (202)401-9223
Fax: (202)401-4562

TO: _____ **DATE:** _____

FAX: (____) _____ - _____

SUBJECT: _____

☐ AS REQUESTED ☐ COMMENT ☑ CLEARANCE ☐ FYI

3) Food Stamp process measures -- these were sent earlier (I think), but wanted to include as part of our final package for clearance

4) Medicaid measure - Assemble discussion of two possible asthma measures we request for consideration

Once we reach agreement on these final issues, we will make conforming changes as needed throughout the document and send to HQ for final clearance.

Mocko

by State MSIS data, to the number of individuals in families with children under age 18 with incomes less than 200 percent of poverty in the State, as determined by ACS data. Because reporting of State-only CHIP program data through MSIS is voluntary, we will use quarterly State-only CHIP enrollment reports provided on the HCFA-21E when a State has chosen not to report this information through MSIS. We specifically invite comments about using families with income below 200 percent of poverty in the measure.

Data for CY 2000 will be compared with data for CY 2001 and States will be ranked according to the percentage improvement. We will award bonuses to the top ten States which have met the mandatory and optional process measures as explained above.

(1) Child poverty - need preamble language (measure has been removed from the regulatory language)

CONSIDERATION OF OTHER MEASURES

We considered a number of other measures related to non-work goals in the statute. One area we explored but which we chose not to include in the regulatory text was child poverty. We looked at two specific measures: the reduction in the State's rate of child poverty for all families with children under 18 and the reduction in the rate of child poverty for working families with children under 18, i.e., families with earnings equivalent to half-time, full year employment (parallel to the food stamp

measure). The data source we considered using was the ACS.

We considered a child poverty measure because it addresses two goals of TANF: promoting work and employment and strengthening child and family well-being by assisting needy children in their own homes or in the homes of relatives.

A number of innovative States are already using child poverty as a measure of their efforts, and some States are already using the resources and flexibility under TANF to address this issue. AFDC was extremely limited in its ability to address child poverty in that the primary flexibility States had was in setting benefit levels. Raising benefit levels sufficiently to affect poverty had no broad public support, however, and would have further weakened States' ability to move families to work. In contrast to AFDC, the TANF program offers States the opportunity to utilize a wide range of investments to help families escape poverty while strengthening their commitment to work, including:

o investments aimed at increasing the stability of work, the wages parents earn, or the hours they work, such as employer partnerships that focus on the first job, on job advancement after the first job, or on combinations of work and training; mentoring and case management strategies; strategies that combine work, education, and training; and supported work for families

with barriers to private sector employment;

o supplements to work, such as more generous earning disregards, earnings supplements, and wage subsidies, are well-known strategies States may employ;

o child support improvements such as increasing the amount of support collected from non-custodial parents that is passed through to children;

o help for families during periods between jobs such as quick re-employment services;

o employment assistance for other families such as a child-only family where a caretaker relative, is not receiving assistance

In addition, there is already strong empirical evidence from rigorous evaluations that several of these strategies can be effective in reducing poverty. For example, interim findings from the Minnesota Family Investment Program, which implemented generous earnings disregards, nearly doubled the percentage of families above poverty; and a strongly employment-focused welfare-to-work program in Portland, Oregon, which stressed getting recipients higher paying jobs along with higher quality, reliable child care, increased the number of families with above

poverty income by nearly one quarter.

After a full consideration of all factors, we chose not to include a child poverty measure in the regulatory text, but we welcome public comment on these and other potential measures. On balance, we determined that a child poverty measure was duplicative of the section 413(i) requirement for States to report on their child poverty rates and take corrective action where any increase in child poverty of five percent or more is attributable to the State's TANF program. More generally, as is illustrated further below, we did not include a number of potential measures where there were other mechanisms in the statute for addressing them, because we were concerned that inclusion of too many measures would spread the bonus funds too thinly and thereby weaken their ability to provide incentives to States to achieve the goals of TANF.

We considered a number of other measures related to non-work goals in the law. These included:

- Child support: The average monthly number of TANF families that have both earned income and child support paid within the same month.

- Diversion: The number of applicants with a financial

(2) Allocation of Bonus

(vi) The total amount of earnings in each quarter of all employed adult recipients in paragraph (a)(2)(v) of this section; and

(vii) The total amount of earnings in the second following quarter of all employed adult recipients in paragraph (a)(2)(v) of this section.

(b) Each State must submit the information in paragraph (a) for both adult TANF recipients and adult SSP-MOE recipients for whom the State would report the data described in paragraph (c) of this section.

(c) Each State must file the information in Sections 1 and 3 of the SSP-MOE Data Report as specified in §265.3(d) of this chapter.

(d) Each State must specify to ACF the measures on which it is competing in each bonus year.

§270.7 What data will we use to measure performance on the non-work measures?

(a) We will use data from the ACS to rank State performance on the child well-being measure, the measure of family formation and stability, the Food Stamp measure and, in part, on the Medicaid/CHIP measure.

(b) We will also use State data submitted to HCFA through the MSIS system to measure State performance on the Medicaid/CHIP measure.

§270.8 How will we allocate the bonus award funds?

(a) In FY 2002 and beyond, we will allocate and award $140 million to the ten States with the highest scores for each work measure as follows, subject to reallocation as specified in §270.9:

(1) Job Entry Rate.....$56 million

(2) Success in the Work Force.....$37 million

(3) Increase in Job Entry Rate.....$28 million

(4) Increase in Success in the Work Force.....$19 million;

(b) In FY 2002 and beyond, we will allocate and award $60 million to the ten States with the greatest improvement in the non-work measures as follows, subject to reallocation as specified in §270.9:

(1) Family Formation/Stability .....$20 million

(2) Food Stamps Measure .....$20 million

(3) Medicaid/CHIP Measure.....$20 million

(c) We will distribute the bonus dollars for each measure based on each State's percentage of the total amount of the State family assistance grants of the 10 States that will receive a bonus.

§270.9 How will we redistribute funds if that becomes necessary?

(a) If we cannot distribute the funds as specified in §270.8, due to the statutory limit on the amount of each State's bonus award, we will reallocate any undistributed funds among the measures listed in §270.4.

(b) If funds still cannot be distributed within the bonus year, they will remain available for distribution in the next

MEASURES RELATED TO PARTICIPATION IN THE FOOD STAMP AND THE MEDICAID AND CHIP PROGRAMS

One of the key goals of welfare reform is to support and sustain working families. Food Stamps and Medicaid are potentially essential supports during the period when families are working but are not yet earning at the level that will enable them to achieve full self-sufficiency. The Administration has expressed concern at the falling levels of coverage in these programs and has sought out a variety of strategies to prompt States to reach working families who are eligible.

- o FOOD STAMPS

Like child care, the Earned Income Tax Credit, and Medicaid, receipt of food stamps is an important support for working families. Our colleagues at U.S. Department of Agriculture are committed to ensuring eligible families obtain food stamps. Families with incomes up to 130 percent of the poverty line, or $17,748 for a family of three, can be eligible for food stamps. A typical family of three with a full time worker earning the minimum wage can get $220 a month in food stamps. The President recently announced a series of actions to help ensure working families access to food stamps, including: (1) allowing States to make it easier for working families to own a car and still be eligible for food stamps; (2) simplifying food stamp

reporting rules to reduce bureaucracy and encourage work; and (3) launching a nationwide public education campaign and a toll-free hotline to help working families know whether they're eligible for food stamps.

As part of this effort, USDA has published "The Nutrition Safety Net at Work for Families: A Primer for Enhancing the Nutrition Safety Net for Workers and Their Children," a companion piece to the DHHS Medicaid guide discussed below. This guide will assist State, local and community leaders in understanding Food Stamp Program access requirements. It also includes best practices for serving working families already implemented in some communities. As it pursues these public education efforts, USDA is committed to vigorous enforcement of the food stamp law and will investigate complaints about State and local practices and pursue administrative and legal action as required.

o MEDICAID/CHIP

Medicaid enrollment dropped by about 1 million from 1996 to 1997. Though there are many potential reasons for the decline, we do not have any definitive answers about why it has occurred. Improvements in earnings and employment resulting from the strong national economy have probably played an important role in this decline, making it possible for some low-income Medicaid families to find jobs that offer health insurance. It is also important to note that

while Medicaid enrollment has declined, the number of people under the poverty level who are uninsured has not increased from 1996 to 1997. Changes in attitudes toward public assistance may also be playing a role in falling TANF, Food Stamp, and Medicaid caseloads.

To help States navigate the opportunities and challenges inherent in providing Medicaid to all eligible families, DHHS developed and issued "Supporting Families in Transition; A Guide to Expanding Health Coverage in the Post-Welfare Reform World." This publication was sent to all State Medicaid Directors and other interested parties. We have a follow-up strategy that includes an educational component, aggressive outreach, and a proactive enforcement process. For example, in New York, the State has agreed to provide Medicaid applications without delay at all TANF offices and, in Maryland, we have worked with the State to identify and correct a problem that existed when TANF cases closed. We are also undertaking research activities to promote increased participation of eligible individuals in these programs.

