

2-1-2001

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Joel Ferber
Legal Services of Eastern Missouri

Theresa Steed

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Recommended Citation

Joel Ferber & Theresa Steed, *The Impact of Welfare Reform on Access to Medicaid: Curing Systemic Violations of Medicaid De-Linking Requirements*, 45 St. Louis U. L.J. (2001).

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**THE IMPACT OF WELFARE REFORM ON ACCESS TO MEDICAID:
CURING SYSTEMIC VIOLATIONS OF MEDICAID DE-LINKING
REQUIREMENTS**

JOEL FERBER* AND THERESA STEED**

I. INTRODUCTION

One of the great social experiments of the twentieth century was the well-publicized reform of our nation's welfare system in 1996. That legislation eliminated the entitlement to welfare cash assistance and reduced funding for a wide array of other benefits for poor children and families. Most notably, Congress transformed the Aid to Families with Dependent Children (AFDC) cash assistance program into a block grant to states, granting states unprecedented flexibility in using federal funds for low-income families, as long as states complied with certain restrictions that attached to the expenditure of those funds. The focus of the federal welfare reform legislation clearly was to move families from welfare to work, which has caused states to engage in a series of strategies to lower their cash assistance rolls and move people into the workforce. These efforts have led to a dramatic decline in states' welfare caseloads.

While Congress gave states wide discretion with regard to cash assistance benefits, it retained the federal entitlement to health insurance under the Medicaid program. Preservation of the Medicaid entitlement would help ensure that poor families retained health insurance when they went to work and would enable families to access health coverage regardless of whether they qualified for cash assistance. Prior to the new welfare law, Medicaid eligibility for families with children had been linked to the receipt of AFDC cash assistance benefits. In the new legislation, Congress sought to protect access

* Joel Ferber is a managing attorney with Legal Services of Eastern Missouri. Mr. Ferber has represented Reform Organization of Welfare (ROWEL) regarding the Missouri Department of Social Services' implementation of the Medicaid de-linking provisions of the federal welfare law. Mr. Ferber wishes to thank Jocelyn Guyer and Liz Schott of the Center on Budget and Policy Priorities for the significant time they spent reviewing and providing input regarding this article. He also wishes to acknowledge Katherine Hayes and Ann Lever for their assistance.

** Theresa Steed is a J.D. candidate at the American University, Washington College of Law. She would like to thank the University's Equal Justice Foundation for its generous support of her work on this article.

to Medicaid by “de-linking” the program from the receipt of cash assistance so that restrictions on cash assistance benefits would not affect families’ health coverage. In short, continued access to health coverage was viewed as an important part of welfare reform.

In spite of this effort, welfare reform has led to widespread losses of Medicaid coverage across the country. Numerous studies document a decline in access to Medicaid, which has not been offset by an increase in access to employer-based coverage for families leaving welfare. A variety of state practices have caused families to lose Medicaid when they lose cash assistance or to be denied Medicaid when they first apply for welfare benefits. The evidence over the last several years demonstrates that an important component of welfare reform, the preservation of access to health coverage for low-income working families, has not achieved its intended result. This unanticipated loss of Medicaid coverage requires careful attention from both advocates and policy makers and is being addressed in a number of ways at the state and federal levels. Health insurance coverage is essential to families making the transition from welfare to work. Therefore, remedying this problem is important to ensuring the success of federal and state welfare reform efforts.

This article addresses the impact of federal and state welfare reform efforts on access to Medicaid coverage. It reviews data showing a steep decline in Medicaid participation and studies documenting the effect of welfare reform on access to Medicaid. The article then explores the reasons for this unprecedented loss of health insurance and the responses of advocates and state and federal agencies to the problem. An analysis of Missouri quality assurance reviews and data on state Medicaid closings provides a window into the causes of welfare-related terminations and denials of Medicaid coverage. Finally, the article describes a set of remedies for families’ loss of health coverage as a result of welfare reform—remedies that can be achieved through litigation or negotiation in individual states.

II. BACKGROUND

On August 22, 1996, President Clinton signed the federal welfare reform law entitled Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRA).¹ In that legislation, Congress eliminated the sixty-one-year-old entitlement to cash assistance—AFDC—and replaced it with a block grant to states known as the Temporary Assistance for Needy Families (TANF).²

1. *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 42 U.S.C.).

2. DAVID A. SUPER ET AL., CTR. ON BUDGET AND POLICY PRIORITIES, *THE NEW WELFARE LAW 1* (1996), available at <http://www.cbpp.org/WECNF813.HTM>. The welfare law actually combined the AFDC program, the JOBS program and the emergency assistance program into one

Although a number of restrictions applied to block grant funds, states were given a wide degree of flexibility in implementing their welfare programs. Most states, including Missouri, had been implementing welfare reform long before the bill passed, pursuant to federal waivers.

As a result of welfare reform and the strong economy, the nation has encountered a significant decline in the welfare caseload. The nation experienced a welfare caseload decline of fifty-two percent from January 1993 to December 1999 while Missouri faced a forty-seven percent caseload decline during the same period.³ This caseload decline is no surprise because one purpose of welfare reform was to reduce the welfare rolls by moving people off of welfare and into the workforce. With regard to Medicaid, however, no such decline was anticipated. Medicaid, the entitlement to health insurance for low-income families, was retained and, as discussed below, the new welfare law included specific provisions designed to protect the Medicaid eligibility of low-income families in their transition from welfare to work.

A. *Key Medicaid Provisions Relating to Families With Children*

1. Section 1931

Although the PRA gave states unprecedented flexibility to restrict the receipt of cash assistance or welfare benefits (e.g., through time limits, sanctions or other limitations on eligibility), the legislation gave states no new authority to restrict access to Medicaid. In fact, one of the compromises that convinced the President to sign the bill was the “Medicaid Savings Clause”—the new section 1931 of the Social Security Act, which separated or “de-linked” Medicaid eligibility from the receipt of cash assistance.⁴ Section 1931 required states to replace the AFDC-Medicaid link with a new category of coverage, under which Medicaid eligibility for families with children could be no more restrictive than the AFDC standards in effect on July 16, 1996.⁵ More specifically, states must at least provide Medicaid coverage to those children

TANF block grant. *Id.* at 3. The law also combined three child care funding streams into one Child Care and Development Block Grant (CCDBG). *Id.* at 9. See Social Security Act §§ 403(a), 418, 42 U.S.C. §§ 603(a), 618 (1994 & Supp. IV 1998).

3. THE ADMINISTRATION FOR CHILDREN AND FAMILIES HOMEPAGE, U.S. DEP’T OF HEALTH & HUMAN SERVS. ADMIN. FOR CHILDREN AND FAMILIES, CHANGE IN TANF CASELOADS, at <http://www.acf.dhhs.gov/news/stats/case-fam.htm> (last modified Aug. 22, 2000). For additional statistics on Missouri’s caseload, see MO. DEP’T OF SOCIAL SERVS., STATEWIDE WELFARE REFORM ACCOMPLISHMENTS, at <http://www.dss.state.mo.us/wreform/ac0200.htm> (Feb. 2000).

4. Social Security Act § 1931, 42 U.S.C. § 1396u-1 (Supp. IV 1998).

5. *Id.* Missouri has implemented this “de-linking” provision by creating a program called Medical Assistance for Families (MAF). See DIV. OF FAMILY SERVS., MO. DEP’T OF SOCIAL SERVS., FAMILY HEALTHCARE PROGRAMS MANUAL § 0905.005.00 (1999).

and parents: (1) whose income and resources are below the state's AFDC income and resource standards, based on the standards and the rules for calculating financial eligibility in effect in the state on July 16, 1996; and (2) who meet AFDC family composition requirements as they were in effect on July 16, 1996.⁶ The underlying goal was that while the welfare law was going to require that people go to work, they should not lose their health insurance coverage. Moreover, families would no longer have to apply for welfare benefits and comply with welfare-related requirements in order to have access to health insurance through the Medicaid program.⁷

2. Option to Expand Medicaid Eligibility

In addition to de-linking Medicaid from cash assistance and imposing minimum criteria, Congress allowed states the flexibility to expand the program by implementing less restrictive income and resource methodologies than were applied in their AFDC programs.⁸ This provision meant that states could cover even more families under Medicaid than they had when eligibility was linked to the receipt of welfare benefits.

3. Sanctions

The welfare law also addressed the issue of how sanctions would apply to Medicaid. Prior to the new welfare law, states sanctioned individuals and in some cases, entire families, for failing to comply with their welfare programs' work requirements. In the PRA, Congress gave states the *option* to terminate the Medicaid of a non-complying *adult*; however, states may not sanction children or pregnant women based on a parent's failure to comply with a work requirement under the new welfare law.⁹ Most states, including Missouri, have

6. Based on the state plan in effect on July 16, 1996, the individual must meet the AFDC definition of a dependent child (i.e. meets AFDC age requirements, is a needy child, is living with one of the specified relatives and is deprived of parental support or care due to the death, absence, incapacity or unemployment of a parent); must be a relative of and living with dependent child; or must be pregnant and expects to give birth in the month or the following three months, and the child, when born, would qualify as an AFDC dependent child. 42 U.S.C. § 1396u-1(b)(1) (Supp. IV 1998).

7. Congress had already begun the process of making Medicaid available to several poverty-related categories of children and pregnant women without requiring them to receive cash assistance benefits. *See infra* text accompanying note 34.

8. Under the PRA a state may do the following: (1) lower its income standards, but not below the income standards applicable under its AFDC state plan on May 1, 1988; (2) increase its income or resource standards over a period by a percentage that does not exceed the percentage increase in the consumer price index for all urban consumers; (3) use income and resource methodologies that are less restrictive than those used under the plan as of July 16, 1996. *See* 42 U.S.C. § 1396u-1(b)(2) (Supp. IV 1998).

9. Social Security Act § 1931(b)(3), 42 U.S.C. § 1396u-1(b)(3) (Supp. IV 1998); LIZ SCHOTT & CINDY MANN, CTR. ON BUDGET AND POLICY PRIORITIES, ASSURING THAT ELIGIBLE

chosen *not* to terminate the Medicaid of an adult who does not comply with a TANF work requirement.¹⁰

4. Time Limits

The federal welfare law imposed a five-year lifetime limit on receipt of TANF-funded cash assistance benefits. Because Medicaid and cash assistance are “de-linked,” the time limits that apply to TANF do not apply to Medicaid and therefore should not have any impact on the receipt of Medicaid coverage. However, these time limits and the new “de-linking” requirements have important ramifications for how families access Medicaid coverage.

Prior to the enactment of the PRA, families were categorically eligible for Medicaid if they were eligible for AFDC. This meant that if a family wanted Medicaid, it usually applied for and received an AFDC cash grant as well. The Medicaid de-linking provision, however, made it possible for a family to receive Medicaid coverage *without* receiving any cash assistance. This is especially important because TANF cash grants are time limited but Medicaid is not. If a family’s primary need is a Medicaid card, rather than TANF benefits (for example, when the family would only be eligible for a small amount of cash assistance), then it can now receive Medicaid without even applying for cash assistance. Thus, a family does not have to run time on its five-year TANF time clock while receiving a small amount of cash assistance when the family is most in need of health insurance. This important change in the way a family accesses Medicaid requires education of both the families who apply for assistance and the caseworkers who assist them, so that families

FAMILIES RECEIVE MEDICAID WHEN TANF ASSISTANCE IS DENIED OR TERMINATED 12, 13 (1998), *available at* <http://www.cbpp.org/11-5-98mcaid.htm>. Not all TANF sanctions can be carried over to Medicaid. Many states have implemented TANF requirements requiring that children are immunized (“shotfare”) or are attending school (“learnfare”). Sanctions for noncompliance with these TANF “conduct” requirements cannot be used to terminate Medicaid because the option to apply a TANF sanction is limited to violation of TANF *work* requirements. *Id.* at 12. States must terminate benefits, however, of adults who fail to cooperate in obtaining medical support without “good cause.” *Id.* at 12-13. *See also* 42 U.S.C. § 1396k (1994).

10. *See* FAMILY HEALTHCARE PROGRAMS MANUAL, *supra* note 5, § 0905.010.40. Thirteen states still sanction Medicaid of non-complying adults: Alabama, Idaho, Indiana, Kansas, Louisiana, Michigan, Mississippi, Nebraska, Nevada, New Mexico, Ohio, South Carolina and Wyoming. *See* CTR. FOR LAW AND SOCIAL POLICY & CTR. ON BUDGET AND POLICY PRIORITIES, STATE POLICY DOCUMENTATION PROJECT: STATES’ IMPLEMENTATION OF SELECTED MEDICAID PROVISIONS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996 40 (2000). When Missouri implemented the de-linking of cash assistance and Medicaid, it also restored the Medicaid coverage of sanctioned individuals. *See* Memorandum from Carmen K. Schulze, Director, Division of Family Services, Missouri Department of Social Services, to All Area and County Offices 2 (Dec. 22, 1997) (on file with the Saint Louis University Law Journal).

can take advantage of their ability to receive Medicaid without cash assistance.¹¹

5. Transitional Medical Assistance (TMA)

In addition to the protection of Medicaid coverage accorded under the welfare law, the PRA left intact an important aspect of the Medicaid program that was designed to ensure that families retain their health coverage when they go to work. The PRA retained the Transitional Medical Assistance (TMA) requirement, under which families leaving welfare for employment were eligible for at least six months, and sometimes up to one year, of transitional Medicaid coverage.¹² The welfare law, however, no longer tied TMA to the length of time a family has received cash assistance, but to having met section 1931 eligibility requirements for three months.¹³ In other words, under the welfare law TMA is no longer triggered by the loss of eligibility for *cash assistance* but by the loss of *Medicaid* eligibility under section 1931. While the trigger for TMA eligibility has changed, the rationale is still that when people leave welfare, usually to take a low-wage job, and often a job that does not provide health insurance, their Medicaid coverage should continue, at least for a transitional period.¹⁴

11. See MO. REV. STAT. § 208.070.6 (Supp. 1999) (requiring caseworkers to explain to applicants the various programs available to them and the consequences of accepting temporary assistance, including but not limited to work requirements and the lifetime limits). Applying for cash assistance may also mean that the applicant must comply with work requirements that are inapplicable to Medicaid.

12. Prior law required states to provide Medicaid to families leaving AFDC because of an increase in earnings for six additional months regardless of income and then for another six months if their earnings did not exceed 185% of the federal poverty level. Social Security Act § 1925, 42 U.S.C. § 1396r-6 (1994). The PRA, however, provides that if a family no longer qualifies for Medicaid under the pre-welfare reform criteria, eligibility for transitional Medicaid will continue provided that the family qualified for section 1931 Medicaid for at least three of the previous six months. Social Security Act § 1931(a), (b)(1)(A), (c)(2), 42 U.S.C. § 1396u-1(a), (b)(1)(A), (c)(2) (Supp. IV 1998).

13. 42 U.S.C. § 1396u-1(a), (b)(1)(A), (c)(2). HCFA interprets this provision to mean that *receiving* three months of section 1931 coverage qualifies an individual for TMA when his earnings or the lapse of earnings disqualify him from section 1931 eligibility. See HEALTH CARE FIN. ADMIN., STATE MEDICAID MANUAL: CHAPTER IV MANDATORY COVERAGE OF CATEGORICALLY NEEDY FAMILIES AND CHILDREN § 3300.1 (1997) (tying extended Medicaid benefits related to employment to "receipt of Medicaid"). Separate rules apply to those families who leave due to child support collection. See 42 U.S.C. § 1396u-1(c)(1) (Supp. IV 1998); MARK GREENBERG & STEVE SAVNER, CTR. FOR LAW AND SOCIAL POLICY, A DETAILED SUMMARY OF KEY PROVISIONS OF THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES BLOCK GRANT OF H.R. 3734: THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996 52 (1996).

14. In addition to covering families who obtain jobs, states can use section 1931 flexibility to improve the *reach* of transitional Medicaid to low-income working families. States can extend Medicaid to low-income working families who would otherwise lose section 1931 eligibility due

6. \$500 Million Fund

In the federal welfare reform law, Congress provided states \$500 million to assist them in implementing the de-linking provisions of the federal welfare law.¹⁵ The fund can be used for computer systems changes, restorations of erroneously terminated families, notice changes, outreach and education, hiring new outstationed workers, and a range of other options.¹⁶ The inclusion of these substantial resources for Medicaid de-linking related activities demonstrates the importance that Congress attached to the Medicaid protections included in welfare reform.¹⁷

7. Automatic Redeterminations of Medicaid Eligibility

The welfare law left in place another Medicaid provision that is especially important in light of the welfare-related declines in Medicaid coverage—the requirement that states are not allowed to automatically terminate eligibility for Medicaid whenever a client loses his or her current basis of Medicaid eligibility. Rather, states are required to affirmatively explore and exhaust all

to earnings before they receive the necessary three months of section 1931 coverage (and thus not qualify for TMA) by disregarding income and resources for three months to ensure that individuals receive the minimum three months of coverage required to trigger TMA eligibility. In this way, states can give more families the opportunity to qualify for up to twelve months of transitional Medicaid. See HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH AND HUMAN SERVS., SUPPORTING FAMILIES IN TRANSITION: A GUIDE TO EXPANDING HEALTH COVERAGE IN THE POST-WELFARE REFORM WORLD 17 (n.d.). This option becomes especially important in states that aggressively divert potential cash and Medicaid applicants immediately into jobs.

15. Social Security Act § 1931(h)(3), 42 U.S.C. § 1396u-1(h)(3) (Supp. IV 1998).

16. See generally DONNA COHEN ROSS & JOCELYN GUYER, CTR. ON BUDGET AND POLICY PRIORITIES, CONGRESS LIFTS THE SUNSET ON THE "\$500 MILLION FUND" EXTENDS OPPORTUNITIES FOR STATES TO ENSURE PARENTS AND CHILDREN DO NOT LOSE HEALTH COVERAGE (1999), <http://www.cbpp.org/12-1-99wel.htm>. Initially Congress time-limited the funding and gave states three years from the date of the implementation of the state TANF plan to spend their allocation. As of June 30, 1999, however, only \$49.7 million had been spent. In response to the serious decline in Medicaid enrollment, Congress realized the crucial need for the fund and lifted the time limit. *Id.* at 1.

17. Each state gets a share of the \$500 million fund. JULIE DARNEL ET AL., THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID AND WELFARE REFORM: STATES' USE OF THE \$500 MILLION FEDERAL FUND 2, 12 (1999), available at <http://www.kff.org>. Depending on the type of administrative activity in which the state wishes to engage, the \$500 million fund will match at a rate of seventy-five percent or ninety percent. *Id.* Activities which are reimbursed at seventy-five percent federal match are eligibility systems changes, new eligibility forms, identifying "at-risk" populations, hiring new Medicaid eligibility workers, making changes in state or local government organizations and inter-government changes. Activities reimbursed at the ninety percent match rate are new publications, training, outreach, outstationed eligibility workers, community activities, public service announcements and education. *Id.*

possible avenues of Medicaid eligibility.¹⁸ If an individual becomes ineligible for the category of benefits that previously made the client eligible for Medicaid, then the state agency should look to see if the client is eligible based on another category of Medicaid coverage.¹⁹ This means, for example, that if a family loses eligibility for section 1931 Medicaid based on earnings, the states should explore the family's continued eligibility for TMA and any other applicable forms of Medicaid coverage.

In addition, federal law and regulations, as interpreted in case law over the years, require that states conduct an *ex parte* redetermination of eligibility before terminating coverage.²⁰ The Health Care Financing Administration (HCFA) summarizes these requirements as follows: "When an individual is about to lose Medicaid because of the loss of eligibility for cash assistance . . . the State is required to make an *ex parte* redetermination of the individual's Medicaid eligibility under any other eligibility group."²¹

An *ex parte* redetermination is a redetermination of eligibility "made by one party, the State, without the involvement of any other party such as the recipient." An "ex parte redetermination is based to the maximum extent possible on information contained in the individual's Medicaid file including information available through SDX or BENDEX that the State believes is accurate."²² HCFA has recently stated that the state must use information from its own sources such as food stamp or child care files wherever possible, rather than requiring unnecessary action by the recipient.²³ Thus, many individuals

18. Letter from Timothy M. Westmoreland, Director, Center for Medicaid and State Operations, to State Medicaid Directors 6 (Apr. 7, 2000) (on file with the Saint Louis University Law Journal).

