

Memorandum

From: Herbert Semmel
Date: January 30, 1997
Subject: Continued Medicaid Pending SSA Appeals Process

To understand the current state of the law on continued Medicaid benefits pending the Social Security Administration (SSA) appeals process of a determination of no disability, some background on the binding effect of the SSA decision on state Medicaid eligibility is necessary.

Prior to 1990, there was a good deal of uncertainty over whether a determination by the Social Security Administration (SSA) that an individual did not meet the SSI definition of disabled was binding on a state determination of Medicaid eligibility based on disability. In 1984, the US Department of Health and Human Services adopted a policy that SSA determinations are binding on state Medicaid determinations. See *Rousseau v. Bordeleau*, 624 F. Supp. 355, 356 (D. R.I. 1985). Courts differed on the validity of this policy. Compare *Rousseau v. Bordeleau* with *Fratone v. Division of Public Welfare of New Jersey Department of Human Services*, CCH Medicare/Medicaid Guide 137,093 (D.N.J. 1988).

In 1990, regulations were adopted by HCFA which affirmed the policy that SSA determinations were binding on the state Medicaid agency in most circumstances. 42 C.F.R. § 435.541. One concern with the policy and regulation was that large numbers of SSA determinations of no disability are reversed during the SSA appeals process, which lasts from one to two years. Although a retroactive award of SSI benefits is made, medical care which is not available when needed can never be replaced.

Senator Leahy expressed these concerns in a letter to HHS Secretary Sullivan after adoption of the regulations in 1990. Secretary Sullivan's reply, dated May 16, 1990, states:

[I]f a Medicaid recipient requests a hearing as a result of a decision that he or she is no longer disabled, the recipient's Medicaid services would be maintained pending the final administrative resolution of the hearing request. Federal financial participation (FFP) continues to be available to State Medicaid agencies for maintaining Medicaid services throughout the appeal process. This is the case whether the determination of non-disability was made by the State or by SSA pursuant to an application for, or review of eligibility for, Supplemental Security Income (SSI) benefits.

THE WHITE HOUSE
WASHINGTON

Pick = to mollify
states

b vs d

Condy
Mann

4 states - no hold in
Nix

Wy

Neb

Cal - MA fraud

Ms. Harriet Rabb

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January 30, 1997

In addition, most of these people are suffering from other chronic physical and mental conditions which require ongoing medical attention and medication. A substantial number rely on Medicaid for anti-psychotic drugs.

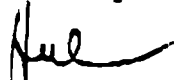
Termination of Medicaid in effect throws onto the street thousands of people most of whom will eventually be determined to be eligible for SSI and Medicaid. In the interim, we can only expect that some, probably a good many, of those affected will revert to the use of illegal drugs and will have no other means to purchase drugs than what they obtain from street crime. If HCFA allows the premature termination of Medicaid benefits during the SSA appeals process, we can anticipate an increase in the kinds of street crime that we all have worked so hard to reduce. Both the individuals dependent on Medicaid for treatment and the public will be the victims.

I am attaching a brief memorandum which outlines the background of the issue and the commitment made by HHS Secretary Sullivan in a May 16, 1990 letter to Senator Leahy (copy attached) to continue Medicaid benefits through the SSA process when persons are terminated from SSI because SSA initially determines they no longer meet the definition of disability. A federal district court noted that premature termination of Medicaid pending SSA appeals "can be catastrophic for many individuals." It declined to issue an injunction because of Secretary Sullivan's letter, saying "[t]his court is confident that it may rely upon the Secretary to continue this reasonable and just policy." See *Disabled Rights Union v. Kizer*, 744 F. Supp. 221 (C.D.Cal. 1990).

I know that you are very busy, but I hope you will take a moment to assure that Secretary Sullivan's "reasonable and just policy" continues, particularly in light of the serious health and safety concerns that are presented.

I discussed this issue today with Jennifer Ryan, who was very attentive to what I had to say. She is following up on the matter with HCFA and I expect to hear from her without delay. However, I bring this matter to your personal attention because of the important policy issues that are raised.

Sincerely,

Herbert Semmel
Staff Attorney

cc: Jennifer Ryan

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January 30, 1997
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Based on this assurance of continued Medicaid benefits during the full SSA appeals process, the validity of the regulation was sustained in *Disability Rights Union v. Kizer*, 744 F. Supp. 221 (C.D. Cal. 1990). Referring to Secretary Sullivan's May 16, 1990 letter, the court states that "[t]he Secretary now takes the position that under the new regulations a Medicaid recipient who timely appeals an initial determination of nondisability by SSA may continue to receive benefits pending final administrative resolution of the appeal."

The court then stated:

Like the court in *Pera*, this court is impressed with the plaintiffs showing that Medicaid is cut off pending appeals that are lengthy and whose denial are reversed in a substantial percentage of instances. It is obvious that the interim delay can be catastrophic for many individuals. Although the Secretary's new policy assuages these concerns, the plaintiffs argue that the Secretary's interpretation is not consistent with the regulations and could be retracted if the Secretary had a "change of Heart." This court is confident that it may rely upon the Secretary to continue this reasonable and just policy.

In Secretary Sullivan's letter to Senator Leahy, he stated that "[t]o address an apparent misunderstanding, HCFA is developing clarifying instructions to the States. We expect these instructions to be released in the near future." The instructions were released, and appear in the State Medicaid Manual § 3272.2, which states

If an individual receiving Medicaid based upon disability is determined by SSA not to be disabled under the SSI disability standard, and he or she is not eligible for Medicaid on some other basis, such a recipient is nonetheless entitled to receive continued Medicaid coverage if he or she timely appeals the SSA disability determination pursuant to the SSA appeals process.

The section goes on to state that benefits continue through the SSA Appeals Council if timely appeals are taken.

Most recently, HCFA has released new State Medicaid Manual provisions, effective February 28, 1997, interpreting the Medicaid provisions of the federal welfare legislation, P.L. 104-193, which among other things changed the definition of "disability" as applied to children. Section 3207 (C) affirms the continuation of Medicaid benefits pending the appeals through the SSA process. It states:

C. Continued Medicaid Benefits During Transition Period

-- For States which provide Medicaid to SSI recipients, continue Medicaid benefits during the SSI redetermination and any subsequent timely appeal by the child or the child's representative payee. If there is a

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timely SSI appeal, continue Medicaid benefits through the hearing. If the SSI denial is upheld on appeal, redetermine Medicaid as provided in subsection D.

The situation with children is the same as that of persons with drug or alcohol addiction; in both cases, there has been a statutory change in the definition of disability which requires an SSA redetermination of disability.

EXECUTIVE OFFICE OF THE PRESIDENT

04-Oct-1996 01:33pm

TO: FORTUNA_D
FROM: Laura Oliven Silberfarb
CC: Barbara E. Washington
SUBJECT: 42 CFR 435.122

Bucket

Message Creation Date was at 4-OCT-1996 13:33:00

"If an agency provides Medicaid to aged, blind, or disabled individuals receiving SSI or optional State supplements, it must provide Medicaid to individuals who would be eligible for SSI or optional State supplements except for an eligibility requirement used in those programs that is specifically prohibited under title XIX."

We think that this means if a person is determined ineligible for SSI based on an eligibility requirement that Medicaid specifically prohibits, those people can be deemed as receiving SSI for the purposes of Medicaid eligibility.

The Medicaid Bureau listed two examples of this: SSI deeming rules on alien sponsors and essential persons. So, for example, if an immigrant was found ineligible for SSI because of the SSI deeming rules, then for the purposes of Medicaid eligibility they would be considered as receiving cash, and therefore, categorically eligible for Medicaid because Medicaid did not have deeming rules.

Advocates may believe that the problem of immigrants currently in the country being kicked off of SSI and not being able to get back on Medicaid in those states that 1) did not decide to kick current immigrants off of Medicaid and 2) do not have a non-cash SSI-related eligibility category that the immigrants would fall under.

There is one part that is subject to interpretation though: the reg language refers to SSI eligibility requirements that are "specifically prohibited under title XIX." Kicking current immigrants off of Medicaid is not "specifically prohibited," instead it is a state option. We suspect that this is why HCFA does not believe this provision retains eligibility for the population in question.

MEDICAID AND WELFARE REFORM.
October 15, 1996

1. Waiver issue
2. Automatic "bucket" for legal immigrants losing SSI → Elena → Anna
3. Section 415 issues? also looking @ states
4. Advocates' request for fast-track eligibility process ✓
5. Action to extend time for redeterminations? ✓
- GC not clear

Covington - b + d mutually exclusive

- 1 - b vs. d
- 2 - Sara R: b supersedes d - no meaning - { ~~the~~ Congress -
- 3 - MA eligibility only - Cindy Mann

Others had spec protection - TFC

3+8

Waive MA law, and ~~the~~ IVA

no spec TFC protecting MA -

IVA

- WISC (2 chrs) - time limit 24/48
- Calif - fraud prev.
- Neb - time limits - only children
- NH - mand jobs preg & c
- Wyo - small - address

Really no meaning

Update to TANF
What states want - why

Legis/leak

Breaux, Chafee, Dingle

MT, Neb, NH

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

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OCT - 4 1996

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

Dear State Medicaid Director:

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) has substantial implications for Medicaid eligibility systems and responsibilities. In order to address implementation issues carefully, we have been working very closely with the joint Federal/State Eligibility Technical Advisory Group (E-TAG). That process is continuing, and will culminate in the issuance of a State Medicaid Manual issuance in December which will address many of the eligibility issues.

In the meantime, we understand that some States are moving ahead to submit Temporary Assistance to Needy Families (TANF) plans. In such cases, we will presume that you will continue to provide Medicaid eligibility for all the groups you covered on July 16, 1996, including permissible legal immigrants. For administrative purposes, we request that you notify us to that effect. If you are going to make any change to Medicaid coverage of eligibility groups, please submit a State Plan Amendment to do so. Plan Amendments may be submitted to us using whatever format you think appropriate, but providing as much information as necessary to describe the eligibility options you are electing for Medicaid. We are happy to work with you on the details of plan amendments as you proceed with implementation.

Please recognize that many legal immigrants (who might otherwise qualify for Medicaid) entering the country on or after August 22, 1996, are not eligible for Medicaid for five (5) years. However, under Section 402 of P. L. 104-193, States must continue to provide Medicaid eligibility, until at least January 1, 1997, to any qualified immigrant receiving Medicaid on August 22, 1996. States should be aware that Section 402 also permits states to continue coverage for most legal immigrants and to receive Federal matching funds for coverage of these individuals. In any event, States must continue to cover immigrants enrolled in Medicaid prior to August 22, 1996 until the State submits a State Plan Amendment to the contrary.

To sum up, in the absence of submitting a State Plan Amendment, you are expected to continue providing Medicaid eligibility for all the groups you covered on July 16, 1996, including permissible legal immigrants.

We will keep you informed as we develop Federal policy to implement this Act and will issue further policy guidance as soon as possible. Thank you for your cooperation in implementing this program.

Sincerely,

A handwritten signature in black ink, appearing to read "Judith D. Moore".

Judith D. Moore
Acting Director
Medicaid Bureau

cc:

All Regional Administrators
All Associate Administrators for Medicaid
Lloyd Bishop, OLIGA
Jennifer Baxendall, NGA
Lee Partridge, APWA
Joy Wilson, NCSL

FACT SHEET #1

LINK BETWEEN MEDICAID AND TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

Prior to enactment of P.L. 104-193, the Personal Responsibility and Work Opportunities Act of 1996:

- o Individuals who received AFDC cash assistance or who were deemed to have received AFDC were automatically eligible for Medicaid. (Section 1902(a)(10)(A)(i)(I) of the Social Security Act)
- o Families who lost AFDC cash assistance because of employment or receipt of child (or spousal) support payments were eligible for transitional Medicaid assistance for an additional period of time. (Sections 1902(a)(10)(A)(i)(I) and 1925 of the Social Security Act)
- o Various rules of the AFDC program were used to establish Medicaid eligibility for other Medicaid-only eligibility groups (e.g., pregnant women and children whose eligibility is related to the poverty level, optional groups of children and caretaker relatives who do not receive AFDC, and the medically needy.) (Section 1902 of the Social Security Act)

The new welfare reform law eliminates the AFDC cash assistance program and replaces it with a block grant program called Temporary Assistance for Needy Families (TANF) (Section 103 of the new law). However, families who meet the AFDC eligibility criteria prior to welfare reform will be eligible for Medicaid. States are not required to make a complete eligibility determination using all the pre-reform AFDC program rules. This determination is replaced by two basic eligibility requirements:

- o The family income and resources must meet the pre-reform AFDC standards (Section 1931(b)(1)(I) of the Social Security Act).
- o The pre-reform AFDC deprivation requirement must be met. (i.e., a child must be living with a parent or other relative and deprived of parental support or care by the death, absence, incapacity or unemployment of a parent.) (Section 1931(b)(1)(A)(ii) of the Social Security Act)

As under pre-reform law, if a family loses Medicaid eligibility because of employment or receipt of support payments or employment and received Medicaid in three of the preceding six months, the family is eligible for a period of extended Medicaid benefits. (Sections 408(a)(11) and 1931(c) of the Social Security Act)

States are permitted to deny Medicaid benefits to adults and heads of household who lose TANF benefits because of refusal to work. However, welfare reform law specifically exempts poverty-related pregnant

women and children from this provision and mandates their continued Medicaid eligibility. (Section 1931(b)(3) of the Social Security Act)

Because the AFDC cash assistance program is eliminated, welfare reform provides that any reference in Title XIX to an AFDC provision or an AFDC State Plan will be considered a reference to the AFDC provision or plan in effect for the State on July 16, 1996, i.e. "pre-reform" AFDC. This effectively freezes the pre-reform AFDC program for all Medicaid eligibility purposes, except that welfare reform also permits States to retain flexibility to change the applicable income and resource methodologies, as follows:

- o A State may lower its income standards, but not below the standards it applied on May 1, 1988. (Section 1931(b)(2)(A) of the Social Security Act)
- o A State may increase its income and resource standards up to the percentage increase in the CPI subsequent to July 16, 1996. (Section 1931(b)(2)(B) of the Social Security Act)
- o A State may also use less restrictive income and resource methodologies than those in effect on July 16, 1996. (Section 1931(b)(2)(C) of the Social Security Act)

Related Fact Sheets:

Link Between Medicaid and SSI Coverage of Children under Welfare Reform

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility Determinations under Welfare Reform

FACT SHEET #2

LINK BETWEEN MEDICAID AND SSI COVERAGE OF CHILDREN UNDER WELFARE REFORM

Under the new law, the definition of childhood disability is no longer linked to the definition of disability for adults. The reference to "comparable severity" in the old law has been deleted.