It is in this context that we are proposing performance measures related to these two programs that will reward State efforts to support work, self-sufficiency, and the well-being of low-income eligible families and also reward States for year to year improvements. We believe that

basing high performance bonus awards on these measures will provide another valuable strategy in the Administrations's efforts to advance the goals of welfare reform, focus attention on these critical supports, assist working families, improve outcomes for children, and encourage States to take action to increase the likelihood that low-income families not receiving cash assistance will participate.

FS- process measures

A. Measure of participation in the Food Stamp Program

In paragraph (d)(1), we propose to require that States meet the following mandatory process measures in order to be considered for a high performance bonus related to food stamp participation:

(i) The State agency has issued policy instructions or regulations clearly specifying that, at first contact with the State agency which administers the Food Stamp Program, individuals must be informed of the opportunity to apply for food stamps in accordance with 7 CFR 273.2(c).

(ii) As evidenced through policy instructions, regulations, and administrative reviews, the State agency is complying with application processing time frames and expedited service rules, as required by 7 CFR 273.2(g).

(iii) As evidenced through policy instructions, regulations, and administrative reviews, the State agency has taken steps to prevent inappropriate denials and terminations of eligible food stamp participants who have

lost TANF eligibility. Since food stamp eligibility is not based on TANF eligibility, States may not deny food stamp eligibility to a family or family member simply because the family is ineligible for TANF.

These measures reflect food stamp policies that are required by statute or regulation. We do not believe that a State which is out of compliance with these requirements should be eligible for a bonus. The Food and Nutrition Service of the U.S. Department of Agriculture will determine whether a State is meeting these mandatory process measures through its ongoing oversight of the Food Stamp Program.

In paragraph (d)(2), we are proposing that, beginning in FY 2002, we will measure the improvement in the number of low-income working families (i.e., families with children under the age of 18 who have an income of less than 130 percent of poverty and earnings equal to at least half-time, full-year minimum wage) receiving food stamps as a percentage of the number of low-income families working in the State. For any given year, we will compare a State's performance on this measure to its performance in the previous year, beginning with a comparison of CY 2000 to CY 2001, based on ACS data. We will rank all States and will award bonuses to the 10 States with the greatest improvement in this measure.

We are proposing this outcome measure in order to encourage States to provide food stamps to eligible, low-income working families. In recent years, States have taken remarkable action to revolutionize the welfare system. A strong economy combined with innovative State policies and an unyielding commitment to helping families become self-sufficient as they move from welfare to work has resulted in a dramatic decline in the number of families receiving cash assistance. Many more individuals are now working to support themselves and their families than ever before. Critical to their continued success, however, is their ability to feed their families adequately. Parents working full-time at minimum wage who are taking advantage of the maximum Earned Income Tax Credit can only reach the poverty line if they also receive food stamps. These individuals may only be able to keep their jobs and feed their families because food stamps help make ends meet.

Participation in the Food Stamp Program, however, has decreased dramatically in recent years. Since March 1996, participation has fallen by over 7 million people. One group for which participation is especially low is the working poor; only 39 percent of individuals with earnings who are eligible for food stamps benefits participate in the Food Stamp Program, compared to a participation rate of 71 percent overall.

Food stamps can make the difference between living in poverty and moving beyond it. It is imperative to the success of welfare reform, and more fundamentally to the well-being of all Americans, that States devote attention to making sure that needed supportive services, in particular food stamps, are available to those families that have left welfare but remain poor.

B. Measure of participation in the Medicaid/CHIP Program

In paragraph (d), we propose that, in order to be considered for a high performance bonus related to Medicaid and CHIP participation, a State would be required to satisfy two sets of programmatic, or process, requirements. First, the State would have to certify its compliance with specific requirements that are mandated by Medicaid statute and regulations. Second, the State would have to document that it has adopted at least two of a list of seven optional policies or practices that are designed to facilitate Medicaid and CHIP enrollment and retention of eligible children and families. Specifically, we propose that, as a prerequisite for consideration, a State must implement the following mandatory processes in its Medicaid and CHIP programs:

(1) The State has issued policy instructions or regulations clearly specifying that, at first contact with the TANF agency, an individual must be given the opportunity to apply for Medicaid in accordance with 42 CFR 435.906;

(2) When eligibility under section 1931 of the Act is lost due to hours of, or earnings from, employment or loss of time-limited earnings disregards, the State issues to the affected family a written notice that meets the requirements of section 1925(a)(2)(A) of the Act and a card or other evidence of the family's entitlement to assistance as required under section 1925(a)(2)(B) of the Act;

(3) The state has issued policy instructions or regulations clearly specifying that family members may not be terminated from Medicaid until it has been determined that they are not eligible under any other Medicaid group; and,

(4) The State has fulfilled all data requirements under the law, including being up to date on all Medicaid and CHIP data submissions, and having the MSIS on-line and operating properly.

All of these programmatic criteria reflect State policy actions and processes that are mandated by Medicaid statute or regulation, and we do not believe that a State that is

out of compliance with these requirements should be eligible for a bonus related to Medicaid and CHIP participation. We propose that, to be eligible for the bonus, States fulfill these process requirements, and that HCFA verify States' compliance through State documentation and the agency's ongoing oversight of the Medicaid program.

In addition to complying with these mandatory process criteria, we propose to require that applicant States meet at least two programmatic options that are designed to maximize participation by those eligible for Medicaid and CHIP. We are proposing this additional requirement for those States that wish to be considered for the Medicaid/CHIP high performance bonus because central to our conception of high performance is an expectation of extra effort on States' part to reach, enroll, and retain their eligible populations. In our view, States that take only the steps that the law and regulations require cannot legitimately be considered high performers. We propose that a State that adopts at least two of the process or programmatic options below (in addition to satisfying the mandatory standards above) would be eligible for consideration for the high performance bonus related to Medicaid and CHIP. We propose that States provide documentation demonstrating that they have adopted two or more of these optional measures, and HCFA verify compliance through the agency's ongoing review of the Medicaid program.

Programmatic Options:

(1) The State accepts mail-in or phone-in applications for Medicaid for families and children, which can be completed without a face-to-face interview;

(2) State Medicaid workers have been outstationed at locations in addition to the locations required under 42 CFR 435. 904(c)(1) and (c)(2);

(3) The State has expanded Medicaid eligibility for recipient and applicant families through the use of less restrictive methodologies, authorized by section 1931(b)(2)(B) and (C) of the Act;

(4) The State uses a definition of "unemployed parent" that includes parents who are employed more than 100 hours per month, as authorized under 45 CFR 233.101 and section 1931(d) of the Act;

(5) The State provides continuous Medicaid eligibility for children for a period of time without regard to changes in circumstances, as authorized by section 1902(e)(12) of the Act;

(6) The State provides a period of presumptive Medicaid eligibility for children, as authorized by section 1920A of the Act; or

(7) The State has simplified the enrollment and reenrollment processes for children and low-income families by implementing such improvements as shortened application forms and reduced documentation and verification requirements for application and redetermination.

Once the States eligible for consideration are identified based on the process measures, we propose that the high performance bonus be distributed based on an outcome measure related to Medicaid and CHIP participation. We are not proposing a specific outcome measure at this time but instead invite comment on two measures we are considering for FY 2002.

One measure we are considering would capture State performance in enrolling and retaining all eligible families and children in Medicaid and CHIP. This measure would hold States accountable for the Medicaid and CHIP participation of those families and children leaving TANF, and also for the participation of eligible families and children who many not participate in, or have any contact with, the TANF program. This broad measure of State performance is most closely consistent with the perspective that section 1931, enacted in PRWORA, reflects the high priority that Congress attached to protecting the Medicaid coverage of individuals and families likely to be affected by welfare policy

changes, without regard to their TANF status.

In operational terms, this measure would be improvement in the ratio of the number of non-disabled, non-elderly individuals enrolled in Medicaid or a State-only CHIP program, to the number of individuals in the State in families with children under age 18 with income below 200 percent of the Federal poverty level (FPL). We propose that the enrollment number (numerator) be based on State MSIS data. Because reporting of State-only CHIP program data through MSIS is voluntary, we would use quarterly State-only CHIP enrollment reports provided on the HCFA-21E when a State has chosen not to report this information through MSIS. We propose that the number of people in families with children below 200 percent of the poverty level would be based on the Census Bureau's American Community Survey. While we propose 200 percent of the FPL because we think it reflects a reasonable expectation for coverage under Medicaid and CHIP, we specifically invite comments about this choice in light of both variation across the Staets in income eligibility for Medicaid and CHIP, and the desire to reward high-performing States.

The alternative outcome measure we are considering would be limited to Medicaid participation among people leaving TANF. State performance with respect to achieving high Medicaid participation among other low-income families and children would be neither rewarded nor penalized.

Under this approach, the population whose Medicaid participation would be measured are the individuals whose TANF cases were closed in the first half of the calendar year (January 1 through June 30) who also were enrolled in Medicaid or CHIP at the time of case closure. The measure of State performance would be the percentage of such persons who are enrolled in Medicaid or CHIP in the second half of the year (July 1 through December 31).