19. See 42 C.F.R. § 435.916(c) (1999) (requiring the agency to "promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility"); 42 C.F.R. § 435.930 (1999) (requiring states to continue to furnish Medicaid regularly to all available individuals until they are found to be ineligible). See also Social Security Act § 1902(a)(19), 42 U.S.C. § 1396a(a)(19) (1994) (requiring the state to ensure that care and services are provided "in a manner consistent with simplicity of administration and the best interests of the recipients"); Social Security Act § 1925(a)(3)(C), 42 U.S.C. § 1396r-6(a)(3)(C) (1994) (requiring automatic redeterminations of eligibility for children in certain transitional Medicaid situations).

20. See *Crippen v. Kheder*, 741 F.2d 102 (6th Cir. 1984), *rev'g* *Crippen v. Dempsey*, 549 F. Supp. 643 (W.D. Mich. 1982) (SSI); *Mass. Ass'n of Older Ams. v. Sharp*, 700 F.2d 749 (1st Cir. 1983) (deeming of step-parent income leading to loss of AFDC); *Mass. Ass'n of Older Ams. v. Comm'r of Pub. Welfare*, 803 F.2d 35 (1st Cir. 1986) (upholding lower court finding that Massachusetts was in contempt for failure to comply with orders issued pursuant to the earlier MAOA court decision) (AFDC and SSI); *Stenson v. Blum*, 476 F. Supp. 1331 (S.D.N.Y. 1979), *aff'd mem.*, 628 F.2d 1345 (2d Cir. 1980), *cert. denied*, 449 U.S. 885 (1980) (SSI).

21. See Letter from Judith D. Moore, Acting Director, Medicaid Bureau, to State Medicaid Directors 1 (Apr. 22, 1997), at <http://www.hcfa.gov/medicaid/wrd1422.htm>.

22. *Id.*

23. See *id.*; Westmoreland, *supra* note 18, at 5-6.

leaving welfare for work should be able to remain eligible for Medicaid coverage without having to engage in additional contacts with the welfare office regarding their Medicaid case. During the redetermination process, Medicaid coverage must continue until the recipient is found ineligible.²⁴

These requirements should ensure continued health coverage for individuals who continue to meet *any* Medicaid eligibility requirement, even if the circumstances on which their eligibility was originally based have changed. These redetermination rules are an important protection against improper terminations of health coverage.

8. Retention of Other Legal Protections

In addition to retaining the Medicaid entitlement, Congress left intact other important legal protections designed to ensure access to the Medicaid program. These protections include the right to apply for benefits and the requirement that states process Medicaid applications within forty-five days (ninety days if a disability is involved), protections that no longer apply to cash assistance.²⁵ The retention of the Medicaid entitlement also meant that other important protections relating to notice and fair hearings for improper denials and terminations remained unaffected by welfare reform.²⁶ These provisions provide critical legal protection against improper denials and terminations of Medicaid.²⁷

24. 42 C.F.R. § 435.930(b) (1999). Considering all bases of Medicaid eligibility also includes consideration of eligibility for section 1115 waiver expansion programs. Although in some states these types of medical coverage are seen as separate from Medicaid and may have a separate application process, if they are funded with any federal Medicaid money, they must be considered before Medicaid is terminated. *See* LIZ SCHOTT, CTR. ON BUDGET AND POLICY PRIORITIES, ISSUES FOR CONSIDERATION AS STATES REINSTATE FAMILIES THAT WERE IMPROPERLY TERMINATED FROM MEDICAID UNDER WELFARE REFORM 11 (2000).

25. *See* 42 C.F.R. § 435.906; 42 C.F.R. § 435.911(a)(2) (1999).

26. *See, e.g.*, 42 C.F.R. § 431.206(c)(2) (1999) (regarding notice of the availability of hearings to challenge disputed decisions at the time of any action affecting a claim); 42 C.F.R. § 431.210 (regarding the required content of such notices); 42 C.F.R. § 431.211 (regarding states' general obligation to mail a notice at least ten days before the date of action, subject to certain limited exceptions); 42 C.F.R. § 431.220-250 (regarding the right to a fair hearing relating to denials and termination of Medicaid benefits).

27. In addition, the law left in place other important legal requirements of the Medicaid program, including the requirements that states establish eligibility standards for a given Medicaid group that are the same for all members of that group, and that states apply their eligibility policies in all subdivisions of the state. *See* Social Security Act § 1902(a)(1), (17), 42 U.S.C. § 1396a(a)(1), (17) (1994). Thus, the eligibility rules must be the same for all Medicaid applicants within the section 1931 group and for all recipients within the section 1931 group, and a states' section 1931 eligibility policies must be the same throughout the state. *See* SUPPORTING FAMILIES IN TRANSITION, *supra* note 14, at 31.

The law preserved other important protections relating to the receipt of Medicaid *services*, such as the requirement that states provide comparable services to all recipients within a

B. Expanding Medicaid through the State Children's Health Insurance Program

Subsequent to the passage of the PRA, Congress enacted, as a part of the Balanced Budget Act of 1997, the state Children's Health Insurance Program (CHIP), which gave states money to expand health coverage to a broader group of low-income children than had previously been covered by Medicaid.²⁸ The CHIP program built upon previous expansions of Medicaid coverage to various poverty-related categories of children and pregnant women in the late 1980s.²⁹ States are allotted this money to expand Medicaid eligibility, establish a separate state program or combine these two approaches. Missouri and many other states have greatly expanded Medicaid eligibility as a result of the CHIP program.³⁰ Missouri expanded coverage to children up to 300% of the federal poverty level.³¹

given eligibility group, the prohibition on arbitrary denial of services based on diagnosis, type of illness, or condition, and the requirement that states provide services in sufficient amount, duration, and scope to reasonably achieve their purpose. *See* 42 U.S.C. § 1396a(a)(10)(B) (1994); 42 C.F.R. § 440.230(b) (1999); 42 C.F.R. § 440.230(c) (1999); 42 C.F.R. § 440.240 (1999).

28. The Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 552-70 (1997) (codified at 42 U.S.C. § 1397aa (Supp. IV 1998)). The state Children's Health Insurance Program is also often referred to as SCHIP but is referred to as CHIP throughout this paper.

29. *See infra* note 34 and accompanying text.

30. Missouri's Senate Bill 632 expanded coverage to children up to 300% of the federal poverty level. MO. REV. STAT. §§ 208.631-208.660 (Supp. 1999). These children were eligible for different levels of coverage based on their family income level. For example, children in families with incomes over 225% of the poverty level had to pay certain premiums and copayments that were not applicable to the lower income groups. *See* FAMILY HEALTHCARE PROGRAMS MANUAL, *supra* note 5, at § 0920.000.00.

31. Through a Medicaid waiver under section 1115 of the Social Security Act, Missouri expanded coverage to several groups of previously uninsured adults, including the following groups of individuals:

- (1) Extended Transitional Medical Assistance (ETMA)—This program covers uninsured adults after the completion of the first twelve months of TMA who are employed, with an eligible child in the home. ETMA covers individuals up to 300% of the federal poverty level. *See id.* § 0910.055.00.
- (2) Extended Women's Health Services—Missouri began providing two years of coverage for women's health services to uninsured women losing their MC+ for Pregnant Women (MPW) coverage, sixty days after their pregnancy ends. To be eligible the woman's MPW coverage must have ended on or after January 31, 1999. There is no income limit. *See id.* § 0925.010.00.
- (3) Custodial Parent (CP)—CP covers uninsured parents with eligible children in the home who are age nineteen or older and cooperating in the pursuit of medical support for their children. CP insures individuals up to 100% of the FPL. *See id.* § 0920.025.00.
- (4) Noncustodial Parent (NCP)— This program covers uninsured noncustodial parents who are current in paying child support at or above their legally

In light of the policies designed to protect Medicaid as part of welfare reform, the retention of a broad range of statutory and regulatory protections, the very broad expansion of health care coverage through the CHIP program, prior Medicaid expansions for children and states' ability to expand coverage under section 1931 of the welfare law, one would have expected a large increase in the numbers of families receiving Medicaid coverage and certainly not a decline in coverage, especially among children.³² As the next section indicates, however, Medicaid enrollment *has* declined, in spite of all of these factors.

III. THE LOSS OF MEDICAID AS A RESULT OF WELFARE REFORM

A. Increase in Enrollment Prior to the New Welfare Law

In the late 1980s, Medicaid enrollment grew substantially; from 1990 to 1995, Medicaid enrollment increased 7.6% per year.³³ This expansion was the result of a variety of factors, including Medicaid eligibility expansions in the late 1980s and demonstration waivers. From 1984 to 1990, the federal government created new poverty-related categories of coverage for pregnant women, children and infants, which contributed to Medicaid spending increases in the early 1990s.³⁴ In addition, a few states opened eligibility for low-income working families through section 1115 waiver demonstrations.³⁵ These expansions, combined with the weakened economy of the early 1990s, perpetuated the steady enrollment growth in the Medicaid program.

obligated amounts. The income limit for NCP is 125% of the Federal Poverty Level. *See id.* § 0935.010.00.

- (5) MC+ for Parents' Fair Share Participants (PFS)—PFS covers uninsured noncustodial parents participating in Missouri's "Parents' Fair Share" program. There are no income or resource requirements for the program. *See id.* § 0940.010.00.

32. For a discussion of early findings regarding states' difficulties in implementing the Medicaid provisions of the welfare law, see Claudia Schlosberg & Joel Ferber, *Access to Medicaid Since the Personal Responsibility and Work Opportunity Reconciliation Act*, 31 CLEARINGHOUSE REV. 528 (1998).

33. *See* LEIGHTON KU & BRIAN BRUEN, THE URBAN INST., THE CONTINUING DECLINE IN MEDICAID COVERAGE 1 (1999), available at <http://www.urban.org>.

34. *See id.* Prior to the enactment of the PRA in 1996, Medicaid had experienced a consistent and substantial growth yearly. "Between 1990 and 1995, the number of children receiving Medicaid, but not cash assistance, increased by 17.6% annually on average." Sara Rosenbaum & Kathleen A. Maloy, *The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act and Its Impact on Medicaid for Families with Children*, 60 OHIO ST. L.J. 1443, 1450 n.40 (1999).

35. However, section 1115 carried with it certain budget constraints, making it a less feasible option than the new section 1931. *See* MARILYN ELLWOOD, THE URBAN INST., THE MEDICAID ELIGIBILITY MAZE: COVERAGE EXPANDS, BUT ENROLLMENT PROBLEMS PERSIST 9 (1999), available at <http://www.urban.org>.

B. The Decline in Medicaid Enrollment Since Welfare Reform

In spite of the welfare law’s Medicaid protections and the recent children’s health expansion, the nation has experienced an unexpected *decline* in Medicaid enrollment following the enactment of the PRA.³⁶ Since 1995, Medicaid enrollment has consistently decreased.³⁷ According to a General Accounting Office (GAO) study, the nation experienced a 7.4% decline in the adult and child portion of Medicaid enrollment (non-elderly and nondisabled children) from 1995 to 1997.³⁸

Relying on data from HCFA, the Urban Institute found 10.6% and 2.7% decreases in Medicaid enrollment for adults and children respectively, as seen in Table 1. Medicaid growth in non-cash categories did not offset the decline in Medicaid coverage for individuals receiving both Medicaid and cash assistance.³⁹

TABLE I
PERCENTAGE CHANGE IN MEDICAID ENROLLMENT FOR ADULTS AND CHILDREN 1995-97⁴⁰

	PERCENT CHANGE		
	1995 – 1996	1996 - 1997	1995 - 1997
ADULTS	-3.7	-7.2	-10.6
Cash	-8.6	-17.1	-24.2
Non-cash	2.6	3.9	6.6
CHILDREN	-1.7	-1.0	-2.7
Cash	-6.8	-14.6	-20.4
Non-cash	3.9	12.2	16.5

36. KU & BRUEN, *supra* note 33, at 1-2.

37. Medicaid enrollment dropped to 41.3 million people in 1996 from 41.6 million in 1995, and to 40.3 million in 1997, a 2.7% decline in two years. *Id.* at 2.

38. U.S. GEN. ACCOUNTING OFFICE, MEDICAID ENROLLMENT: AMID DECLINES, STATES EFFORTS TO ENSURE COVERAGE AFTER WELFARE REFORM VARY app. II, at 44 (1999).

39. Individual states have experienced great variability in enrollment decline. For example, Wisconsin experienced a nineteen percent decline, Ohio decreased by nearly sixteen percent and ten other states had a decline of more than ten percent. *Id.* Twenty states had a decline of between three percent and ten percent. *Id.* Six states had a decline of two percent or less while only four states had increases of five percent or more. *Id.* at 44-45. A recent five-state study by Mathematica Policy Research, Inc., found significant Medicaid enrollment decline in three states. *See* ELLWOOD, *supra* note 35, at 2. From 1995 to 1998, Medicaid declined by twelve percent in California, eighteen percent in Florida and twenty-nine percent in Wisconsin. *Id.* This decline occurred at the same time that these states were *expanding* eligibility and while the number of uninsured persons was rising.

40. *See* KU & BRUEN, *supra* note 33.

1. Enrollment Decline Not Replaced by Employer-Based Coverage

This Medicaid enrollment decline is not being replaced by employer-based health coverage. As families begin to transition to work, they are often finding low-wage jobs that are less likely to offer health benefits. An Urban Institute report found that only twenty-three percent of adults and twenty-seven percent of children have private employer-based health insurance after leaving welfare.⁴¹ At the same time, the number of uninsured Americans increased by 2.5 million from 1996 to 1998.⁴²

2. Decline in Child Participation in Spite of CHIP

Given states' opportunities to expand coverage under section 1931 and CHIP one would have anticipated an increase in Medicaid enrollment for children, however, several studies have shown an aggregate *decrease* in child health coverage.⁴³ A twelve-state study by Families USA found that *fewer* children were covered under the CHIP *and* Medicaid programs in 1999 than were covered by Medicaid alone in 1996.⁴⁴

3. Dramatic Decline in Adult Participation

Because there has been no systematic effort to expand Medicaid to adults comparable to the expansions for children under CHIP, low-income parents have been hardest hit by the effects of welfare reform. A fifteen-state study by Families USA revealed that in the last four years, adult Medicaid enrollment has dropped twenty-seven percent in the fifteen states with the most uninsured adults.⁴⁵

41. BOWEN GARRETT & JOHN HOLAHAN, THE URBAN INST., WELFARE LEAVERS, MEDICAID COVERAGE, AND PRIVATE HEALTH INSURANCE 2 tbl.1 (2000), available at <http://www.urban.org>. See also Bowen Garrett & John Holahan, *Health Insurance Coverage After Welfare*, HEALTH AFF., Jan. 2000, at 175, 178.

42. See CATHERINE HOFFMAN & ALAN SCHLOBOHM, THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, UNINSURED IN AMERICA: A CHART BOOK § 1, at 3 (2000), available at <http://www.kff.org/content/archive/1407>.

43. Between 1996 and 1998, the number of low-income children enrolled in Medicaid declined by fourteen percent, from 9.2 million in 1996 to 7.9 million in 1998. See ROSS & GUYER, *supra* note 16, at 1. This figure reflects only the beginning of CHIP implementation by the states.

44. The report found that Medicaid coverage alone dropped 8.9%, but more significantly, Medicaid and CHIP participation combined fell two percent. See FAMILIES USA, ONE STEP FORWARD, ONE STEP BACK: CHILDREN'S HEALTH COVERAGE AFTER CHIP AND WELFARE REFORM 2 (1999).

45. See FAMILIES USA, GO DIRECTLY TO WORK, DO NOT COLLECT HEALTH INSURANCE: LOW-INCOME PARENTS LOSE MEDICAID 5 (2000). The three states with the greatest percentage declines in parents enrolled in Medicaid during the four-year period from January 1996 to

C. *Research on the Impact of Welfare Reform on Medicaid*

In addition to studies that measure the overall decline in Medicaid participation among children and adults, researchers have attempted to measure specifically the impact of welfare reform on access to Medicaid. At least two studies have tried to isolate the extent to which the decline is the result of welfare reform, while a number of other studies examine the receipt of Medicaid coverage by individuals leaving TANF. These studies confirm the negative impact of welfare reform on access to Medicaid coverage.

1. *Studies Measuring the Extent of the Medicaid Decline Caused by Welfare Reform*

A study conducted for Families USA by Lewin Associates in the spring of 1999 found that changes in welfare policy between 1994 and 1997 caused 1.25 million people to lose Medicaid, sixty-five percent of whom were children. More than half of the 1.25 million children and adults who would have been enrolled in Medicaid absent welfare reform were instead uninsured in 1997.⁴⁶ The report also found that: (1) poor people are more likely than those just above the poverty line to become uninsured as a result of welfare reform; (2) minority children are more likely to go uninsured than white children as a result of welfare reform; and (3) the number of people becoming uninsured as a result of welfare reform is likely to increase considerably in the future.⁴⁷

An Urban Institute report considered the extent to which the decline in Medicaid caseloads in recent years could be explained by welfare reform policies rather than the strong economy and other factors. It concluded that the decline in Medicaid caseloads between 1995 and 1996 could be attributed in roughly equal measure to state welfare policies and to macroeconomic factors, such as lower unemployment rates and higher earnings.⁴⁸

December 1999 were: Georgia (-50%), Texas (-46%) and Ohio (-42%). *Id.* at 3, 5. Among the other significant findings were that: (1) over half (51%) of low-income adults in Texas are uninsured; California has nearly 3 million (2,822,000) uninsured low-income adults; and over the four-year period studied, New York's low-income adult Medicaid enrollment decreased by over 100,000 persons. *See id.* at 3.

46. FAMILIES USA, LOSING HEALTH INSURANCE: THE UNINTENDED CONSEQUENCES OF WELFARE REFORM 2 (1999). The report estimated that 675,000 low-income people became uninsured in 1997, sixty-two percent of whom were children. *Id.*

47. *Id.* at 2-3.

48. JOCELYN GUYER, CTR. ON BUDGET AND POLICY PRIORITIES, HEALTH CARE AFTER WELFARE: AN UPDATE OF FINDINGS FROM STATE-LEVEL LEAVER STUDIES 40 (2000) (citing LEIGHTON KU & BOWEN GARRETT, THE URBAN INSTITUTE, HOW WELFARE REFORM AND ECONOMIC FACTORS AFFECTED MEDICAID PARTICIPATION: 1984-1996 (2000)).

2. TANF Leaver Studies

A number of studies attempt to track what has happened to families who have left welfare. These “TANF leavers” studies have found a significant loss of Medicaid coverage among “TANF leavers.”⁴⁹

A national study by the Urban Institute examined the impact of welfare reform on the thirteen hundred families that left welfare at some point between 1995 and 1997.⁵⁰ The report found that half of the children in these families lost their Medicaid coverage. The study also found that these children had only limited access to coverage through their parents’ employers. As a result, a quarter of the children in families that left welfare ended up uninsured. An even larger share of parents who left welfare between 1995 and 1997 lost Medicaid and ended up uninsured—sixty-four percent lost Medicaid and forty-one percent became uninsured.⁵¹

State leavers studies generally show that a majority of those who leave welfare obtain employment with low earnings, and that most of those jobs do not provide health insurance.⁵² Moreover, many of the adults and children leaving TANF are not receiving Medicaid and have no other access to health insurance, private or government.⁵³

Figure 1 summarizes the key findings of a recent review of state TANF leavers studies. Typically, roughly one-half of parents in families that have left welfare and more than one-third of those children lose Medicaid, while most do not have employment-based health care coverage.⁵⁴ Figure 2 highlights findings from Missouri’s leavers study, showing numbers that are

49. Leavers studies track only those families who were on welfare previously rather than eligible individuals who have never received welfare or Medicaid benefits for whatever reason. As discussed below, leavers studies do not measure the Medicaid impact of state efforts to divert people from applying for cash welfare benefits. State leavers studies are also not useful for comparing different states’ performance because of the different methodologies employed in the various studies. *See id.* at 9 (regarding the practical shortcomings of these state-level studies).