The new definition says: (1) an individual under the age of 18 shall be considered to be disabled under SSI if that child has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least twelve months; and (2) no individual under the age of 18 who engages in substantial gainful activity may be considered disabled.

In addition to the new definition of disability for children, the law mandates two changes to current evaluation criteria in SSA's regulations. SSA must: (1) discontinue the individualized functional assessment (IFA) for children; and (2) eliminate maladaptive behavior in the domain of personal/behavioral function in determining whether a child is disabled.

In most States, individuals who are eligible for SSI are also eligible for Medicaid. These changes will result in some children losing SSI, and therefore Medicaid eligibility. However, many of the children affected could still continue to be covered under Medicaid because they meet other Medicaid eligibility criteria. States are required to perform a redetermination of Medicaid eligibility in any case where an individual loses SSI and that determination affects the individual's Medicaid eligibility.

Section 204(a) of the new law provides that SSI payments, for all beneficiaries, including children, may only begin as of the first day of the month following: (1) the date the application is filed or, if later, (2) the date the person first meets all eligibility factors. This is a delay in SSI eligibility in comparison with the old law.

Under Section 211 of the new law, SSA is required to redetermine the eligibility of recipients under age 18 by August 22, 1997. No SSI-eligible child may lose benefits by reason of a redetermination of disability using the new definition earlier than July 1, 1997.

Also under Section 211, SSA is required to send notices to the representative payees of all affected recipients no later than January 1, 1997.

Related Fact Sheets:

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility Determinations Under Welfare Reform

FACT SHEET #3

LINK BETWEEN MEDICAID AND THE IMMIGRATION PROVISIONS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY ACT OF 1996

Medicaid Eligibility of Legal Immigrants

The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) identifies two categories of legal immigrants: "qualified aliens" and others.

"Qualified Alien" Defined: A "qualified alien" is an alien who is lawfully admitted for permanent residence under various sections of the Immigration and Nationality Act (INA) including: an asylee, a refugee, an individual who has been paroled into the U.S. for a period of one year, an individual who has had his/her deportation withheld, and who has been granted conditional entry. This definition also includes battered immigrants, and/or immigrants who would be indigent without assistance, because their sponsors are not providing adequate support.

States have the following options to cover legal immigrants, as long as these individuals meet the financial and other eligibility requirements of the program.

Immigrants Residing in the U.S.

States are not required to end Medicaid coverage or eligibility for any "qualified aliens" residing in the U.S. before August 22, 1996. If the State Plan already provides such coverage and eligibility, HCFA will presume the State will continue to provide Medicaid to these individuals, until a State Plan Amendment is submitted to the contrary.

- o For immigrants who are "qualified aliens" receiving Medicaid benefits (were enrolled in the State's Medicaid program) on August 22, 1996, States must continue Medicaid coverage until at least January 1, 1997. After that date, HCFA will assume that States are continuing to cover these individuals, unless the State amends its State Plan to discontinue coverage of these individuals.
- o For immigrants who are "qualified aliens" residing in the United States before August 22, 1996, but were not enrolled on that date, whether eligible or not, States have the option not to provide Medicaid beginning on August 22, 1996. To do so, the State must amend its State Plan.
- o For other immigrants who are not "qualified aliens," Medicaid eligibility was terminated on August 22, 1996 under P.L. 104-193, except for those receiving SSI. For these immigrants, Medicaid eligibility continues until SSA redetermines eligibility (see page 4).

Excepted Groups of Immigrants

There is an excepted group of immigrants to whom the State **must** provide Medicaid coverage, provided the individuals are otherwise eligible. The following groups of immigrants are considered part of the excepted group:

- o Refugees -- For the first 5 years after entry to U.S. in that status
- o Asylees -- For the first 5 years after granted asylum
- o Individuals whose deportation is being withheld by the INS -- For the first 5 years after grant of deportation withholding
- o Lawful Permanent Residents -- After they have been credited with 40 quarters of coverage under Social Security (based upon their own work and/or that of spouses or parents) and no Federal means-tested public benefits were received by the individual in the quarter to be credited (or the spouse/parent on whose work record quarters were credited). Members of this group are not excepted if the immigrant arrives in the U.S. after August 22, 1996.
- o Honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children -- At any time.

Immigrants Admitted to the U.S. On or After August 22, 1996

There is a mandatory ban on Medicaid eligibility for immigrants who are "qualified aliens" newly admitted to the U.S. on or after August 22, 1996. The ban is in effect for the first five years they are in the U.S. in that status, unless the individual is a member of one of the excepted groups. After the five-year ban expires, an immigrant's access to Medicaid is at State option (for those otherwise eligible). For those who have individual sponsors who sign new, legally binding affidavits of support (required elsewhere in welfare reform, beginning no later than February 1997), States must deem the income and resources of the immigrant's sponsor (and sponsor's spouse) to be available to support the immigrant when determining the immigrant's eligibility for Medicaid. For most immigrants, deeming will not take effect for five years.

Individuals who have been credited with 40 quarters of work without receiving assistance are not considered an excepted group under these provisions.

Sponsor to "Qualified Alien" Deeming of Income and Resources

There is no deeming of sponsors' income and resources for individuals who entered the U.S. under the old affidavits of support. The new deeming requirements apply to Medicaid in the following situations:

- o Deeming applies only to sponsors signing new, legally binding affidavits of support.
- o The sponsor's and sponsor spouse's income and resources will be counted when determining the income and resources available to the immigrant they sponsor.
- o Deeming applies only to immigrants who are sponsored by individuals.
- o Under the omnibus appropriations amendments, deeming does not apply to battered immigrants or to those who would be indigent, defined as unable to obtain food and shelter without assistance, because their sponsors are not providing adequate support.
- o Deeming continues until the earlier of naturalization by the immigrant or the immigrant's being credited with 40 quarters of Social Security coverage. Such quarters do not include any quarters after December 31, 1996 in which the immigrant (or the immigrant's spouse/parent on whose work record the immigrant is credited with quarters) receives Federal means-tested benefits.
- o Sponsors must reimburse Federal, State, and local governments for the cost of means-tested benefits received by the sponsored immigrant during the deeming period, but excluding the costs of emergency medical services.

Emergency Services

Provided they meet the financial and categorical eligibility requirements, both qualified aliens and non-qualified aliens continue to be eligible for emergency services under Medicaid.

SSI/ Medicaid Connection for "Qualified Aliens"

Other provisions of welfare reform ban receipt of SSI cash benefits for both current and new otherwise eligible "qualified aliens," unless they are a member of one of the excepted groups listed above.

Individuals who continue to receive SSI cash benefits would be eligible for Medicaid under the usual rules. The Social Security Administration must redetermine the SSI eligibility of all immigrants within one year of enactment. Upon redetermination, the immigrant may lose cash assistance if he/she is not a member of one of the above excepted groups.

States are required to perform a redetermination of Medicaid eligibility in any case where an individual loses SSI and that termination affects the individual's eligibility for Medicaid. Those losing or barred in the future from receiving SSI cash benefits will find their Medicaid benefits affected in the following ways:

- o A State that has opted under its Medicaid plan to cover non-cash SSI-related groups would automatically continue Medicaid for "qualified aliens" who fit into those groups.
- o A State that has not previously opted under its Medicaid State plan to cover non-cash SSI-related groups could, as always, submit a State plan amendment to provide coverage for non-cash SSI-related groups. HCFA is exploring options to permit States to do this as simply as possible.

In addition, a State that opts to cover only SSI cash recipients may still be able to cover some of the "qualified aliens" under other provisions of current Medicaid law (i.e., poverty-related pregnant women and children, medically needy, etc.).

An immigrant who loses SSI cash benefits would continue to be eligible for Medicaid until the State conducts a Medicaid eligibility redetermination (which requires consideration of other bases for Medicaid eligibility for which the individual may qualify) and has found that the individual does not qualify for Medicaid by any other means.

Related Fact Sheets:

[Link Between Medicaid and Temporary Assistance for Needy Families \(TANF\)](#)

[Link Between Medicaid and Coverage of SSI Children under Welfare Reform](#)

[Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996](#)

FACT SHEET #4

INCREASED FEDERAL MATCHING RATES FOR EXTRA ADMINISTRATIVE COSTS OF ELIGIBILITY DETERMINATION UNDER WELFARE REFORM

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) has substantial implications for Medicaid eligibility systems and responsibilities. Section 114 of the law (Section 1931(h) of the Social Security Act) provides a special fund of \$500 million for enhanced Federal matching for States' expenditures attributable to the administrative costs of Medicaid eligibility determinations due to the law. The specific features of this provision are described below:

Federal Financial Participation (FFP) Rates

The normal FFP rate for States' administrative costs for eligibility determinations in the Medicaid program is 50 percent. However, under this new law, the Secretary is given discretion to increase the FFP rate above 50 percent, up to a fixed national cap of \$500 million for this enhanced funding. This enhanced funding is for extra administrative costs applicable to the increased cost of eligibility determinations due to welfare reform.

National Limitation on Total Funding

The total Federal funds available for enhanced match are limited to \$500 million.

Time Limitations

The \$500 million is available nationally for expenditures during the Fiscal Years 1997 through 2000. For each state, however, the enhanced funding is available for only the first 12 calendar quarters in which a State's Temporary Assistance to Needy Families (TANF) program is in effect after August 21, 1996.

Related Fact Sheets:

[Link Between Medicaid and Temporary Assistance for Needy Families \(TANF\)](#)

[Link Between Medicaid and Coverage of SSI Children under Welfare Reform](#)

[Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996](#)

Sara Rosenbaum

10/4

b vs d

- ① - TANF } unified forms
- MA }

who in Wlt

2 offices, applications

Fast track to get TANF; TANF → MA

② Applic of current fed regs

- children SSI } redetermination
- TANF } rule ambiguous

Benton vs. Rhodie

So many ways in

legal immigrants

Alan Weill-Romer

Natl Health Law Program
- Claudia Schick

bifurc
method
hold harmless

1a Rule save states
ran out of
time on redet

1a Can cut off
legal imm early

Cindy Mann

Cover Non-cash SSI-related exps?

Yes - new sub-option

No - on switch

① Waiver

IVA = MA

Admin exaggerated

~~Jan~~ → my fav
- Wlt
- Sara's 3
Jan

② Less restrictive - interpret broadly - states like too

→ ③ Transition - redetermination

→ ④ SSI categories - (or waiver opt-in)

→ ⑤ Jan. Aug issue → OK - gd for legis fix - yes, covered

⑦ Aug-Jan - not on

⑥ Laura issue

*July 1

MEDICAID ISSUES IN WELFARE REFORM IMPLEMENTATION

10/2/96

ISSUE	PRODUCT	NEXT STEP
Immigration Issues: o Interaction of SSI and Medicaid -nursing home patients o ✓State option to continue Medicaid		
✓Children dropped from SSI		
How to re-do existing waivers <i>/ later</i>		
Delinking from AFDC o use of \$500 million enhanced match		

HCFA doc

DRAFTWhite House Report - Delinking Medicaid from AFDC - Potential Problems and Medicaid Bureau Implementation Efforts

Prior to welfare reform, receipt of AFDC benefits guaranteed eligibility for Medicaid in all States. Under welfare reform, the link between receipt of AFDC and eligibility for Medicaid is severed. Regardless of whether an individual is eligible for TANF, states in general will be required to maintain Medicaid eligibility for individuals eligible for benefits as of July 16, 1996.

We have identified the following potential problems/difficulties relating to delinking Medicaid from receipt of AFDC benefits.

- o States will have to reconfigure their data processing systems to accommodate dual Medicaid/TANF eligibility requirements and processes.
- o A number of currently eligible individuals may fall through the cracks as a result of the transition from AFDC to TANF and the delinking of AFDC and Medicaid eligibility systems. States and the federal government will have to find ways of identifying those individuals and, to the extent possible, maintaining Medicaid coverage for them under the new program.
- o State eligibility workers and policy staff will have to adjust to the new TANF program requirements and delinking Medicaid from receipt of cash benefits. This may require changes in staff size, training in the new program requirements and procedures, and adjustments to new workloads.

Medicaid Bureau Implementation Efforts

The Medicaid Bureau is engaged in a number of implementation efforts. These include:

- o Weekly teleconference consultations with the Medicaid Eligibility Technical Advisory Group (E-TAG) on various policy and technical issues arising from the welfare reform legislation. The E-TAG is a group of ten State Medicaid eligibility experts, each from a State in each of HCFA's ten regions. The APWA and representatives from the Department also participate in these teleconferences.
- o Consultation meetings with various outside organizations and advocacy groups, to take place within the next few weeks.
- o Issuance of operating instructions on welfare reform to the States in the form of a State Medicaid Manual transmittal in early December 1996.

WHTANF2.WPD

DRAFT**White House Report - Loss of Medicaid for SSI Children Losing Benefits**

Under current law, children can be eligible for SSI based on a disability. In addition to medical criteria, disability determinations for children can be based on Individual Functional Assessments (IFA). In most States, receipt of SSI also guarantees eligibility for Medicaid.

Under welfare reform, the definition of disability is changed to eliminate the use of IFAs in determining whether a child is disabled. A determination of disability must be based only on medical criteria. This will result in an estimated 300,000 children currently eligible for SSI no longer being directly eligible for Medicaid because they will not be considered disabled in the absence of IFAs. These children for the most part have serious but not severe functional limitations, or certain mental or emotional disorders.

If these children lose SSI, they will also lose the direct Medicaid eligibility based on receipt of SSI benefits. Some should be able to requalify for SSI and Medicaid under the medical criteria for disability. Many of them should be able to requalify for Medicaid under another, non-disability related group; e.g., one of the poverty-level children's groups. However, some (exact number unknown) will not be able to requalify for Medicaid under any eligibility group, and will lose Medicaid as a result.

WHKIDS.WPD
RTrudel 8/29/96

DRAFT**MEDICAID WELFARE REFORM IMPLEMENTATION STRATEGY**

The HCFA strategy for implementing welfare reform in Medicaid basically consists of the following three major steps:

- o Creating coordinating groups to assure good communications about the myriad of issues involved in implementing welfare reform.
- o Undergoing an external consultation process to assure that we understand the views of our customers and partners.
- o Developing the policy guidance necessary to set forth the parameters of the new program as it affects Medicaid.

Each of these approaches is discussed below.

1. Coordinating Groups

To coordinate across the various components of HCFA involved in welfare reform, we have created an HCFA Welfare Reform Steering Committee. It is headed by Sally Richardson, the Acting Deputy Administrator. It meets on a weekly basis to examine the status of implementation and to provide direction on major policy issues.

The lead component for the day-to-day work on implementation is the Medicaid Bureau. Judy Moore, the Deputy Director of the Bureau, is in charge of the Bureau's work. She is assisted by several workgroups and Medicaid Bureau staff, which is also working with other agencies, such as ACF and FNS on cost allocation issues, with SSA on children's issues, and with the Departmental Work Group on immigration issues. Staff from four HCFA Regional Offices are participating in the development of eligibility policy.