We would choose this approach because nearly all individuals leaving TANF are likely to be eligible for a minimum of six months of transitional Medicaid under section 1925 or to qualify for Medicaid under other eligibility groups (e.g., section 1931, poverty-related children) or to be eligible for CHIP. Continued health insurance coverage is a critical support to families making the transition from welfare to self-sufficiency, and we expect States to achieve a high rate of Medicaid and CHIP participation among this population in order to be considered high performers. We propose that bonuses would be awarded to the ten States with the largest percentage improvement in their Medicaid/CHIP participation rates. The data to be used will be submitted by States for purposes of this evaluation.

We specifically invite the public's comments on these two outcome measures. We also invite comment on whether, in addition to awarding those States with the greatest

improvement in their participation rates, we should consider awarding those States with the highest absolute levels of participation in the bonus year.

CONSIDERATION OF OTHER MEASURES

We considered a number of other measures related to non-work goals in the statute. One area we explored but which we chose not to include in the regulatory text was child poverty. We looked at two specific measures: the reduction in the State's rate of child poverty for all families with children under 18 and the reduction in the rate of child poverty for working families with children under 18, i.e., families with earnings equivalent to half-time, full year employment (parallel to the food stamp measure). The data source we considered using was the ACS.

We considered a child poverty measure because it addresses two goals of TANF: promoting work and employment and strengthening child and family well-being by assisting needy children in their own homes or in the homes of relatives.

A number of innovative States are already using child poverty as

(3+4) Regulatory language - -

(d) Measure of participation by low-income working families in the Food Stamp Program

(1) Mandatory Process Measures

In order to compete on the Food Stamp outcome measure in paragraph (d)(2), States must meet all the following mandatory process measures. The Food and Nutrition Service of the U. S. Department of Agriculture will determine whether a State is meeting these mandatory process measures through its ongoing oversight of the Food Stamp Program.

(i) The State agency has issued policy instructions or regulations clearly specifying that, at first contact with the State agency which administers the Food Stamp Program, individuals must be informed of the opportunity to apply for food stamps in accordance with 7 CFR 273.2(c).

(ii) As evidenced through policy instructions, regulations, and administrative reviews, the State agency is complying with application processing time frames and expedited service rules, as required by 7 CFR 273.2(g).

(iii) As evidenced through policy instructions, regulations, or administrative reviews, the State agency has taken steps to prevent inappropriate denials and terminations of eligible food stamp participants who have lost TANF eligibility.

(2) Outcome Measure

(i) Beginning in FY 2002, we will measure the improvement in the number of low-income working families (i.e., families with children under age 18 who have an income less than 130 percent of poverty and earnings equal to at least half-time, full-year minimum wage) receiving Food Stamps as a percentage of the number of low-income working families (as defined in this subparagraph) in the State.

(ii) For any given year, we will compare a State's performance on this measure to its performance in the previous year, beginning with a comparison of CY 2000 to CY 2001, based on ACS data.

(iii) We will rank all States that meet the conditions in paragraph (d)(1) of this section and will award bonuses to the 10 States with the greatest percentage improvement in this measure.

(e) Measure of participation in the Medicaid/CHIP Program

(1) Conditions

In order to compete on the Medicaid/CHIP outcome measure to be included in the final rule, States must meet all mandatory process measures in paragraph (e)(2) and must have implemented at least two of the optional measures in paragraph (e)(3).

(2) Mandatory Process Measures

(i) The State has issued policy instructions or regulations clearly specifying that, at first contact with the TANF agency, an individual must be given the opportunity to apply for Medicaid in accordance with 42 CFR 435.906;

(ii) When eligibility under section 1931 of the Act is lost due to hours of, or earnings from, employment or loss of time-limited earnings disregards, the State issues to the affected family a written notice that meets the requirements of section 1925(a)(2)(A) of the Act, and a card or other evidence of the family's entitlement to assistance, as required under section 1925(a)(2)(B) of the Act;

(iii) The State has issued policy instructions or regulations clearly specifying that family members may not be terminated from Medicaid until it has been determined that they are not eligible under any other Medicaid group; and,

(iv) The State has fulfilled all data requirements under the law, including being up to date on all Medicaid and CHIP data submissions, and having the MSIS on-line and operating properly.

(3) Optional Process Measures

(i) The State accepts mail-in or phone-in applications for Medicaid for families and children, which can be completed without a face-to-face interview;

(ii) State Medicaid workers have been outstationed at locations in addition to the locations required under 42 CFR 435. 904 (c)(1) and (c)(2);

(iii) The State has expanded Medicaid eligibility for recipient and applicant families through the use of less restrictive methodologies, authorized by section 1931(b)(2)(B) and (C) of the Act;

(iv) The State uses a definition of "unemployed parent" that includes parents who are employed more than 100 hours per month, as authorized under 45 CFR 233.101 and section 1931(d) of the Act;

(v) The State provides continuous Medicaid eligibility for children for a period of time without regard to changes in circumstances, as authorized by section 1902(e)(12) of the Act;

(vi) The State provides a period of presumptive Medicaid eligibility for children, as authorized by section 1920A of the Act; or

(vii) The State has simplified the enrollment and

reenrollment processes for children and low-income families implementing such improvements as shortened application forms and reduced documentation and verification requirements for application and redetermination.

Suggested Press Guidance
9/23/99

BACKGROUND: The New York Times may have a story this weekend about New York mayor Giuliani's plans to require certain welfare recipients to enter drug treatment. Advocates in New York are concerned about the plan, particularly about possible invasions of privacy if Medicaid records are examined. HCFA provided background information, and noted that the privacy provisions in the state Medicaid plan must be followed. The city's proposal must be approved by the state.

CONTACT: Melissa Skolfield, HHS. 690-7850, 800-800-7759.

Q: What does the Administration think of New York City's plan to require certain welfare recipients to enter drug treatment? Do you believe the plan raises privacy concerns? Will the Administration take action to block the plan? And if you do object, what will you do, since this seems to be allowed under the 1996 welfare reform bill?

A: It's not clear yet what the city intends to do, nor whether the state will permit it. But there are confidentiality provisions in New York state's Medicaid plan, and we expect them to be followed.

ADDITIONAL BACKGROUND:

MEDICAID RECORD CONFIDENTIALITY BACKGROUND:

this makes it sound like there is state flexibility here.

In general, a state may access Medicaid beneficiaries' records only to determine eligibility, determine the proper level of medical assistance, provide services, and investigate and prosecute Medicaid fraud and abuse. A Medicaid beneficiary's files may not be accessed for the operation of any other state program without the informed consent of the beneficiary. [Based on 42 CFR Part 431.300-306] It appears that because the local Departments of Social Services are considered part of the central administration of the Medicaid program in New York state, they do have access to the adjudicated claims file. And under the 1996 welfare law and ACF's subsequent guidance and regulations, states can require substance abuse treatment as part of personal responsibility agreements for TANF (welfare) recipients. However, it is not clear that the local Department of Social Services can use Medicaid files to refer Medicaid recipients to non-Medicaid programs.

At this point, it's not clear what the city intends to do, nor whether the state will permit it. The bottom line is that there are confidentiality provisions in New York state's Medicaid plan, and we expect them to be followed.

ACTUAL LANGUAGE FROM NY STATE MEDICAID PLAN

"Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning any applicants or recipients to purposes directly connected with the administration of the plan" [Effective date: October 1, 1987 Citation: 42 CFR 431. 301]

TANF BACKGROUND

The 1996 welfare law and ACF's subsequent guidance and regulations regarding it address substance abuse in several ways:
--states can require, as part of personal responsibility agreements under the law, substance abuse treatment;
--the federal law does not bar states from requiring substance abuse testing;
--states can use federal TANF funds for substance abuse treatment as long as it is non-medical (e.g., discussion support groups). In other words, the types of substance abuse treatment that would not be covered under Medicaid, could be covered by TANF. Similarly, Medicaid would cover the health-related, medical substance abuse treatment programs that could not be covered under TANF.
--also, the law does permit states to deny benefits to those convicted of felony substance abuse violations.

It is important to stress that states can, and should, use TANF and Medicaid funds for treatment programs because substance abuse can be a barrier for parents trying to get jobs.

September 25, 1999, Saturday
Metropolitan Desk

Welfare Officials To Search Records Of Drug Treatment

By NINA BERNSTEIN

The Giuliani administration is planning to search thousands of medical billing records for evidence it can use to place welfare applicants in mandatory drug and alcohol treatment programs as a condition of receiving public assistance, city welfare officials say.

The information will be culled from computerized **Medicaid** insurance bills submitted in the past on behalf of applicants who have voluntarily sought treatment for drug and alcohol problems. The record search is for the applicants' own good, welfare officials said this week, and will be used to push them to finish treatment and to get jobs faster.

Officials say that record checks are needed because the city's current system of drug screening and testing is finding unrealistically low rates of substance abuse among welfare mothers who need help.

But privacy experts and lawyers for the poor say the record search may violate a Federal law protecting the confidentiality of drug and alcohol treatment records. They contend that the city's plan will frighten poor people from seeking treatment or benefits and will send a chilling message to anyone considering help for drug or alcohol problems.

The issue, privacy experts say, is a classic example of the conflict between public concern over the loss of privacy, especially in health care records, and public support for using computer databases to monitor or track suspect groups, like welfare recipients, illegal immigrants and parents who fail to pay child support.