50. Garrett & Holahan, *Health Insurance Coverage After Welfare*, *supra* note 41, at 175, 178; GUYER, *supra* note 48, at 38-39.

51. Although most former welfare recipients had a job (fifty-six percent), the study found that only one-third of these workers had private employer coverage. With only a minority maintaining Medicaid, more than one in three mothers (thirty-four percent) and nearly one in four children (twenty-four percent) in working families that had left welfare joined the ranks of the uninsured. GUYER, *supra* note 48, at 39.

52. *See generally id.*; MARK GREENBERG, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, PARTICIPATION IN WELFARE AND MEDICAID ENROLLMENT 1 (1998), available at <http://www.kff.org>.

53. *See generally id.*

54. *See id.* at 5. Guyer found that in most states, roughly one in six children and parents who have left welfare are likely to be enrolled in private coverage. *See* GUYER, *supra* note 48, at 21. An earlier review of state leavers studies found that typically among families who *are employed*, only twenty-five percent or less report employment-based health care coverage. *See* GREENBERG, *supra* note 52, at 5.

even worse than the general trends. In Missouri, less than twenty percent of adults and fewer than forty percent of children who left welfare in 1997 were receiving medical assistance one year later.⁵⁵

Figure 1: Major Findings from Recent Review of State TANF Leavers Studies

- The majority of children—and most likely the overwhelming majority—in families leaving welfare remain eligible for Medicaid or CHIP, as do most of their parents.
- In most states, roughly half of parents in families that have left welfare and more than one-third of children in those families lose Medicaid.
- Families that lose Medicaid when they leave welfare are at high risk of becoming uninsured because they have limited access to private coverage.
- Families are more likely to have unmet medical needs after leaving welfare.
- A significant minority of families is not aware that medical benefits may continue after a loss of welfare.

Figure 2: Missouri Medicaid Enrollment for People Leaving Welfare in 1997

- Nineteen percent of adults received Medicaid one year later.
- Thirty-eight percent of children received Medicaid one year later.

D. Implications of the Research

The overwhelming evidence from all of these studies is that the numbers of uninsured are rising and that people are losing Medicaid when they lose their cash assistance. In spite of the legal protections designed to protect Medicaid and well-publicized expansions of the Medicaid program, Medicaid coverage and access to health insurance is continually declining. The Medicaid provisions of the welfare law have not succeeded in ensuring that health coverage is preserved when families leave the welfare rolls. The next section examines the reasons for these trends.

55. See SHARON RYAN ET AL., UNIV. OF MO., DEP'T OF ECON., EVALUATIONS OF OUTCOMES FOR THE AFDC/TANF AND FUTURES POPULATIONS: 1993-1998, PART III 46 tbl.II.13 (1998); GUYER, *supra* note 48, at 16 tbl.2.

IV. REASONS FOR THE UNINTENDED LOSS OF HEALTH COVERAGE

A. *State Practices that Contribute to the Loss of Medicaid*

As discussed earlier, the federal welfare law's focus clearly was to move people off of welfare and into the workforce. The law, along with political factors, created significant pressures on states to adopt policies that would reduce their welfare caseloads, which has had a direct impact on the types of policies that states have adopted in implementing welfare reform. In addition to time limiting receipt of cash assistance for families, the PRA imposed strict work participation rates on states. The failure to meet these rates triggers financial penalties.⁵⁶ In addition, the PRA rewards states that reduce their caseloads with caseload reduction credits that reduce the work participation rates that states must meet.⁵⁷ The welfare law's time limits, work participation requirements, caseload reduction credits and overall message encouraged states to adopt various approaches to decrease welfare rolls. These state strategies have had the unintended consequence of reducing Medicaid participation as well. The effort to move welfare recipients into the workforce quickly and the many other program changes that resulted from the federal law also created additional responsibilities for welfare caseworkers who ultimately are responsible for implementing the de-linking of Medicaid and cash assistance.⁵⁸ This section discusses the various types of practices that are contributing to improper denials and terminations of Medicaid coverage to families moving from welfare to work.

1. Front-end Practices Contributing to the Medicaid Decline

Many states have adopted a variety of "front-end" strategies that are designed to move low-income families into work and divert them from receiving cash assistance benefits. These are called "front-end" approaches because they occur at the point at which recipients seek to apply for TANF cash assistance rather than when they leave TANF due to employment or some other reason. A recent study examines the relationship between these types of policies (and others) on health coverage.⁵⁹ Researchers concluded that declines in health coverage are associated with policies that deter access to

56. See 42 U.S.C. § 607 (1994 & Supp. IV 1998); 42 U.S.C. § 609(a)(3) (Supp. IV 1998).

57. 42 U.S.C. § 607(b)(3) (Supp. IV 1998).

58. For example, caseworkers were responsible for applying the PRA's significant changes in the food stamp program and the new welfare-to-work policies that most states implemented in response to the PRA.

59. Wendy Chavkin et al., *State Welfare Reform Policies and Declines in Health Insurance*, 90 AM. J. PUB. HEALTH 900 (2000).

TANF benefits.⁶⁰ Figure 3 describes some of the study's major findings regarding these "front-end" practices.⁶¹

Figure 3: Major Findings Regarding Impact of TANF Diversion on Medicaid Decline

- Policies requiring applicants to seek alternative resources before obtaining TANF are predictive of increases in uninsured for the total population and for children.
- In states that deterred enrollment by offering lump-sum cash payments to would-be applicants, the decrease in TANF enrollment was 38.8% compared to 31.5% in states without it.
- The decline in adult Medicaid enrollment was nearly five percent greater in states with a lump-sum deterrent than in states without that policy.
- Policies requiring a job search prior to TANF enrollment are predictive of declines in both TANF and Medicaid. In states that adopted a mandatory job-search policy for TANF enrollment, TANF caseloads were reduced by forty-two percent compared to a reduction of thirty percent for states without the policy.
- Medicaid enrollment for all TANF recipients fell by eighteen percent in states with a pre-enrollment job search policy compared to a reduction of eleven percent for those without it.

a. Diversion Grants

In an effort to prevent families from applying for TANF, many states now offer "diversion grants," which are one-time payments to cover an unexpected expense, such as car repairs. At least twenty-three states have implemented such diversion programs.⁶² In the course of attempting to apply for benefits,

60. The authors analyzed the impact of such deterrent policies as: (1) providing lump sum payments instead of TANF enrollment; (2) mandating applicants make an alternative resource search prior to enrollment; and (3) requiring a mandatory job search prior to enrollment. *Id.*

61. Of the nine states that have implemented at least two of these strategies, six of them already had uninsured rates in the top third of all states in 1996. *Id.* at 906. An extreme version of these "front-end" practices occurred in New York City, leading to class action litigation. *See generally* Reynolds v. Giuliani, 35 F. Supp. 2d 331 (S.D.N.Y. 1999). *See also* discussion of Reynolds, *infra* notes 67-69.

62. *See* STATE POLICY DOCUMENTATION PROJECT, *supra* note 10. The states with diversion programs are Alaska, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Iowa, Kentucky, Maine, Maryland, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, South Dakota, Texas, Utah, Virginia, Washington and West Virginia. Although the policies differ from state to state, the basic idea is that the social services office provides recipients with a one-time payment (e.g., for three months) in lieu of TANF benefits, thereby diverting the family

families may be informed about a new diversion alternative and steered away from applying for TANF cash assistance. Unfortunately, during the diversion from cash assistance, families may be diverted from applying for Medicaid as well.

In addition to the problem of states diverting families from applying for Medicaid, the diversion grant may actually increase families' income for the month to a point at which they are no longer even eligible for Medicaid. Many states have recognized the practical implications of counting the diversion grant as income when assessing Medicaid eligibility.⁶³ As a result, some states have chosen to disregard the grant, while others (e.g., Minnesota) have chosen to prorate the grant as income in the first month and as an asset in the following month, thus preserving Medicaid eligibility for the family.⁶⁴

b. Up-Front Job Search

Another example of front-end diversion is mandatory job search. Immediate job search creates two potential problems. When states require applicants to meet certain TANF obligations before they can even submit an application, such as attending an orientation session or participating in job search, the TANF application may never be submitted or a joint application for TANF and Medicaid may be submitted, but the state will not process it until the TANF requirements are fulfilled.⁶⁵ The second potential problem, with regard to health coverage, is that the applicant may obtain a job immediately

from receiving cash assistance, and allowing the state to avoid counting the family as part of their welfare caseloads. In exchange, the family agrees to forego welfare benefits for a specified period of time.

63. For a discussion of steps that states with diversion programs can take to ensure that low-income families receive Medicaid, see CINDY MANN, *CTR. ON BUDGET AND POLICY PRIORITIES, THE INS AND OUTS OF DE-LINKING: PROMOTING MEDICAID ENROLLMENT OF CHILDREN WHO ARE MOVING IN AND OUT OF THE TANF SYSTEM* 10 (1999).

64. See Rosenbaum & Maloy, *supra* note 34, at 1464-65. The George Washington University study noted that while many states reported that they have adjusted their Medicaid policies to deal with these lump sum diversion payments, these adjustments were not reflected in most state Medicaid plans. *Id.*

65. A state cannot deny an application solely because a TANF requirement was not met, nor can it decline to act on the Medicaid portion of a joint TANF/Medicaid application if the application for TANF benefits is denied, withdrawn or deferred. See Social Security Act § 1902(a)(8), 42 U.S.C. § 1396a(a)(8) (1994) (requiring states to provide all individuals wishing to apply for Medicaid with an opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals); 42 C.F.R. § 435.906 (1999) (requiring state agencies to afford individuals "the opportunity to apply for Medicaid without delay"); 42 C.F.R. § 435.911 (requiring a determination of Medicaid eligibility for all Medicaid applicants within specified time frames); 42 C.F.R. § 435.913 (requiring the agency to dispose of each application by a finding of eligibility or ineligibility, absent documentation that the applicant voluntarily withdrew the application, and the agency sent a notice confirming the withdrawal, or the applicant died or could not be located).

and the individual's earnings will exceed the Medicaid financial eligibility standards. Unless the state has sufficient earned income disregards in place, the new earnings may disqualify the family for Medicaid.⁶⁶

c. Families Discouraged From or Otherwise Denied the Right to Apply

More subtle forms of informal "diversion" can occur that also lead to an improper denial of coverage. Rather than accepting every application for the applicable public benefits program, caseworkers may inform potential applicants that they are ineligible and should not apply.⁶⁷ Potential applicants may also be told that applications are no longer being taken on a given day and that they should come back another day, thereby precluding the family from receiving a timely determination of eligibility or from applying altogether.⁶⁸ Denying families the right to apply for Medicaid is a violation of the legal requirements of the Medicaid program.⁶⁹

d. Failure to Process a Joint Application for Medicaid and TANF

Another practice that can lead to a loss of Medicaid at the "front-end" is states' failure to process a joint application for both TANF and Medicaid.

66. States are allowed to determine their own standards for the amount of income and assets and disregard certain amounts from specific sources. As discussed earlier, section 1931 allows states to increase the amount of income and assets that are disregarded in order to make more families eligible for Medicaid. See Social Security Act § 1931(b)(2)(C), 42 U.S.C. § 1396u-1(b)(2)(C) (Supp. IV 1998).

67. See, e.g., *Reynolds v. Giuliani*, 35 F. Supp. 2d 331, 344-45 (S.D.N.Y. 1999), where the city's "Job Centers" turned away persons seeking to apply for benefits and informed them that they were ineligible. One such Job Center turned away eighty-four percent of the individuals seeking assistance without taking an application. *Id.* at 343. See also *Southside Welfare Rights Org. v. Stangler*, 156 F.R.D. 187 (W.D. Mo. 1993) (imposing strict remedies on the defendants, the Missouri Department of Social Services, ensuring that each individual receive an application on the day that he or she contacts the local DFS office and that no individual be denied the right to apply for food stamps).

68. For example, in *Reynolds*, applicants who arrived at the city's Job Centers after certain times of the day were turned away and told to return on another day. *Reynolds*, 35 F. Supp. 2d at 345. Several courts have enjoined state social service agencies to discontinue practices of discouraging individuals from applying for benefits on their first visit. See, e.g., *id.* at 347 (Medicaid and food stamps); *Alexander v. Hill*, 625 F. Supp. 564 (W.D.N.C. 1985) (AFDC and Medicaid); *Stangler*, 156 F.R.D. at 187; *Robertson v. Jackson*, 766 F. Supp. 470 (E.D. Va. 1991); *Harley v. Lyng*, 653 F. Supp. 266 (E.D. Pa. 1986) (food stamps).

69. *Reynolds*, 35 F. Supp. 2d at 334-35. Individuals must be given the right to apply for Medicaid without delay. Social Security Act § 1902(a)(8), 42 U.S.C. § 1396a(a)(8) (1994); 42 C.F.R. § 435.906 (1999). Applications for Medicaid must be processed within ninety days in cases involving disability determinations and forty-five days in all other cases. See 42 C.F.R. § 435.911. See, e.g., *Brown v. Luna*, 735 F. Supp. 762 (M.D. Tenn. 1990); *Alexander v. Hill*, 625 F. Supp. 564 (W.D.N.C. 1982), *aff'd*, 707 F.2d 780 (4th Cir. 1983), *modified upon motion for further relief*, 625 F. Supp. 564 (W.D.N.C. 1985) (challenging state violations of Medicaid application processing requirements).

Sometimes, a state agency receiving a joint application may determine eligibility for cash assistance without making a separate determination of Medicaid eligibility. States may simply treat the denial of eligibility for TANF as a denial of Medicaid—assuming that since TANF eligibility is being rejected, they need not make a separate Medicaid eligibility determination. This practice violates Medicaid de-linking requirements and the requirement that all Medicaid applications be processed within certain time frames. (The TANF denial could be based on a failure to meet a job search or other requirement that only applies to TANF or the joint application could be delayed based on the failure to meet TANF job search requirements.) Advocates in South Carolina report that this practice has been a significant contributing factor to the failure of eligible families to obtain eligibility for health insurance.⁷⁰

2. “Back-end” Termination of Coverage

In many instances, the problem is at the “back-end,” or when people leave cash assistance. Sometimes, individuals leaving TANF also lose their Medicaid, instead of receiving transitional Medicaid or some other form of Medicaid coverage for which they qualify. This can happen in a number of ways. Families may lose coverage based on states’ improper use of procedural mechanisms to terminate eligibility or their misapplication of substantive Medicaid requirements.

a. Procedural Terminations of Medicaid

i. Failure to Complete a Joint Redetermination for TANF and Medicaid Eligibility.

A family may lose Medicaid eligibility because the state agency determines that it failed to comply with a redetermination of the family’s TANF eligibility. The caseworker or case manager may call the client for an orientation meeting related to compliance with a work requirement, enclosing a TANF reinvestigation notice. If the client fails to appear at the interview, the worker simply closes the entire case, including TANF, Medicaid and sometimes even food stamps—even though only the TANF case should have

70. See, e.g., Letter from Elizabeth Bangston Hutto, South Carolina Appleseed Legal Justice Center, to Barbara Longshore, Director of Medicaid Eligibility, South Carolina Department of Health and Human Services (Oct. 12, 1999) (on file with the Saint Louis University Law Journal); Letter from Elizabeth Hutto, Staff Attorney, South Carolina Appleseed Legal Justice Center, to Roger Poston and Bunny Jones, Deputy Director, South Carolina Department of Health and Human Services (July 19, 1999) (on file with the Saint Louis University Law Journal). Telephone interview with Elizabeth Bangston Hutto, Staff Attorney, South Carolina Appleseed Legal Justice Center (Mar. 17, 2000) (on file with author).

been affected.⁷¹ Advocates in Pennsylvania found that this is one of the most significant reasons for loss of Medicaid coverage.⁷²

ii. Failure to Meet a TANF Verification Requirement

Families may also improperly lose Medicaid when the family fails to verify its assets, which are countable in some states for TANF cash assistance but not for Medicaid, for example a car. Additionally, a recipient may report employment and then receive a letter asking for income verification. The failure to supply such verification may be a reason to terminate cash assistance but not Medicaid.⁷³ During the first six months of TMA eligibility, there is no income limit and therefore verification of the amount of earnings is not required to establish ongoing eligibility.⁷⁴

iii. Voluntary Withdrawals from the TANF Program

Another common problem is that a welfare recipient obtains a job and requests that his or her case be closed, causing the welfare office to terminate the individual's cash assistance and Medicaid. The recipient may not be aware that there is a continued right to Medicaid upon obtaining employment. Advocates in Pennsylvania found that there was an especially high number of "voluntary closings" by individuals whose Medicaid terminated upon their loss of cash assistance.⁷⁵ This has also been a significant problem in Missouri as discussed in the next section. These "voluntary" closings are clearly avoidable through client education and the incorporation of proper safeguards to ensure that recipients truly intend to give up their health coverage.

71. See, e.g., Letter from Joel Ferber, Attorney, Gateway Legal Services, to Gary Stangler, Director, Missouri Department of Social Services 4 (June 2, 1999) (on file with the Saint Louis University Law Journal) (illustrating the importance of separating TANF and Medicaid reinvestigations).

72. Overhead Presentation by Anne Torregrossa, Pennsylvania Health Law Project, TANF Medicaid Roundtable (Dec. 6, 1999). See *infra* Part III.B.2. (regarding evidence of the same problem in Missouri).

73. Pennsylvania Health Law Project, *supra* note 72. Pennsylvania advocates similarly found that failure to provide requested verification was a significant reason for lost TANF and Medicaid benefits. *Id.*

74. Social Security Act § 1925(1), 42 U.S.C. § 1396r-6(1) (1994). Further verification of earnings may help establish the recipient's continuing eligibility for section 1931 coverage, especially in states that have higher income rules for their section 1931 programs than they have for their cash assistance programs. However, in no circumstances should the lack of verification of earnings disqualify an individual for Medicaid when the state has all the information it needs to place the individual in transitional Medicaid.

75. The Pennsylvania State Medicaid agency reported that sixteen percent of TANF/Medicaid case closings reviewed by the agency were closed "voluntarily." Telephone Interview with Rich Weishaupt, Community Legal Services (July 21, 1999) (on file with author).

iv. Automatic Terminations of Medicaid by the Computer System

In some states, such as Washington, Medicaid was terminated “automatically” because the computer automatically terminated coverage when someone left cash assistance, unless there was manual intervention by the caseworker.⁷⁶ Advocates in North Carolina similarly report that “county DSS [staff] must manually override the computer to prevent the automatic termination.”⁷⁷ HCFA has acknowledged that many states’ computer systems were not updated to provide Medicaid consistent with the welfare law’s de-linking of cash assistance and Medicaid.⁷⁸ In these instances, computer problems can cause large numbers of families to lose Medicaid immediately upon the termination of their receipt of cash assistance benefits.

b. Misapplication of Substantive Medicaid Requirements

i. Expiration of a TANF Time Limit or Sanction

States may treat the termination of eligibility for TANF as a termination of Medicaid without recognizing that TANF was lost for a reason that should not affect Medicaid. One such example would be a time limit, which can occur when recipients reach their federal five-year limit in 2002, or sooner in states that have shorter time limits.⁷⁹ Because many individuals have not yet reached their time limits, the more common problem has been that states may close a family’s Medicaid when the TANF case is closed due to a sanction. The

76. See Letter from Amy L. Crewdson & Janet Varon, Columbia Legal Services, to Tom Bedell, Acting Assistant Secretary, Washington State Medical Assistance Administration 1-2 (Nov. 15, 1999) (on file with the Saint Louis University Law Journal); see also CASSIE SAUER, CHILDREN’S ALLIANCE, DEPARTMENT OF SOCIAL AND HEALTH SERVICES AGREES TO STOP IMPROPER TERMINATION OF HEALTH COVERAGE 1 (n.d.).