2. Consultations

HCFA proposes to engage in discussions with a wide-ranging group of customers and partners in the Medicaid program to address eligibility issues which must be decided as part of the implementation process. In addition, we will seek ideas about greater flexibility in Medicaid eligibility, and proposals for allocating the \$500 million transition fund of enhanced matching dollars for State administrative expenses related to implementing the new law. In the next 4 to 6 weeks, we will meet with advocacy and other groups representing Medicaid beneficiaries, provider groups, State and local intergovernmental groups, and other interested parties.

In early October, welfare reform will be preeminent among the issues on the agenda of the annual meeting of the National Association of State Medicaid Directors (NASMD). A regular

meeting of the Camden Yards Group, an informal working group that has been meeting on Medicaid issues since 1993 and which consists of representatives from the National Governors Association, the National Conference of State Legislatures, the NASMD, the National Association of Counties, and the Association of State and Territorial Health Officers, is scheduled in conjunction with the NASMD meeting to further discuss Medicaid issues related to welfare reform.

The Medicaid Bureau has already begun discussions with the Medicaid Eligibility Technical Advisory Group, which is a standing committee of staff from the APWA, State Medicaid Agencies, and HCFA. This group meets weekly to go over the questions which State eligibility experts have on their minds, and to begin the development of policy guidance. The National Association of State Medicaid Directors recognizes this group as one with the technical expertise to work on the intricacies of the technical issues. They are discussing issues such as the de-linking of Medicaid from AFDC, the changes in SSI, and other eligibility-related issues which arise with this legislation.

HCFA and Medicaid staff will have ongoing discussions within HHS, with other Departments such as the Social Security Administration and the Department of Agriculture (FNS), and with OMB and the White House.

3. Policy Guidance Strategy

The vehicle for issuing policy guidance relatively quickly will be a State Medicaid Manual for the eligibility policy issues. HCFA will issue a Federal Register Notice for the allocation of the enhanced match. We plan to accomplish both forms of guidance in December. In addition, HCFA's Medicaid Bureau will issue some direct letters to the State Medicaid Directors on subjects that need to be handled before December. For example, the Medicaid Bureau will issue a letter on provisions which took effect upon enactment of the law. These would include provisions relating to aliens, SSI children, and public notices. In addition, since some States will move quickly with submission of their State Plans under TANF, the Medicaid Bureau will send States a letter to provide guidance on the submission of related Medicaid State Plan Amendments.

Options to create - medically needy
most need an optional budget

Reg 435.122 - incl for SST

lien provision - SST cut in past - still considered

HCFA thinks no - how just target legal
- pressure is to make it bigger,
Leaver ~~1/7~~

Don't know why - HCFA disinclined



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201*FAT to
Diana Fortune*

DATE: September 18, 1996

NOTE TO: Carol H. Rasco, Assistant to the President, Office of Domestic Council

SUBJECT: HCFA's Top Five Welfare Reform Questions

1. Delinking of AFDC (TANF) and Medicaid Eligibility

How can we ensure that those who were qualified for assistance under the old AFDC rules who are dropped from the rolls because of TANF requirements maintain their Medicaid eligibility?

2. SSI Issues affecting Medicaid

Similarly, how will SSI children dropped from the Medicaid rolls be picked up under a new eligibility category?

3. Immigrant Issues

How can we ensure that the most legal immigrants continue to receive Medicaid?

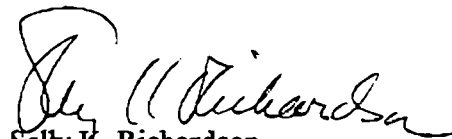
NOTE: (How can we ensure state outreach efforts designed to expand coverage to all Medicaid eligibles under welfare reform?)

4. Impact on Health Care Reform Waivers

How does welfare reform effect the Medicaid health care reform waivers?

5. Enhanced Match

How should the \$500 million enhanced match funding be distributed among the states?


Sally K. Richardson
Acting Deputy Administrator

MA

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

18-Sep-1996 08:34pm

TO: Diana M. Fortuna
TO: Nancy-Ann E. Min

FROM: Nicolette Highsmith
 Office of Mgmt and Budget, HD

CC: Barry T. Clendenin
CC: Mark E. Miller
CC: barbara E. Washington

SUBJECT: Comments on HCFA's Draft White House Report

At a meeting of the welfare implementation work group, you requested that HCFA provide a summary of issues facing Medicaid in light of welfare reform. Last week, you sent us a document from HCFA entitled, "White House Report - Delinking Medicaid from AFDC," which addressed such Medicaid issues.

We wanted to clarify a couple of points made in the document to avoid confusion.

1) HCFA's first paragraph notes that "regardless of whether an individual is eligible for TANF, states in general will be required to maintain Medicaid eligibility for individuals eligible for benefits as of July 16, 1996."

The law states that an individual's eligibility for Medicaid will be based on the income and asset standards used to determine AFDC eligibility as of July 16, 1996. This means two things: 1) Medicaid is no longer linked to TANF cash assistance. This could result in families receiving TANF without being eligible for Medicaid, and 2) It is not a "grandfather" provision for people receiving AFDC on 7/16/96. If individual circumstances change, such that they no longer meet the AFDC eligibility standards as of 7/16/96, they would lose Medicaid.

2) HCFA also made the point that "a number of currently eligible individuals may fall through the cracks as a result of the transition from AFDC to TANF and the delinking of AFDC and Medicaid eligibility systems."

"Theoretically," individuals eligible for Medicaid as of 7/16/96 would not lose coverage under the law. What could happen, is that, in implementing the law, states' systems that are currently in place for tracking eligibility may not accurately track the transition from AFDC to Medicaid. Furthermore, Medicaid offices will have the added responsibility of determining Medicaid eligibility for individuals on cash assistance, which could cause administrative complications. Thus, due to the result of systems or administrative problems (not the law), some eligible individuals might lose coverage.

HCFA's document did not fully explain the subtle technicalities of the Medicaid issues. As Judy Moore mentioned in the last meeting, some of these Medicaid

issues are extremely technical, but some of them have the impact of either retaining or eliminating Medicaid coverage for individuals.

We wanted you to be aware of our understanding of what the major outstanding issues for Medicaid are:

Immigration

1) Mandatory SSI Ban - In general, SSI eligibility also confers Medicaid eligibility. It is unclear if an immigrant continues to be eligible for Medicaid, if they lose SSI coverage due to the mandatory ban on SSI for current immigrants in the country. The law is vague on this point and HCFA has had different interpretations. HCFA is working through this eligibility complication.

2) Deeming - As you know, this issue cuts across many agencies. The general issue is what types of exclusions (i.e. car, house) are used in the determining income level of the sponsor for the purposes of determining the immigrant's eligibility for federal benefits.

1115 Waivers

HCFA is looking into issues surrounding Medicaid 1115 waivers and eligibility. HCFA is looking into the question of whether states can cover individuals under their 1115 Medicaid waivers (if currently eligible under the 1115 waiver), who could lose coverage under the welfare law (i.e. immigrants).

SSI Kids

HCFA partly addressed this issue in their document by noting that guidance would go out to the states on SSI children losing SSI benefits, and therefore Medicaid eligibility. SSA intends to send letters to beneficiaries that will lose coverage as a result of the redetermination policy. We are not sure if HCFA has consulted with SSA on inserting a Medicaid part to the SSA letter or whether HCFA intends to send out letters to beneficiaries noting the policy change and noting that individuals can reapply for Medicaid, based on other criteria.

Administrative Allocation

The Welfare bill includes \$500 million for increased Federal Medicaid Administrative Matching funds for states to set up new eligibility systems (because Medicaid will have to determine eligibility for individuals who would have received AFDC). The law gives the Secretary the authority to determine the appropriate FMAP percentage (i.e. % Federal versus % state funds). HCFA will also have to determine how the funds will be allocated across the states.

We assume that these would be the issues that HCFA would present to the DPC in a more detailed meeting.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

23-Sep-1996 06:52pm

TO: Nicolette Highsmith

FROM: Diana M. Fortuna
 Domestic Policy Council

CC: Nancy-Ann E. Min
CC: Barry T. Clendenin
CC: Mark E. Miller
CC: barbara E. Washington

SUBJECT: RE: Comments on HCFA's Draft White House Report

Thank you so much for your helpful analysis. Here are several thoughts and questions about these issues.

1. I am very interested in your point that immigrants losing SSI may not automatically lose Medicaid too. Would this be true even if the state chose not to exercise their option to keep Medicaid for legal immigrants as of 1/1/97?

Your point about waivers being a vehicle to keep legal immigrants is also very interesting. I imagine we will want to pursue this. You probably know that, on the food stamp side, we worked hard to design a waiver to delay the implementation in several states so that they have a bit more time to develop an interim verification system for immigration status.

2. If legal immigrants don't lose SSI until, say, June of next year, when SSA gets around to looking at their case, but the Governor of the state declares on 1/1/97 that his state no longer provides Medicaid to legal immigrants, does the person have Medicaid from January through June? (I think the issue of legal immigrants in nursing homes will become big on the radar screen in the coming weeks, and this would be relevant to that.)

3. On SSI kids, I am very interested in how many will be able to keep Medicaid under Waxman and other provisions, and how many will lose Medicaid altogether. Is this a HCFA question only, or do you guys have any thoughts here? DPC thinks we should be proactive in reaching out to families here, so that those who have a right to continuing Medicaid know about it.

4. On Medicaid vs. TANF eligibility, I understand your point. So, if a woman now on Medicaid goes to work as a result of a work program/work requirement and raises her income beyond the AFDC level in effect on 7/16/96, then she is no longer eligible for

Medicaid beyond the one year of transitional Medicaid that the law offers, right? Her kids may qualify under Waxman's provisions, but probably not her.

At the NGA/NCLS/APWA conference, someone from one of those organizations said they thought there was potentially a chance for states to add a SECOND year of transitional Medicaid coverage. But I have never seen any basis for that in the law, have you? I assume this could be done through a (budget neutral) waiver, though.

5. Also at the NGA conference, there was discussion of some limitation in the law in Medicaid growth to the CPI. Can you explain how that works?

I have been pushing HHS/HCFR to sit down and meet with us on all this soon. At the moment, Monahan has promised me a meeting on October 1, with paper to arrive in advance. (I will let you know time and place as soon as I do.) I am a bit concerned about whether this is early enough, given that the State Medicaid Directors are meeting 10/7-9, and people will certainly be expecting some straight answers from HCFR by then -- not on everything, but on some things. At the moment, I think HCFR is not as far along in terms of giving NGA/NCLS/APWA guidance as other agencies.

By the way, I hear from Monahan that HHS is discussing the mechanism by which states can signal their intention on whether legal immigrants are still eligible for Medicaid. One option is to make the default position that they ARE covered. This way, a Governor would have to take a proactive position to drop them.

I also assume the state legislature can get involved in this decision if they pass a law, but otherwise the Governor's actions control.

Hope someone from your unit is coming to our welfare reform subgroup meeting tomorrow (Tuesday) at 3 in room 211. We are going to try to make it at the same time every week.

Let me know if you think we need a WH/OMB meeting to take stock of where we are on Medicaid, with counsel's office and intergovernmental in attendance as well.

I am also going to send Mark and Nicolette a copy of a draft timeline of critical dates that I am just beginning. Let me know if you have any comments.

Sorry for the long note!

EXECUTIVE OFFICE OF THE PRESIDENT

Office of Management and Budget
Associate Director for Human Resources
260 Old Executive Office Building
Washington, DC 20503

Fax #: 395-5730

Phone #: 395-4844

FACSIMILE COVER SHEET

DATE:

10-3

TO:

Liana FortunaMark Miller

Fax Number: _____

Number of pages (including cover sheet):

5

FROM:

Keith Fortuna

REMARKS:

C. D. Miller
September 24, 1996**Implementation of the AFDC-related Medicaid provisions — General Discussion**

ATP
WAC
Comments?

The welfare law includes a provision that protects Medicaid eligibility for people who have qualified for Medicaid based on their receipt of AFDC. This provision was adopted pursuant to an amendment sponsored by Senator Chafee and Senator Breaux, among others, but a question relating to how a subsection in that provision relating to waivers is interpreted threatens to undo the guarantee of coverage that this amendment was intended to establish. Some states apparently have suggested that the waiver provision in section 1931 allows them to link Medicaid eligibility to eligibility under their TANF program (assuming they follow AFDC waiver policies in both programs) and permits them to disregard that portion of section 1931 that makes children and parents who meet July, 1996 AFDC income and asset standards and family composition rules eligible for Medicaid.

This interpretation undermines the central thrust of the Chafee-Breaux amendment in that it would leave Medicaid eligibility subject to restrictions imposed by states under their TANF programs. Nothing in the language or legislative history of section 1931 supports the view that states do not have to apply the general eligibility criteria established in section 1931 if a state chooses to continue its AFDC waiver policies.

A more reasonable reading of section 1931, and the reading that both Senator Chafee and Senator Breaux believe is the correct reading of this section, is that section 1931 sets forth the criteria that states must apply to determine the eligibility of children and parents who otherwise would have qualified for Medicaid based on their receipt of AFDC. It provides, in general, that children and parents who meet a state's AFDC income and asset standards and family composition rules, as they were in effect on July 16, 1996, shall be eligible for Medicaid. The waiver provision in section 1931(d) modifies this general rule by allowing states that have *waivers pertaining to these eligibility criteria* to apply their waiver rules rather than the July 16, 1996 rules.

For example, with respect to the income criteria that must be applied, if a state has a waiver that provides for more generous earned income disregards, that state may apply its expanded disregard rule in lieu of the standard earned income disregard in effect on July 16, 1996. Similarly, if a state has a waiver that expands coverage for two-parent families by eliminating the standard AFDC-UP "100-hour rule", the state could apply its two-parent family rule rather than the standard family composition rule in effect on July 16, 1996.

The waiver provision was included in the Chafee-Breaux amendment to allow states flexibility and the opportunity to achieve cross-program coordination. It permits states that choose to continue their waiver policies under TANF to use the same income

and asset standards and methodologies and family composition rules to determine Medicaid eligibility. Even though the programs are technically "delinked", a single application can be used for both programs and one eligibility determination can apply to both programs.

While the Chafee-Breaux provision allows for and encourages cross-program coordination, it also assures that children and parents who are not eligible for TANF due to tightened eligibility rules or restrictions such as time limits are separately considered with respect to Medicaid eligibility based on the criteria established by section 1931. As you know, Congress made funds available to states for the specific purpose of defraying the costs associated with these Medicaid eligibility determinations.