Federal officials said they had no official notification of the plan. "But there are confidentiality provisions in New York's **Medicaid** plan, and we expect them to be followed," said Christopher H. Peacock, spokesman for the Federal Health Care Financing Administration, which oversees **Medicaid** records.

Jason A. Turner, Commissioner of the city's Human Resources Administration, said no breach of confidentiality would be involved because the billing records

to be checked are submitted by drug and alcohol treatment providers to the city's **Medicaid** office, and both **Medicaid** and public assistance fall under his agency. "These are our own records," he said. "We are not interfering with the doctor-patient relationship. We're helping poor people here."

But advocates of the poor who support treatment as a condition of aid say the record search crosses the line.

"If people go into treatment thinking their records are confidential and then, lo and behold, the information is illegally disclosed, that will upset just about everybody," said Paul N. Samuels, a lawyer and the director of the Legal Action Center, a nonprofit advocacy organization that specializes in substance abuse issues and has offices in New York and Washington. "Violating confidentiality is an ambush that will drive many people away from treatment."

No date has been set to start searching applicants' records. The plan is one of several new measures introduced by Mr. Turner to meet a deadline set by Mayor Rudolph W. Giuliani, who vowed last year that by the year 2000, "New York will be the first city in the nation, on its own, to end welfare."

Mr. Giuliani, whose welfare overhaul is expected to be a centerpiece of his likely campaign for the United States Senate, did not mean an end to public assistance, Mr. Turner said. The Mayor meant that all adult recipients would be moving from welfare to work through a variety of assignments, including treatment for drug and alcohol abuse that is a barrier to employment, Mr. Turner said.

The Mayor has cited one estimate that 20 percent of all people on public aid have such substance abuse problems. Ten percent is the figure more commonly accepted by substance abuse experts. But among mothers, who are the bulk of adult recipients, only 2 percent have been identified as substance abusers through a system of screening and testing put in place two years ago, Mr. Turner said.

In several other jurisdictions around the country, including Florida and Los Angeles County, officials have also identified lower-than-expected rates of welfare mothers as substance abusers, for reasons that remain unclear. But no other state is known to be contemplating a record search like New York's, according to the Washington office of the Legal Action Center, which represents many treatment centers nationwide.

Brian J. Wing, Commissioner of the State Office of Temporary and Disability Assistance, which oversees city and county welfare operations, approved the city's record search plan, said Daniel D. Hogan, his deputy. Mr. Hogan added that some upstate counties have already conducted such searches case by case.

Marc Rotenberg, executive director of the Electronic Privacy Information Center, a civil liberties advocacy group based in Washington, said: "Welfare recipients are among the first to lose their privacy. But the unfortunate consequences of these tracking and matching technologies tend to make their way up the line."

A Federal law passed in the 1970's makes it a crime, with few exceptions, to disclose information about patients in drug and alcohol treatment programs without the patients' narrowly defined written consent. That consent does not allow redisclosure for any other purposes. Experts on privacy law call the measure unique and exemplary, and contrast it to the blanket consent forms

allowed in the gathering of other types of health care information.

Corinne Carey, a lawyer who has studied drug testing and welfare reform nationwide, said that instead of searching records, the city should be asking why more mothers on public assistance are not being identified by the city's current screening system for substance abuse.

As tougher rules and a strong economy have combined to shrink New York City's welfare rolls to about 670,000 from 1.1 million in 1994, including children, fewer substance abusers are applying for public assistance because they cannot deal with the hurdles or meet the work requirements, said Ms. Carey, who works for the Urban Justice Center, an advocacy organization opposed to the record search. Others hide their problems from caseworkers because they fear losing their children.

And some advocates suggest drug use may actually be lower than experts thought in the younger generation of poor mothers who saw crack devastate parents or older siblings.

A different kind of explanation was offered by Bill Panepinto, an administrator in the State Office of Alcohol and Substance Abuse Services. The substance abuse screening form used by the city was intended to be the framework for a personal interview by a trained worker, he said, but for the last two years it has instead been handed out to welfare applicants as a nine-question paper test. Those who answer yes to two or more questions are referred to certified alcohol and substance abuse counselors for further assessment, including a drug test.

Seven out of 10 welfare applicants referred to mandatory residential treatment end up cut from all assistance, said Michael Kink, legislative counsel to Housing Works, one of about 30 advocacy, legal services and provider organizations that met yesterday because of concern about the city's plan. "The sanction rate shows that this program is designed more to drive people off the rolls than to get people help," he said.

Mr. Turner vigorously defends the program's intentions. Now, he said, mothers are known to coach each other in the waiting room on how to answer the questionnaire to avoid being assigned to mandatory treatment. But treatment billing records may show they have been in and out of care many times, he said. "If you're sick and your children are at risk because you're a substance abuser," he said, "we believe it's not compassionate to ignore that fact."

Like most states, New York considered but rejected a requirement that all public assistance applicants submit to drug tests. Instead, it asks drug-use questions of all applicants, but uses physical tests only on those whose answers or behavior raise a reasonable suspicion of abuse.

Universal testing is permitted under the Federal welfare overhaul, but only Michigan is planning to use that approach, which has been widely criticized as expensive, ineffective and vulnerable to constitutional challenge.

Organizations mentioned in this article:

Related Terms:

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NYT article

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Like most states, New York considered but rejected a requirement that all public assistance applicants submit to drug tests. Instead, it asks drug-use questions of all applicants, but uses physical tests only on those whose answers or behavior raise a reasonable suspicion of abuse.

Universal testing is permitted under the Federal welfare overhaul, but only Michigan is planning to use that approach, which has been widely criticized as expensive, ineffective and vulnerable to constitutional challenge.

Table 1: State Allocations and Ex ditur fr $500 Million Fund, as of 3-99

18 by 10/31/99

28 by 12/3/99

STATE	Total (Base and Secondary) State Allocation from $500 million TANF fund	Expenditures from $500 million TANF fund, as of 3-99	%Spent of Total Allocation	Amount Remaining of Allocation, as of 3-99	Date by which funds must be used (no later than 9/30/00)
ALABAMA	$ 6,504,897	$ 0	0%	$ 6,504,897	11/15/99 •
ALASKA	$ 3,039,335	$ 7,500	0%	$ 3,031,835	07/01/00
ARIZONA	$ 7,691,603	$ 17,901	0%	$ 7,673,702	10/01/99 •
ARKANSAS	$ 5,095,513	$ 1,117,803	22%	$ 3,977,710	07/01/00
CALIFORNIA	$ 83,719,458	$ 4,453,468	5%	$ 79,265,990	11/26/99 •
COLORADO	$ 5,166,316	$ 0	0%	$ 5,166,316	07/01/00
CONNECTICUT	$ 5,756,737	$ 0	0%	$ 5,756,737	10/01/99 •
DELAWARE	$ 2,801,757	$ 233	0%	$ 2,801,524	03/10/00
DISTRICT OF COLUMBIA	$ 3,259,072	$ 0	0%	$ 3,259,072	03/01/00
FLORIDA	$ 22,262,239	$ 950,856	4%	$ 21,311,383	10/01/99 •
GEORGIA	$ 11,591,549	$ 0	0%	$ 11,591,549	01/01/00 •
HAWAII	$ 3,435,742	$ 0	0%	$ 3,435,742	07/01/00
IDAHO	$ 3,288,535	$ 541,328	16%	$ 2,747,207	07/01/00
ILLINOIS	$ 19,363,894	$ 15,016	0%	$ 19,348,878	07/01/00
INDIANA	$ 7,545,162	$ 452,521	6%	$ 7,092,641	10/01/99 •
IOWA	$ 4,782,362	$ 2,405,247	50%	$ 2,377,115	01/01/00
KANSAS	$ 4,496,386	$ 389,409	9%	$ 4,106,977	10/01/99 •
KENTUCKY	$ 7,269,014	$ 0	0%	$ 7,269,014	10/16/99 •
LOUISIANA	$ 9,029,185	$ 0	0%	$ 9,029,185	01/01/00
MAINE	$ 3,569,238	$ 0	0%	$ 3,569,238	11/01/99 •
MARYLAND	$ 7,595,943	$ 0	0%	$ 7,595,943	12/09/99 •
MASSACHUSETTS	$ 9,463,490	$ 1,696,987	18%	$ 7,767,503	09/30/99 •
MICHIGAN	$ 16,975,445	$ 2,606,516	16%	$ 13,368,929	09/30/99 •
MINNESOTA	$ 7,708,769	$ 3,798,670	49%	$ 3,910,099	07/01/00
MISSISSIPPI	$ 6,617,604	$ 197,678	3%	$ 6,419,926	10/01/99 •
MISSOURI	$ 8,561,965	$ 3,298,443	39%	$ 5,263,522	12/01/99 •
MONTANA	$ 2,764,134	$ 7,653	0%	$ 2,756,481	02/01/00
NEBRASKA	$ 3,308,247	$ 0	0%	$ 3,308,247	12/01/99 •
NEVADA	$ 3,258,808	$ 3,258,808	100%	$ 0	12/03/99 •
NEW HAMPSHIRE	$ 2,875,952	$ 302,916	11%	$ 2,573,036	10/01/99 •
NEW JERSEY	$ 11,012,253	$ 3,078,591	28%	$ 7,933,662	02/01/00
NEW MEXICO	$ 4,860,333		0%	$ 4,860,333	07/01/00
NEW YORK	$ 37,034,556	$ 387,892	1%	$ 36,646,664	12/02/99 •
NORTH CAROLINA	$ 11,550,703	$ 0	0%	$ 11,550,703	01/01/00
NORTH DAKOTA	$ 2,537,922	$ 47,094	2%	$ 2,490,828	07/01/00
OHIO	$ 16,909,161	$ 2,915,724	17%	$ 13,993,437	10/01/99 •
OKLAHOMA	$ 5,938,082	$ 291,222	5%	$ 5,646,860	10/01/99 •
OREGON	$ 5,740,656	$ 1,497,655	26%	$ 4,243,001	10/01/99 •
PENNSYLVANIA	$ 17,553,339	$ 2,854	0%	$ 17,550,485	03/03/00
RHODE ISLAND	$ 3,459,771	$ 3,002	0%	$ 3,456,769	05/01/00
SOUTH CAROLINA	$ 6,221,783	$ 0	0%	$ 6,221,783	10/12/99 •
SOUTH DAKOTA	$ 2,642,597	$ 824,458	31%	$ 1,818,139	12/01/99 •
TENNESSEE	$ 9,250,889	$ 0	0%	$ 9,250,889	10/01/99 •
TEXAS	$ 27,523,806	$ 0	0%	$ 27,523,806	11/05/99 •
UTAH	$ 4,006,172	$ 0	0%	$ 4,006,172	10/01/99 •
VERMONT	$ 2,891,672	$ 0	0%	$ 2,891,672	09/20/99 •
VIRGINIA	$ 8,531,522	$ 2,020,109	24%	$ 6,511,413	02/01/00
WASHINGTON	$ 10,443,170	$ 2,364,205	23%	$ 8,078,965	01/10/00
WEST VIRGINIA	$ 5,420,593	$ 121,629	2%	$ 5,298,964	01/11/00
WISCONSIN	$ 7,023,766	$ 49,362	1%	$ 6,974,404	09/30/99 •
WYOMING	$ 2,475,344	$ 212,028	9%	$ 2,263,316	01/01/00
TOTAL	$ 490,826,441	$ 39,333,778	8%	$ 451,492,663	