77. Advocates state that only a few TANF termination codes do *not* cause automatic Medicaid termination. See Letter from Douglas S. Sea, Attorney, Legal Services of Southern Piedmont, Inc., to Linda Lattimore, Health Care Financing Administration 2 (Nov. 29, 1999) (on file with the Saint Louis University Law Journal). Wisconsin advocates allege widespread computer problems affecting access to Medicaid, including a computer-caused failure to automatically redetermine Medicaid eligibility, late reviews due to an overburdened computer system, and failure to transfer recipients to transitional Medicaid upon employment. See Letter from Shirin Cabraal, Staff Attorney, Legal Action of Wisconsin, Inc., to Pamela Carson, Health Care Financing Administration 5 (Oct. 20, 1999) (on file with the Saint Louis University Law Journal); Letter from Shirin Cabraal, Staff Attorney, Legal Action of Wisconsin, Inc., to Joseph Lekan, Secretary, Wisconsin Department of Health and Family Services 7-8 (April 21, 2000) (on file with the Saint Louis University Law Journal).

78. See Westmoreland, *supra* note 18, at attach. 4.

79. According to the State Policy Documentation Project, fifteen states have shorter time limits than that imposed by federal law: Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Louisiana, Massachusetts, Nebraska, North Carolina, Ohio, Oregon and Utah. See STATE POLICY DOCUMENTATION PROJECT, *supra* note 10.

aforementioned study published in the *American Journal of Public Health* demonstrated that states with more restrictive sanctions policies experienced greater declines in Medicaid enrollment. Sanctioning an entire family's TANF grant for initial non-compliance with workfare was significantly associated with declines in Medicaid enrollment for TANF recipients.⁸⁰

ii. TANF is Terminated Due to Earnings

A caseworker may inappropriately terminate Medicaid because a family has earnings, making the family ineligible for TANF. Earnings, however, may *qualify* the family for transitional Medicaid, which is presently being denied to many families coming off cash assistance. A study in Florida found that in 1998, only nine percent of adults leaving cash assistance were receiving TMA.⁸¹ For more than three years after the welfare law was enacted, official Florida policy held that in order to be eligible for TMA, an individual must have received *cash assistance* for three out of the last six months. This legally incorrect policy was not revised until September 1999.⁸²

Whether clients lose transitional Medicaid through illegal policy or burdensome procedures, terminating Medicaid due to an increase in earnings contradicts the language and intent of the welfare law.⁸³ New earnings may be

80. Chavkin et al., *supra* note 59, at 903. The study did note, however, that certain "supportive" policies, such as a guarantee of child care for TANF recipients had a positive effect on Medicaid enrollment.

81. See Letter from Miriam Harmatz & Charles Elsesser, Florida Legal Services, Inc., to David Cade, Director, Family and Children's Health Program Group, Health Care Financing Administration 1-2 (Aug. 13, 1999) (on file with the Saint Louis University Law Journal) (citing MARILYN R. ELLWOOD & KIMBALL LEWIS, *THE URBAN INST., ON AND OFF MEDICAID: ENROLLMENT PATTERNS FOR CALIFORNIA AND FLORIDA IN 1995 (1999)*, available at <http://newfederalism.urban.org/html/occa27/html>.). Although the authors of the study used 1995 data, they found no change in policy which would indicate that the situation differed significantly in 1998. *Id.* at 2. In fact, advocates argued that the state's failure to properly implement the TMA benefit, which was a problem prior to welfare reform, has become even more critical in light of welfare reform. *Id.*

82. See Memorandum from Kim Shaver, Chief of Program Policy, Florida Department of Children and Families, to District Economic Self-Sufficiency Services Program Administrators, Program Manager, & District Adult Services Program Administrators 4 (Sept. 20, 1999) (on file with the Saint Louis University Law Journal).

83. In a recent Washington state survey, for example, fifty-eight percent of the respondents left welfare due to earnings, yet only about one-third of the respondents were receiving Medicaid coverage for the parent. See WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES, *WASHINGTON'S TANF SINGLE PARENT FAMILIES AFTER WELFARE 1, 3 (1998)*, available at <http://www.wa.gov/WORKFIRST/about/98final.pdf>. As discussed below, Missouri has had similar problems with transitional Medicaid based on the proper criteria. See *infra* Part III.B.

a reason to discontinue TANF, but they are precisely a reason to *continue* Medicaid coverage.⁸⁴

iii. Failure to Implement a De-linking Policy

Many states have terminated health coverage simply because they failed to implement a policy de-linking cash assistance from Medicaid until long after the welfare law became effective.⁸⁵ A state may not have timely implemented a written policy in regulations or policy manuals or a state may have a legally correct policy that was not timely implemented by the field staff in local welfare offices.

For example, Missouri first implemented a section 1931 Medicaid category on December 30, 1997, more than a year after the welfare law's de-linking provision became effective. The state did not incorporate the new section 1931 category in its policy manual until December 1999. As recently as fall of 1999, South Carolina had not implemented the de-linking of TANF and Medicaid, and was still sanctioning Medicaid for violations of TANF requirements.⁸⁶ Florida did not implement a de-linking policy until October 1999.⁸⁷ The failure of states to implement proper de-linking policies on a

84. As discussed earlier, the federal welfare law requires the states to provide transitional Medicaid to families who lose eligibility for section 1931 Medicaid due to increased earnings or the expiration of an earnings disregard if they were eligible for section 1931 Medicaid for at least three out of the six months prior to the termination of section 1931 Medicaid. *See supra* note 12. If new earnings do not exceed the state's section 1931 income eligibility limits, then the family can remain in section 1931 regardless of its welfare status. If new earnings are greater than section 1931 income eligibility limits, the family is eligible for transitional Medicaid which has no income limit for the first six months.

85. The failure to implement a de-linking policy is also a cause of the "front-end" denials of Medicaid described earlier because a TANF denial or diversion at the front-end can also lead to a denial of Medicaid if the two programs are still linked. This scenario is included in this section because it has been identified as a common basis for erroneous terminations of Medicaid for former welfare recipients and has been cited by HCFA as a basis for Medicaid reinstatement. *See Westmoreland, supra* note 18, at attach. 4 (providing that if a state did not implement its section 1931 category until some time after its TANF program went into effect, the State must review Medicaid/TANF terminations that occurred before the State had an operative section 1931 category and reinstate coverage for improperly terminated families).

86. Telephone Interview with Elizabeth Bangston Hutto, Staff Attorney, South Carolina Appleseed Legal Justice Center (Mar. 17, 2000) (on file with author); Letter from Elizabeth Bangston Hutto & Susan B. Berkowitz, Staff Attorney & Director, South Carolina Appleseed Legal Justice Center, to Lillian Jones, Deputy Director, South Carolina Department of Health and Human Services 3 (Aug. 11, 2000) (on file with the Saint Louis University Law Journal).

87. *See Shaver, supra* note 82, at 1. This policy memorandum also made changes such as elimination of the "100 hour" rule, elimination of verification of a shelter obligation, and clarification that it is the termination of section 1931 Medicaid that triggers receipt of transitional Medicaid, rather than termination of TANF. *Id.* at 2, 4. Advocates in Virginia also continue to report deficiencies in state policies related to the de-linking of Medicaid and cash assistance, transitional Medicaid and *ex parte* reviews. Letter from Jill A. Hanken, Staff Attorney, Virginia

timely basis is a major reason why individuals leaving welfare have also lost their Medicaid coverage.

B. Missouri Findings on Improper Medicaid Terminations Resulting from Welfare Reform

1. The Context

Advocates and state officials have sought to determine whether Missouri's experience was comparable to national trends regarding the impact of welfare reform on Medicaid decline. In March 1999, various advocacy organizations and community groups began to address their concerns that the state had not properly implemented the de-linking of cash assistance and welfare.⁸⁸ That advocacy continues as of this writing. Legal Services advocates and community organizations decided based on anecdotal evidence, that there was indeed a problem in Missouri. Those advocates and organizations sought to find whether the problem was systemic or limited to the isolated cases that had come to their attention.⁸⁹

Poverty Law Center, to Dennis Smith, Director, Virginia Department of Medical Assistance Services 1 (June 16, 2000) (on file with the Saint Louis University Law Journal).

88. These advocacy efforts included letters sent to state leaders and meetings with state Medicaid administrators. *See, e.g.*, Letter from Joel D. Ferber, Attorney, Legal Services of Eastern Missouri, Inc., to Gary Stangler, Director, Missouri Department of Social Services (Apr. 19, 2000) (on file with the Saint Louis University Law Journal); Ferber, *supra* note 71, at 4; Letter from Reform Organization of Welfare, to Mike Hash, Acting Administrator, Health Care Financing Administration (Aug. 27, 1999) (on file with the Saint Louis University Law Journal); Letter from Jeanette Oxford, Executive Director, Reform Organization of Welfare, & Joel D. Ferber, Attorney, Legal Services of Eastern Missouri, to Gary Stangler, Director, Missouri Department of Social Services (Nov. 23, 1999) (on file with the Saint Louis University Law Journal); Letter from Citizens for Missouri's Children, to Tom Lenz, Associate Regional Administrator, Division of Medicaid and State Operations (Feb. 4, 2000) (on file with the Saint Louis University Law Journal); Letter from Joel D. Ferber, Attorney, Gateway Legal Services, Inc., to Gary Stangler, Director, Missouri Department of Social Services (Mar. 1, 1999) (on file with the Saint Louis University Law Journal). In addition, favorable editorials and articles have appeared in several Missouri newspapers. *See infra* note 141 (regarding media coverage of the Medicaid de-linking issue).

89. Missouri has experienced a significant expansion of Medicaid coverage pursuant to the CHIP program and a Medicaid waiver. From July 1998 to February 2000, it experienced an overall increase in Medicaid coverage of 81,988 children (all categories), 23,803 of whom are in the traditional Medicaid categories. MO. DIVISION OF FAMILY SERVS., MC+ RECIPIENTS FROM MONTHLY MANAGEMENT REPORT 1 (n.d.) (on file with the Saint Louis University Law Journal). Nevertheless, the state has encountered serious difficulties ensuring that families continue to receive health coverage as they move from welfare to work. Evidence from a variety of sources demonstrates that Missouri has improperly terminated families from Medicaid, consistent with the national findings and findings from other states.

Advocacy groups reviewed state data to determine whether it revealed any trends that might explain the scenarios involving individual clients. An analysis of transitional Medicaid data showed that despite large drops in cash assistance, there was no corresponding increase in TMA receipt.⁹⁰ In fact, TMA receipt greatly fluctuated during a period in which there were substantial caseload declines, and in some months, there were substantial decreases in both programs. Overall, from January 1997 to December 1999, enrollment in TANF declined by more than 26,000 cases while TMA likewise dropped by 680 cases for the same time period.⁹¹ Missouri's TANF leavers study shows that the great majority of Missouri welfare recipients are obtaining employment when they leave cash assistance, and thus should qualify for transitional Medicaid.⁹² At the very least, these facts raised an inference that a problem existed in Missouri.

Advocates also reviewed whether the decrease in individuals receiving both Medicaid and cash assistance was being offset by increases in non-cash Medicaid categories. If all children leaving TANF had continued Medicaid during this period, advocates surmised that the increase in non-cash Medicaid should have more than equaled the TANF decline. Citizens for Missouri's Children reported a substantial decrease in the number of Missouri children covered by Medicaid in 1997 and 1998.⁹³ A review of state data by Legal Services similarly revealed a loss of coverage for children and adults during that same period. Legal Services' findings show that the increase in children receiving Medicaid without cash assistance from August 1, 1997 to July 31, 1998 was only sixty-nine percent of the amount by which the number of children receiving Medicaid *with* cash assistance declined.⁹⁴ Reviews of

90. See Ferber, *supra* note 71, at 6.

91. These data are compiled from Missouri's Monthly Management Reports for the months indicated. See MC+ RECIPIENTS FROM MONTHLY MANAGEMENT REPORT, *supra* note 89; see generally MO. DEP'T OF SOCIAL SERVS., MONTHLY MANAGEMENT REPORTS (Jan. 1997 – Dec. 1999) (on file with author).

92. Ryan, *supra* note 55, at 21-22. According to Missouri's TANF leavers study, the rate of employment one year after leaving welfare ranged between sixty percent and seventy percent for the different groups of leavers. *Id.*

93. See CITIZENS FOR MISSOURI'S CHILDREN, HEALTH CARE COUNTS: BARRIERS TO MC+ COVERAGE FOR ST. LOUIS CHILDREN 6-7 (1999).

94. See MC+ RECIPIENTS FROM MONTHLY MANAGEMENT REPORT, *supra* note 89. During this period, the number of children receiving Medicaid coverage in Missouri declined by 5,468. *Id.* This is consistent with national findings that the loss of health coverage for persons receiving cash assistance was not being offset entirely by increases in non-cash Medicaid coverage in the early years of welfare reform. See KU & BRUEN, *supra* note 33, at 2-3. Similar findings led to the negotiated settlement in Pennsylvania, where advocates discerned that non-cash Medicaid growth did not make up for the decline in people receiving TANF and Medicaid. Presentation of Pat Redmond, Philadelphia Citizens for Children and Youth, Welfare Reform at the Crossroads Conference (Oct. 18, 1999) (on file with the Saint Louis University Law Journal). As indicated

Missouri TANF and Medicaid case closings, discussed in the next section, more dramatically demonstrate the link between welfare reform and a loss of health coverage.

2. State Quality Assurance Reviews

Missouri State Quality Assurance Reviews provide clear and dramatic evidence of systemic and unlawful terminations of Medicaid coverage.⁹⁵

In response to the national reports and problems identified by advocates, Missouri conducted a series of Quality Assurance Reviews that looked specifically at TANF recipients who lost TANF and Medicaid. These reviews confirm the problems that advocates had noticed from their individual clients' experiences in receiving health coverage after leaving cash assistance. The bottom-line finding was:

There are still families who lose eligibility for Temporary Assistance and also lose eligibility for healthcare benefits—even though some, or all, of the household members are eligible for participation in one of the family healthcare programs.⁹⁶

These results provide a window into what may be occurring in other states experiencing Medicaid losses as a result of welfare reform.

a. Workers' Failure to Apply De-linking Policies

Figure 4 shows the key findings from a review of cases closed in February 1999. It demonstrates caseworkers' lack of familiarity with the de-linking of Medicaid and cash assistance and their practice of improperly closing Medicaid cases when families fail to respond to a request for a face-to-face interview relating to cash assistance—even though a face-to-face interview is not a requirement of the Missouri Medicaid program. The Missouri Division of Family Services noted that “[t]here are many reasons why DFS staff may not be identifying opportunities to place families in medical programs when Temporary Assistance eligibility is lost,” including confusion resulting from the “de-linking” of cash assistance and Medicaid and unfamiliarity with the new medical programs covering children, parents and pregnant women.⁹⁷

earlier, Missouri showed dramatic increases in Medicaid enrollment—in all Medicaid categories—subsequent to its implementation of CHIP and the Medicaid expansion.

95. Missouri advocates obtained copies of these results from public records requests to the state Department of Social Services.

96. See IM TRAINING AND DEVELOPING UNIT, MO. DIV. OF FAMILY SERVS., MC+ TRAINER'S GUIDE 7 (1999).

97. *Id.* at 9.

Figure 4: Key Findings from Review of Cases Closed in February 1999

- Some workers are unsure of what to do with Medical Assistance for Families (MAF) cases when Temporary Assistance eligibility ends.
 - Several Medicaid cases were closed when the family did not respond to a request for a face-to-face interview on the Temporary Assistance case.
 - The Medicaid case was closed when the Temporary Assistance grant was discontinued.
-

b. Medicaid Cases Closed in February 1999

Figure 5 demonstrates that many recipients whose TANF cases were closed (forty-five percent) had no type of Medicaid. Thus, terminated recipients are not retaining coverage through transitional Medicaid nor are they necessarily regaining coverage through the Missouri's CHIP or Medicaid expansion programs. Additionally, a high percentage (forty percent) of closings were caused by a "failure to cooperate."⁹⁸ It was not clear whether the failure to cooperate related solely to Temporary Assistance requirements or to Medicaid as well.⁹⁹

Figure 5: Results from an Analysis of all TANF Cases Closed in February 1999

- Forty-five percent had no type of Medicaid.
 - Forty percent of the closings were for failure to cooperate.
 - It was not clear whether these recipients were not cooperating with Medicaid requirements or if their failure to cooperate related solely to TANF.
-

c. Results of Case File Reviews

Figure 6 shows some of the key findings from 809 case files reviewed by state quality assurance reviewers. Most notably, only seven percent of the case closings had been reviewed for other categories of Medicaid eligibility.¹⁰⁰ Because states are required to affirmatively explore other categories of Medicaid eligibility before terminating the coverage of any Medicaid recipient,

98. See MO. DIV. OF FAMILY SERVS., MEDICAID PROJECT—TEMPORARY ASSISTANCE, TRANSITIONAL MEDICAID 1 (n.d.) (on file with the Saint Louis University Law Journal).

99. *Id.*

100. See MO. DIV. OF FAMILY SERVS. QUALITY ASSURANCE STAFF, TEMPORARY ASSISTANCE CLOSINGS ANALYSIS 2 (n.d.) (on file with the Saint Louis University Law Journal).

almost every one of these closings (i.e., at least ninety-three percent) was improper and in violation of the Medicaid statute.¹⁰¹

A high percentage (forty-two percent) of the closings indicated possible Medicaid eligibility although there was no indication that the Agency attempted to make a final determination that these individuals were in fact eligible.¹⁰² Additionally, in only nine percent of these cases had recipients reapplied for Medicaid or were active in another case, thereby demonstrating that terminated recipients are not automatically being covered by CHIP or the state's Medicaid expansion.¹⁰³ Almost half (forty-six percent) of the closed TANF cases still had open food stamp cases even though their TANF and Medicaid cases were closed—suggesting probable Medicaid eligibility and confirming that information necessary to conduct an *ex parte* review was available to maintain Medicaid eligibility.¹⁰⁴ In only twelve percent of the cases did caseworkers explain Medicaid options available to the recipient at the time of the closing.¹⁰⁵

Figure 6: Case Files Reviewed by State Quality Assurance Reviewers—Key Findings

- Only seven percent of the case closings had been reviewed for other categories of Medicaid eligibility.
 - Forty-two percent of the closings indicated possible Medicaid eligibility.
 - Only nine percent had reapplied for Medicaid or were active in another Medicaid case.
 - Forty-six percent were receiving food stamps when the Temporary Assistance and Medicaid cases were closed.
 - In only twelve percent of the cases did caseworkers explain other Medicaid options available to recipients at the time of the closing.
-

101. See Westmoreland, *supra* note 18.

102. See MO. DIV. OF FAMILY SERVS. QUALITY ASSURANCE STAFF, *supra* note 100.

103. *Id.*

104. Because food stamps are available to families with gross income up to 130% of the poverty line, food stamp recipients who lost TANF benefits will generally be eligible for Medicaid as well. Moreover, food stamp files contain the kind of information (e.g., family income and assets) that can help the state agency ascertain continued eligibility for the Medicaid program. As indicated earlier, HCFA now requires states to check Medicaid recipients' food stamp files in determining their continued eligibility for the program when they lose their original basis of Medicaid eligibility. See *supra* text accompanying notes 22-24.

105. MO. DIV. OF FAMILY SERVS. QUALITY ASSURANCE STAFF, *supra* note 100.

d. Breakdown of Reasons for Medicaid Case Closings

Figure 7 shows the results of a review of the closing codes for the 809 closed cases reviewed by the state agency. Many (thirty-seven percent) of these cases were closed for “reinvestigation of the cash case.”¹⁰⁶ However, cash assistance criteria are often not appropriate reasons to terminate Medicaid.

Figure 7: Results from a Quality Assurance Review of 809 Cases Closed in February 1999

- Thirty-seven percent of these cases were closed for “reinvestigation of the cash case.”
- Twelve percent were voluntary requests to close the case.
- Twelve percent were closed because the client reported a change.
- Ten percent of the cases were based on wage match/new hire match/welfare to work.
- Twenty-nine percent of the cases were closed for other reasons.

