

ACKNOWLEDGMENTS

This report would not have been possible without the cooperation and support we received from staff at all levels in each of the study states. Program administrators fielded many questions from us about formal policies and procedures, and local staff talked openly with us about how those policies and procedures play out in practice and let us observe them as they went about their daily routines. Clients shared their thoughts on both the benefits and costs of applying for public benefits. We would like to thank everyone who graciously shared their time with us for making this report possible.

We would also like to thank staff from the U.S. Departments of Health and Human Services and Agriculture for providing guidance and feedback throughout this project. As project officer, Michael Dubinsky, guided the project from beginning to end. Ann McCormick, Ann Burek, Penny Pine, Margaret Andrews, and Rosemarie Downer provided useful feedback throughout the project. Karl Koerper and Howard Rolston provided comments on a draft of the final synthesis report.

Stacy Dean, Dottie Rosenbaum and David Super from the Center on Budget and Policy Priorities helped us to gain a better understanding of the intricacies of the Food Stamp Program and the options available to states to simplify the application and recertification processes for families. Cindy Mann from the Kaiser Family Foundation provided a thorough review of the final report. Vicki Grant and Nancy Gantt from the Southern Institute for Children and Families worked with us to coordinate our work with the Robert Wood Johnson Foundation's project, Supporting Families After Welfare Reform.

The work for this project was completed as a team effort, involving staff from multiple organizations. At Mathematica Policy Research (MPR), LaDonna Pavetti directed the project. Robin Dion, Megan McHugh, Angela Merrill, Jessica Mittler, and Charles Nagatoshi conducted site visits and authored the state site visit summaries. Megan McHugh also helped with drafting the first chapter of the synthesis report. As a consultant to MPR, Liz Schott contributed to virtually every aspect of the project. In addition to co-authoring the final synthesis report, she conducted site visits, authored several of the site visit summaries and reviewed those she did not write. Her extensive knowledge of TANF and the Food

Stamp and Medicaid programs helped all of us to do a better job on this project. Margaret Boeckmann, also a consultant to MPR, conducted several site visits and helped to synthesize the information collected. Julie Osnes of the Rushmore Group, Inc. helped us to identify potential sites and reviewed all of the site visit summaries and the final synthesis report. Marilyn Ellwood reviewed an early draft of the synthesis report and provided comments that substantially improved the final product. Ruchika Bajaj managed the project. Brianna Stanton helped us to prepare the data we collected for analysis. Daryl Hall coordinated the editing of the reports and Donna Dorsey provided ongoing and consistent administrative support. Staff from our survey division helped us to recruit clients for the focus groups.

Our subcontractors, George Washington University Center for Health Services Research and Policy (GWU-CHSRP) and American Management Services, Inc. (AMS) participated in all aspects of the project. Kathleen Maloy acted as project director at GWU-CHSRP, supervising project staff and reviewing all project reports. Her extensive knowledge of Medicaid for families helped everyone to better understand the intricacies of Medicaid enrollment and retention. Jennifer Stuber and Michelle Posner conducted site visits. Lea Nolan and Julie Darnell, a consultant to GWU-CHSRP from Northwestern University, conducted site visits and authored the state site visit summaries. Soeurette Cyprien provided administrative support. At AMS, Gary Hyzer acted as project director. Along with Allison Logie, Lara Petrou Green and Ben Marglin, he conducted site visits and authored the state site visit summaries. AMS staff also helped to develop the methodology to document the case flow in each of the sites and to assess the use of automated systems. Gary Hyzer also assisted with drafting the chapter on information systems in the final synthesis report.

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All reports are available on Mathematica Policy Research's website at: www.mathematica-mpr.com/3rdlevel/welrefimpact.htm.

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KEY FINDINGS AND RECOMMENDATIONS

This study, conducted by Mathematica Policy Research, Inc. and its subcontractors, American Management Systems, Inc. and the George Washington University Center for Health Services Research and Policy, was commissioned by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture to identify strategies states and local welfare offices are using to promote participation in food stamps, Medicaid and SCHIP and the ongoing challenges they face in providing support to working families.

KEY FINDINGS

The experiences of the study sites suggest the need for diverse strategies to increase participation in programs that support working families. These strategies focus on three different themes: (1) awareness, (2) simplification, and (3) reduction of risk points.

Increasing Program Awareness

- A carefully designed public information campaign combined with locally based outreach activities appears to be a promising strategy for increasing program awareness and enrollment.

Program Simplification

- The ease of applying for benefits depends on which benefits a family is seeking. In all the study sites, working families applying for and retaining children's Medicaid and SCHIP can do so through a relatively simple process; with a few exceptions, it is more complicated to apply for and retain Medicaid for the whole family (including parents) and substantially more burdensome to apply for food stamps.
- Efforts to change the culture and structure of the welfare office were important components of some sites' efforts to increase participation in food stamps, Medicaid and SCHIP.