Both Senator Chafee and Senator Breaux believe that it was well understood that their amendment, which adopted by the Senate by a vote of 97 to 2, established standards for determining Medicaid eligibility for children and parents to assure that their eligibility for Medicaid was not dependent on state action under TANF. To quote the chief sponsor of the amendment, Senator Chafee, during the Senate debate, "(U)nder our amendment, we make sure that no low-income mothers and children who are eligible for Medicaid under current law, under the existing law, will lose their health care coverage under Medicaid if the state lowers its eligibility standards for cash assistance or AFDC." Congressional Record, S8345, July 19, 1996. Any interpretation of section 1931 that would allow states to disregard the eligibility criteria established in section 1931 runs directly counter to this common understanding of the meaning of this provision.

1931f?

September 24, 1996

Interpretation of the Waiver Provision in Section 1931 — Legal Analysis

This paper briefly summarizes the interpretation of section 1931, as added to title XIX by section 114 of PL 104-193, and specifically the waiver provision in subsection (d) of section 1931, that Senator Chafee and Senator Breaux believe was intended by their amendment.

Subsection (b) of 1931 sets forth the general rule on how eligibility for Medicaid will be determined for those who have qualified for Medicaid based on their receipt of AFDC. It provides that persons shall be eligible for medical assistance if they meet (1) the income and resource standards for determining eligibility under a state plan approved under title IV-A, using the standards and methodologies in effect on July 16, 1996, and (2) the state plan "deprivation", or family composition, rules as of July 16, 1996. (Variations of these standards and methodologies are permitted under section 1931(b)(2).)

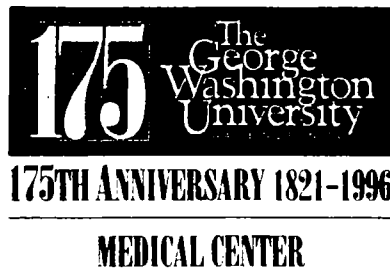
While the meaning of the waiver provision in section 1931(d) is open to some interpretation, it is clear that section 1931(b) is the general provision establishing the rules for how eligibility will be determined and that subsection (d), addressing the issue of how waivers may affect eligibility determinations, is ancillary to that general provision. This interpretation is consistent with the construct of section 1931; subsection (b) is set forth as the general rule and does not state that it is the rule except as provided in subsection (d). Indeed, there is nothing in section 1931 to suggest that subsection (d) was intended to be applied in such a way as to override and eliminate the guarantees established by the eligibility criteria set forth in subsection (b).

The understanding of the lead sponsors of the Chafee-Breaux amendment is that subsection (d) grants states the flexibility to rely on their waiver policies *in applying the eligibility criteria established in subsection (b)*. In light of the fact that subsection (b) establishes the general rules for determining eligibility for Medicaid (for the formerly AFDC-related population), the most reasonable construction of subsection (d) is that the AFDC waivers described in that subsection (i.e., waivers that "affect the eligibility of individuals for medical assistance under this title") refer to those waivers that relate to the specific eligibility rules — the income and asset standards and methodologies and family composition rules — that must now be applied to determine eligibility for medical assistance pursuant to subsection (b). In other words, under subsection (b) states must apply AFDC income and asset standards and methodologies and family composition rules to determine eligibility for Medicaid. However, under subsection (d), states have the option to apply the rules they have developed through the waiver process in lieu of the standard state plan rules that pertain to these eligibility criteria.

Thus, states with waivers that expand or restrict standard earned income disregard rules, asset requirements, two-parent family rules, or rules regarding countable income could apply those waiver policies in lieu of the standard, July 16, 1996 income and asset standards and methodologies and family composition rules. The waiver provision allows states to substitute waiver rules for the standard rules *while maintaining the basic criteria that must be applied to determine Medicaid eligibility.*

While this is the most reasonable interpretation of the two subsections of 1931, it is possible to read subsections (b) and (d) as independent provisions. However, even if one were to read these subsections as independent provisions, there is no basis for reading section 1931(b) out of the law as some states are urging. If the provisions were independent, subsection (d) would allow states to determine Medicaid eligibility pursuant to its waiver policies linking to its block grant, but states would still be required to evaluate whether any child or parent who is not eligible under those policies meets the requirements of section 1931(b). This would assure that the intent of the Chafee-Breaux amendment is accomplished in that no person who meets the AFDC family composition requirements whose income and assets are below state standards as of July, 1996 will be denied Medicaid coverage.

The fact that Congress made available up to \$500 million to defray the costs associated with making separate eligibility determinations under the criteria set forth in subsection (b) suggests that Congress clearly understood that separate evaluations of Medicaid eligibility would be required under section 1931. It is also particularly revealing that the Senate explicitly and overwhelmingly rejected, on a vote of 68 to 31, a substitute amendment offered by Senator Roth that would have eliminated the eligibility standards set forth in section 1931(b), relying instead on a grandfather provision that would only have guaranteed coverage to current recipients of AFDC and Medicaid. As Senator Roth correctly pointed out during the debate, "The difference (between the Roth substitute and the Chafee-Breaux amendment) is that the Chafee-Breaux amendment applies to categories rather than people." Congressional Record, S8347, July 19, 1996. Subsection (b) is the provision in the Chafee-Breaux amendment that defines the categories of people who must be covered. Any interpretation of section 1931 that allows states to disregard the eligibility criteria set forth in subsection (b) and to deny Medicaid coverage to parents and children without regard to whether those parents and children meet those criteria would accomplish much of what the Roth substitute proposed and which 68 Senators voted not to accept.



CENTER FOR HEALTH POLICY RESEARCH

MEMORANDUM

To: Bruce Vladeck, Administrator, Sally Richardson, Deputy Administrator and Deborah Chang, Director, Policy and Legislation

From: Sara Rosenbaum and Kay Johnson

Subject: Follow-up to recent meeting

Date: September 30, 1996

Thank you for inviting us to meet with you earlier this month. The purpose of this memorandum is to follow up on several of the points that were raised.

1. Categories of title IV-A Waivers Covered by the Waiver Exemption Under Section 1931

Read literally section 1931(d) appears to exempt from at least some aspects of section 1931 state that operate their Title IV-A programs under one or more Section 1115 waivers that "affects eligibility of individuals for medical assistance". While discussions with individuals who worked on the final legislation indicate that the scope of the exemption was meant to apply only to specific types of demonstrations (i.e., those that directly address a Medicaid eligibility issue, such as an extended work transition program or a specific change in budgeting methodologies for Medicaid) nothing in the statute itself appears to narrow the scope of the exemption. Since any Title IV-A waiver would affect medical assistance, if a state's waiver program meets the timeliness rules under section 1931(d), then we believe that the state should be eligible for an exemption.

2. Scope of the Waiver Exemption under Section 1931

While, as noted, we believe that the scope of the qualifying waivers provision is broad, we do not believe that the exemption from otherwise applicable duties under Section 1931 is broad. We would interpret section 1931(d) to allow a waiver of the bifurcated application process and the methodologies requirements but not of the "hold harmless" program. That is, a state with a Title IV-A waiver that "affects eligibility for medical assistance" would be permitted to continue to issue Medicaid cards

automatically to any individual who qualifies for IV-A waiver benefits and could use waiver standards and methodologies (where the waiver covers this issue) but would have to recognize a "hold harmless" population consisting of individuals who meet its eligibility standards as in effect on July 16, 1996.

We do not read section 1931(d) as eliminating states' obligation to create a new mandatory categorically needy coverage group consisting of individuals who satisfy their 7/16/96 financial eligibility rules but who no longer qualify for assistance (e.g., because the state subsequently tightened eligibility requirements under its waiver). Were HCFA to read section (d) as extinguishing waiver states' "hold harmless" obligations this interpretation would effectively read out of existence in more than 40 states the President's commitment to not deprive former welfare recipients of their access to Medicaid.

3. Fast-track certification process for states with TANF programs no more liberal than their AFDC programs

In those states that do not have Title IV-A waivers and that must implement section 1931(b), we recommend that HCFA develop a fast track certification process that would permit a state to certify that its TANF eligibility requirements are no more liberal (either categorically or financially) for some or all of covered populations than its prior AFDC requirements. For these "no more liberal" populations, states could continue to issue cards automatically and without a separate eligibility determination.

4. Implementation of Medicaid Provisions for Current Resident Qualified Aliens

Since states' option to deny Medicaid to qualified aliens who were residents as of August 22, 1996, extends only to certain classes of qualified aliens, we recommend that states be required to demonstrate as part of their state plan submissions that they have the capacity to separate out mandatory coverage aliens from those whose coverage is at state option. In other words the election should be permitted only if a state has the means of identifying those qualified aliens for whom coverage continues to be mandatory under section 402 (i.e., refugees, asylees, parolees, members of the armed services and their families, persons with sufficient work history and veterans and their families).

5. Redetermination Requirements

The provisions of 42 CFR sections 435.916 and 435.930 should be read as requiring a redetermination of any individual for whom welfare reform potentially may terminate Medicaid coverage before coverage can be terminated. The issue is not merely

requalifying children and adults for coverage but also ensuring that those who continue to remain eligible for coverage do so if there exists any alternative basis of eligibility.

6. Continued duty to cover emergency care, including active labor, for pregnant women who are either undocumented aliens or post-enactment "qualified aliens"

Based on our discussions with Medicaid agency staff, we believe that a number of agencies are under the impression that the Act in some way alters their duty under Section 1903(v) of the Act to extend Medicaid coverage to otherwise qualified aliens with emergency conditions, at least where pregnant women are concerned. We believe that it is important that HCFA guidance clarify that the Act does nothing to alter this state duty.

Agency concerns appear to be based, not on the law, but on the legislative history accompanying Title IV of the Act (pertaining to public assistance for non-citizens). The Conference Agreement states that :

The allowance for emergency medical services under Medicaid is very narrow. The conferees intend that it apply only to medical care that is strictly of an emergency nature, such as medical treatment administered in an emergency room, critical care unit, or intensive care unit. The conferees do not intend that emergency medical services include prenatal or delivery care that is not strictly of an emergency nature as specified herein.

Conference Agreement at Cong. Rec. H8296 (July 30, 1996).

Other than this bit of dicta, the Act does not address either section 1903(v) or section 1867 (EMTALA). There are no changes to the statute. Therefore, in our opinion this fragment of legislative history should be read as simply restating the obvious: that in the case of federal Medicaid funds, FFP is available only for emergencies; and that in the case of hospital care, the EMTALA duty applies only to emergencies. Unless a pregnancy-related condition constitutes an emergency, there is no coverage under either statute. Both the EMTALA and Medicaid definitions of "emergency" extend to pregnant women with emergency conditions (including but not limited to active or emergency labor); the new law does not alter the scope of either statute.

Both the Medicaid and EMTALA offer crucial protections for pregnant women. During the mid-1980s, we conducted two studies which found that one of the most common, serious gaps in service reported by state and local maternal and child health officials was the lack of care for uninsured pregnant women with emergencies. Specifically we found that pregnant women in labor experienced enormous difficulties in

gaining admission to a hospital. In 1986, 15 state health agencies reported that hospitals were denying admission to women in active labor and another 13 reported that hospitals were denying admission to women not yet in active labor.¹ This practice was driven by the increasing number of pregnant women who were uninsured and who, with their infants, would become part of the hospital's uncompensated care burden if admitted as patients.^{2,3} Some reports were dramatic (e.g., women in labor being turned away when the newborn was partially visible), but many, many reports made it clear that increasing numbers of poor, uninsured pregnant women felt they had to wait until they were in labor to try to gain entry to hospitals. In turn, hospitals grew more likely to turn away patients they could not afford.

The Emergency Medical Treatment Act, including its definition of emergency, has made a sizable difference in access during a pregnancy-related emergency.⁴ In addition, state obligations to finance emergency hospital care involving otherwise qualified undocumented pregnant women under Medicaid has made it possible for hospital emergency hospital services to survive what otherwise would be their almost certain financial demise under a reading of the Act that would terminate states' emergency coverage duties with respect to pregnant women. While nothing in welfare reform alters current law, it is evident that clarification of this point is needed.

The clarification of these maternity-related issues, particularly states' continuing obligations under the Medicaid hospitals' duties under EMTALA, both merit HCFA's attention in its forthcoming guidance. Given that an estimated one-third of all births are covered by Medicaid and that infants born to undocumented women and qualified aliens will be U.S. citizens, it is critical that every available tool be used to maximize infant health.

¹Rosenbaum, Hughes, and Johnson. Maternal and Child Health Services for Medically Indigent Children and Pregnant Women. *Medical Care*, 1988.

² Sloan et al. Identifying the Source of Uncompensated Hospital Care: A statistical profiles. Vanderbilt University, 1984.

³Gold and Kenny. Paying for Maternity Care. *Family Planning Perspectives*, 17:48-55, 1985.

⁴ Emergency Medical Treatment and Active Labor Act, P.L. 99-272, 42 U.S.C. Section 1395dd (1986) (renamed and amended in 1989). The 1996 version of the Act set out the hospitals obligation to examine and treat emergency medical conditions and women in active labor. The 1989 amendments further emphasized obligations during active labor.

* First WH? Thu
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~~COB~~

DRAFT

10/2/96 2:00p.m.

Dear State Medicaid Director:

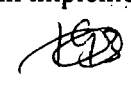
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) has substantial implications for Medicaid eligibility systems and responsibilities. In order to address implementation issues carefully, we have been working very closely with the joint Federal/State Eligibility Technical Advisory Group (E-TAG). That process is continuing, and will culminate in the issuance of a State Medicaid Manual issuance in December which will address many of the eligibility issues.

alt? In the meantime, we understand that some States are moving ahead to submit Temporary Assistance to Needy Families (TANF) plans. In such cases, we will presume that you will continue to provide Medicaid eligibility for all the groups you covered on July 16, 1996, including permissible legal immigrants. For administrative purposes, we request that you notify us to that effect. If you are going to make any change to Medicaid coverage of eligibility groups, please submit a State Plan Amendment to do so. Plan as you usually would. Amendments may be submitted to us using whatever format you think appropriate, but providing as much information as necessary to describe the eligibility options you are electing for Medicaid. We are happy to work with you on the details of plan amendments as you proceed with implementation.

even if income? Please recognize that many legal immigrants (who might otherwise qualify for Medicaid) entering the country after August 22, 1996, are not eligible for Medicaid for five (5) years. However, under Section 402 of P. L. 104-193, States must continue to provide Medicaid eligibility until at least January 1, 1997, to any qualified immigrant who entered the U.S. prior to or before August 22, 1996 who was receiving Medicaid on that date. States should be aware that Section 402 also permits states to continue coverage for most legal immigrants and to receive Federal matching funds for coverage of these individuals. In any event, States must continue to cover immigrants enrolled in Medicaid prior to August 22, 1996 until the State submits a State Plan Amendment to the contrary.