Source: Health Care Financing Administration, financial information; Agency for Children and Families, dates of fund expiration.

Administration for Children and Families
U.S. Department of Health and Human Services

STATUS OF TANF PLANS
as of 9/29/97 10:00AM

Source: U.S. Dept. of Health & Human Services/Administration for Children & Families

States/D.C./Territories submitted: 51	Tribes submitted: 11
States/D.C./Territories certified: 51	Tribes certified: 10*
States/D.C. pending: 0	Tribes pending: 1
*NOTE: Tribal plans are approved, unlike state and territory plans which are certified.	

In effect
Latest

Subm Date — Certified Approval — Effective — Later of A

Wisconsin	8/22/96	9/30/96	09/30/96	
Michigan	8/27/96	9/30/96	09/30/96	
Ohio	9/19/96	11/1/96	10/01/96	✓
Florida	9/20/96	10/8/96	10/01/96	✓
Vermont	9/20/96	11/18/96	09/20/96	
Massachusetts	9/23/96	1/28/97	09/30/96	✓
Maryland	9/27/96	1/10/97	12/09/96	✓
Oregon	9/27/96	11/1/96	10/01/96	
Arizona	9/30/96	11/1/96	10/01/96	
Kentucky	9/30/96	11/18/96	10/18/96	
Maine	9/30/96	12/27/96	11/01/96	
Oklahoma	9/30/96	11/1/96	10/01/96	
Tennessee	9/30/96	12/20/96	10/01/96	
Utah	9/30/96	12/13/96	10/01/96	
Alabama	10/1/96	12/7/96	11/15/96	
Connecticut	10/1/96	1/22/97	10/01/96	✓
Indiana	10/1/96	11/1/96	10/01/96	

Kansas	10/1/96	11/27/96	10/01/96
Louisiana	10/1/96	1/10/97	01/01/97
Mississippi	10/1/96	11/27/96	10/01/96
Missouri	10/1/96	12/23/96	12/01/96
Nebraska	10/1/96	12/7/96	12/01/96
New Hampshire	10/1/96	11/12/96	10/01/96
South Dakota	10/1/96	12/7/96	12/01/96
Texas	10/1/96	11/26/96	11/05/96
Red Cliff Band of Lake Superior Chippewas (WI)	10/2/96	9/29/97	10/1/97
California	10/9/96	12/7/96	11/26/96
New Jersey	10/15/96	1/29/97	02/01/97
South Carolina	10/12/96	1/3/97	10/12/96
New York	10/17/96	12/13/96	12/02/96
Wyoming	10/17/96	12/23/96	01/01/97
Nevada	10/18/96	12/24/96	12/03/96
North Carolina	10/18/96	1/10/97	01/01/97
Montana	11/1/96	2/13/97	2/1/97
Georgia	11/15/96	1/21/97	01/01/97
Iowa	11/15/96	1/21/97	01/01/97
West Virginia	11/26/96	2/13/97	01/11/97
District of Columbia	12/4/96	4/2/97	03/01/97
Virginia	12/6/96	2/21/97	02/01/97
Washington	12/12/96	1/14/97	01/10/97
Guam	1/9/97	6/27/97	07/01/97
Delaware	1/22/97	4/11/97	03/10/97
Pennsylvania	1/22/97	4/23/97	03/03/97
Osage Tribe (OK)	2/21/98		
Forest County Potawatomi (WI)	3/4/97	6/30/97	7/1/97
Rhode Island	3/13/97	6/9/97	05/01/97
Klamath Tribe (OR)	3/20/97	5/15/97	7/1/97

New Mexico	4/4/97	6/5/97	07/01/97
Hawaii	4/7/97	6/27/97	07/01/97
Minnesota	5/1/97	7/1/97	07/01/97
North Dakota	5/1/97	6/26/97	07/01/97
Colorado	5/13/97	6/27/97	07/01/97
Sokaogon Chippewa (WI)	5/14/97	9/29/97	10/1/97
Idaho	5/15/97	6/27/97	07/01/97
Illinois	5/19/97	7/1/97	07/01/97
Arkansas	5/21/97	6/26/97	07/01/97
Stockbridge-Munsee (WI)	5/22/97	9/29/97	10/1/97
Virgin Islands	5/22/97	6/30/97	07/01/97
Alaska	5/30/97	6/27/97	07/01/97
Sisseton-Wahpeton (SD)	6/3/97	9/29/97	10/1/97
Puerto Rico	6/12/97	6/30/97	07/01/97
Confederated Tribes of Siletz Indians	6/26/97	9/29/97	10/1/97
Pascua Yaqui (AZ)	6/27/97	10/21/97	11/1/97
White Mountain Apache	6/30/97	10/24/97	11/1/97
Southern Callifornia Tribal Chairman's Association	1/30/98	2/25/98	3/1/98

Department of Health and Human Services
Welfare Reform
Administration for Children and Families
Return to the ACF Welfare Reform Information Main Page

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Questions? Contact: ACF Public Affairs: 202-401-9215 or e-mail us.

OPTIONS TO EXTEND THE LIFE OF THE $500 MILLION FUND FOR TANF-MEDICAID OUTREACH

BACKGROUND

(h) TRANSITIONAL INCREASED FEDERAL MATCHING RATE FOR INCREASED ADMINISTRATIVE
COSTS.--

(1) IN GENERAL.--Subject to the succeeding provisions of this subsection, the Secretary shall
provide that with respect to administrative expenditures described in paragraph (2) the per centum specified in section 1903(a)(7) shall be increased to such percentage as the Secretary specifies.
(2) ADMINISTRATIVE EXPENDITURES DESCRIBED.--The administrative expenditures described
in this paragraph are expenditures described in section 1903(a)(7) that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs of eligibility determinations that (but for the enactment of this section) would not be incurred.
(3) LIMITATION.--The total amount of additional Federal funds that are expended as a result of the application of this subsection for the period beginning with fiscal year 1997 and ending with fiscal year 2000 shall not exceed $500,000,000. In applying this paragraph, the Secretary shall ensure the equitable distribution of additional funds among the States.
(4) TIME LIMITATION.--This subsection shall only apply with respect to a State for expenditures incurred during the first 12 calendar quarters in which the State program funded under part A of title IV (as in effect on and after the welfare reform effective date) is in effect.

(i) WELFARE REFORM EFFECTIVE DATE.--In this section, the term "welfare reform date" means the
effective date, with respect to a State, of title I of the Personal Responsibility and Work Opportunity
Reconciliation Act of 1996 (as specified in section 116 of such Act)[328].