Mitigating Potential Risk Points

- In an environment where each program has its own eligibility, application and renewal requirements, sophisticated automated systems, well-trained staff and explicit case processing procedures help to reduce the risk of families not having their benefits determined properly.
- While TANF families previously were at high risk of not having their benefits determined accurately during critical transitions, the study sites have largely addressed these issues.

RECOMMENDATIONS AND NEXT STEPS

- Use the lessons learned from public information and local outreach campaigns for children's Medicaid and SCHIP to inform families about the availability of Section 1931 Medicaid and the Food Stamp Program.
- Expand efforts to provide families with opportunities to apply for and renew benefits outside of the welfare office and evaluate the relative effectiveness of alternative strategies.
- Continue to encourage states to take advantage of the flexibility they have to simplify application and renewal requirements and identify key program requirements that make simplification difficult.
- Explore options for aligning eligibility requirements and application procedures for Medicaid and food stamps.
- Explore options, including providing increased funding, to help states maximize their use of technology to increase enrollment and promote retention in food stamps, Medicaid and SCHIP.
- Redesign the food stamp quality control system to account for the complex circumstances of working families.
- Encourage states to set enrollment goals for food stamps, Medicaid and SCHIP and reward them for their accomplishments.

EXECUTIVE SUMMARY

During recent years, the nation has witnessed unprecedented changes in the circumstances of low-income families. Since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), cash assistance caseloads have declined by more than half. Studies of families who have left the welfare rolls show that about 60 percent are working at any point in time (Acs and Loprest 2001). In addition, between 1994 and 1999, the employment rate for never-married mothers increased from 47 to 65 percent (Moffitt 2002).

The increase in employment among former welfare recipients has been accompanied by strong support for providing “work supports” to low-income working families, including nutritional assistance through the Food Stamp Program, health insurance through Medicaid and the State Children’s Health Insurance Program (SCHIP) and child care and transportation assistance through a broad array of federal and state initiatives. However, low levels of participation among former TANF recipients and other potentially eligible families in the Food Stamp and Medicaid programs have raised concerns about whether welfare offices are organized and equipped to deliver these benefits to working families, and whether federal requirements constrain their ability to do so. In response to these concerns, the federal government and some states have started to reassess the way eligibility for these benefits is determined, and to implement new strategies to reach more working families. Unlike other benefits that might be made available to working families, food stamps and Medicaid are entitlements, meaning that receipt of program benefits is not subject to the same state and local constraints that may affect benefits such as child care and transportation.

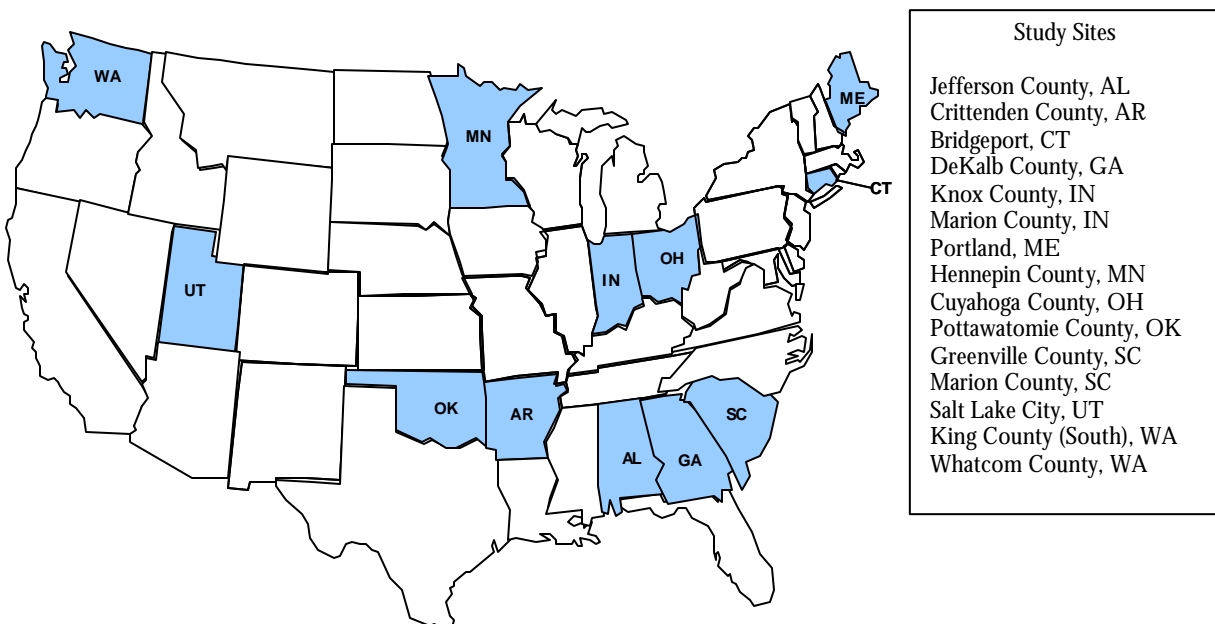
STUDY PURPOSE AND DESIGN

This study, conducted by Mathematica Policy Research, Inc. and its subcontractors, American Management Systems, Inc. and the George Washington University Center for Health Services Research and Policy, was commissioned by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture to identify strategies states and local welfare offices are using to promote participation in food stamps, Medicaid and SCHIP and the ongoing challenges they face in providing support to working families.