A relatively high percentage of the closings (twelve percent) were due to *voluntary* requests to close the case.¹⁰⁷ These are typically situations where the client calls and reports a new job and asks to have her case closed. Most clients are generally unaware that Medicaid can continue when they lose cash assistance.¹⁰⁸ Figure 8 shows that ninety-eight out of ninety-nine clients contacted by the Agency reported that Medicaid coverage was important to them.¹⁰⁹ Therefore, it is clear that recipients are not really *voluntarily* giving up health insurance.

Figure 8: Results from Survey of Ninety-nine clients whose TANF and Medicaid Cases were Closed in February 1999

- Ninety-eight of ninety-nine clients answered that Medicaid was important to them.
- Fifty percent did not understand why their Medicaid benefits were closed.

106. *Id.*

107. *Id.*

108. Most clients (fifty-seven percent) were unaware of their ability to receive Medicaid when they left welfare for work. *Id.* (results from client surveys).

109. *Id.*

- Eighty-nine percent stated that their caseworker did not explain that they may be eligible for Medicaid benefits under another program.
 - Fifty-seven percent were not aware they could continue to receive Medicaid benefits if they went to work.
-

Many of the cases (twelve percent) were closed because the client reported a “change.”¹¹⁰ Changes that were based on new earnings should have led to TMA coverage rather than a loss of Medicaid altogether. Ten percent of the case closings were based on wage match, new hire or welfare to work. These individuals should have been given TMA rather than have their cases closed. A high number of cases (twenty-nine percent) were closed for other reasons. These “other” reasons include reasons that should have resulted in a continuation of Medicaid eligibility because they were based on new employment or some type of work-related sanction that does not apply to Medicaid.¹¹¹

e. Continued Failure to Apply De-linking Requirements—November 1999 Findings

Figure 9 displays the findings from a more recent quality assurance review. This review showed that county offices were still failing to provide TMA to eligible families, did not understand program requirements, were closing Medicaid cases improperly, and were not de-linking TANF and Medicaid.¹¹² Additional reviews completed by DFS county offices showed that these problems persisted even after training conducted during the summer of that same year.¹¹³

110. MO. DIV. OF FAMILY SERVS. QUALITY ASSURANCE STAFF, *supra* note 100. The documents provided by the state did not break down the type of “changes” that were being reported.

111. These “other” codes include “IMES” (which is a closing based on earnings), “failed to cooperate with Futures” and “IM-16 from Futures” (which relates to a failure to comply with a work requirement, which is not a proper reason to terminate Medicaid). *Id.*

112. Memorandum from Jody Cornwell, Assistant Deputy Director, Missouri Division of Family Services, to Mary Fallen, Assistant Deputy Director, Missouri Division of Family Services 2-3 (Nov. 23, 1999) (on file with the Saint Louis University Law Journal).

113. Missouri Division of Family Services county offices also conducted separate reviews of cases closed in September 1999. These reports also revealed systemic problems in terminating Medicaid coverage improperly. For example, *one half* of Area 2’s cases were closed in error, most often for “failure to verify wages,” which is not a reason to close a section 1931 Medicaid case. *See* Memorandum from Nita Williams, Missouri Division of Family Services, to Mary Fallen, Assistant Deputy Director, Missouri Division of Family Services 1 (Nov. 15, 1999) (on file with the Saint Louis University Law Journal). Area 2 noted that supervisors were not following up with their workers on this issue (the improper closing of Medicaid cases). Other county office reviews demonstrate similar problems. *Id.*

Figure 9: Findings from Second Quality Assurance Review, November 1999.

- Some staff did not understand that Medicaid eligibility months “could” be used in meeting TMA criteria. As a result, the decision was made that there was no TMA eligibility. (In fact, states are required to use Medicaid eligibility months to determine TMA eligibility under federal law.)
 - Staff did not understand the correct policies regarding eligibility for TMA.
 - Medicaid is closed at the time Temporary Assistance is closed with no exploration of eligibility for TMA.
 - Medicaid cases are closed when a participant did not respond to a Temporary Assistance Reinvestigation request—workers did not separate Medicaid eligibility from Temporary Assistance eligibility and ended Medicaid coverage incorrectly.
 - Staff did not know that state policy allowed them to accept the client’s statement regarding employment to establish TMA eligibility.
-

f. Implications of Missouri Findings

The Missouri quality assurance findings generally speak for themselves. Many of the practices that were identified in state quality assurance reviews are in direct violation of federal Medicaid law and regulations and recent HHS guidance. They run counter to efforts to ensure that families moving from welfare to work maintain their health insurance coverage. In large part, these practices tell the story of why Medicaid enrollment has declined nationwide and why TANF recipients are losing health coverage when they leave welfare. County welfare offices are not implementing many of the key requirements that are designed to protect Medicaid eligibility, including the welfare law’s provisions that were designed to de-link cash assistance and Medicaid. The programs are still very much linked in the practices and procedures of state agencies so that when TANF cash assistance is terminated the client also loses health coverage. Missouri findings suggest that federal requirements exist only on paper for large numbers of Medicaid beneficiaries whom the de-linking, TMA and *ex parte* provisions are designed to protect. The failure to translate these requirements into practice demonstrates that the de-linking of cash assistance and Medicaid has not yet achieved the intended result.

Moreover, the Missouri reviews show that recipients are clearly unaware of their right to continued health coverage when they lose their TANF benefits. The Missouri data provides strong evidence that corrective measures are needed to protect Medicaid eligibility in light of welfare reform. The next two sections address the responses to and the remedies for these widespread problems.

V. RESPONSES TO IMPROPER TERMINATION OF MEDICAID COVERAGE DUE TO WELFARE REFORM

A. *National Response*

The loss of health insurance coverage resulting from welfare reform has caused concern at the federal level among advocates, legislators and the Clinton Administration in particular. The late Senator Chafee, author of the Medicaid de-linking provision of the federal welfare law, indicated that he was “deeply concerned” about “reports that people are losing their Medicaid coverage” when they leave welfare and noted that this result “directly contradicts the intent of the 1996 welfare law and could very well undermine states’ future success in helping people become self-sufficient.”¹¹⁴ Chris Jennings, the health policy coordinator at the White House, similarly stated that there were “unacceptable barriers” to getting and keeping Medicaid in some states.¹¹⁵ The Administration’s response has been formalized in a series of responses from the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS), which are discussed below.

1. HCFA Guidance

In March 1999, HCFA issued an extensive guide to states regarding how to ensure access to Medicaid in light of welfare reform. *Supporting Families in Transition—A Guide to Expanded Health Coverage in the Post-Welfare World* encourages states to make it easier for working families to receive health coverage. The guide reiterates many of the legal requirements of the Medicaid program that are designed to ensure access to the program, including the requirement that states de-link their Medicaid and TANF programs and create a category of Medicaid coverage that does not require participation in cash assistance. HCFA describes the importance of providing health coverage to eligible families and documents a number of steps that states must take to prevent families from losing Medicaid coverage.¹¹⁶ The guidance also describes states’ options to expand eligibility to create a broader safety net for needy and low-income families.¹¹⁷ Finally, HCFA includes a number of explicit instructions for ameliorating the harms caused by errant state policies, many of which are discussed further in Section VI entitled “Remedies for Improper Terminations and Denials of Medicaid Coverage.” This directive

114. Robert Pear, *Poor Workers Lose Medicaid Coverage Despite Eligibility*, N.Y. TIMES, April 12, 1999, at A1.

115. *See id.* Jennings further noted that “[i]t isn’t necessarily intentional . . . but it has the same effect. People lose out on access to affordable health coverage.” *Id.*

116. *See* SUPPORTING FAMILIES IN TRANSITION, *supra* note 14.

117. *Id.* For example, the guidance suggests expanding section 1931 coverage, using less restrictive financial methodologies and easing deprivation requirements.

underscores the importance the federal government places on Medicaid as a supportive service for working families.

2. HCFA State Reviews

HCFA is also engaged in a process of reviews in all fifty states, including Missouri, regarding their compliance with these Medicaid de-linking requirements. HCFA declared that the goal of these reviews was “to make sure that States fulfill their responsibilities under the law, as well as, understand the flexibility available to them to operate their programs.”¹¹⁸ These reviews have included reviews of case files to determine compliance in a number of core areas selected by HCFA,¹¹⁹ as well as meetings with state officials, advocates and social services providers. As of this writing, HCFA has not made available to the public any final reports on the results of these reviews. It is unclear whether the reviews will lead to specific corrective action recommendations in states that have demonstrated non-compliance.

3. Guidance on Reinstatement, Medicaid Redeterminations, and Computer System Changes

The clearest and most significant response from HCFA came in the guidance dated April 7, 2000, which required states to take several steps to address the loss of Medicaid resulting from welfare reform. That response directed states to evaluate whether they had improperly terminated families from Medicaid and to reinstate health coverage for those families.¹²⁰ The guidance also clarified states’ obligations to engage in *ex parte* reviews prior to terminating Medicaid coverage and to change their computer systems to reflect the de-linking of Medicaid and cash assistance. This guidance is discussed in more detail below.

118. See HEALTH CARE FINANCING ADMINISTRATION, DISCUSSION ON TOPICS FOR THE ON-SITE REVIEWS OF STATE MEDICAID ENROLLMENT AND ELIGIBILITY PROCESSES 1 (1999) (on file with the Saint Louis University Law Journal).

119. The core areas reviewed by HCFA officials include:

- Eligibility and enrollment processes;
- Maintaining coverage for families who leave public assistance programs;
- Reaching families potentially eligible for Medicaid;
- Children’s Health Insurance Program (CHIP) review;
- Optional policies for Medicaid—outreach activities and eligibility expansions;
- Ensuring administrative efficiency and Medicaid quality control; and
- Computer systems.

Id. at 1-2.

120. See Westmoreland, *supra* note 18, at 3.

B. State-Based Advocacy and Negotiation

Much of the effort to combat the unintended loss of Medicaid coverage has occurred at the state level. In a number of states, coalitions of advocates have sought to ensure that states implement the de-linking of Medicaid and cash assistance. In a few states, lawsuits have been filed to challenge state and local practices that have caused improper losses of health coverage.

1. Litigation

In an effort to prevent “front-end” diversion, Medicaid claimants in New York City brought suit against Mayor Giuliani challenging the city’s conversion of income support centers to job employment centers.¹²¹ Plaintiffs alleged that the city systematically prevented otherwise eligible individuals from obtaining food stamps, Medicaid and cash assistance by imposing unreasonable requirements upon families during the application process.¹²² The court determined that the welfare offices that were converted to employment centers were not properly taking applications for food stamps and Medicaid.¹²³ The court concluded that although the state has a right to create its own welfare program it could not overlook the urgent needs of individuals applying for food stamps or medical assistance.¹²⁴

Furthermore, “[i]n its quest to enhance the delivery of food stamps, Medicaid and cash assistance benefits to the City’s most needy residents, the City cannot lose sight of the requirements imposed by federal statutes and regulations.”¹²⁵ The court enjoined the city from converting any more income support centers into job centers, stating that the “defendants’ practices . . . endanger numerous individuals in need of public assistance, including children, expectant mothers, and the disabled.”¹²⁶ The court directed the City to allow any applicant for public assistance, Medicaid or food stamps, to apply for the assistance the first day the individual visits the office.¹²⁷ In addition,

121. *Reynolds v. Giuliani*, 35 F. Supp. 2d 331, 342 (S.D.N.Y. 1999).

122. *Id.* at 333.

123. A number of legal protections are implicated when the state fails to process a Medicaid or food stamp application or provide coverage based on a policy that relates solely to TANF. *See generally id.* The Medicaid Act requires that eligibility be determined with “reasonable promptness.” Social Security Act § 1902(a)(8), 42 U.S.C. § 1396a(a)(8) (1994). Regulations interpret this requirement to mean that, except in “unusual circumstances,” applications for Medicaid must be processed within ninety days in cases involving disability determinations, and in forty-five days in all other cases. 42 C.F.R. § 435.911(a)(1), (2) (1999). *See also* 7 U.S.C. § 2020(e)(1)(B)(iii) (1994) (entitling a household to apply for food stamps on the first day it contacts a food stamp office during business hours).

124. *Reynolds*, 35 F. Supp. 2d at 347.

125. *Id.* at 342.

126. *Id.* at 339.

127. *Id.* at 347.

the court compelled the city to create a corrective action plan in order to rectify the violations of federal law in regards to food stamp and Medicaid processing regulations.¹²⁸

The court has since refused to lift its preliminary injunction, thus preventing the city from converting its remaining welfare offices into job centers.¹²⁹ The court stated that the audits submitted to the court were “hastily conceived” and “fundamentally flawed” and denied the defendant’s motion to vacate the injunction.¹³⁰

Medicaid claimants also have commenced legal actions in response to “back-end” terminations of Medicaid. In Florida, for example, plaintiffs filed suit to stop unlawful terminations of Medicaid coverage.¹³¹ The plaintiffs alleged that the Department of Children and Families engaged in various practices that violated federal regulations.¹³² Those allegations from Florida are congruent with state advocates’ complaints nationwide. Plaintiffs’ motions for class certification and a preliminary injunction were pending at the time of this writing.

New York City Medicaid claimants also brought suit to challenge “back-end” terminations of coverage.¹³³ Plaintiffs alleged that they were systematically terminated from Medicaid when their cash assistance case was

128. *Id.* at 348.

129. *See Reynolds v. Giuliani*, No. 98 Civ. 8877 (WHP), 2000 WL 1013952, at *26 (S.D.N.Y. July 21, 2000). *See also* Nina Bernstein, *Judge Rules Against City on Welfare*, N.Y. TIMES, July 25, 2000, at B1.

130. *Reynolds*, 2000 WL 1013952, at *15.

131. Pl.’s Compl. ¶ 3, *Grant v. Kearney*, No. 99-2147 (S.D. Fla. 2000) (on file with the Saint Louis University Law Journal).

132. The complaint lists the following illegal practices:

- (a) failure to continue Medicaid eligibility upon termination of TANF;
- (b) failure to accurately redetermine Medicaid eligibility;
- (c) failure to automatically provide transitional Medicaid when § 1931 Medicaid is terminated due to an increase in earnings;
- (d) failure to provide extended Medicaid automatically for four months when § 1931 Medicaid is terminated due to an increase in child support or alimony income;
- (e) failure to provide notice to families terminated from TANF as a result of earned income of their right to extended Medicaid;
- (f) failure to provide adequate notice when § 1931 Medicaid is terminated concurrent with or subsequent to the termination of TANF or when transitional Medicaid or extended Medicaid eligibility is terminated;
- (g) failure to provide a notice as required by federal law when Medicaid eligibility under any particular eligibility category is terminated concurrent with or subsequent to the termination of TANF or when transitional or extended Medicaid is terminated.

See id. at ¶ 67.

133. *Mangracina v. Turner*, No. 9 Civ. 5585 (S.D.N.Y. Aug. 1998) (on file with the Saint Louis University Law Journal).

closed based on alleged non-compliance with the state's public assistance employment program in violation of federal and state law. Plaintiffs claimed that the state was improperly terminating Medicaid benefits when recipients were placed under a sanction relating to their cash assistance benefits. Many of the plaintiffs only discovered the terminations when they sought necessary and urgent medical care and were told that their Medicaid cards were no longer active. These sanctions were based on the state's failure to update its computer system to ensure that a TANF employment sanction did not automatically result in a Medicaid sanction.¹³⁴ As a result of the court case, New York State has revised its computer system so as to not automatically terminate Medicaid benefits when cash assistance sanctions were implemented and the parties have reached settlement in substance as to retroactive relief.¹³⁵

2. Negotiated Resolutions of Systematic Medicaid Terminations

More than litigation, a series of state-based advocacy efforts and negotiations between advocates and states has led to significant revisions in states' de-linking practices.

Health advocates in Washington State negotiated an agreement with the State Department of Social and Health Services to remedy the violations of the de-linking provision of the welfare law.¹³⁶ A coalition comprised of Columbia Legal Services, the Welfare Rights Organizing Coalition and the Children's Alliance began to advocate for the settlement after an exit survey from the State revealed that only fifty-seven percent of children and thirty-six percent of

134. Presentation of Plaintiffs' Counsel, Marc Cohan, at National Legal Aid and Defenders Association Conference, Berkeley, California (July 27, 2000) (on file with author).

135. Telephone Conversation with Rebecca Scharf, plaintiffs' counsel (Oct. 6, 2000) (on file with author).

136. The agreement includes plans to:

- Stop improperly cutting off families from health care when they leave TANF.
- Continue Medicaid for families who ask to stop their cash benefits, unless they confirm in writing that they also want health coverage stopped.
- Make significant changes to ACES, the state's computer system, that will stop the computer from automatically terminating families' health coverage.
- Reinstate adults and children who were improperly terminated from health coverage since 1997 for a period of ninety days. These families' cases will be reviewed to see if they are eligible to continue to receive health coverage.
- Reimburse families who are improperly terminated for their past medical bills.
- Stop repeated requests by the state for information from families that they have already provided, and stop requests for information and verification not necessary for Medicaid eligibility.

See SAUER, *supra* note 76, at 1; Memorandum from Claudia Schlosberg, to Health Advocates Group 1 (Sept. 27, 1999) (on file with the Saint Louis University Law Journal); NORTHWEST HEALTH LAW ADVOCATES, WASHINGTON DELAYS MEDICAID REINSTATEMENT TO SPRING 2000; ALTERS PLAN TO MAINTAIN MEDICAID FOR FAMILIES VOLUNTARILY LEAVING TANF 1 (1999) (on file with the Saint Louis University Law Journal).

adults were receiving Medicaid after leaving TANF.¹³⁷ The group combined media coverage, anecdotal evidence and the threat of legal action to incite a state response.

The approach of the advocates in Washington was based on the earlier successful negotiations in Pennsylvania. After the Medicaid rolls decreased by 54,000 children between July 1996 and September 1998, advocates in Pennsylvania developed a strategy to restore benefits to wrongly terminated families.¹³⁸ The coalition included Community Legal Services, the Pennsylvania Health Law Project, the Philadelphia Health Law Project and numerous community organizations dedicated to preserving health insurance for low-income people entitled to coverage. As a result of the negotiations with the state, Pennsylvania agreed to reinstate families who were improperly terminated from Medicaid. The coalition attributes its success to the widespread dissemination of information about the Medicaid program and media coverage of the improper terminations.¹³⁹ Advocates in Maryland and that state's Medicaid agency also have negotiated a settlement that included reinstatement of Medicaid for certain categories of families who lost coverage due to welfare reform, as well as a series of prospective changes to the state's Medicaid eligibility policies and procedures.¹⁴⁰

Media campaigns have been integral to the success of these state-based advocacy efforts to elicit a systemic response to these problems. Pennsylvania's coalition relied heavily on the support of the local newspapers to publicize the problem and create a greater understanding of Medicaid as a support service for families who are models of compliance with welfare reform. Because half of the improperly-terminated children were from Philadelphia, the coalition worked with the media there to insure that the public became informed that the loss of Medicaid was unnecessary and could be reversed. Stories ran in the *Philadelphia Daily News* and the *Philadelphia Inquirer* with editorials in both newspapers. Editorials also appeared in the *Harrisburg Patriot*. Following Pennsylvania's lead, advocates in several other states have relied on the media as part of their advocacy strategy.¹⁴¹

137. See FAMILIES USA, ORGANIZING FOR CHANGE: STOPPING ILLEGAL CUTOFFS IN WASHINGTON 1 (n.d.), available at <http://www.familiesusa.org/actkit.html>.

138. See FAMILIES USA, ORGANIZING FOR CHANGE: STEMMING THE TIDE IN PENNSYLVANIA 1 (n.d.), available at <http://www.familiesusa.org/actkit.html>.

139. *Id.*

140. See MARYLAND MEDICAID AGENCY, MARYLAND'S CORRECTIVE ACTION PLAN FOR TCA/MA 1 (n.d.) (on file with the Saint Louis University Law Journal). See also Press Release, FIP Legal Clinic Urges further State Action to Help Families Who Were Denied Medical Assistance When They Left Welfare for Work (Sept. 23, 1999) (on file with the Saint Louis University Law Journal).