Availability and use of 1931(b) outreach funds

Background:

- Section 1931(h) of the Personal Responsibility and Work Opportunity Act provided for a $500 million fund available to States at enhanced Federal matching rates for certain administrative expenditures. This provision was implemented in a Federal Register notice (MB-110-NC) and an All-State Medicaid Director Letter from the Medicaid Bureau, both dated May 14, 1997. Section 1931(h)(3) of the Act established a $500 million fund and provided the authority for DHHS to establish a basis for allocating the fund among States.
- Section 1931(h)(3) of the Act further stipulates that these funds must be used within "the period beginning with fiscal year 1997 and ending with fiscal year 2000."
- Section 1931(h)(4) of the Act stipulates that States' allocations of the $500 million fund are available for expenditures "incurred during the first 12 calendar quarters in which the State program funded under part A of title IV (as in effect on and after the welfare reform effective date) is in effect." [Part A of title IV refers to pre-reform provisions-- the regulations state that these outreach funds are "available ... only during the first 12 calendar quarters in which the State's Temporary Assistance to Needy Families program ... is in effect after August 21, 1996."]

California's timeline for TANF implementation:

- The "effective date" for California's TANF program was 11/26/96. This is the date when ACF "certified as complete" California's TANF program, notifying the State that their TANF program met statutory requirements. The approval was not retroactive. HCFA has interpreted this to mean that the TANF program was in effect during the first quarter of FY 1997. Hence, the 12 quarter period for California was established as 10/1/96 through 9/30/99.
- California began expending TANF funds in December 1996.
- California later changed their TANF program by enacting CalWORKS. AB 1542, the bill that enacted CalWORKS, was signed on August 11, 1997.
- The effective date for CalWORKS was January 1998. The 58 counties began enrolling eligible recipients into CalWORKS throughout 1998.
- California implemented its 1931 group under its Medi-Cal program in January 1998.

California's allocation of funds:

- California's allotment of the Federal outreach funds is $83,719,458. To date, they have allocated $17.9 million of these funds through contracts with counties. Many counties have in turn subcontracted with community organizations to carry out outreach activities.
- California began claiming the enhanced administrative funds in the quarter ending 9/30/98. Through the quarter ending 3/31/99, California has claimed $13.1 million.
- The State and advocates are concerned that the September 1999 end date for use of the State's outreach allocation will occur around the same time that TANF benefits will be discontinued for many recipient, and when outreach efforts would be particularly useful. Further, some of the community organizations that have contracted with the State for use of a portion of these outreach funds have remaining funds available for outreach, should the State's end date for use of the funds be extended.

May 14, 1997

Dear State Medicaid Director:

This letter and attachments provides guidance on how State Medicaid Agencies must report, and the Health Care Financing Administration (HCFA) will track, certain Medicaid administrative expenditures and budget projections relating to the provision of the Welfare Reform legislation (Public Law 104-193, enacted August 22, 1996), the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which established a special $500 million fund available to States for enhanced Federal matching for such expenditures.

In consultation with State intergovernmental groups, HCFA allocated two amounts from the $500 million fund to each State Agency, to be used for allowable expenditures. The first allocation is a minimum amount and is generally the same for all States ($2 million). States may make claims for any allowable expenditures against this allocation at the enhanced Federal matching rate of 90 percent. The second amount differs among States and was based on State specific factors such as caseload and Medicaid administrative expenditures. States may make claims for allowable expenditures against this allocation at two rates, 90 or 75 percent, relating to the category of expenditure.

The allocated funds are available to each State for certain administrative expenditures attributable to the costs of Medicaid eligibility determinations related to this Welfare Reform provision and incurred during the first three years the State's Temporary Assistance for Needy Families (TANF) program is in effect, but no earlier than October 1, 1996 and no later than September 30, 2000.

There are 3 attachments to this letter. The first attachment contains more detailed guidance describing this provision and the reporting requirements that States must follow in order to claim for allowable expenditures at the enhanced Federal matching rates. The second attachment is a chart showing the States' allocations from the $500 million enhanced Federal matching Fund. The third attachment is the Federal Register notice (MB-103-NC) implementing this provision.

If you have any questions or require further information, please contact your HCFA Regional Office.

Sincerely,

/s/

Judith D. Moore
Acting Director
Medicaid Bureau

ATTACHMENT

STATE REPORTING OF EXPENDITURES AND BUDGET PROJECTIONS RELATING TO $500 MILLION ENHANCED FEDERAL MATCHING FUND

Background - Repeal of the AFDC Program. Title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) replaced the open-end funded Aid to Families with Dependent Children (AFDC) cash assistance program with the block grant funded Temporary Assistance for Needy Families (TANF) program. Previously, receipt by a family of cash assistance under the AFDC program conferred automatic Medicaid eligibility. Under section 1931 of the Social Security Act (the Act), as amended by section 114(a) of PRWORA, in general State agencies must provide Medicaid eligibility to those low-income families meeting the eligibility requirements for AFDC under the States' AFDC State plans in effect as of July 16, 1996.

$500 Million Fund Established. To assist State Medicaid agencies with the additional Medicaid administrative expenditures that they will incur as a result of determining AFDC-related Medicaid eligibility, section 1931(h) of the Act, established a $500 million enhanced Federal matching fund and directed the Secretary of the Department of Health and Human Services to ensure the equitable distribution of the fund among the States and territories.

Two Allocations Of The Fund For Each State. In consultation with State intergovernmental groups, the Health Care Financing Administration (HCFA) allocated two amounts to each State agency from the $500 million fund: a minimum (Base) Allocation which is generally the same for all States ($2,000,000); and an additional amount (Secondary Allocation), which differs among States and was allocated in accordance with a formula based on State specific factors such as caseload and Medicaid administrative expenditures. State agencies may claim Federal funding for allowable activities against the Base Allocation at a 90-percent enhanced Federal matching rate. States may claim Federal funding for allowable activities against the Secondary Allocation at two rates: a 90-percent enhanced Federal matching rate for specified activities considered critical to protecting recipients; and a 75-percent enhanced Federal matching rate for other allowable activities.

Period for Which Enhanced Funds Are Available. A State agency may claim enhanced Federal matching funds for allowable expenditures incurred during the first 12 calendar quarters (3 years) in which the State's TANF program is in effect. Furthermore, the enhanced Federal matching funds are only available for allowable expenditures for the period beginning with Federal fiscal year 1997 (that is October 1, 1996) and ending with Federal fiscal year 2000 (that is, September 30, 2000).

One Enhanced Federal Matching Rate for the Base Allocation. We established the higher 90-percent enhanced Federal matching rate associated with the Base Allocation to recognize the pressing startup and other common costs among States related to the transition from AFDC to the TANF program. The higher Federal matching rate for the Base Allocation will help expedite funds to States for such costs.

Two Enhanced Federal Matching Rates for the Secondary Allocation. We established the two enhanced Federal matching rates associated with the Secondary Allocation to recognize two priorities of activities related to this provision. Items of the highest priority are indicated in the Allowable Activities section below by an asterisk (*) and are claimed at the higher 90-percent Federal matching rate. These items are associated with beneficiary oriented activities such as outreach, public service announcements, and education. The higher 90 percent enhanced rate encourages such activities and recognizes the importance of ensuring that individuals do not lose their eligibility inappropriately, are correctly determined (or redetermined) eligible, and understand program requirements during the critical period of transition to TANF. The lower 75-percent enhanced Federal matching rate addresses the other activities performed during the transition period.

Allowable Activities. Expenditures for activities allowable for enhanced Federal matching funds under this provision include only those that would otherwise be Federally matched as Medicaid administrative expenditures at a 50 percent rate under section 1903(a)(7) of the Act. These are expenditures attributable to the increased administrative costs of Medicaid eligibility determinations and directly related activities incurred because of the transition from AFDC to TANF, and resulting from the enactment of section 1931 of the Act. For example, expenditures related to new Medicaid eligibility workers (including outstationed eligibility workers) hired by a State to implement the provisions of section 1931 of the Act would be allowable at the enhanced Federal matching rates. In addition, PRWORA activities performed by current eligibility workers would be allowable at the enhanced Federal matching rates. On the other hand, expenditures related to activities of outstationed eligibility workers who determine Medicaid eligibility for Supplemental Security Income (SSI) related individuals, such as the aged and disabled, or other non-PRWORA activities would not be allowable at the enhanced Federal matching rates.

With respect to the Base Allocation all of the allowable activities on the following list would be claimable at the 90 percent enhanced Federal matching. With respect to the Secondary Allocation, those allowable activities indicated with an asterisk (*) would be claimable at the 90 percent enhanced Federal matching rate. The other allowable activities with no asterisk would be claimable against the Secondary Allocation at the 75 percent enhanced Federal matching rate.

- Educational activities (relating to current or potential beneficiaries).*
- Public service announcements (PSAs).*
- Outstationing of eligibility workers (more workers or new locations, for example, churches, day care centers, WIC offices, health care providers).*
- Training related to the section 1931 provisions--*
  - Eligibility workers
  - Providers
  - Outstationed eligibility workers and other individuals
  - Community

- Outreach activities (for example, general or targeted mailing campaigns, contracts to assist beneficiaries with the redetermination process).*
- Developing and disseminating new publications (targeted to at-risk populations).*
- Local community activities (for example, meetings with community leaders and speeches to community groups).*
- Hiring new Medicaid eligibility workers (related to section 1931 determinations).
- Designing new eligibility forms, for example, a single application for TANF and Medicaid whether eligibility is linked or not.
- Identification of "at-risk" TANF recipients (in this context, at-risk refers to vulnerability to losing Medicaid eligibility as a result of the TANF provisions).
- State and local government organizational changes related to the section 1931 provisions.
- Intergovernmental activities.
- Eligibility systems related changes.
- Other activities identified by States and approved by the Secretary as applicable to the enhanced matching fund provisions.