To sum up, in the absence of submitting a State Plan Amendment, you are expected to continue providing Medicaid eligibility for all the groups you covered on July 16, 1996, including permissible legal immigrants.

We will keep you informed as we develop Federal policy to implement this Act and will issue further policy guidance as soon as possible. Thank you for your cooperation in implementing this program.

Sincerely, 

Judith D. Moore
Acting Director, Medicaid Bureau

cc:
All Regional Administrators
All Associate Administrators for Medicaid
Lloyd Bishop, OLIGA
Jennifer Baxendall, NGA
Lee Partridge, APWA
Joy Wilson, NCSL

Keith & Mark to call buty

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paper COM or Monday
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FACT SHEET DRAFT 10/2

LINK BETWEEN MEDICAID AND TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
(TANF)

Prior to enactment of P.L 104-193, the Personal Responsibility and Work Opportunities Act of 1996:

- o Individuals who received AFDC cash assistance or who were deemed to have received AFDC were automatically eligible for Medicaid. (Section 1902(a)(1) (A)(I)(I) of the Social Security Act)
- o Families who lost AFDC cash assistance because of employment or receipt of child (or spousal) support payments were eligible for transitional Medicaid assistance for an additional period of time. (Sections 1902(a)(1)(A)(I) and 1925 of the Social Security Act)
- o Various rules of the AFDC program were used to establish Medicaid eligibility for other Medicaid-only eligibility groups (e.g., pregnant women and children whose eligibility is related to the poverty level, optional groups of children and caretaker relatives who do not receive AFDC, and the medically needy.) (Section 1902 of the Social Security Act)

The new welfare reform law eliminates the AFDC cash assistance program and replaces it with a block grant program called Temporary Assistance for Needy Families (TANF) (Section 103 of the new law). However, families who meet the AFDC eligibility criteria prior to welfare reform will be eligible for Medicaid. States are not required to make a complete eligibility determination using all the pre-reform AFDC program rules. This determination is replaced by two basic eligibility requirements:

- o The family income and resources must meet the pre-reform AFDC standards (Section 1931(b)(1)(I) of the Social Security Act).
- o The pre-reform AFDC deprivation requirement must be met. (i.e., a child must be living with a parent or other relative and deprived of parental support or care by the death, absence, incapacity or unemployment of a parent.) (Section 1931(b)(1)(A)(ii) of the Social Security Act)

As under pre-reform law, if a family loses Medicaid eligibility because of employment or receipt of support payments or employment and received Medicaid in three of the preceding six months, the family is eligible for a period of extended Medicaid benefits. (Section 408(a)(11) of P.L 104-193 and Section 1931(c) of the Social Security Act)

Conf. -
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Law

States are permitted to deny Medicaid benefits to other adults and heads of household who lose TANF benefits because of refusal to work. However, welfare reform law specifically exempts poverty-related pregnant women and children from this provision and mandates their continued Medicaid eligibility. (Section 1931(b)(3) of the Social Security Act)

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Because the AFDC cash assistance program is eliminated, welfare reform provides that any reference in Title XIX to an AFDC provision or an AFDC State Plan will be considered a reference to the AFDC provision or plan in effect for the State on July 16, 1996, i.e. "pre-reform" AFDC. This effectively freezes the pre-reform AFDC program for all Medicaid purposes, except that welfare reform also ~~permits~~ gives States to retain flexibility to change the applicable income and resource methodologies, as follows:

- o A State may lower its income standards, but not below the standards it applied on May 1, 1988. (Section 1931(b)(2)(A) of the Social Security Act)
- o A State may increase its income and resource standards by any increase in the CPI subsequent to July 16, 1996. (Section 1931(b)(2)(B) of the Social Security Act)
- o A State may also use less restrictive income and resource methodologies than those in effect on July 16, 1996. (Section 1931(b)(2)(C) of the Social Security Act)

Related Fact Sheets:

Link Between Medicaid and SSI Coverage of Children under Welfare Reform

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility Determinations under Welfare Reform

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LINK BETWEEN MEDICAID AND SSI COVERAGE OF CHILDREN UNDER WELFARE REFORM

Under the new law, the definition of childhood disability is no longer linked to the definition of disability for adults. The reference to "comparable severity" in the old law has been deleted.

The new definition says: (1) an individual under the age of 18 shall be considered to be disabled under SSI if that child has a medically determinable physical or mental disability, which results in marked and severe functional limitation, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least twelve months; and (2) no individual under the age of 18 who engages in substantial gainful activity may be considered disabled.

In addition to the new definition of disability for children, the law mandates two changes to current evaluation criteria in SSA's regulations. SSA must: (1) discontinue the individualized functional assessment (IFA) for children; and (2) eliminate maladaptive behavior in the domain of personal/behavioral function in determining whether a child is disabled.

In most States, individuals who are eligible for SSI are also eligible for Medicaid. These changes will result in some children losing SSI, and therefore Medicaid eligibility. However, many of the children affected will still continue to be covered under Medicaid because they meet other Medicaid eligibility criteria.

Section 204(a) of the new law provides that SSI payments may only begin as of the first day of the month following: (1) the date the application is filed or, if later, (2) the date the person first meets all eligibility factors. This is a delay in SSI eligibility in comparison with the old law.

Under Section 211 of the new law, SSA is required to redetermine the eligibility of recipients under age 18 by August 22, 1997. No SSI-eligible child may lose benefits by reason of a redetermination of disability using the new definition earlier than July 1, 1997.

Also under Section 211, SSA is required to send notices to the representative payees of all affected recipients no later than January 1, 1997.

Other Fact Sheets

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility

before 8/22
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LINK BETWEEN MEDICAID AND THE IMMIGRATION PROVISIONS OF
THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY ACT OF 1996

Medicaid Eligibility of "Qualified Aliens"

States are given certain options to cover immigrants who are "qualified aliens" under Medicaid, as long as these individuals meet the financial tests and other eligibility requirements of the program. If a State opts to cut off Medicaid benefits for immigrants currently receiving them, that cannot occur until after January 1, 1997.

States options are further constrained by requirements that they must cover certain excepted subgroups of immigrants. The rules pertaining to qualified aliens are based upon when the immigrant came to the United States.

Current "Qualified Aliens" Already in the US on or before August 22, 1996 (Date of Enactment)

States have the option to provide Medicaid to an immigrant who is a "qualified alien" and who is already in the U.S. before the date of enactment (if otherwise eligible for Medicaid) unless the individual is a member of one of the excepted subgroups, in which case the individual (if otherwise eligible for Medicaid) must be covered. Excepted subgroups of immigrants for this purpose include:

- o Refugees -- Only for first 5 years after entry to U.S. in that status
- o Asylees -- Only for first 5 years after granted asylum
- o Individuals whose deportation is being withheld by the INS -- Only for first 5 years after grant of deportation withholding
- o Lawful Permanent Residents -- only after they have been credited with 40 quarters of coverage under Social Security (based upon their own work an/or that of spouses or parents) and no Federal means-tested public benefits were received by the individual in the quarter to be credited (or the spouse/parent on whose work record quarters were credited)
- o Honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children -- at any time.

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how to handle

- No homes
- Regs?

Even if ~~SSI~~ state opts in to MA, people who lose SSI may not fall into
Use \$500m as bait existing MA category -
There is no deeming of sponsor income and resources for individuals who entered the U.S. under
the old affidavits of support.

why say
this -
deeming elsewhere?

Redetermination of the immigrant's ~~Medicaid~~ ^{SSI} eligibility is expected to occur at the regular
Medicaid redetermination interval, so there will continue to be a rolling redetermination process.
Immigrants would be subject to the usual Medicaid eligibility rules until the State redetermination.

awk.

New "Qualified Aliens" Admitted to the U.S. on or After August 22, 1996

no cutoff in 1997

There is a mandatory ban on Medicaid eligibility for immigrants who are "qualified aliens"
newly admitted to the U.S. after enactment for the first five years they are in the US in that
status, unless the individual is a member of one of the excepted subgroups below. After the
five-year ban expires for an immigrant admitted to the U.S. after enactment, their access to
Medicaid is a matter of State option (for those otherwise eligible). For those who have
individual sponsors that sign new, legally binding affidavits of support (required elsewhere in
welfare reform, no later than February 1997), States must deem the income and resources of
the immigrant's sponsor (and sponsor's spouse) to be available to support the immigrant when
determining the immigrant's eligibility for Medicaid.

all
apply
if > 5 yrs

For certain immigrants admitted after enactment (and otherwise Medicaid-eligible), States
must provide full Medicaid benefits, for the time period specified below. These excepted
subgroups of immigrants for these purposes are:

- o Refugees -- Only for first 5 years after entry to U.S. in that status
- o Asylees -- Only for first 5 years after granted asylum
- o Those whose deportation has been withheld by the INS -- Only for first 5 years after grant
of withholding
- o Honorably discharged US veterans, active duty military personnel, and their spouses and
unmarried dependent children -- at any time (both during and after the first five years).

Cuban/Haitian entrants remain eligible for refugee and entrant assistance.

Steve?

Sponsor to Immigrant Deeming of Income and Resources

The new deeming requirements apply to Medicaid in the following situations:

- o Deeming applies only to sponsors signing new, legally binding affidavits of support.
- o The sponsor's and sponsor spouse's income and resources will be counted when
determining the income and resources available to the immigrant they sponsor.

when
does
it begin -
say

- o Deeming applies only to immigrants who are sponsored by individuals.
- o Under the omnibus appropriations amendments, deeming does not apply to battered immigrants or to those whose sponsors become indigent.
- o Deeming continues until the earlier of naturalization by the immigrant or the immigrant's being credited with 40 quarters of Social Security coverage. Such quarters do not include any quarters after December 31, 1996 in which the immigrant (or the immigrant's spouse/parent on whose work record the immigrant is credited with quarters) receives Federal means-tested benefits.
- o Sponsors must reimburse Federal, State, and local governments for the cost of means-tested benefits received by the sponsored immigrant during the deeming period, but excluding the costs of emergency medical services.

Emergency Services

Medicaid must pay for the treatment of emergency medical conditions of illegal aliens, legal immigrants who are not qualified aliens, and qualified aliens who are not covered under the state's regular Medicaid program. However, to receive emergency services, the individual must meet the financial and other Medicaid eligibility requirements (including the residency requirement), but not any requirement to receive cash assistance.

SSI/ Medicaid Connection for Immigrants

Other provisions of welfare reform ban receipt of SSI cash benefits by both current and new otherwise eligible "qualified aliens," with the following exceptions:

- o Refugees -- Only for first 5 years after entry to U.S. in that status
- o Asylees -- Only for first 5 years after granted asylum
- o Individuals whose deportation is being withheld by the INS -- Only for first 5 years after grant of deportation withholding
- o Lawful Permanent Residents -- only after they have been credited with 40 quarters of coverage under Social Security (based upon their own work and/or that of spouses or parents) and no Federal means-tested public benefits were received by the individual (or the spouse/parent on whose work record quarters were credited)
- o Honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children -- at any time.

Appeals? (ch. imm?)
 ie, 1/1 - July 97?
 - No
 - Pt?

Individuals who continue to receive SSI cash benefits would be eligible for Medicaid under the usual rules. Those who are currently receiving SSI cash benefits would lose them after the date when Social Security redetermines their eligibility (within one year after enactment), unless SSA finds that they meet the above exceptions. Those losing or barred in the future from receiving SSI cash benefits by this provision in welfare reform would find their Medicaid benefits affected in the following ways:

- o A State that has opted under its Medicaid plan to cover non-cash SSI-related groups would have ~~a new sub-option to continue or be~~ Medicaid for "qualified aliens" after January 1, 1997. *automatically? automatically?*
- o A State that has not previously opted under its Medicaid State plan to cover non-cash SSI-related groups could, as always, submit a State plan amendment to do so.
- o A State that opts to cover only SSI cash recipients may still be able to cover some of the "qualified aliens" who would lose SSI under other provisions of current Medicaid law (i.e., poverty-related pregnant women and children, medically needy, etc.). *how for immigrants?*

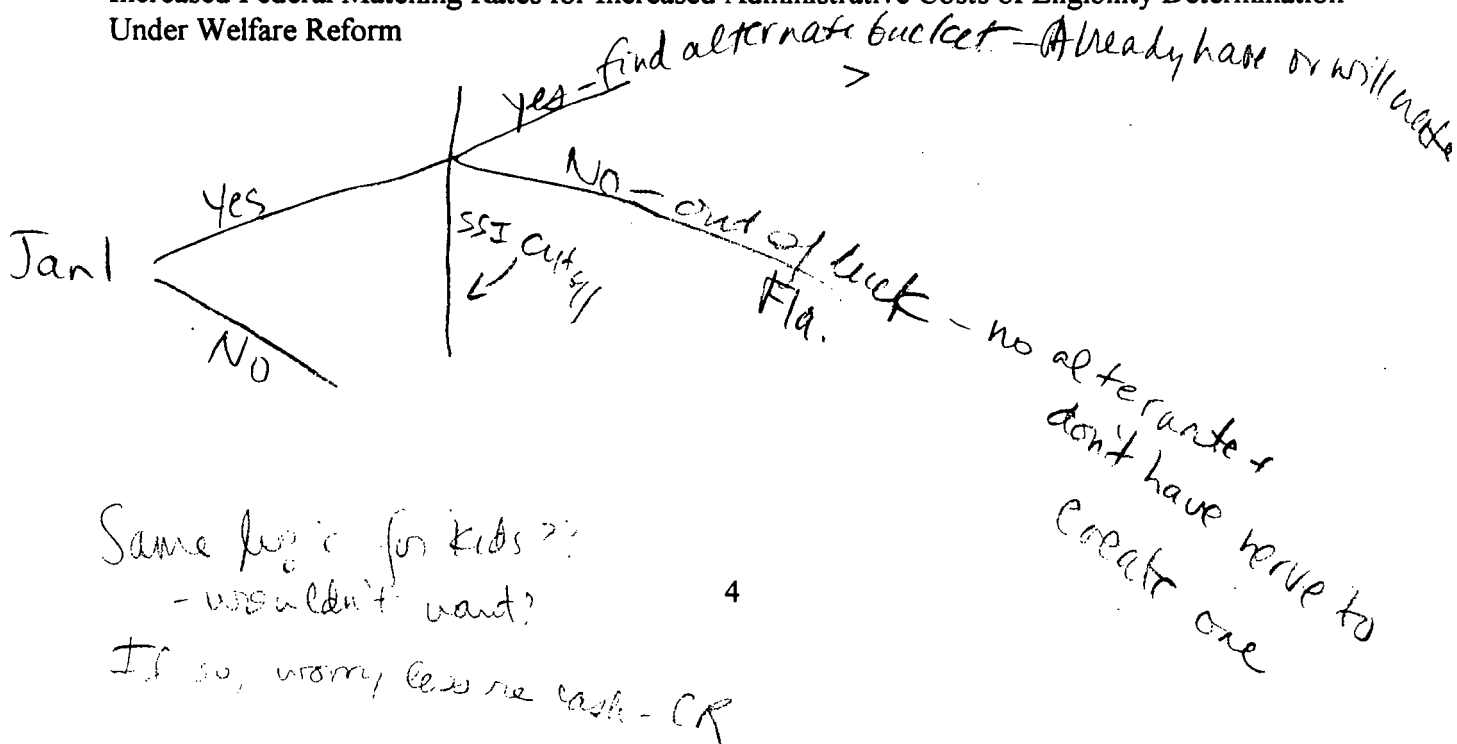
An immigrant who loses SSI cash benefits would continue to be eligible for Medicaid until the State conducts a Medicaid eligibility redetermination (which requires consideration of other bases for Medicaid eligibility for which the individual may qualify) and takes explicit action to discontinue Medicaid coverage. *what could they be?*

Related Fact Sheets:

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and SSI Coverage of Children Under Welfare Reform

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility Determination Under Welfare Reform



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aside
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INCREASED FEDERAL MATCHING RATES FOR INCREASED
ADMINISTRATIVE COSTS OF ELIGIBILITY DETERMINATION
UNDER WELFARE REFORM

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) has substantial implications for Medicaid eligibility systems and responsibilities. Section 114 of the law (Section 1931(h) of the Social Security Act) provides a special fund of \$500 million for enhanced Federal matching for States' expenditures attributable to the administrative costs of Medicaid eligibility determinations due to the law. The specific features of this provision are described below:

Federal Financial Participation (FFP) Rates

The normal FFP rate for States' administrative costs for eligibility determinations in the Medicaid program is 50 percent. However, under this new law, the Secretary is given discretion to increase the FFP rate above 50 percent, up to a fixed national cap of \$500 million for this enhanced funding. This enhanced funding is for the administrative costs applicable to the extra costs of eligibility determinations due to welfare reform.