141. Washington combined its threat of litigation with articles in the *Seattle Times*, the *Herald* and the *News Tribune*. Unlike Pennsylvania, however, the Washington coalition's contact with the media strained their relationship with the Department of Social and Health Services. See

VI. REMEDIES FOR IMPROPER TERMINATIONS AND DENIALS OF MEDICAID COVERAGE

A. *Prospective Changes Designed to Improve Future Compliance*

1. Revising Regulations and Policies

In some states, individuals have lost health coverage because the state's written policies do not properly implement the de-linking of Medicaid and cash assistance. In order to ensure that eligible individuals receive health coverage, it is necessary to have regulations and policies in place that clearly state the rules. As pointed out earlier, many states have not timely implemented policies that accurately reflect the de-linking of cash assistance and Medicaid.¹⁴² Many states are now taking action to revise their regulations and policies to include provisions that should limit the extent of improper and unnecessary Medicaid terminations and denials.

For example, in February 2000, the Florida Department of Children and Families issued a policy informing caseworkers that they are now required to obtain written confirmation of a voluntary request for case closure, which should reduce the number of persons losing Medicaid when they leave cash assistance for a job.¹⁴³ Ohio also has taken significant steps to correct and clarify its Medicaid Manual policies. The policy now clearly states that caseworkers must conduct an *ex parte* review, without requiring a face-to-face interview, if the information can be obtained without the interview.¹⁴⁴ Missouri advocates sought revisions in the policies and state Manual governing Missouri's Medicaid program. On December 7, 1999, a little over three years after the welfare law was enacted, the state of Missouri finally published a new

FAMILIES USA, *supra* note 137, at 2. Missouri advocates have also educated the media to draw attention to improper Medicaid and food stamp denials and elicit a positive state response. *See, e.g.,* Melinda Roth, *State of Pain*, RIVERFRONT TIMES, Feb. 9, 2000, at 16; Kevin Robbins, *Medicaid Coverage Will Be Reinstated to Thousands*, ST. LOUIS POST-DISPATCH, Apr. 27, 2000, at B1; Editorial, *Three Questions About Health*, ST. LOUIS POST-DISPATCH, Apr. 27, 2000, at B2; Donna McGuire, *Many Eligible for Food Stamps, Medicaid Lose Benefits*, KANSAS CITY STAR, June 19, 2000, at B1.

142. *See supra* text accompanying notes 85-87.

143. *See* Memorandum from Kim Shaver & Kim Brock, Chief of Program Policy & Chief of Technologies and Systems Development, Florida Department of Children and Families, to District Economic Self-Sufficiency Services Program Administrators, District 11 Economic Self-Sufficiency Services Program Manager and District Adult Services Program Administrators 7 (Feb. 21, 2000) (on file with the Saint Louis University Law Journal).

144. Memorandum from Jacqueline Romer-Sensky, Director, Ohio Department of Human Services, to All Public Assistance Manual Holders 3 (Oct. 20, 1999) (on file with the Saint Louis University Law Journal).

Manual that reflected the de-linking of Medicaid and cash assistance.¹⁴⁵ Figure 10 lists some of the key policy and procedural issues that often require clarification.

Figure 10: Key State Policies that Improve Medicaid De-linking

- Clearly state the family's option to receive Medicaid only (without cash benefits);
- Describe simplified Medicaid eligibility criteria such as the elimination of a resource limit and the deprivation of parental support requirement (if the state has elected these options);
- State explicitly that face-to-face interviews are not required for Medicaid reinvestigation (if this option is adopted by the state);
- Clarify that when a recipient fails to comply with a TANF reinvestigation, only the cash assistance may be closed—not Medicaid (where the reinvestigation only relates to TANF);
- Allow applicants to re-open applications denied because of a lack of information. (This decreases the burden on the applicant and the agency);
- Require caseworkers to use information available in the file to continue Medicaid eligibility (e.g., a recent food stamp or TANF review) (consistent with federal *ex parte* redetermination requirement);
- Stagger Medicaid redeterminations so that the redeterminations for Medicaid do not coincide with TANF case closures to ensure that the programs are de-linked;
- Ensure that Medicaid redeterminations occur every twelve months so that any intervening loss of TANF has no impact on continued Medicaid coverage;
- State explicitly that it is not necessary to verify earnings to put a recipient on TMA (consistent with federal TMA requirement that there is no income limit for the first six months of TMA);
- Provide that a voluntary withdrawal for Medicaid must be in writing;
- Mandate that prior to taking action to close Medicaid, caseworkers should explore eligibility for Transitional Medical Assistance and all other Medicaid categories (as required by federal Medicaid redetermination provisions);
- For states with diversion programs, the agency should clarify that:

145. See Memorandum from Denise Cross, Director, Missouri Division of Family Services, to All Area and County Offices (Dec. 7, 1999) (on file with the Saint Louis University Law Journal); FAMILY HEALTHCARE PROGRAMS MANUAL, *supra* note 5.

- (1) TANF job searches may not delay the processing of the Medicaid portion of the application (consistent with federal Medicaid application processing requirements);
 - (2) Workers should inform the family that they may still be eligible for Medicaid while the parent is attempting to comply with work requirements; and
 - (3) Workers should promptly determine eligibility regardless of whether the family has complied with work requirements (consistent with federal Medicaid application processing requirements).
-

The establishment of legally correct regulations and policies is an important first step toward correcting states' failures to properly de-link Medicaid and cash assistance. It is also a step that is readily achievable through either negotiation or litigation.¹⁴⁶

2. Training

In states where a "de-linking" problem is identified, training is often an important part of the remedy. Even if the proper de-linking policies are in place, training is needed to ensure that the policies are actually implemented. Advocates have argued for training all workers and supervisors regarding Medicaid de-linking requirements. This includes training on section 1931 (the de-linking provision), transitional Medicaid requirements and the requirement that the state automatically redetermine the Medicaid eligibility of recipients who lose one basis of health coverage. States must stress the difference between TANF rules and Medicaid/CHIP rules and the procedures necessary for informing every family of its health care options. As HHS points out, states can send a strong and clear message to their employees about the importance of Medicaid and CHIP eligibility through special staff training.¹⁴⁷

As a response to problems identified in Missouri, the state implemented statewide training of its caseworkers, which attempted to clarify these issues and remedy some of the problems discussed in this article. Missouri also conducted follow-up training with supervisors regarding these same issues. Other states have also conducted specific training on these issues as a response to improper Medicaid terminations. For example, Pennsylvania's campaign to

146. See *e.g.*, *Reynolds v. Giuliani*, 35 F. Supp. 2d 331 (S.D.N.Y. 1999); *Harley v. Lyng*, 653 F. Supp. 266, 282 (E.D. Pa. 1986).

147. See SUPPORTING FAMILIES IN TRANSITION, *supra* note 14, at 10. Training can also be an important part of any court-based remedy for noncompliance with Medicaid de-linking requirements. See *e.g.*, *Reynolds*, 35 F. Supp. 2d at 347-48; *Harley*, 653 F. Supp. at 280-82; *Robertson v. Jackson*, 766 F. Supp. 470 (E.D. Va. 1991) (demonstrating that courts have ordered state agencies to retrain their staffs in response to widespread violations of requirements concerning public assistance programs).

restore medical assistance to needy families began with caseworker training as early as June 1998 immediately after the Medicaid policy was revised.¹⁴⁸ In addition, Washington,¹⁴⁹ Florida,¹⁵⁰ Wisconsin¹⁵¹ and Ohio¹⁵² all indicate that they have conducted extensive staff training on Medicaid de-linking policy.

3. Supervisory Approval/Supervisory Reviews

Because of the complicated nature of the Medicaid program and caseworkers' many other responsibilities, training may not be enough to ensure that workers properly implement the de-linking of Medicaid and TANF. HHS stated in its guidance that supervisory reviews are a clear message to caseworkers of the importance of Medicaid eligibility.¹⁵³ Advocates, therefore, have suggested that the state require supervisory approval before any TANF case is closed to help ensure that transitional Medicaid continues. One approach would be to require supervisory approval at least until it is clearly established that county welfare offices have fully implemented Medicaid de-linking requirements for a significant period of time.

In December 1998, Pennsylvania began conducting ongoing supervisory reviews of closed TANF cases in which there were no open Medicaid cases.¹⁵⁴ As of July 1, 1999, supervisory reviews were preventing erroneous determinations of ineligibility in more than ten percent of the cases.¹⁵⁵ In Maryland, a centralized state office review of closed Medicaid/TANF cases yielded very high numbers of erroneously denied and closed cases.¹⁵⁶ In some

148. See PA. DEP'T OF PUBLIC WELFARE, STATEWIDE INITIATIVES TO SUPPORT FAMILIES LEAVING WELFARE: MEDICAL COVERAGE 1 (Aug. 19, 1999) (on file with the Saint Louis University Law Journal).

149. See COLUMBIA LEGAL SERVS., CLS QUESTIONS ABOUT IMPLEMENTATION OF REINSTATEMENT AND REIMBURSEMENT PLAN 7 (Feb. 22, 2000) (on file with the Saint Louis University Law Journal).

150. See Memorandum from Kim L. Shaver & Kim Brock, Chief of Program Policy & Chief of Technologies and Systems Development, Florida Department of Children and Families, to District 11 Economic Self-Sufficiency Services Program Administrators, District Economic Self-Sufficiency Services Program Manager and District Adult Services Program Administrator 1 (May 17, 2000) (on file with the Saint Louis University Law Journal).

151. See Letter from Joe Leean, Secretary, Wisconsin Department of Health and Family Services, to Shirin Cabraal, Staff Attorney, Legal Action of Wisconsin 2 (May 4, 2000) (on file with the Saint Louis University Law Journal).

152. See Letter from Jacqueline Romer-Sensky, Director, Ohio Department of Human Services, to the Director, County Department of Human Services 1 (Nov. 10, 1999) (listing dates which Ohio caseworkers would be trained on new policy and application procedures) (on file with the Saint Louis University Law Journal).

153. SUPPORTING FAMILIES IN TRANSITION, *supra* note 14, at 14.

154. STATEWIDE INITIATIVES TO SUPPORT FAMILIES LEAVING WELFARE, *supra* note 148.

155. Memorandum from Ann Torregrossa, et al., to CLS & PLA Public Benefits and Intake Staff 2 (July 1, 1999) (on file with the Saint Louis University Law Journal).

156. See MARYLAND MEDICAID AGENCY, *supra* note 140, at 57.

weeks, over sixty percent of the closures/denials were reversed while the state typically reversed well over thirty percent of the local level decisions.¹⁵⁷ Missouri implemented supervisory review in a substantial number of counties but there is no centralized monitoring of how these reviews are being implemented or their impact on Medicaid de-linking.¹⁵⁸

4. Simplified Processes

One of the things states can do to improve access is simplify their practices and procedures. California advocates have identified serious problems with the state's redetermination process. They have argued that the redetermination packets used by the California state agency are incomprehensible and inconsistent. For example, the standard redetermination packets require a twelfth grade reading level and sixty percent more information and supporting documentation than the IRS Form 1040.¹⁵⁹ In addition, some counties require families to complete additional forms.¹⁶⁰ Eliminating such burdensome practices is clearly a part of the solution to improper and unlawful terminations of Medicaid.

HCFA recognizes that states have considerable flexibility under Medicaid and CHIP to simplify the application and enrollment processes.¹⁶¹ While some states still require a face-to-face interview for Medicaid redeterminations, the law does not require it. Currently, Missouri uses a mail-in redetermination process for Medicaid participants. However, many caseworkers still require a face-to-face interview. This is an issue that may require efforts in addition to a mere policy revision to ensure that workers actually implement the simplified procedure.¹⁶² HHS has stated that "application and enrollment processes

157. MARYLAND DEP'T OF HUMAN RES., MA CASE REVIEWS, CLOSED AND DENIED TCA ASSISTANCE UNITS 1 (1999) (on file with the Saint Louis University Law Journal).

158. Documents obtained from public records requests and conversations with state officials indicate that many of Missouri's counties were requiring supervisory approval before a Medicaid case closing.

159. Letter from Yolanda Vera et al., to Diana Bonta, Director, Department of Health Services (July 27, 1999) (on file with the Saint Louis University Law Journal) (citing STAN K. DORN & ANN M.K. PATTERSON, THE HEALTH CONSUMER ALLIANCE, RED TAPE EPIDEMIC: HEALTH COVERAGE FOR WORKING FAMILIES AT RISK 1 (April 1999) (on file with the Saint Louis University Law Journal)).

160. *See id.* As the letter points out, these practices are out of compliance with a 1985 California Court of Appeals decision, *Edwards v. Myers*, 167 Cal. App. 3d 1070 (Cal. Ct. App. 1985). The parties in that case stipulated to a judgment and as a result, developed a standard form to be used in Medicaid eligibility redeterminations. *Id.*

161. *See* SUPPORTING FAMILIES IN TRANSITION, *supra* note 14, at 16.

162. Missouri advocates have asked the state to separate the Medicaid and TANF reinvestigation process so that Medicaid cases are not closed for reasons that only apply to TANF. Ferber, *supra* note 71, at 11. This would ensure that Medicaid redeterminations do not coincide with TANF case closures and also distinguish the TANF closure from a separate

should not be a barrier to low-income families applying for Medicaid.”¹⁶³ States can take steps to simplify application forms, reduce documentation requirements, allow mail-in applications and expedite application processing to facilitate Medicaid and CHIP participation.¹⁶⁴

5. Notices

States may need to revise their notices to applicants and recipients, as part of their response to improper de-linking of Medicaid and cash assistance. Notices must comply with clearly established due process requirements as well as specific provisions that relate to the de-linking of Medicaid and cash assistance benefits.

a. General Due Process Requirements

Federal Medicaid law and regulations include very specific requirements that relate to any loss or denial of health coverage. The right to proper notice and a fair hearing challenging any adverse action affecting Medicaid can be an important safeguard against violations of Medicaid de-linking requirements.¹⁶⁵ Due process requires that notices clearly apprise recipients of their denial of Medicaid benefits, the reason for the denial and their rights to appeal.¹⁶⁶

determination of ongoing Medicaid eligibility while allowing the agency to obtain any information it needs to evaluate Medicaid eligibility. *Id.*

163. SUPPORTING FAMILIES IN TRANSITION, *supra* note 14, at 24.

164. *Id.*

165. Proper notice must comply with Medicaid requirements regarding all terminations of Medicaid benefits. 42 C.F.R. § 431.206(c)(2) states that the Medicaid agency must give notice of the availability of hearings to challenge disputed decisions “at the time of any action affecting his or her claim.” Furthermore, 42 C.F.R. § 431.210 recounts the required content of such notices. According to this regulation, the required content includes:

- (1) what action the State intends to take;
- (2) the reasons for the intended action;
- (3) the specific regulations that support, or the change in Federal law that requires the action;
- (4) an explanation of an individual’s right to an evidentiary or an agency hearing; and
- (5) the circumstances under which assistance is continued unchanged if a hearing is requested until the hearing has been held and a decision issued.

Finally, 42 C.F.R. § 431.211 states that, “the State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.231 and 431.214 of this subpart.” HCFA has stated that a failure to provide proper notice is not a proper termination of Medicaid eligibility and is one basis for reinstating families’ Medicaid coverage. Westmoreland, *supra* note 18, at 2.

166. 42 C.F.R. § 431.245 (1999); 42 C.F.R. § 435.912. *See also* SUPPORTING FAMILIES IN TRANSITION, *supra* note 14, at 9.

Notices must be written in a manner that is clearly understandable to the intended recipients of the notices and in languages understood by non-English speaking clients.

To satisfy due process, notice must be “reasonably calculated under all of the circumstances to apprise interested parties of the pendency of the action” and “must be of such nature as reasonably to convey the required information.”¹⁶⁷ At “minimum, due process requires the [State] agency to explain, in terms comprehensible to the claimant, exactly what the agency proposes to do and why the agency is taking this action.”¹⁶⁸ Moreover, “constitutionally adequate notice must not only contain the necessary minimum amount of relevant data, it must also not mislead its recipient about that data’s significance.”¹⁶⁹ Due process also requires that such “legal information be clearly and simply presented.”¹⁷⁰ In addition to these general due process requirements that relate to any Medicaid denial or termination, there are specific notice provisions that are particularly relevant to the problems addressed in this article.¹⁷¹ These are discussed in the next two sections.

b. Transitional Medicaid Notice Requirements

States also must provide a clear description of the right to TMA when earnings cause an individual to become ineligible for section 1931 coverage.¹⁷² States must comply with specific legal requirements relating to transitional Medicaid, which are even more important in light of welfare reform. Federal law requires states to notify recipients losing eligibility for section 1931 coverage of: (1) an explanation of the right to transitional Medicaid; (2) a description of the reporting requirements; (3) the circumstances which require termination of this assistance, such as the absence of a child in the home; and

167. *Mullane v. Central Hanover Bank and Trust Co.*, 339 U.S. 306, 314 (1950). Notice should be tailored to the capacities and circumstances of their intended recipients. *Goldberg v. Kelley*, 397 U.S. 254, 268-69 (1970); *Dealy v. Heckler*, 616 F. Supp. 266, 272 (W.D. Mo. 1984).

168. *Harley v. Lyng*, 653 F. Supp. 266, 272 (E.D. Pa. 1986) (citing *Ortiz v. Eichler*, 616 F. Supp. 1046, 1061 (D. Del. 1986)).

169. *Mayhew v. Cohen*, 604 F. Supp. 850, 857 (E.D. Pa. 1984).

170. *Ellender v. Schweiker*, 575 F. Supp. 590, 604 (S.D.N.Y. 1983).

171. States that do not comply with these requirements are denying recipients a meaningful opportunity to be heard in violation of due process requirements. See *Goldberg*, 397 U.S. at 267; *Mullane*, 339 U.S. at 314. The fundamental requisite of due process of law is the opportunity to be heard. *Goldberg*, 397 U.S. at 267. The hearing must be at a meaningful time and in a meaningful manner. *Id.*

172. For these reasons, advocates have often called on states to revise their notices. For example, Missouri advocates argued for multiple revisions to the state’s closing notices, denial notices and approval letters, to ensure that individuals were fully apprised of the de-linking of cash assistance and Medicaid, and the right to TMA.

(4) a card or other evidence of Medicaid eligibility.¹⁷³ In addition, because the closing of a TANF case no longer has any legal relationship to Medicaid eligibility, states may consider revising their notices to remind families that they remain eligible for Medicaid even though they have lost TANF, and that they should continue to access health services through Medicaid. Indeed, notices that fail to advise clients of these important differences may run afoul of the due process provisions described above.

c. Ex Parte Requirements

States also must comply with notice requirements relating to eligibility redeterminations. HCFA has recently stated that if the *ex parte* review does not suggest eligibility under another category, the state must provide individuals a reasonable opportunity to provide information to establish continued eligibility. As part of this process, the state must explain the potential basis of Medicaid eligibility (such as disability or pregnancy).¹⁷⁴ This means states must first provide information to recipients about these alternative bases of Medicaid eligibility and, if the individual is found to be ineligible under the alternative criteria, provide notice that these criteria have not been met.

Proper notice is clearly needed to ensure that Medicaid recipients' health coverage is not improperly denied or terminated as a result of welfare reform, and that they continue to receive health coverage pending the outcome of any action the agency plans to take against them. Therefore, states should carefully review their notices as part of any corrective action they take to remedy improper terminations of Medicaid caused by their implementation of welfare reform.

6. Outreach

Outreach and marketing are critical components of any effort to resolve systemic denials of Medicaid coverage resulting from state welfare reform efforts. Families must be educated about all of their health care options under

173. Social Security Act § 1925(a)(7), 42 U.S.C. § 1396r-6(a)(2) (1994). In *Grant v. Kearney*, the Florida plaintiffs have specifically alleged that the state is violating the rules regarding transitional Medicaid notice (42 U.S.C. § 1396r-6(a)(2)) by failing to provide: (1) a statement advising the family of its right to extended medical benefits; (2) an explanation of the family's reporting requirements if they wish to continue to receive Medicaid after their first six months; (3) an explanation that the family may cease to be eligible for Medicaid when there is no longer a child in the family and that the family must notify the Department if a child leaves home or reaches applicable age; and (4) a card or other evidence of the family's eligibility for Medicaid. See Pl.'s Complaint, *supra* note 131.