In order for State agencies to claim Federal funds for these allowable activities at the appropriate enhanced Federal matching rates associated with the two allocations, and for HCFA to properly track State expenditures against the allocations, States will need to report the expenditures on the Form HCFA-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance program) and Form HCFA-37 (Medicaid Program Budget Report), as described in the sections below.

REPORTING EXPENDITURES FOR STATE AND LOCAL ADMINISTRATION - FORM HCFA-64.10 AND 64.10P

Waiver Schedules of the Forms HCFA-64.10/10p). In order for State agencies to claim Federal funds for allowable administrative activities at the correct enhanced Federal matching rates associated with the Base and Secondary Allocations, and for HCFA to track State expenditures against the two allocations, States must create two separate waiver schedules for the Form HCFA-64.10, one for each of the two allocations. Note, line 14 of the Form HCFA-64.10 has previously allowed Federal share entries to be reported only in column (d) at the 50 percent rate. In order to allow the reporting of expenditures at the enhanced Federal matching rates of 90 and 75 percent, the Medicaid Budget and Expenditure System (MBES) has been modified to

allow entries to be reported on the Form HCFA-64.10 in columns (b) at 90 percent, and (c) at 75 percent.

Base Allocation. In order to report and claim expenditures against the Base Allocation at the associated 90 percent Federal matching rate, the State must create a waiver schedule of the Form HCFA-64.10, indicating "TANF" in the "TYPE OF WAIVER" block and "BASE ALLOC" in the "WAIVER NUMBER" block. All allowable expenditures for which States are claiming against the Base allocation must be reported on line 14 (OTHER FINANCIAL PARTICIPATION) of this waiver schedule of the Form HCFA-64.10. The total computable amounts must be reported in column (a) and the (90 percent) Federal share amounts must be reported in columns (b) and (f).

Secondary Allocation. In order to report and claim expenditures against the Secondary Allocation at the associated 90 and 75 percent Federal matching rates, the State must create a waiver schedule of the Form HCFA-64.10, indicating "TANF" in the "TYPE OF WAIVER" block and "SECONDARY ALLOC" in the "WAIVER NUMBER" block. All allowable expenditures for which States are claiming against the Secondary allocation must be reported on line 14 (OTHER FINANCIAL PARTICIPATION) of this waiver schedule of the Form HCFA-64.10. The sum of all the total computable amounts for both the 75 percent and the 90 percent activities must be reported in column (a). The 90 percent Federal share amounts must be reported in column (b) and the 75 percent Federal share amounts must be reported in column (c). The sum of the Federal share amounts reported in columns (b) and (c) must be reported in column (f).

Base Form of the Form HCFA-64.10. Line 14 of the base form of the Form HCFA-64.10 must include the combined totals in each of the columns from all the "TANF" waiver forms, as well as the usual current administrative expenditures reported by the States on this form. Note, any entries on the base form of the Form HCFA-64.10 in columns (b) at 90 percent and (c) at 75 percent must reflect only the TANF expenditures related to the Base and Secondary Allocations.

The following example illustrates how to complete the Form HCFA-64.10/10p.

Example. For the third quarter of FY 1999 the State has the following current quarter total computable "Other Financial Participation" administrative expenditures:

- $100,000,000 in regular Medicaid administrative expenditures
- $6,500,000 in total administrative expenditures for allowable TANF related activities:
  - $1,000,000 in expenditures for TANF activities to be applied towards the Base Allocation at 90 percent.
  - $3,000,000 in expenditures for TANF activities to be applied towards the Secondary Allocation at 90 percent.
  - $2,500,000 in expenditures for TANF activities to be applied towards the

Secondary Allocation at 75 percent.

- $50,000 in prior period expenses. In addition to the above current quarter expenditures, in the third quarter of FY 1999 the State has $50,000 of total computable allowable TANF related expenditures related to a prior period, FY 1998, to be reported against the Secondary Allocation at 75 percent.

In order to report the above regular and TANF related administrative expenditures, the State will need to do the following:

- For the Base Allocation current quarter expenditures, create a Form HCFA-64.10 waiver schedule for the third quarter of FY 1999, indicating on line 14 $1,000,000 in Column (a) and $1,000,000 in column (b). The system will calculate the federal share of $900,000 (90 percent of $1,000,000) for column (b) and report $900,000 in column (f). Indicate "TANF" as the Type of Waiver and "BASE ALLOC" as the Waiver Number. Indicate June 30, 1999 in the Quarter Ended block.

- For the Secondary Allocation current quarter expenditures, create a Form HCFA-64.10 waiver schedule for the third quarter of FY 1999, indicating on line 14 $5,500,000 ($3,000,000 plus $2,500,000) in column (a), $ 3,000,000 in column (b), and $2,500,000 in column (c). The system will compute $2,700,000 in column (b) (90 percent of $3,000,000), $1,875,000 in column (c) (75 percent of $2,500,000) , and $4,575,000 in column (f) ($2,700,000 plus $1875,000). Indicate "TANF" as the Type of Waiver and "SECONDARY ALLOC" as the Waiver Number. Indicate June 30, 1999 in the Quarter Ended block.

- Base Form HCFA-64.10. For line 14 of the third quarter FY 1999 current quarter expenditures base Form HCFA-64.10, indicate $106,500,000 total computable in column (a), $4,0000,000 in column (b), $2,500,000 in column (c), and $100,000,000 in column(d). The system will compute $3,600,000 (Federal share at 90 percent) in column (b), $1,875,000 (Federal share at 75 percent) in column (c), $50,000,000 (Federal share at 50 percent) in column (d), and $55,475,000 total Federal share in column f). Indicate June 30, 1999 in the Quarter Ended block.

- For the FY 1998 prior period expenditures applicable to the Secondary Allocation, create a Form HCFA-64.10p waiver schedule for FY 1998, indicating on line 14 $50,000 in columns (a) and (c). The system will compute $37,300 (75 percent of $50,000) in columns (c) and (f). Indicate "TANF" as the Type of Waiver and "SECONDARY ALLOC" as the Waiver Number. Indicate June 30, 1999 in the Quarter Ended block. Indicate 1998 in the Fiscal Year block.

- Summary Form HCFA-64. Finally, the total computable amounts of $106,500,000, and the associated Federal shares of $55,475,000, for the current third quarter of FY 1999 (which were reported on the base Form HCFA-64.10),

will be included on line 6 in columns (c) and (d) of the summary Form HCFA-64.

The total computable amount of $50,000, and the associated Federal shares of $37,300 for the prior period FY 1998, will be included on line 7 in columns (c) and (d) of the summary Form HCFA-64.

TRACKING ALLOWABLE EXPENDITURES AGAINST THE STATE ALLOCATIONS

Section 1931(h) of the Act provides for enhanced Federal matching for States' claims against the Base and Secondary Allocations. These enhanced Federal matching rates are in addition to Federal funds that would ordinarily be available for such expenditures at the 50 percent matching rate available under section 1903(a)(7) of the Act. Therefore States' claims for allowable administrative activities will reduce their Base and Secondary Allocations only by the amounts that are in excess of the usual 50 percent Federal matching rate, and not by the entire Federal matching amount. Specifically, States' allocations will be reduced by the amount of the claim multiplied by the difference between the enhanced Federal matching rate percentage and the (usual) 50 percent rate.

Using the example above, the State's allocations would be reduced by the following:

- The Base Allocation would be reduced by $400,000 (900,000 - $500,000) with respect to the total computable expenditure of $1,000,000, which received 90 percent Federal matching.

- The Secondary Allocation would be reduced by $1,200,000 ($2,700,000 - $1,500,000) with respect to the total computable expenditure of $3,000,000, which received 90 percent Federal matching.

- The Secondary Allocation would be reduced by $625,000 ($1,875,000 - $1,250,000) with respect to the total computable expenditure of $2,500,000, which received 75 percent Federal matching.

- The Secondary Allocation would be reduced by $12,500 ($37,500 - $25,000) with respect to the prior period total computable expenditure of $50,000, which received 75 percent Federal matching.

The above amounts will be tracked against the States' respective Base and Secondary Allocations by the grants analysts in the HCFA's Medicaid Bureau and reflected in the quarterly grant awards for each State.

POSSIBLE REALLOCATION OF FUNDS: TRACKING ALLOWABLE EXPENDITURES AFTER THE ALLOCATIONS ARE MET

Once a State's has claimed up to its Base and Secondary allocations (that is, the State's

allocations have been reduced to $0) Federal funds will only be available for allowable expenditures at the usual 50 percent matching rate. However, it is possible that certain States may never reach their allocations; that is, they may not incur sufficient expenditures during the applicable period to use up their entire allocations. If there are such unused funds, HCFA would reallocate the unused Federal funds to those other States that may have incurred allowable expenditures in excess of their allocations during the applicable period, if the excess allowable expenditures have been reported appropriately.