National Limitation on Total Funding

The total Federal funds available for enhanced match are limited to \$500 million.

Time Limitations

The \$500 million is available nationally for expenditures during the Fiscal Years 1997 through 2000. For each state, however, the enhanced funding is available for only the first 12 calendar quarters in which a State's Temporary Assistance to Needy Families (TANF) program is in effect after August 21, 1996.

Related Fact Sheets

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and Coverage of SSI Children under Welfare Reform

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

FACT SHEET#3

10/4 DRAFT

LINK BETWEEN MEDICAID AND THE IMMIGRATION PROVISIONS OF
THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY ACT OF 1996

Medicaid Eligibility of "Qualified Aliens"

In general, the Medicaid eligibility rules pertaining to immigrants who are "qualified aliens" depend upon when the immigrant came to the United States. States have the following options to cover immigrants, as long as these individuals meet the financial tests and other eligibility requirements of the program:

"Qualified Alien" Defined: A "qualified alien" is an alien who is lawfully admitted for permanent residence under various sections of the Immigration and Nationality Act (INA) including: an asylee, a refugee, an individual who has been paroled into the U.S. for a period of one year, an individual who has had his/her deportation withheld, and who has been granted conditional entry. This definition also includes battered immigrants, and/or immigrants who would be indigent without assistance, because their sponsors are not providing adequate support.

Immigrants in the U.S. Before August 22, 1996

- o For immigrants who are "qualified aliens", who were receiving Medicaid benefits (were enrolled in the State's Medicaid program) on August 22, 1996, States **must continue** Medicaid coverage until at least January 1, 1997. After that date, HCFA will assume that States are continuing to cover these individuals, unless the State formally indicates that it intends to discontinue coverage.
- o For immigrants who are "qualified aliens" who were residing in the United States before August 22, 1996, but were **not** receiving Medicaid benefits (were not enrolled) on that date, whether eligible or not; States have the option to terminate coverage beginning on August 22. To do so, the State must formally amend its State Plan.

There is no deeming of sponsors' income and resources for individuals who entered the U.S. under the old affidavits of support.

States are not required to end Medicaid coverage or eligibility for any qualified aliens, including aliens losing SSI cash assistance, who were residing in the U.S. before August 22, 1996. States have a variety of options for continuing coverage and eligibility for all such qualified aliens. If the State Plan already provides such coverage and eligibility, HCFA will presume the State will continue to provide Medicaid to these individuals, until a State Plan Amendment is submitted to the contrary.

INSERT BILL'S NEW LANGUAGE HERE: Redetermination of the immigrant's Medicaid eligibility is expected to occur at the regular Medicaid redetermination interval, so there will continue to be a rolling redetermination process. Immigrants would be subject to the usual Medicaid eligibility rules until the State redetermination.

Excepted Groups of Immigrants

There is an excepted group of immigrants to whom the State *must* provide Medicaid coverage, provided the individuals are otherwise eligible. The following groups of immigrants are considered part of their excepted group:

- o Refugees -- For the first 5 years after entry to U.S. in that status
- o Asylees -- For the first 5 years after granted asylum
- o Individuals whose deportation is being withheld by the INS -- For the first 5 years after grant of deportation withholding
- o Lawful Permanent Residents -- After they have been credited with 40 quarters of coverage under Social Security (based upon their own work and/or that of spouses or parents) and no Federal means-tested public benefits were received by the individual in the quarter to be credited (or the spouse/parent on whose work record quarters were credited) *Members of this group are not excepted if the immigrant arrives in the U.S. after August 22, 1996.*
- o Honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children -- At any time.

New "Qualified Aliens" Admitted to the U.S. on or After August 22, 1996

There is a mandatory ban on Medicaid eligibility for immigrants who are "qualified aliens" newly admitted to the U.S. on or after August 22, 1996. The ban is in effect for the first five years they are in the US in that status, unless the individual is a member of one of the excepted subgroups. After the five-year ban expires, an immigrant's access to Medicaid is a matter of State option (for those otherwise eligible). For those who have individual sponsors who sign new, legally binding affidavits of support (required elsewhere in welfare reform, beginning no later than February 1997), States must deem the income and resources of the immigrant's sponsor (and sponsor's spouse) to be available to support the immigrant when determining the immigrant's eligibility for Medicaid.

Individuals who have been credited with 40 quarters of work without receiving assistance are not considered an excepted group under these provisions.

Sponsor to Immigrant Deeming of Income and Resources

The new deeming requirements apply to Medicaid in the following situations:

- 
- o Deeming applies only to sponsors signing new, legally binding affidavits of support.
 - o The sponsor's and sponsor spouse's income and resources will be counted when determining the income and resources available to the immigrant they sponsor.
 - o Deeming applies only to immigrants who are sponsored by individuals.
 - o Under the omnibus appropriations amendments, deeming does not apply to battered immigrants or to those who would be indigent, defined as unable to obtain food and shelter without assistance, because their sponsors are not providing adequate support.
 - o Deeming continues until the earlier of naturalization by the immigrant or the immigrant's being credited with 40 quarters of Social Security coverage. Such quarters do not include any quarters after December 31, 1996 in which the immigrant (or the immigrant's spouse/parent on whose work record the immigrant is credited with quarters) receives Federal means-tested benefits.
 - o Sponsors must reimburse Federal, State, and local governments for the cost of means-tested benefits received by the sponsored immigrant during the deeming period, but excluding the costs of emergency medical services.

Emergency Services

Medicaid must pay for the treatment of emergency medical conditions of illegal aliens, legal immigrants who are not qualified aliens, and qualified aliens who are not covered under the state's regular Medicaid program. However, as under current law, to receive emergency services, the individual must meet the financial and other Medicaid eligibility requirements (including the residency requirement), but not any requirement to receive cash assistance.

SSI/ Medicaid Connection for Immigrants

Other provisions of welfare reform ban receipt of SSI cash benefits for both current and new otherwise eligible "qualified aliens," unless they are a member of one of the excepted groups listed above.

Individuals who continue to receive SSI cash benefits would be eligible for Medicaid under the usual rules. The Social Security Administration must redetermine the SSI eligibility of all immigrants within one year of enactment. Upon redetermination, the immigrant may lose cash assistance if he/she is not member of one of the above excepted groups. Those losing or barred in the future from receiving SSI cash benefits will find their Medicaid benefits affected in the following ways:

- o A State that has opted under its Medicaid plan to cover non-cash SSI-related groups would have a new sub-option to continue Medicaid for "qualified aliens".
- o A State that has not previously opted under its Medicaid State plan to cover non-cash SSI-related groups could, as always, submit a State plan amendment to do so.
- o A State that opts to cover only SSI cash recipients may still be able to cover some of the "qualified aliens" under other provisions of current Medicaid law (i.e., poverty-related pregnant women and children, medically needy, etc.).

An immigrant who loses SSI cash benefits would continue to be eligible for Medicaid until the State conducts a Medicaid eligibility redetermination (which requires consideration of other bases for Medicaid eligibility for which the individual may qualify) and takes explicit action to discontinue Medicaid coverage by submitting a State Plan Amendment.

US Laura

OMB

DRAFT

10/2/96 2:00p.m.

Dear State Medicaid Director:

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) has substantial implications for Medicaid eligibility systems and responsibilities. In order to address implementation issues carefully, we have been working very closely with the joint Federal/State Eligibility Technical Advisory Group (E-TAG). That process is continuing, and will culminate in the issuance of a State Medicaid Manual issuance in December which will address many of the eligibility issues.

In the meantime, we understand that some States are moving ahead to submit Temporary Assistance to Needy Families (TANF) plans. In such cases, we will presume that you will continue to provide Medicaid eligibility for all the groups you covered on July 16, 1996, including permissible legal immigrants. For administrative purposes, we request that you notify us to that effect. If you are going to make any change to Medicaid coverage of eligibility groups, please submit a State Plan Amendment to do so. Plan Amendments may be submitted to us using whatever format you think appropriate, but providing as much information as necessary to describe the eligibility options you are electing for Medicaid. We are happy to work with you on the details of plan amendments as you proceed with implementation.

Please ^{on or} recognize that many legal immigrants (who might otherwise qualify for Medicaid) entering the country after August 22, 1996, are not eligible for Medicaid for five (5) years. However, under Section 402 of P. L. 104-193, States must continue to provide Medicaid eligibility, until at least January 1, 1997, to any qualified immigrant who entered the U.S. prior to or before August 22, 1996 who was receiving Medicaid on that date. States should be aware that Section 402 also permits states to continue coverage for most legal immigrants and to receive Federal matching funds for coverage of these individuals. In any event, States must continue to cover immigrants enrolled in Medicaid prior to August 22, 1996 until the State submits a State Plan Amendment to the contrary.

To sum up, in the absence of submitting a State Plan Amendment, you are expected to continue providing Medicaid eligibility for all the groups you covered on July 16, 1996, including permissible legal immigrants.

We will keep you informed as we develop Federal policy to implement this Act and will issue further policy guidance as soon as possible. Thank you for your cooperation in implementing this program.

Sincerely,

Judith D. Moore
Acting Director, Medicaid Bureau

cc:

All Regional Administrators
All Associate Administrators for Medicaid
Lloyd Bishop, OLGA
Jennifer Baxendall, NGA
Lee Partridge, APWA
Joy Wilson, NCSL

FACT SHEET DRAFT 10/2

LINK BETWEEN MEDICAID AND TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

Prior to enactment of P.L. 104-193, the Personal Responsibility and Work Opportunities Act of 1996:

- o Individuals who received AFDC cash assistance or who were deemed to have received AFDC were automatically eligible for Medicaid. ~~[Section 1902(a)(1)(A)(i)(I) of the Social Security Act]~~ Section 1902(a)(10)(A)(i)(I)
- o Families who lost AFDC cash assistance because of employment or receipt of child (or spousal) support payments were eligible for transitional Medicaid assistance for an additional period of time. ~~[Sections 1902(a)(1)(A)(i)(I) and 1925 of the Social Security Act]~~ Section 1902(a)(10)(A)(i)(I)
- o Various rules of the AFDC program were used to establish Medicaid eligibility for other Medicaid-only eligibility groups (e.g., pregnant women and children whose eligibility is related to the poverty level, optional groups of children and caretaker relatives who do not receive AFDC, and the medically needy.) (Section 1902 of the Social Security Act)

The new welfare reform law eliminates the AFDC cash assistance program and replaces it with a block grant program called Temporary Assistance for Needy Families (TANF) (Section 103 of the new law). However, families who meet the AFDC eligibility criteria prior to welfare reform will be eligible for Medicaid. States are not required to make a complete eligibility determination using all the pre-reform AFDC program rules. This determination is replaced by two basic eligibility requirements:

- o The family income and resources must meet the pre-reform AFDC standards (Section 1931(b)(1)(I) of the Social Security Act).
- o The pre-reform AFDC deprivation requirement must be met. (i.e., a child must be living with a parent or other relative and deprived of parental support or care by the death, absence, incapacity or unemployment of a parent.) (Section 1931(b)(1)(A)(ii) of the Social Security Act)

As under pre-reform law, if a family loses Medicaid eligibility because of employment or receipt of support payments or employment and received Medicaid in three of the preceding six months, the family is eligible for a period of extended Medicaid benefits. (Section 408(a)(1) of P.L. 104-193 and Section 1931(c) of the Social Security Act) of the Social Security Act

States are permitted to deny Medicaid benefits to ^{the} other adults and heads of household who lose TANF benefits because of refusal to work. However, welfare reform law specifically exempts poverty-related pregnant women and children from this provision and mandates their continued Medicaid eligibility. (Section 1931(b)(3) of the Social Security Act)

This provision would have sunset in 9/30/98.

-1-

Because the AFDC cash assistance program is eliminated, welfare reform provides that any reference in Title XIX to an AFDC provision or an AFDC State Plan will be considered a reference to the AFDC provision or plan in effect for the State on July 16, 1996, i.e. "pre-reform" AFDC. This effectively freezes the pre-reform AFDC program for all Medicaid purposes, except that welfare reform also permits ^{the} States to retain flexibility to change the applicable income and resource methodologies, as follows:

- o A State may lower its income standards, but not below the standards it applied on May 1, 1988. (Section 1931(b)(2)(A) of the Social Security Act)
- o ~~A State may increase its income and resource standards by any increase in the CPI subsequent to July 16, 1996. (Section 1931(b)(2)(B) of the Social Security Act)~~
- o A State may also use less restrictive income and resource methodologies than those in effect on July 16, 1996. (Section 1931(b)(2)(C) of the Social Security Act)

Related Fact Sheets:

Link Between Medicaid and SSI Coverage of Children under Welfare Reform

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility Determinations under Welfare Reform

▶ A state may increase its income and standards above that of 7/16/96, but not more than the percentage increase in the CPI-U over the same period.