174. Westmoreland, *supra* note 18, at 7.

Medicaid and CHIP.¹⁷⁵ To accomplish this, states may draw on funding from the \$500 million in federal funding for the administrative costs of implementing the Medicaid de-linking provisions of the welfare law. HCFA has specifically recommended that states provide Medicaid and CHIP outreach to families at TANF sites to help ensure that Medicaid requirements are properly applied. States should make clear in all of their TANF-related informational materials that coverage under Medicaid and CHIP does not require welfare eligibility and that regardless of whether families apply for or receive TANF assistance, they are encouraged to apply for Medicaid and/or CHIP.

HCFA has suggested several approaches to successful enrollment including: billboards and posters, public service announcements on television and radio and dissemination of materials in churches, schools and community-based organizations. States can include material on transitional Medicaid with all CHIP-related information.¹⁷⁶ Pennsylvania conducted a major marketing campaign, including public service announcements, to advise low-income families of program and policy changes related to the de-linking of Medicaid and welfare. The campaign included a \$290,000 three-week ad campaign during the period in which the state was reinstating individual Medicaid coverage.¹⁷⁷

In order to reach as many families as possible states must engage in aggressive outreach efforts. States may create application sites outside of the welfare office in order to promote the message that Medicaid is available to low-income families, regardless of whether they receive cash assistance. In addition, states can place Medicaid and CHIP eligibility workers in the community, for example, in hospitals, health centers, schools and career centers. Regulations do not prohibit volunteers from assisting outstationed workers as long as a state official makes the final determination. That gives states an opportunity to work with a broad range of public and private organizations.¹⁷⁸

175. See *supra* text accompanying notes 106-08 (showing that according to a state survey, eighty-nine percent of clients whose Medicaid/TANF case was closed stated that the caseworker did not explain the options of Medicaid benefits under other programs, and fifty-seven percent stated that they were not aware their benefits would continue if they went to work).

176. SUPPORTING FAMILIES IN TRANSITION, *supra* note 14, at 27-28. Missouri advocates also suggested that the state consider buying ads in church bulletins and other in-house correspondence of religious organizations. While newspaper advertisements are less likely to be effective as other forms of outreach in reaching Medicaid clients, such ads should at least be included in freely distributed papers. See Ferber, *supra* note 71, at 11.

177. COMMUNITY LEGAL SERVS. ET AL., MEDICAID REINSTATEMENT AND RETENTION FACT SHEET (1999) (on file with the Saint Louis University Law Journal).

178. See SUPPORTING FAMILIES IN TRANSITION, *supra* note 14, at 31-32.

7. Systematic and Ongoing Monitoring

Another component of a remedy for improper terminations of Medicaid is systemic and ongoing monitoring of closed TANF and Medicaid cases. HCFA recognized that a state review of all closed TANF cases in which Medicaid did not continue is an essential element of preventing improper terminations in its March 1999 policy guidance.¹⁷⁹ In addition, litigation involving comparable patterns and practices of denials of benefits has often included requirements that states review random samples of case files or engage in detailed reporting regarding a particular issue on which they were out of compliance.¹⁸⁰ Such monitoring is an important component of any remedy for states' continued pattern of denying Medicaid coverage to eligible families.

Advocates have recommended that states implement ongoing monitoring of closed TANF cases to ensure that Medicaid eligibility was evaluated properly. This could include regular supervisory case reviews of closed TANF cases to determine if Medicaid was denied or terminated improperly. States also could make Medicaid eligibility case reviews part of their regular quality control audits. States that have been most responsive to the problem of unlawful terminations of Medicaid coverage have adopted specific strategies to monitor compliance with de-linking provisions.¹⁸¹ Systematic monitoring also can be built into any court-ordered remedy for violations of de-linking requirements or can be implemented by states as part of negotiated settlements of disputes involving these issues.

179. *See id.* at 22.

180. *See, e.g.,* Southside Welfare Rights Org. v. Stangler, 156 F.R.D. 187, 193-94 (W.D. Mo. 1993) (holding that defendants must conduct case file reviews to determine whether the state is in compliance with court orders); Alexander v. Hill, 549 F. Supp. 1355, 1360 (W.D.N.C. 1982) (holding that the state defendants must submit to plaintiff's counsel a monthly report of cases received by the Disability Determination Section and all cases overdue with or without good cause); Harley v. Lyng, 653 F. Supp. 266, 282 (E.D. Pa 1986) (holding that the Department of Public Welfare must gather and maintain appropriate data necessary to monitoring compliance with the Food Stamp Act); Reynolds v. Giuliani, No. 98 Civ. 8877(WHP), 2000 WL 1013952 (S.D.N.Y. July 21, 2000) (involving City defendants who engaged in extensive audits, including case file reviews and unannounced visits to local offices, review of fair hearing decisions, and on-site performance reviews, to monitor their compliance with the court's preliminary injunction).

181. As indicated above, Missouri has used its Quality Control Reviewers to conduct reviews of closed TANF cases. The state has also conducted county office reviews to identify whether cases were improperly closed, and to identify and resolve deficiencies. Maryland has implemented a centralized case review system to monitor its local offices' compliance with de-linking requirements. MARYLAND MEDICAID AGENCY, *supra* note 140. Washington state has conducted quality control audits of closed TANF and Medicaid cases and Pennsylvania has engaged in supervisory reviews of Medicaid terminations. NORTHWEST HEALTH LAW ADVOCATES, *supra* note 136, at 2; Torregrossa, *supra* note 155.

8. Computer and Other “Systems” Changes

As discussed above, computer system problems are often the reason for loss of Medicaid after a TANF closure. HCFA has now directed states to make the systems changes necessary to implement the de-linking of Medicaid and cash assistance.¹⁸² Computer systems changes have been an important part of the negotiated settlements in various states that have agreed to change their “de-linking” practices and procedures and to reinstate families.¹⁸³ Such changes can also be part of litigation-based remedies to unlawful Medicaid terminations.¹⁸⁴

States can also implement other changes in their systems to improve the process for consumers at the front-end; states could de-link TANF and Medicaid earlier in the process. Several states have de-linked TANF and Medicaid computer codes so that the computer system is less likely to make automatic determinations on Medicaid cases whenever an action is taken on a cash assistance case.¹⁸⁵ With the process de-linked at the outset, caseworkers will become more familiar with separating the cases, thereby decreasing the likelihood of any misapplication of federal requirements regarding the de-linking of Medicaid and cash assistance. A state may want to ensure that there are two separate entry decisions: one for cash and one for Medicaid. State agencies may want to stop associating individuals’ Medicaid coverage with their cash assistance eligibility in the “system” at the outset, so that a termination of cash assistance will not lead to an improper termination of Medicaid coverage.

States also may explore whether they can revise their computer systems to extend TMA automatically to all families whose earnings place them over the section 1931 income cut-offs. The Missouri state agency has revised its programming to ensure that sanctioned individuals do not lose Medicaid and

182. Westmoreland, *supra* note 18, at 7.

183. In Missouri, the continuation of Medicaid when someone goes to work is entirely dependent upon the actions of caseworkers rather than just the computer system. Because this system, too, is prone to error due to lack of knowledge of de-linking provisions on the part of many workers, advocates have suggested that the state explore other systems changes that would ensure that Medicaid continues when families lose TANF. In particular, advocates have recommended that the state review possible systems revisions at both the “front-end” and the “back-end” of the TANF/Medicaid eligibility review process. *See* Ferber, *supra* note 71, at 12.

184. *See, e.g.*, Southside Welfare Rights Org. v. Stangler, 156 F.R.D. 187, 194-95 (W.D. Mo. 1993) (holding that defendants were required to demonstrate that they had improved their computer programming); Reynolds v. Giuliani, 35 F. Supp. 331, 347-48 (S.D.N.Y. 1999); Robertson v. Jackson, 766 F. Supp. 470, 479 (1991); Harley v. Lyng, 653 F. Supp. 266, 282-83 (E.D. Pa. 1986); Bennett v. White, 671 F. Supp. 343, 350 (E.D. Pa. 1987).

185. Some states have made changes to their systems to ensure that TANF and Medicaid are treated separately in the computer systems. South Dakota, Delaware and Arizona have implemented or are in the process of implementing new computer systems that consider Medicaid eligibility separately. *See* MANN, *supra* note 63, at 14.

that applicants are placed in the correct Medicaid eligibility category.¹⁸⁶ Advocates have recommended that the agency explore all possible options to ensure that transitional Medicaid continues automatically upon a TANF closing based on a change in income.¹⁸⁷ For example, Pennsylvania has modified its computer systems so that when the cash case is closed for earnings, the computer automatically suggests opening a transitional Medicaid case. The worker then decides which category is applicable (section 1931 or TMA).¹⁸⁸ Part of Washington's plan is to fix the automatic termination of health coverage that caused many families to lose coverage improperly.¹⁸⁹

9. Making Compliance with Medicaid De-linking Requirements a Mandatory Component of Performance Evaluations

In addition to the supervisory reviews and monitoring that are discussed above, states may want to consider making Medicaid de-linking, including compliance with the *ex parte* redetermination requirement, a part of the performance evaluations of the caseworkers and supervisors who are responsible for implementing the de-linking of cash assistance and Medicaid. The realization that compliance with these requirements will be a critical component of job performance could cause field staff to focus a greater level of attention to de-linking issues and lower the number of improper denials and terminations. This can also be a part of any court-imposed remedy for ongoing and systemic violations of Medicaid law and regulations relating to the de-linking of cash assistance and Medicaid.

10. Imposing a Moratorium on Medicaid Case Closings

Another remedy that states may want to consider while they are working to correct systemic and unlawful Medicaid terminations is to impose a temporary moratorium on all Medicaid closings for cash assistance recipients pending resolution of the other problems that are causing such denials and terminations. HCFA has recommended such a moratorium as a possible approach in states

186. As a result of the *Mangracina* case, discussed above, New York State has reprogrammed its computers so that Medicaid continues unchanged when a cash assistance work sanction is imposed. See *supra* text accompanying note 135.

187. See Ferber, *supra* note 71, at 12; Letter from Joe Squillace, to Tom Lenz, Division of Medicaid and State Operations, Health Care Financing Administration (Feb. 4, 2000) (on file with the Saint Louis University Law Journal).

188. See Presentation of Pat Redmond, Philadelphia Citizens for Children and Youth, TANF Medicaid Roundtable (Dec. 6, 1999) (on file with the Saint Louis University Law Journal); E-mail from Richard Weishaupt, Attorney, Community Legal Services, to Joel Ferber, Attorney, Legal Services of Eastern Missouri (Sept. 6, 2000, 09:26:00 CST); E-mail from Richard Weishaupt, Attorney, Community Legal Services, to Joel Ferber, Attorney, Legal Services of Eastern Missouri (Oct. 5, 2000, CST 11:35:00 CST) (on file with the Saint Louis University Law Journal).

189. See NORTHWEST HEALTH LAW ADVOCATES, *supra* note 136.

whose computer systems are responsible for unlawful Medicaid terminations. HCFA notes that “a short-term moratorium on Medicaid case closings based on certain computer codes pending implementation of other solutions might be an option for some States” as a remedy for computer-based terminations.¹⁹⁰ In this context, HCFA has stated that “Medicaid case closings could be held as long as Federal requirements on the frequency of redeterminations are met.”¹⁹¹ States may also want to impose a moratorium on Medicaid closings in all TANF cases pending statewide training of all staff and an audit of closed TANF cases. Of course, a moratorium on such case closings can also be a component of any court-ordered temporary or preliminary relief.¹⁹²

11. Fiscal Sanctions

A more drastic remedy for violations of de-linking requirements that may be available in cases of persistent non-compliance is the imposition of fiscal sanctions on non-complying state agencies. A number of courts have imposed fiscal sanctions on state agencies that demonstrate consistent violations of federal requirements governing public assistance programs over a long period of time.¹⁹³ These sanctions are typically only imposed after a finding of contempt for violating an existing injunction or consent decree. HCFA also has the authority to impose sanctions on states that violate Medicaid program rules, but has not yet pursued such sanctions against states that fail to comply with de-linking requirements.¹⁹⁴ Financial sanctions are not likely to be an

190. Westmoreland, *supra* note 18, at 5.

191. *Id.* Maryland suspended automatic closings of Medicaid cases pending written confirmation from a centralized unit confirming that the proposed closings were in fact no longer eligible for any category of Medicaid coverage. See MARYLAND MEDICAID AGENCY, *supra* note 140.

192. In *Reynolds v. Giuliani*, discussed earlier, the court preliminarily enjoined the City of New York from converting welfare offices into “Job Centers” which had led to improper denials of Medicaid coverage. See *supra* notes 67-69, 123-30.

193. See, e.g., *Alexander v. Hill*, 549 F. Supp. 1355, 1362 (W.D.N.C. 1982); *Fortin v. Comm’r of Mass. Dep’t of Pub. Welfare*, 692 F.2d 790, 794 (1st Cir. 1982); *Rodriguez v. Swank*, 496 F.2d 1110, 1110 (7th Cir. 1974); *Mikel v. Gourley*, No. 76-881c(1), slip op. at 4 (E.D. Mo. Sept. 29, 1986) (requiring state defendants to pay a \$100 fine to each AFDC and Medicaid claimant whose hearing decision was delayed beyond the federally mandated time frame).

194. See 42 U.S.C. § 1396c (1994) (regarding HCFA’s authority to withhold federal payment, in whole, in compliance action against states who fail to comply with Medicaid program requirements or to disallow certain unauthorized expenditures of federal Medicaid funds). See also 42 U.S.C. § 1316(d) (1994); 42 C.F.R. § 430.35(a) (1999). In *Commonwealth of Massachusetts v. Departmental Grant Appeals Board*, 698 F.2d 22, 25 (1st Cir. 1983), the court found that a state’s acts in noncompliance with the state’s plan do not satisfy or deviate from any of the thirty-six requirements listed in 42 U.S.C. § 1396a. Unlike a disallowance, a compliance action involves at least the potential of a cessation of all federal funds. *Id.* at 30. While HCFA has clear authority to monitor state compliance with federal requirements and to take enforcement action when states deviate from the law, it rarely initiates a compliance against a state. See Draft

immediate remedy for violations of Medicaid de-linking provisions but are certainly a tool to be considered in states that continue to violate program rules after they have been put on notice of their unlawful conduct and have been given opportunities to correct violations of Medicaid program requirements.

12. Funding Corrective Action for Systemic Violations of Medicaid De-linking Requirements

As discussed in other sections of this article, states may also remedy systemic Medicaid denials and terminations by taking advantage of the \$500 million de-linking fund that was created as part of the welfare law.¹⁹⁵ Many states still have not spent their full allotment. Clearly, these funds can be used to address many of the program, policy and systems changes needed to correct improper terminations of Medicaid.¹⁹⁶

B. Reinstatement

Reinstatement or restoring health coverage to persons improperly terminated is one of the most hotly contested issues in resolving states' violations in de-linking Medicaid from cash assistance. Reinstatement is an important remedy for these violations. As discussed earlier, terminations may be illegal because no automatic redetermination of eligibility was made or no notice was provided. In addition, many terminations are improper because a family was actually eligible for TMA or some other category of Medicaid coverage when their TANF and Medicaid benefits were terminated.

On April 7, 2000, HCFA issued a guidance to state Medicaid directors requiring that they reinstate coverage for families and children who have been terminated improperly from Medicaid, including erroneous computer terminations and improper redeterminations of eligibility. "States have a continuing obligation to provide Medicaid to all persons who have not been properly determined ineligible for Medicaid."¹⁹⁷ HHS lists steps that the states must take to identify families who were terminated wrongly and instructs the states to reinstate coverage.¹⁹⁸

Memorandum from Claudia Schlosberg, National Health Law Program, to Interested Persons 1-2 (Mar. 15, 1999) (on file with the Saint Louis University Law Journal) (explaining HCFA's enforcement authority). Thus, enforcement by private litigants is critical to ensuring that provisions of the Medicaid statute and regulations are enforced.

195. See *supra* notes 15-16 and accompanying text.

196. Missouri claimed to have spent or obligated most of its \$500 million funds but there was some disagreement between the state and advocates about whether the funds were used properly, and whether they were focused on the section 1931 population. Squillace, *supra* note 187.

197. Westmoreland, *supra* note 18, at 2.

198. HHS charges states to identify improper actions by investigating: (a) requirements for TANF-related terminations; (b) requirements for terminations of disabled children eligible for Medicaid under section 4913 of the Balanced Budget Act of 1997; (c) improper denials of

At least four states (Pennsylvania, Washington, Maryland and Missouri) as of this writing have restored coverage to persons erroneously terminated from Medicaid. Pennsylvania restored access to some 32,000 recipients who lost Medicaid when they lost TANF from July 1997 to September 1998.¹⁹⁹ Maryland estimates that it will spend approximately \$22 million to reinstate families who lost coverage,²⁰⁰ and Washington has identified and sent mailings to 42,732 families.²⁰¹ These states agreed to reinstate families prior to the issuance of HCFA's guidance. Prior to the guidance, the state of Missouri notified several thousand families who lost TANF and Medicaid that they could reapply, which resulted in almost one thousand regaining coverage after reapplying for Medicaid.²⁰²

As of this writing, most states are in the process of formulating their responses to the guidance, including whether and how they should reinstate families no longer receiving Medicaid.²⁰³ There are many issues that states

eligibility. After the states have made this investigation, they must reinstate families who were improperly terminated, take all reasonable measure to contact the families, and properly redetermine eligibility once the family is reinstated. The guidance gives states the option of giving families retroactive benefits, but does offer Federal Financial Participation (FFP) to states that do make retroactive payments. *Id.*

199. SCHOTT, *supra* note 24, at 2.

200. FIP Legal Clinic Urges Further State Action to Help Families Who Were Denied Medical Assistance When They Left Welfare for Work, *supra* note 140.

201. SCHOTT, *supra* note 24, at 5. Washington automatically reinstated 29,610 of those families. *Id.*

202. Memorandum from Denise Cross, Director, Missouri Division of Family Services, to All Area and County Offices 1 (Jan. 14, 2000) (on file with the Saint Louis University Law Journal). As of April 18, 2000, the Division of Family Services had mailed 6,545 letters to former TANF parents who were not receiving any medical assistance. DFS received 1,720 applications, 968 of which were approved for some category of Medicaid. 1,976 were returned as undeliverable and 2,849 were delivered but did not respond. E-Mail from Charles Bentley, Division of Family Services, to Joel Ferber, Attorney, Legal Services of Eastern Missouri (June 30, 2000, 07:02 PM CST) (on file with the Saint Louis University Law Journal). This type of restoration of Medicaid coverage would not satisfy HCFA's April 7th guidance which requires automatic reinstatement of improperly terminated families, rather than requiring those families to reapply for benefits.

203. Early evidence suggests that states are taking varying approaches in responding to the April 7th guidance. Some states, such as Missouri and Ohio are in the process of developing and implementing relatively comprehensive reinstatement plans while others, such as Wisconsin and Virginia, are taking the position that they have complied with federal law and need not implement reinstatement for families who lost health coverage during the state's implementation of welfare reform. *See, e.g.*, Letter from Chris Elliott, Executive Director, Reform Organization of Welfare, and Joel Ferber, Attorney, Legal Services of Eastern Missouri, to Denise Cross, Director, Missouri Division of Family Services 1 (Sept. 13, 2000) (on file with Saint Louis University Law Journal); Letter from Peggy L. Bartels, Administrator, Wisconsin Department of Health and Family Services, to Timothy M. Westmoreland, Director, Center for Medicaid and State Operations 1 (June 9, 2000) (on file with the Saint Louis University Law Journal); Hanken, *supra* note 87.

need to address in determining how to implement a reinstatement plan. Some of these issues are discussed briefly below.