In order for HCFA to reallocate any potential unused amounts from the $500 million fund to those States that may be able to use them, and for such States to claim the reallocated fund at the enhanced Federal matching rates, the States will need to continue to report and HCFA will need to continue to track the amounts of allowable expenditures incurred by such States during the applicable period under these provisions. This would need to be done even after the States have reached their allocations in order for HCFA at the time of reallocation to identify and match the expenditures at the appropriate enhanced Federal matching rate. Therefore, States that want to be eligible for any potential reallocation will need to continue to report allowable expenditures, even after they have reached their allocations.

However, after a State has claimed up to its allocations, but prior to the availability of any reallocation, HCFA would have to defer or disallow claims for allowable expenditures at the enhanced Federal matching rates, if the State were to continue to report and claim the expenditures at the 90/75 percent enhanced Federal matching rate on line 14 columns (b) and (c) of the waiver schedule of Form HCFA-64.10/10p. That is, prior to the availability of any reallocated amounts, Federal funds would not yet be available for States' claims which are in excess of their State allocations at other than the 50 percent rate and amounts of claims in excess of 50 percent would have to be deferred or disallowed.

In order to avoid the need for deferral or disallowance actions yet still provide information that would be used by HCFA to pay claims against potential reallocated funds, States should continue to report the allowable expenditures in excess of its allocations, but only at the 50 percent rate, on line 14 in column (d) of the Secondary Allocation waiver schedule of Form HCFA-64.10/10p. Since these amounts will only be reported in the 50 percent column (d) on line 14, the State will also need to distinguish between amounts of the allowable expenditure that would be claimed at 90 or 75 percent. In order to properly distinguish these expenditures, States should use the narrative sheet of the Form HCFA-64 to indicate and separately identify the amounts of the expenditures that would have been claimed at 90 percent and at 75 percent.

> Example. A State has claimed up to its Base Allocation and Secondary Allocation by the end of FY 1998 (September 30, 1998). In the first quarter of FY 1999 the State has allowable TANF related expenditures which otherwise could have been claimed at the enhanced Federal Matching rates of 90 percent and 75 percent in the total computable amounts of $1 million and $2 million, respectively. On line 14 of the Secondary Allocation waiver schedule of the Form HCFA-64.10, the State should report $3 million ($1 million plus $2 million) in the total computable column (a) and $1.5 million (50 percent of $3 million) in the 50 percent Federal matching rate column (d). On the

narrative sheet of the HCFA-64, the State should indicate to the effect: "The $3 million total computable TANF related expenditures reported on line 14 in column (a) of the Secondary Allocation waiver schedule of the Form 64.10, represents $1 million in allowable expenditures for activities that could otherwise have been claimed at an enhanced Federal matching rate of 90 percent, and $2 million at 75 percent, except that the State has already claimed up to its TANF allocation."

MEDICAID PROGRAM BUDGET REPORT FORM HCFA-37.10

States must include and report all allowable TANF expenditures on line 14, Other Financial Services, of the Form HCFA-37.10. Include and enter the total computable portion in column A and the Federal share in column B. This line will no longer automatically calculate the Federal share in column B. After entering the total computable amount you must calculate the Federal share in order to receive reimbursement since line 14 will now reflect the multiple Federal matching rates. In order for HCFA to relate the amounts indicated on line 14 to the TANF provisions, the State must indicate in the narrative section of the Form HCFA-37.12 the amount of TANF expenditures they are requesting for both the Base and Secondary allocation. The example below illustrates the completion of the Form HCFA-37.

Example. For FY 1999 the State projects the following (dollars are in thousands):

- $100,000 in total computable regular line 14 Other Financial Participation administrative expenditures, to be Federally matched at 50 percent. The projected Federal share of this amount would be $50,000.
- $1,000 in total computable expenditures to be applied against the base allocation at the 90 percent Federal matching rate. The projected Federal share of this amount would be $900.
- $3,000 in total computable expenditures to be applied against the secondary allocation at the 90 percent Federal matching rate. The projected Federal Share of this amount would be $2,700.
- $2,550 in total computable expenditures to be applied against the secondary allocation at the 75 percent Federal matching rate. The projected Federal share of this amount would be $1,913.

In accordance with this information the State must complete the Form HCFA-37 as follows:

- On the Form HCFA-37.10, the State must report the following for budget year FY 1999:
  - $106,550 ($100,000 + $1,000 + $3,000 + $2,550) on line 14 column A.

- $55,513 ($50,000 + $900 + $2,700 + $1,913) on line 14 in column B.

- In the narrative section of the Form HCFA-37.12 the State must indicate language to the effect for FY 1999:

  - "Explanation of Line 14 of the Form HCFA-37.10. The $106,550 Other Financial Participation total computable expenditure amounts includes $100,000 in regular expenditures Federally matchable at 50 percent, and "Section 1931 related TANF expenditures" as follows: $1,000 applicable towards the Base Allocation and Federally matchable at 90 percent, $3,000 applicable to the Secondary Allocation and Federally matchable at 90 percent, and $2,550 applicable to the Secondary Allocation and Federally matchable at 75 percent. The $55,513 Other Financial Participation Federal Share expenditure amounts reflects the above total computable expenditures at the respective Federal Matching rates: $50,000, $900, $2,700, and $1913."

$500 MILLION ENHANCED MATCH ALLOCATION PERIOD		
ALABAMA	11/15/99	10/1/96 - 9/30/99
ALASKA	7/1/97	7/1/97 - 6/30/2000
ARIZONA	10/1/96	10/1/96 - 9/30/99
ARKANSAS	7/1/97	7/1/97 - 6/30/2000
CALIFORNIA	11/26/99	10/1/96 - 9/30/99
COLORADO	7/1/97	7/1/97 - 6/30/2000
CONNECTICUT	10/1/96	10/1/96 - 9/30/99
DELAWARE	3/10/97	1/1/97 - 12/31/99
DISTRICT OF COLUMBIA	3/1/97	1/1/97 - 12/31/99
FLORIDA	10/1/96	10/1/96 - 9/30/99
GEORGIA	1/1/97	1/1/97 - 12/31/99
GUAM	7/1/97	7/1/97 - 6/30/2000
HAWAII	7/1/97	7/1/97 - 6/30/2000
IDAHO	7/1/97	7/1/97 - 6/30/2000
ILLINOIS	7/1/97	7/1/97 - 6/30/2000
INDIANA	10/1/96	10/1/96 - 9/30/99
IOWA	1/1/97	1/1/97 - 12/31/99
KANSAS	10/1/96	10/1/96 - 9/30/99
KENTUCKY	10/16/96	10/1/96 - 9/30/99
LOUISIANA	1/1/97	1/1/97 - 12/31/99
MAINE	11/1/96	10/1/96 - 9/30/99
MARYLAND	12/9/96	10/1/96 - 9/30/99
MASSACHUSETTS	9/30/96	10/1/96 - 9/30/99
MICHIGAN	9/30/96	10/1/96 - 9/30/99
MINNESOTA	7/1/97	7/1/97 - 6/30/2000
MISSISSIPPI	10/1/96	10/1/96 - 9/30/99
MISSOURI	12/1/96	10/1/96 - 9/30/99
MONTANA	12/16/96	10/1/96 - 9/30/99
NEBRASKA	12/1/96	10/1/96 - 9/30/99
NEVADA	12/3/96	10/1/96 - 9/30/99
NEW HAMPSHIRE	10/1/96	10/1/96 - 9/30/99
NEW JERSEY	2/1/97	1/1/97 - 12/31/99
NEW MEXICO	7/1/97	7/1/97 - 6/30/2000
NEW YORK	12/2/96	10/1/96 - 9/30/99
NORTH CAROLINA	1/1/97	1/1/97 - 12/31/99
NORTH DAKOTA	7/1/97	7/1/97 - 6/30/2000
OHIO	10/1/96	10/1/96 - 9/30/99
OKLAHOMA	10/1/96	10/1/96 - 9/30/99
OREGON	10/1/96	10/1/96 - 9/30/99
PENNSYLVANIA	3/3/97	1/1/97 - 12/31/99
PUERTO RICO	7/1/97	7/1/97 - 6/30/2000
RHODE ISLAND	6/1/97	4/1/97 - 3/31/2000
SOUTH CAROLINA	10/12/96	10/1/96 - 9/30/99
SOUTH DAKOTA	12/1/96	10/1/96 - 9/30/99
TENNESSEE	10/1/96	10/1/96 - 9/30/99
TEXAS	11/6/96	10/1/96 - 9/30/99
UTAH	10/1/96	10/1/96 - 9/30/99
VERMONT	9/20/99	10/1/96 - 9/30/99
VIRGINIA	2/1/97	1/1/97 - 12/31/99
VIRGIN ISLANDS	7/1/97	7/1/97 - 6/30/2000
WASHINGTON	1/10/97	1/1/97 - 12/31/99
WEST VIRGINIA	1/11/97	1/1/97 - 12/31/99
WISCONSIN	9/30/99	10/1/96 - 9/30/99