FACT SHEET

DRAFT 10/2

LINK BETWEEN MEDICAID AND SSI COVERAGE OF CHILDREN UNDER WELFARE REFORM

Under the new law, the definition of childhood disability is no longer linked to the definition of disability for adults. The reference to "comparable severity" in the old law has been deleted.

The new definition says: (1) an individual under the age of 18 shall be considered to be disabled under SSI if that child has a medically determinable physical or mental ^{impairment} disability, which results in marked and severe functional limitation, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least twelve months; and (2) no individual under the age of 18 who engages in substantial gainful activity may be considered disabled.

In addition to the new definition of disability for children, the law mandates two changes to current evaluation criteria in SSA's regulations. SSA must: (1) discontinue the individualized functional assessment (IFA) for children; and (2) eliminate maladaptive ^{behavior as a medical} personal behavioral function in determining whether a child is disabled. ^{criteria in its listing of impairments used for evaluating mental disabilities in children}

In most States, individuals who are eligible for SSI are also eligible for Medicaid. These changes in the ^{welfare reform law} will result in some children losing SSI, and therefore Medicaid eligibility. However, many of the children affected will still continue to be covered under Medicaid because they meet other Medicaid eligibility criteria. *

Section 204(a) of the new law provides that SSI payments may only begin as of the first day of the month following: (1) the date the application is filed or, if later, (2) the date the person first meets all eligibility factors. This is a delay in SSI eligibility in comparison with the old law ^{for all beneficiaries, including children}

Under Section 211 of the new law, SSA is required to redetermine the eligibility of recipients under age 18 by August 22, 1997. No SSI-eligible child may lose benefits by reason of a redetermination of disability using the new definition earlier than July 1, 1997. ^(all?)

Also under Section 211, SSA is required to send notices to the representative payees of all affected recipients no later than January 1, 1997.

Other Fact Sheets

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility

* Sentence about redetermination.

FACT SHEET#3

10/2 DRAFT

LINK BETWEEN MEDICAID AND THE IMMIGRATION PROVISIONS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY ACT OF 1996

Medicaid Eligibility of "Qualified Aliens"

States are given certain options to ^{provide Medicaid to} ~~cover~~ immigrants who are "qualified aliens" under ^{the new law} Medicaid, as long as these individuals meet the financial tests and other eligibility requirements of the program. If a State opts to cut off Medicaid benefits for immigrants currently receiving them, that cannot occur until after January 1, 1997.

States' options are further constrained by requirements that they must cover certain excepted subgroups of immigrants. [The rules pertaining to qualified aliens are based upon when the immigrant came to the United States.]

this statement is confusing

Current "Qualified Aliens" Already in the US on or before August 22, 1996 (Date of Enactment)

States have the option to provide Medicaid to an immigrant who is a "qualified alien" and who ^{was} ~~is~~ already in the U.S. before the date of enactment (if otherwise eligible for Medicaid) unless the individual is a member of one of the excepted subgroups, in which case the individual (if otherwise eligible for Medicaid) must be covered. Excepted subgroups of immigrants for this purpose include:

- o Refugees -- Only for first 5 years after entry to U.S. in that status
- o Asylees -- Only for first 5 years after granted asylum
- o Individuals whose deportation is being withheld by the INS -- Only for first 5 years after grant of deportation withholding
- o Lawful Permanent Residents -- only after they have been credited with 40 quarters of coverage under Social Security (based upon their own work an/or that of spouses or parents) and no Federal means-tested public benefits were received by the individual in the quarter to be credited (or the spouse/parent on whose work record quarters were credited)
- o Honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children -- at any time.

There is no deeming of sponsor income and resources for individuals who entered the U.S. under the old affidavits of support.

This
is
unclear

Redetermination of the immigrant's Medicaid eligibility is expected to occur at the regular Medicaid redetermination interval, so there will continue to be a rolling redetermination process. Immigrants would be subject to the usual Medicaid eligibility rules until the State redetermination.

New "Qualified Aliens" Admitted to the U.S. on or After August 22, 1996

There is a mandatory ban on Medicaid eligibility for immigrants who are "qualified aliens" newly admitted to the U.S. after enactment for the first five years they are in the US in that status, unless the individual is a member of one of the excepted subgroups below. After the five-year ban expires for an immigrant admitted to the U.S. after enactment, their access to Medicaid is a matter of State option (for those otherwise eligible). For those who have individual sponsors that sign new, legally binding affidavits of support (required elsewhere in welfare reform, no later than February 1997), States must deem the income and resources of the immigrant's sponsor (and sponsor's spouse) to be available to support the immigrant when determining the immigrant's eligibility for Medicaid.

in Section
423 of
the
Social
Security
Act

For certain ^{excepted} immigrants admitted after enactment (and otherwise Medicaid-eligible), States must provide full Medicaid benefits, for the time period specified below. These excepted subgroups of immigrants for these purposes are:

- o Refugees -- Only for first 5 years after entry to U.S. in that status
- o Asylees -- Only for first 5 years after granted asylum
- o Those whose deportation has been withheld by the INS -- Only for first 5 years after grant of withholding
- o Honorably discharged US veterans, active duty military personnel, and their spouses and unmarried dependent children -- at any time (both during and after the first five years).

Cuban/Haitian entrants remain eligible for refugee and entrant assistance.

Sponsor to Immigrant Deeming of Income and Resources

The new deeming requirements apply to Medicaid in the following situations:

- o Deeming applies only to sponsors signing new, legally binding affidavits of support.
- o The sponsor's and sponsor spouse's income and resources will be counted when determining the income and resources available to the immigrant they sponsor.

- o Deeming applies only to immigrants who are sponsored by individuals.
- o Under the omnibus appropriations ^{act of FY1997} ~~amendments~~, deeming does not apply to battered immigrants or to those whose sponsors become indigent.
- o Deeming continues until the earlier of naturalization by the immigrant or the immigrant's being credited with 40 quarters of Social Security coverage. Such quarters do not include any quarters after December 31, 1996 in which the immigrant (or the immigrant's spouse/parent on whose work record the immigrant is credited with quarters) receives Federal means-tested benefits.
- o Sponsors must reimburse Federal, State, and local governments for the cost of means-tested benefits received by the sponsored immigrant during the deeming period, but excluding the costs of emergency medical services.

Emergency Services

Medicaid must pay for the treatment of emergency medical conditions of illegal aliens, legal immigrants who are not qualified aliens, and qualified aliens who are not covered under the state's regular Medicaid program. However, to receive emergency services, the individual must meet the ^{as under current law} financial and other Medicaid eligibility requirements (including the residency requirement), but not any requirement to receive cash assistance.

SSI/Medicaid Connection for Immigrants

Other provisions of welfare reform ban receipt of SSI cash benefits ^{for} by both current and new otherwise eligible "qualified aliens," with the following exceptions:

- o Refugees -- Only for first 5 years after entry to U.S. in that status
- o Asylees -- Only for first 5 years after granted asylum
- o Individuals whose deportation is being withheld by the INS -- Only for first 5 years after grant of deportation withholding
- o Lawful Permanent Residents -- only after they have been credited with 40 quarters of coverage under Social Security (based upon their own work an/or that of spouses or parents) and no Federal means-tested public benefits were received by the individual (or the spouse/parent on whose work record quarters were credited)
- o Honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children -- at any time.

Individuals who continue to receive SSI cash benefits would be eligible for Medicaid under the usual rules. Those who are currently receiving SSI cash benefits would lose them after the date when Social Security redetermines their eligibility (within one year after enactment), unless SSA finds that they meet the above exceptions. Those losing or barred in the future from receiving SSI cash benefits by this provision in welfare reform would find their Medicaid benefits affected in the following ways:

- o A State that has opted under its Medicaid plan to cover non-cash SSI-related groups would have a new sub-option to continue or ban Medicaid for "qualified aliens" after January 1, 1997.
- o A State that has not previously opted under its Medicaid State plan to cover non-cash SSI-related groups could, as always, submit a State plan amendment to do so.
- o A State that opts to cover only SSI cash recipients may still be able to cover some of the "qualified aliens" who would lose SSI under other provisions of current Medicaid law (i.e., poverty-related pregnant women and children, medically needy, etc.).

An immigrant who loses SSI cash benefits would continue to be eligible for Medicaid until the State conducts a Medicaid eligibility redetermination (which requires consideration of other bases for Medicaid eligibility for which the individual may qualify) and takes explicit action to discontinue Medicaid coverage.

Related Fact Sheets:

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and SSI Coverage of Children Under Welfare Reform

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility Determination Under Welfare Reform

FACT SHEET

DRAFT 10/2

**INCREASED FEDERAL MATCHING RATES FOR INCREASED
ADMINISTRATIVE COSTS OF ELIGIBILITY DETERMINATION
UNDER WELFARE REFORM**

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) has substantial implications for Medicaid eligibility systems and responsibilities. Section 114 of the law (Section 1931(h) of the Social Security Act) provides a special fund of \$500 million for enhanced Federal matching for States' expenditures attributable to the administrative costs of Medicaid eligibility determinations due to the law. The specific features of this provision are described below:

Federal Financial Participation (FFP) Rates

The normal FFP rate for States' administrative costs for eligibility determinations in the Medicaid program is 50 percent. However, under this new law, the Secretary is given discretion to increase the FFP rate above 50 percent, up to a fixed national cap of \$500 million for this enhanced funding. This enhanced funding is for the administrative costs applicable to the ~~extra costs~~ of eligibility determinations due to welfare reform. *extra*
increased workload

National Limitation on Total Funding

The total Federal funds available for enhanced match are limited to \$500 million.

Time Limitations

The \$500 million is available nationally for expenditures during the Fiscal Years 1997 through 2000. For each state, however, the enhanced funding is available for only the first 12 calendar quarters in which a State's Temporary Assistance to Needy Families (TANF) program is in effect after August 21, 1996.

Related Fact Sheets

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and Coverage of SSI Children under Welfare Reform

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

FAX**SPECIAL!**

Date:

10/17/96

Number of pages including cover sheet:

4

To:

Alvin J. Tortura
W H / Domestic Policy

Phone:

Fax phone:

CC:

From:

Pat Woods

Phone:

(202) 401-5879

Fax phone:

(202) 690-5672

REMARKS:

☐ Urgent☐ For your review☐ Reply ASAP☐ Please comment

Re: MED C under Welfare Reform
John wanted to be sure to get
your clearance on this before
HCF A sends it out. If possible,
please give us your comments/clearance
by 10/18. Thanks.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

OCT - 9 1996

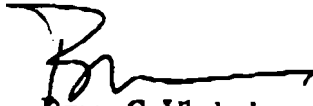
NOTE TO: Kevin Thurm
Thru: ES _____
COS _____

SUBJECT: Medicaid Eligibility Quality Control (MEQC) Under Welfare Reform--
INFORMATION

Attached for your review and clearance is an All State Medicaid Directors' letter giving states preliminary guidance for modifying their MEQC programs under welfare reform. We need to release this letter immediately to provide instructions to states for selecting the next MEQC sample for review during the early part of October 1996. *

We briefly discussed this matter at the recent departmental meeting on Medicaid eligibility reform. The State Medicaid Directors' letter does not contain any controversial issues. It merely provides states with options in selecting their MEQC sample. We are receiving calls from states and regional offices requesting MEQC sampling and review information. This letter will serve to address their immediate concerns until more formal instructions can be released through the State Medicaid Manual.

Please call me if you wish to discuss this matter further.


Bruce C. Vladeck

Attachment

96-0807

DRAFT

Dear State Medicaid Director:

This letter is to provide you with preliminary guidance on the options available for modifying your state Medicaid eligibility quality control (MEQC) sampling procedures to accommodate the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. These options may not apply to those states which chose to operate alternate MEQC programs under either an approved MEQC pilot or a section 1115 waiver.

The new legislation replaces the Aid to Families with Dependent Children (AFDC) program with the Temporary Assistance for Needy Families program effective October 1, 1996, and repeals section 408 of the Social Security Act (the Act) governing payment accuracy and performance measures under the AFDC program. However, the statute at section 1903(u) of the Act, on which the MEQC program is based, remains in place.

Although the welfare reform law did not repeal or revise section 1903(u) of the statute, it does affect the MEQC program. Specifically, the requirement to operate an AFDC quality control (QC) program no longer exists. As a result, states which choose to cease conducting AFDC/QC reviews will have their Medicaid error rates based on a single overall medical assistance only (MAO) sample which will include those individuals formerly eligible for AFDC cash as AFDC-related.

States have three options for MEQC sampling. First, those states which choose to continue their AFDC/QC programs may continue to incorporate the AFDC/QC findings in the MEQC error rate calculation. Otherwise, you have two options for including the previous AFDC cash population in the MEQC sample. First, you may retain your current MAO sample size and continue to conduct full-field case reviews (the AFDC-related cases will be part of the MAO stratum). Second, you may increase your sample size by a minimum of 25 percent to accommodate the larger MAO universe, but conduct abbreviated reviews (e.g., cease home visits). States that decide to increase the sample and conduct abbreviated reviews should document a maintenance of staffing effort in

DRAFT

Page 2 - All State Medicaid Directors

DRAFT

their sampling plan. You may also wish to consider stratifying your MAO sample to ensure that your sample reflects two or more coverage groups, e.g., long-term care cases and other MAO cases. When your state determines its sampling method, submit an amended sampling plan to indicate the choices you made for MEQC sampling.

We believe these options are the most reasonable approaches to MEQC since they do not increase current state staffing levels for MEQC and provide you with flexibility in meeting the requirements of the MEQC program. The options were developed in consultation with the state Medicaid QC Directors attending the recent national quality control directors' conference. Please direct any questions on this matter to your regional office.

Sincerely,

DRAFT

Judith D. Moore
Acting Director
Medicaid Bureau

bcc:

All Regional Administrators

All Associate Regional Administrators
Division of Medicaid

State Medicaid Quality Control Directors

Lee Partridge
American Public Welfare Association

Joy Wilson
National Conference of State Legislators

Jennifer Bexendell
National Governors' Association

Lloyd Bishop
Office of Legislative & Inter-Governmental Affairs, HCFA



OCT - 4 1996

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

Dear State Medicaid Director:

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) has substantial implications for Medicaid eligibility systems and responsibilities. In order to address implementation issues carefully, we have been working very closely with the joint Federal/State Eligibility Technical Advisory Group (E-TAG). That process is continuing, and will culminate in the issuance of a State Medicaid Manual issuance in December which will address many of the eligibility issues.