1. Reinstating Groups of Terminated Families or Making Individualized Determinations

Reinstatement does not require a case-by-case redetermination of eligibility. In fact, it is likely to be more administratively feasible for states to reinstate classes of people, whom the state suspects were wrongly terminated.²⁰⁴ Maryland, Pennsylvania and Washington all reinstated classes of people rather than making individual determinations. States should not fear the cost of reinstating entire classes of people since many of the reinstated families will not use their reinstated Medicaid, whereas reviewing ongoing individual cases could consume significant resources.²⁰⁵

2. Notice to Families

One of the most significant issues states must address is notifying families of the restoration of their benefits. The guidance acknowledges that “states may have to reinstate individuals and families who have not been in contact with the Medicaid agency for some time” and directs states to take “all reasonable steps” to identify the individual or family’s current address.²⁰⁶ States should look outside the traditional social services database as many families might have moved recently or the department might otherwise have the wrong address.²⁰⁷ States can use television or radio to notify these families through public service announcements that they may have erroneously lost health benefits.²⁰⁸ For example, Pennsylvania conducted a major marketing campaign to locate families eligible for reinstatement, checking TANF, food stamp and other files in an effort to obtain more current addresses.²⁰⁹ States

204. SCHOTT, *supra* note 24, at 3-4. For example, a specific policy or practice may have caused an identifiable group of individuals to lose Medicaid improperly. The state could choose to restore coverage of that entire class of recipients. *Id.*

205. *Id.* In a given time period, it is unlikely that an excessive number of families will have any current medical needs. In Pennsylvania, for example, only about twelve percent of the reinstated families actually used the coverage. In addition, not all will continue to receive Medicaid beyond the initial reinstatement period (only sixteen percent in Pennsylvania). *Id.*

206. Westmoreland, *supra* note 18, at 4.

207. In Washington, for example, over twenty-five percent of the notices sent to families were returned as undeliverable with no forwarding address. See SCHOTT, *supra* note 24, at 7.

208. Pennsylvania established a toll-free number, dedicated staff to respond to the calls from the help line, and spent \$290,000 on public service announcements. COMMUNITY LEGAL SERVS. ET AL., *supra* note 177.

209. See Redmond, *supra* note 94. In Pennsylvania, some 3,200 individuals returned the form and the documentation. Pennsylvania advocates reported that this was much higher than expected for a direct mail campaign. *Id.*

can fund these initiatives with their portion of the \$500 million designated for Medicaid de-linking-related activities.

3. Retroactive Benefits

Existing Medicaid laws and regulations require states to reimburse providers (for unpaid bills) and families (for paid bills) if the family was improperly terminated from Medicaid.²¹⁰ HCFA clearly states that full federal financial participation will be available to states that opt to provide retroactive benefits. Washington, Pennsylvania and Maryland chose to provide retroactive benefits. Although HCFA gave states the option of covering services provided prior to reinstatement, advocates have argued that retroactive benefits should be part of reinstatement.

Advocates have argued that such coverage is critical for families who are making the transition from welfare to work because an unexpected medical expense can be devastating for a family trying to become self-sufficient.²¹¹ For example, a family's inability to pay the bills might lead to a poor credit rating making it impossible to obtain a badly needed loan.²¹²

210. Federal regulations require states to make Medicaid coverage effective for eligible families who receive Medicaid-covered services. 42 C.F.R. § 435.914 (1999). Medicaid coverage is not effective unless Medicaid is paying for covered services. When such improper determinations are reversed, the Agency must make corrective payments retroactive to the date that the incorrect action was taken. 42 C.F.R. § 431.246 (1999).

211. See, e.g., Roth, *supra* note 141, at 16.

212. Letter from Christopher Elliott, Executive Director, Reform Organization of Welfare, & Joel D. Ferber, Attorney, Legal Services of Eastern Missouri, to Denise Cross, Director, Missouri Division of Family Services 3 (June 30, 2000) (on file with the Saint Louis University Law Journal).

The issue of retroactive relief is an especially difficult issue in litigation because of "Eleventh Amendment" considerations. The Supreme Court has interpreted the Eleventh Amendment to preclude federal courts from ordering state agencies to pay retroactive benefits, thereby making it far more difficult for advocates to force state agencies to provide such relief, even if the relief is arguably required by the Medicaid statute. See *Edelman v. Jordan*, 415 U.S. 651 (1974) (holding that suits seeking "retrospective" or "retroactive" relief from a state official's violation of federal law are barred by the Eleventh Amendment); *Seminole Tribe v. Florida*, 517 U.S. 44 (1996); see generally Vicki C. Jackson, *Seminole Tribe, the Eleventh Amendment, and the Potential Evisceration of Ex Parte Young*, 72 N.Y.U. L. REV. 495 (1997).

However the Supreme Court has carved out an exception allowing suits brought against state officials seeking "prospective" relief, known as the "*Ex parte Young*" exception. *Ex Parte Young*, 209 U.S. 123, 159-60 (1908). In *Ex Parte Young*, the Court held that Eleventh Amendment immunity does not shield State officials acting in violation of federal law. In those circumstances, the officials' unauthorized actions are stripped of their official character and may be challenged in a federal suit. *Id.* Thus, suits that are brought against state officials challenging a violation of federal law, which seek only prospective relief, are allowed under the Eleventh Amendment. Therefore, the Eleventh Amendment should not bar courts from ordering Medicaid reinstatement, which is different from requiring states to provide retroactive reimbursement for past medical expenses. Reinstating individuals who previously lost coverage and redetermining

4. Reinstatement Period

In the states that have already begun reinstating families, the reinstatement period has varied slightly. HCFA's guidance allows Federal Financial Participation for up to 120 days to allow states adequate time to review ongoing eligibility for reinstated families. Maryland and Pennsylvania chose to reinstate families for sixty days. Pennsylvania, however reinstated families for six months if their case records showed earnings when the family left TANF.²¹³ Washington's chose to reinstate people for ninety days.²¹⁴

States will need to conduct *ex parte* reviews during this time period, before families' lose their Medicaid again. Therefore it is important to ensure that the time period is long enough to correctly determine eligibility. Another significant benefit to the ninety-day period is that it will satisfy the "three of the last six months" requirement necessary to trigger transitional Medicaid eligibility for families whose earnings disqualify them under section 1931.²¹⁵

In a related issue, states must determine the period of time for which benefits will be reinstated. States should examine policies and practices beginning at the point which the state TANF plan went into effect. Section 1931 de-linking policy became operative on the day that states' TANF plans went into effect, so the state should have implemented a section 1931 coverage category on that date. The "end date" for reinstatement should extend to the point at which all of the state's de-linking problems have been clearly resolved, through training, policy changes, computer corrections and any other necessary corrective measures.²¹⁶

their continued Medicaid eligibility is clearly "prospective" relief, allowable under the Eleventh Amendment. For further discussion of Eleventh Amendment considerations, see generally Carlos Manuel Vazquez, *Night and Day: Coeur D'Alene, Breard and the Unraveling of the Prospective-Retrospective Distinction in Eleventh Amendment Doctrine*, 87 GEO. L.J. 1 (1998); Vicki C. Jackson, *Principle and Compromise in Constitutional Adjudication: The Eleventh Amendment and State Sovereign Immunity*, 75 NOTRE DAME L. REV. 953 (2000).

213. SCHOTT, *supra* note 24, at 12.

214. SAUER, *supra* note 76, at 1.

215. See SCHOTT, *supra* note 24, at 12. Although HCFA has not indicated that it will require states to offer families the additional TMA, FFP is available for states wishing to provide TMA based on three months of reinstated coverage. Washington has taken advantage of the FFP to reinstate families for ninety days, with the opportunity to receive transitional Medicaid.

216. For a more detailed discussion of the many issues involved in reinstatement of eligible families, see *id.* Among the other issues that states must address are: (1) whether to provide Transitional Medical Assistance to reinstated families who became employed during the period between their initial Medicaid termination and reinstatement; (2) the process by which reinstated families will regain health coverage; (3) estimating the costs of reinstatement; (4) how the state obtains information to determine continued eligibility after reinstatement; (5) whether to use reinstatement as an opportunity to explore food stamp eligibility of reinstated families.

C. *Policy Changes That Can Alleviate the Loss of Medicaid Resulting from Welfare Reform*

States also may implement certain policy changes that can help alleviate the problem of persons losing health coverage as a result of welfare reform policies, practices and procedures. These approaches, which are discussed below, can lead to less verification, fewer visits to the welfare office, and reduce the incidences of procedural denials and terminations of Medicaid coverage.

1. Twelve-Month Continuous Eligibility

The Balanced Budget Act (BBA) offered states the option to provide twelve-month continuous coverage for Medicaid-eligible children regardless of intervening changes in circumstances.²¹⁷ Without this policy, states redetermine eligibility for a child whenever the beneficiary's income changes. This results in discontinuous coverage²¹⁸ and can lead to the improper terminations of coverage that have been described earlier in this paper. Under twelve-month continuous coverage a TANF case closing should not prompt a Medicaid redetermination that might cause such a Medicaid closing, since the children remain eligible regardless of changes in income or circumstances. Continuous eligibility also reduces the likelihood that there will be erroneous terminations of coverage since intervening changes in circumstances need not be reported or considered during the twelve-month period of continuous eligibility.²¹⁹

Adopting this option can help move states toward a more seamless system whereby individuals would not go on and off of Medicaid, interrupting their continuity of care. A byproduct of this option is to alleviate some of the churning of the caseload that occurs under welfare reform.

217. Social Security Act, § 1902(e)(12); 42 U.S.C. § 1396a(e)(12) (Supp. IV 1998).

218. The Congressional Budget Office estimates that children stay enrolled in Medicaid only nine months in a year. See ANDY SCHNEIDER, CENTER ON BUDGET AND POLICY PRIORITIES, OVERVIEW OF MEDICAID PROVISIONS IN THE BALANCED BUDGET ACT OF 1997, at 8 (Sept. 1998).

219. Even if a state does not adopt twelve month continuous eligibility, it may still adopt a policy under which the loss of TANF cash assistance is a "non-event" for the purposes of Medicaid eligibility, unless TANF is lost for a reason that clearly and directly affects Medicaid eligibility (such as moving out of state, death, or a reported *increase* in income). While this approach is not as strong a protection as twelve month continuous coverage, it at least assures that individuals losing TANF for failing to meet procedural requirements that are unrelated to Medicaid still retain their Medicaid eligibility until their next regularly scheduled *Medicaid* redetermination.

2. Presumptive Eligibility

Another step states can take to increase participation and provide medical assistance to families with children is presumptive eligibility.²²⁰ This option is not directly responsive to the de-linking problem, but it is a way to make it easier to enroll children and pregnant women in Medicaid. Under the procedure, qualified entities, such as medical providers, preliminarily review a child's or pregnant woman's eligibility for Medicaid. If it appears that the person is eligible, the provider can issue a temporary Medicaid card that provides coverage immediately.²²¹ People can apply and be presumed eligible at the time they apply and given a limited period of Medicaid eligibility based on an initial review of the case by a qualified entity. Presumptive eligibility can be an effective outreach strategy for reaching new individuals not receiving Medicaid, and is therefore a way to bring back to a state's system, individuals who have lost coverage due to welfare reform.²²²

3. Expanding Health Coverage Under Section 1931 of the Welfare Law or Through Adoption of Family-Based Health Insurance Programs

Another policy option that states should consider is to take advantage of the welfare law's flexibility to broaden the income and resource rules under section 1931, which was discussed earlier. Since receipt of Medicaid is no longer tied to eligibility for TANF, states may expand their Medicaid programs under this provision to include more low-income working families. Expanding Medicaid through section 1931 will keep families with higher wages eligible

220. See 42 U.S.C. § 1396r-1A (Supp. IV 1998). States previously had this option only with respect to pregnant women during the prenatal period. For a more detailed discussion of the presumptive eligibility option, see DONNA COHEN ROSS, CENTER ON BUDGET AND POLICY PRIORITIES, PRESUMPTIVE ELIGIBILITY FOR CHILDREN: A PROMISING NEW STRATEGY FOR ENROLLING UNINSURED CHILDREN IN MEDICAID (1998); FAMILIES USA, PROMISING IDEAS IN CHILDREN'S HEALTH INSURANCE, PRESUMPTIVE ELIGIBILITY FOR CHILDREN 1 (2000).

221. Based on the family's declaration that its income is below the state's Medicaid income guidelines, a wide array of persons and entities can determine that children are presumptively eligible for Medicaid coverage. Among the many entities/individuals that can make a presumptive eligibility determination are physicians, health clinics, community health centers, school-based programs that receive Medicaid funding for health services provided to students, WIC programs, Head Start programs, and child care providers. Presumptive eligibility is not only an effective outreach tool/strategy but is also a way to recapture some of the children who have lost Medicaid due to welfare reform. See ROSS, *supra* note 220, at 2.

222. For a discussion of the effectiveness of presumptive eligibility as a Medicaid outreach and enrollment strategy, see *supra* notes 220-221 and accompanying text. A variation on presumptive eligibility also has been employed as a court-ordered remedy for violations of public assistance application processing rules in welfare and Medicaid cases. See, e.g., *Smith v. Miller*, 665 F.2d 172, 174 (7th Cir. 1981). In *Smith*, the court ordered the state to approve automatically requests for Medicaid benefits that were not processed timely. *Id.* Thus, presumptive eligibility could be a remedy for situations in which Medicaid applications are delayed based on TANF requirements that are legally inapplicable to Medicaid. See *supra* note 220.

for section 1931 Medicaid for a longer period, and alleviate some of the problems that occur when families become eligible for transitional Medicaid, including some of the problems that have been discussed in the earlier sections of this article.²²³ Other measures, such as eliminating the asset test for families would reduce the amount of documentation parents need to provide for eligibility determinations and make the process of getting and keeping Medicaid easier.²²⁴ Several states have taken advantage of this option to expand coverage to working parents who would not otherwise be eligible for Medicaid.²²⁵ For example, Missouri made its Medicaid eligibility requirements “less restrictive” than the old AFDC-based Medicaid category by eliminating the assets test for families receiving the Missouri section 1931 Medicaid.²²⁶ A number of states have chosen to adopt less restrictive earnings disregards, thereby allowing more families to retain eligibility when they go to work without using up their TMA.²²⁷ This is a way to help ensure that families who go to work continue receiving health care benefits.²²⁸

223. In addition to many states’ apparent inability to ensure the receipt of transitional Medicaid by eligible families, there are administrative requirements, such as quarterly reporting, that make continued receipt of transitional Medicaid more complicated than maintaining eligibility under section 1931. For a more detailed discussion of state options in expanding coverage through use of section 1931, see JOCELYN GUYER & CINDY MANN, *CTR. ON BUDGET AND POLICY PRIORITIES, TAKING THE NEXT STEP: STATES CAN NOW TAKE ADVANTAGE OF FEDERAL MEDICAID MATCHING FUNDS TO EXPAND HEALTH CARE COVERAGE TO LOW-INCOME WORKING PARENTS* (1998). *See also* DUBAY ET AL., *URBAN INSTITUTE, EXTENDING MEDICAID TO PARENTS: AN INCREMENTAL STRATEGY FOR REDUCING THE NUMBER OF UNINSURED* (2000), available at http://newfederalism.urban.org/html/series_b/b20/b20.html.

224. *FAMILIES USA*, *supra* note 45, at 30-31.

225. *See* STATE POLICY DOCUMENTATION PROJECT, *supra* note 10, at 3. As discussed earlier, the technical mechanism for expanding coverage under section 1931 is to adopt a “less restrictive income or resource methodology.” For example, the practical effect of disregarding a greater degree or earnings from the eligibility determination is to broaden the circumstances in which low-wage working families qualify for section 1931 Medicaid. *See* GREENBERG, *supra* note 52, at 16 n.39.

226. *See* Memorandum from Carmen K. Schulze, Director, Division of Family Services, Missouri Department of Social Services, to All Area and County Offices 4 (Dec. 29, 1998) (on file with the Saint Louis University Law Journal).

227. Earnings disregards refer to the amount of money an individual earns from employment which the state excludes from the evaluation of a family’s income level. For instance, the state of Florida disregards the first two-hundred dollars plus fifty percent of remaining earnings in determining Medicaid eligibility for families with children. *See* STATE POLICY DOCUMENTATION PROJECT, *supra* note 10, at 3. Washington State has implemented a more generous earned income disregard (fifty percent of gross earnings), more liberal treatment of assets, and broader eligibility for two-parent families under TANF, and has extended those same standards to section 1931 eligibility. GREENBERG, *supra* note 52, at 16.

228. Although the focus of this article is the states’ failure to properly de-link TANF and Medicaid, states also may take certain measures to assure that TANF eligible children are *automatically* eligible for Medicaid. Many states have adopted more generous income or

In addition, a growing number of states have elected to convert their children's health programs into family-based programs that include children and their parents.²²⁹ These types of programs go beyond TMA by providing low-to-moderate income working parents the same opportunity as their children to secure coverage on an ongoing basis, and can provide coverage to low-income working families that are diverted from welfare, along with families leaving welfare.²³⁰ Of course, the evidence from state implementation of the welfare law makes it clear that Medicaid expansions alone do not ensure that persons will not fall through the cracks and lose health insurance when they move from welfare to work.²³¹

VII. CONCLUSION

This article has focused on a well-documented systemic problem that is a direct consequence of federal and state welfare reform efforts. The review of state and national studies confirms the harsh reality that the number of uninsured has increased as a result of welfare reform. Even in states such as Missouri that have not experienced significant Medicaid declines, a closer look at the data reveals a systemic unlawful termination of Medicaid coverage for families leaving TANF. This article has described many of the components of any state-based remedy for these terminations, whether it is achieved through litigation, negotiation or as a result of a state agency's own initiative in responding to this problem.

This article demonstrates that expanding eligibility does not necessarily ensure that eligible individuals will be covered. Although expanding the

resource standards for TANF. Under section 1931, states may align their Medicaid resource and income standards to match their TANF requirements, thereby ensuring that all families receiving TANF are eligible for Medicaid. For a more in-depth discussion of this option, see MANN, *supra* note 63, at 8-9. States also may expand coverage to two-parent families by easing or eliminating the "deprivation of parental support" requirement of the former AFDC program as a condition of Medicaid eligibility. See 63 Fed. Reg. 42,270, 42,272 (Aug. 7, 1998). Many states, including Missouri, have taken this option.

229. GUYER, *supra* note 48, at 44. For a description of major expansions of coverage of parents in low-income working families, see JOCELYN GUYER, CTR. ON BUDGET AND POLICY PRIORITIES, A GROWING NUMBER OF STATES ADOPTING INITIATIVES TO EXPAND COVERAGE FOR THE CHILDREN AND PARENTS IN LOW-INCOME WORKING FAMILIES 1 (1999). The article highlights expansions in Rhode Island, the District of Columbia, Wisconsin, Connecticut, California and Missouri. *Id.*

230. GUYER, *supra* note 48, at 44. For example, Wisconsin provides health insurance to families with income up to 185% of the poverty line under its "BadgerCare" program, using a combination of Medicaid and CHIP funds. *Id.*

231. As discussed earlier, Missouri has engaged in a very broad expansion of Medicaid for children and adults, yet many families have lost health coverage when they left cash assistance. See *supra* notes 55, 95-113 and accompanying text (regarding Missouri's TANF leavers study and regarding the findings from state quality assurance reviews).

program is an important step towards improving access, it is also crucial that states implement training, supervisory reviews and reinstatement to prevent more families from losing health care coverage. While these issues need to be addressed in each state, it is also important to remember that the underlying problem is also a direct result of *federal* welfare reform. Congress sent clear signals to states to move people off of welfare as quickly as possible, which led to a variety of strategies that had the unintended effect of causing many thousands of people to lose Medicaid.

When TANF is re-authorized, Congress may need to re-evaluate the message it wishes to send states about what constitutes “successful” welfare reform, and include clearer signals that Medicaid retention is an important measure of success. Continued health coverage should be a factor in determining the various sanctions and financial incentives that are applicable to states implementing welfare reform. Medicaid retention should be at least as important as caseload reduction in determining whether states meet their work participation rates under the TANF block grant. Moreover, Medicaid retention should be incorporated as a performance measure in evaluating states’ performance under the Medicaid program itself, and should be a factor in determining states’ access to federal matching funds under the program.

In the interim, the problem will continue to be addressed in each individual state with varying degrees of success—often dependent on the strength of the legal resources and advocacy coalitions, and the political dynamics in each state.