In the meantime, we understand that some States are moving ahead to submit Temporary Assistance to Needy Families (TANF) plans. In such cases, we will presume that you will continue to provide Medicaid eligibility for all the groups you covered on July 16, 1996, including permissible legal immigrants. For administrative purposes, we request that you notify us to that effect. If you are going to make any change to Medicaid coverage of eligibility groups, please submit a State Plan Amendment to do so. Plan Amendments may be submitted to us using whatever format you think appropriate, but providing as much information as necessary to describe the eligibility options you are electing for Medicaid. We are happy to work with you on the details of plan amendments as you proceed with implementation.

Please recognize that many legal immigrants (who might otherwise qualify for Medicaid) entering the country on or after August 22, 1996, are not eligible for Medicaid for five (5) years. However, under Section 402 of P. L. 104-193, States must continue to provide Medicaid eligibility, until at least January 1, 1997, to any qualified immigrant receiving Medicaid on August 22, 1996. States should be aware that Section 402 also permits states to continue coverage for most legal immigrants and to receive Federal matching funds for coverage of these individuals. In any event, States must continue to cover immigrants enrolled in Medicaid prior to August 22, 1996 until the State submits a State Plan Amendment to the contrary.

To sum up, in the absence of submitting a State Plan Amendment, you are expected to continue providing Medicaid eligibility for all the groups you covered on July 16, 1996, including permissible legal immigrants.

We will keep you informed as we develop Federal policy to implement this Act and will issue further policy guidance as soon as possible. Thank you for your cooperation in implementing this program.

Sincerely,

A handwritten signature in black ink, appearing to read "Judith D. Moore". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Judith D. Moore
Acting Director
Medicaid Bureau

cc:

All Regional Administrators
All Associate Administrators for Medicaid
Lloyd Bishop, OLIGA
Jennifer Baxendall, NGA
Lee Partridge, APWA
Joy Wilson, NCSL

FACT SHEET #1

LINK BETWEEN MEDICAID AND TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

Prior to enactment of P.L 104-193, the Personal Responsibility and Work Opportunities Act of 1996:

- o Individuals who received AFDC cash assistance or who were deemed to have received AFDC were automatically eligible for Medicaid. (Section 1902(a)(10)(A)(i)(I) of the Social Security Act)
- o Families who lost AFDC cash assistance because of employment or receipt of child (or spousal) support payments were eligible for transitional Medicaid assistance for an additional period of time. (Sections 1902(a)(10)(A)(i)(I) and 1925 of the Social Security Act)
- o Various rules of the AFDC program were used to establish Medicaid eligibility for other Medicaid-only eligibility groups (e.g., pregnant women and children whose eligibility is related to the poverty level, optional groups of children and caretaker relatives who do not receive AFDC, and the medically needy.) (Section 1902 of the Social Security Act)

The new welfare reform law eliminates the AFDC cash assistance program and replaces it with a block grant program called Temporary Assistance for Needy Families (TANF) (Section 103 of the new law). However, families who meet the AFDC eligibility criteria prior to welfare reform will be eligible for Medicaid. States are not required to make a complete eligibility determination using all the pre-reform AFDC program rules. This determination is replaced by two basic eligibility requirements:

- o The family income and resources must meet the pre-reform AFDC standards (Section 1931(b)(1)(I) of the Social Security Act).
- o The pre-reform AFDC deprivation requirement must be met. (i.e., a child must be living with a parent or other relative and deprived of parental support or care by the death, absence, incapacity or unemployment of a parent.) (Section 1931(b)(1)(A)(ii) of the Social Security Act)

As under pre-reform law, if a family loses Medicaid eligibility because of employment or receipt of support payments or employment and received Medicaid in three of the preceding six months, the family is eligible for a period of extended Medicaid benefits. (Sections 408(a)(11) and 1931(c) of the Social Security Act)

States are permitted to deny Medicaid benefits to adults and heads of household who lose TANF benefits because of refusal to work. However, welfare reform law specifically exempts poverty-related pregnant

women and children from this provision and mandates their continued Medicaid eligibility. (Section 1931(b)(3) of the Social Security Act)

Because the AFDC cash assistance program is eliminated, welfare reform provides that any reference in Title XIX to an AFDC provision or an AFDC State Plan will be considered a reference to the AFDC provision or plan in effect for the State on July 16, 1996, i.e. "pre-reform" AFDC. This effectively freezes the pre-reform AFDC program for all Medicaid eligibility purposes, except that welfare reform also permits States to retain flexibility to change the applicable income and resource methodologies, as follows:

- o A State may lower its income standards, but not below the standards it applied on May 1, 1988. (Section 1931(b)(2)(A) of the Social Security Act)
- o A State may increase its income and resource standards up to the percentage increase in the CPI subsequent to July 16, 1996. (Section 1931(b)(2)(B) of the Social Security Act)
- o A State may also use less restrictive income and resource methodologies than those in effect on July 16, 1996. (Section 1931(b)(2)(C) of the Social Security Act)

Related Fact Sheets:

[Link Between Medicaid and SSI Coverage of Children under Welfare Reform](#)

[Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996](#)

[Increased Federal Matching Rates for Increased Administrative Costs of Eligibility Determinations under Welfare Reform](#)

FACT SHEET #2

LINK BETWEEN MEDICAID AND SSI COVERAGE OF CHILDREN UNDER WELFARE REFORM

Under the new law, the definition of childhood disability is no longer linked to the definition of disability for adults. The reference to "comparable severity" in the old law has been deleted.

The new definition says: (1) an individual under the age of 18 shall be considered to be disabled under SSI if that child has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least twelve months; and (2) no individual under the age of 18 who engages in substantial gainful activity may be considered disabled.

In addition to the new definition of disability for children, the law mandates two changes to current evaluation criteria in SSA's regulations. SSA must: (1) discontinue the individualized functional assessment (IFA) for children; and (2) eliminate maladaptive behavior in the domain of personal/behavioral function in determining whether a child is disabled.

In most States, individuals who are eligible for SSI are also eligible for Medicaid. These changes will result in some children losing SSI, and therefore Medicaid eligibility. However, many of the children affected could still continue to be covered under Medicaid because they meet other Medicaid eligibility criteria. States are required to perform a redetermination of Medicaid eligibility in any case where an individual loses SSI and that determination affects the individual's Medicaid eligibility.

Section 204(a) of the new law provides that SSI payments, for all beneficiaries, including children, may only begin as of the first day of the month following: (1) the date the application is filed or, if later, (2) the date the person first meets all eligibility factors. This is a delay in SSI eligibility in comparison with the old law.

Under Section 211 of the new law, SSA is required to redetermine the eligibility of recipients under age 18 by August 22, 1997. No SSI-eligible child may lose benefits by reason of a redetermination of disability using the new definition earlier than July 1, 1997.

Also under Section 211, SSA is required to send notices to the representative payees of all affected recipients no later than January 1, 1997.

Related Fact Sheets:

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996

Increased Federal Matching Rates for Increased Administrative Costs of Eligibility Determinations Under Welfare Reform

FACT SHEET #3

LINK BETWEEN MEDICAID AND THE IMMIGRATION PROVISIONS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY ACT OF 1996

Medicaid Eligibility of Legal Immigrants

The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) identifies two categories of legal immigrants: "qualified aliens" and others.

"Qualified Alien" Defined: A "qualified alien" is an alien who is lawfully admitted for permanent residence under various sections of the Immigration and Nationality Act (INA) including: an asylee, a refugee, an individual who has been paroled into the U.S. for a period of one year, an individual who has had his/her deportation withheld, and who has been granted conditional entry. This definition also includes battered immigrants, and/or immigrants who would be indigent without assistance, because their sponsors are not providing adequate support.

States have the following options to cover legal immigrants, as long as these individuals meet the financial and other eligibility requirements of the program.

Immigrants Residing in the U.S.

States are not required to end Medicaid coverage or eligibility for any "qualified aliens" residing in the U.S. before August 22, 1996. If the State Plan already provides such coverage and eligibility, HCFA will presume the State will continue to provide Medicaid to these individuals, until a State Plan Amendment is submitted to the contrary.

- o For immigrants who are "qualified aliens" receiving Medicaid benefits (were enrolled in the State's Medicaid program) on August 22, 1996, States must continue Medicaid coverage until at least January 1, 1997. After that date, HCFA will assume that States are continuing to cover these individuals, unless the State amends its State Plan to discontinue coverage of these individuals.
- o For immigrants who are "qualified aliens" residing in the United States before August 22, 1996, but were not enrolled on that date, whether eligible or not, States have the option not to provide Medicaid beginning on August 22, 1996. To do so, the State must amend its State Plan.
- o For other immigrants who are not "qualified aliens," Medicaid eligibility was terminated on August 22, 1996 under P.L. 104-193, except for those receiving SSI. For these immigrants, Medicaid eligibility continues until SSA redetermines eligibility (see page 4).

Steve ?

Excepted Groups of Immigrants

There is an excepted group of immigrants to whom the State **must** provide Medicaid coverage, provided the individuals are otherwise eligible. The following groups of immigrants are considered part of the excepted group:

- o Refugees -- For the first 5 years after entry to U.S. in that status
- o Asylees -- For the first 5 years after granted asylum
- o Individuals whose deportation is being withheld by the INS -- For the first 5 years after grant of deportation withholding
- o Lawful Permanent Residents -- After they have been credited with 40 quarters of coverage under Social Security (based upon their own work and/or that of spouses or parents) and no Federal means-tested public benefits were received by the individual in the quarter to be credited (or the spouse/parent on whose work record quarters were credited). Members of this group are not excepted if the immigrant arrives in the U.S. after August 22, 1996.
- o Honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children -- At any time.

Immigrants Admitted to the U.S. On or After August 22, 1996

There is a mandatory ban on Medicaid eligibility for immigrants who are "qualified aliens" newly admitted to the U.S. on or after August 22, 1996. The ban is in effect for the first five years they are in the U.S. in that status, unless the individual is a member of one of the excepted groups. After the five-year ban expires, an immigrant's access to Medicaid is at State option (for those otherwise eligible). For those who have individual sponsors who sign new, legally binding affidavits of support (required elsewhere in welfare reform, beginning no later than February 1997), States must deem the income and resources of the immigrant's sponsor (and sponsor's spouse) to be available to support the immigrant when determining the immigrant's eligibility for Medicaid. For most immigrants, deeming will not take effect for five years.

Individuals who have been credited with 40 quarters of work without receiving assistance are not considered an excepted group under these provisions.

Sponsor to "Qualified Alien" Deeming of Income and Resources

There is no deeming of sponsors' income and resources for individuals who entered the U.S. under the old affidavits of support. The new deeming requirements apply to Medicaid in the following situations:

- o Deeming applies only to sponsors signing new, legally binding affidavits of support.
- o The sponsor's and sponsor spouse's income and resources will be counted when determining the income and resources available to the immigrant they sponsor.
- o Deeming applies only to immigrants who are sponsored by individuals.
- o Under the omnibus appropriations amendments, deeming does not apply to battered immigrants or to those who would be indigent, defined as unable to obtain food and shelter without assistance, because their sponsors are not providing adequate support.
- o Deeming continues until the earlier of naturalization by the immigrant or the immigrant's being credited with 40 quarters of Social Security coverage. Such quarters do not include any quarters after December 31, 1996 in which the immigrant (or the immigrant's spouse/parent on whose work record the immigrant is credited with quarters) receives Federal means-tested benefits.
- o Sponsors must reimburse Federal, State, and local governments for the cost of means-tested benefits received by the sponsored immigrant during the deeming period, but excluding the costs of emergency medical services.

Emergency Services

Provided they meet the financial and categorical eligibility requirements, both qualified aliens and non-qualified aliens continue to be eligible for emergency services under Medicaid.

SSI/ Medicaid Connection for "Qualified Aliens"

Other provisions of welfare reform ban receipt of SSI cash benefits for both current and new otherwise eligible "qualified aliens," unless they are a member of one of the excepted groups listed above.

Individuals who continue to receive SSI cash benefits would be eligible for Medicaid under the usual rules. The Social Security Administration must redetermine the SSI eligibility of all immigrants within one year of enactment. Upon redetermination, the immigrant may lose cash assistance if he/she is not a member of one of the above excepted groups.

States are required to perform a redetermination of Medicaid eligibility in any case where an individual loses SSI and that termination affects the individual's eligibility for Medicaid. Those losing or barred in the future from receiving SSI cash benefits will find their Medicaid benefits affected in the following ways:

- o A State that has opted under its Medicaid plan to cover non-cash SSI-related groups would automatically continue Medicaid for "qualified aliens" who fit into those groups.
- o A State that has not previously opted under its Medicaid State plan to cover non-cash SSI-related groups could, as always, submit a State plan amendment to provide coverage for non-cash SSI-related groups. HCFA is exploring options to permit States to do this as simply as possible.

In addition, a State that opts to cover only SSI cash recipients may still be able to cover some of the "qualified aliens" under other provisions of current Medicaid law (i.e., poverty-related pregnant women and children, medically needy, etc.).

An immigrant who loses SSI cash benefits would continue to be eligible for Medicaid until the State conducts a Medicaid eligibility redetermination (which requires consideration of other bases for Medicaid eligibility for which the individual may qualify) and has found that the individual does not qualify for Medicaid by any other means.

Related Fact Sheets:

[Link Between Medicaid and Temporary Assistance for Needy Families \(TANF\)](#)

[Link Between Medicaid and Coverage of SSI Children under Welfare Reform](#)

[Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996](#)

FACT SHEET #4

INCREASED FEDERAL MATCHING RATES FOR EXTRA ADMINISTRATIVE COSTS OF ELIGIBILITY DETERMINATION UNDER WELFARE REFORM

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) has substantial implications for Medicaid eligibility systems and responsibilities. Section 114 of the law (Section 1931(h) of the Social Security Act) provides a special fund of \$500 million for enhanced Federal matching for States' expenditures attributable to the administrative costs of Medicaid eligibility determinations due to the law. The specific features of this provision are described below:

Federal Financial Participation (FFP) Rates

The normal FFP rate for States' administrative costs for eligibility determinations in the Medicaid program is 50 percent. However, under this new law, the Secretary is given discretion to increase the FFP rate above 50 percent, up to a fixed national cap of \$500 million for this enhanced funding. This enhanced funding is for extra administrative costs applicable to the increased cost of eligibility determinations due to welfare reform.

National Limitation on Total Funding

The total Federal funds available for enhanced match are limited to \$500 million.

Time Limitations

The \$500 million is available nationally for expenditures during the Fiscal Years 1997 through 2000. For each state, however, the enhanced funding is available for only the first 12 calendar quarters in which a State's Temporary Assistance to Needy Families (TANF) program is in effect after August 21, 1996.

Related Fact Sheets:

Link Between Medicaid and Temporary Assistance for Needy Families (TANF)

Link Between Medicaid and Coverage of SSI Children under Welfare Reform

Link Between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996