Our research design established three overarching foci: (1) assessing how to identify and ameliorate the opportunity costs (i.e. burdens) for families trying to initially apply for or retain benefits; (2) assessing how procedures for processing changes in eligibility status (i.e. transitions) create risk points for potentially losing benefits; and (3) determining whether the experiences of TANF and non-TANF families differ in ways that are important to understand current program participation. By focusing on the concept of opportunity costs, we acknowledge that working families now constitute the primary group of eligible families, and that these families have varying needs and may have less ability or willingness to deal with cumbersome procedures for getting benefits. The concept of risk points at critical transitions reflects the reality that working families frequently experience income and other changes in their circumstances and may need and receive a different combination of benefits as compared with a non-working family receiving cash assistance.

We collected data for this study primarily through three-day site visits to 15 sites in 12 states; a team of two to three researchers conducted the site visits. The objective of each site visit was to gain information from a wide variety of perspectives on the enrollment and retention policies and practices that might affect participation in Medicaid, SCHIP, and food stamps. During each visit, the research team conducted 60- to 90-minute semi-structured interviews with administrators and staff of the state agencies, local welfare offices, and community-based organizations that serve clients. We also conducted focus groups with clients who were recruited by staff from the welfare office or community agencies.

The sites included in the study were selected based on one or more of the following criteria: (1) self-selection by participating in the “Supporting Families Under Welfare Reform” project funded by the Robert Wood Johnson Foundation; (2) implementation of specific promising practices of interest; and (3) demonstration of higher levels of program participation.



THE STUDY CONTEXT: LOW LEVELS OF PROGRAM PARTICIPATION AMID CONTINUED NEED

For many families, increased employment does not always translate into improved financial circumstances. Parents leaving the welfare rolls usually work full time, earning between \$7 and \$8 per hour, leaving many of them well below the poverty line (Moffit 2002). Since the implementation of welfare reform, poverty rates for families have been declining steadily. In 2000, the overall poverty rate reached its lowest level since 1979 and poverty rates for female-headed families hit an all-time low. However, a recent Urban Institute study indicates that when all types of income are taken into account (including earnings, cash assistance and food stamps) about 300,000 more single-parent families lived in extreme poverty (below 50 percent of the poverty line) in 1998 than in 1996. Although many single parent families left welfare for work during this time period, their income from earnings was not sufficient to offset the income loss resulting from lower rates of participation in government programs. The authors note that if families with children took full advantage of the government programs for which they qualified, in 1998, 3.8 million fewer persons would have been poor and 2.0 million fewer would have been extremely poor in 1998 (Zedlewski et al. 2002).

Medicaid: Expanding Eligibility for Children but Slowing Rates of Enrollment for Families and Continued High Levels of Uninsurance for Low-Income Families

Trends in Medicaid enrollment. Total Medicaid enrollment grew throughout the early 1990s, declined between 1996 and 1998, but began rising again in 1999.¹ Between June 1996 and June 2000, total Medicaid enrollment in the 50 states and District of Columbia rose 1.7 percent, but trends in enrollment varied significantly across states. For example, Ohio's enrollment grew by 51.1 percent, while Georgia's enrollment declined 13.0 percent (See Appendix A-1). The growth in the Medicaid program in the early 1990s was fueled primarily by federal and state policies designed to expand Medicaid eligibility for poverty-level children and pregnant women, and by an economic downturn that increased the number of people in need. The enrollment rate slowed in the mid-to-late 1990s; this is often attributed to both the strong economy and federal welfare reform, which moved families from cash assistance to work and created confusion about Medicaid eligibility (Ku and Bruen 1999). The most recent rise in Medicaid enrollment can be largely attributed to SCHIP² that was created by the Balanced Budget Act of 1997. By 2001, about 4.6 million children were enrolled in SCHIP at some point during the year, up from less than 2 million children in FY 1999

¹ Total Medicaid enrollment includes these main categories of enrollees: elderly, blind and disabled persons, pregnant women, children, and families.

² States are required to determine whether children are eligible for Medicaid for enrolling them in SCHIP. This requirement, combined, with extensive outreach to make families aware of SCHIP has resulted in more children (and sometimes families) enrolling in Medicaid.

(Centers for Medicare and Medicaid Services 2002 and Health Care Financing Administration 2001).

Continued high rates of uninsurance and associated problems. Between 1994 and 1998, rates of uninsurance for persons under 65 rose steadily from 17.1 percent to 18.4 percent. Between 1998 and 1999, the uninsurance rate declined to 17.4 percent (National Center for Health Statistics 2001). Two-thirds of the 42 million uninsured Americans are in working families with incomes less than 200 percent of the federal poverty level; more than one-third of the uninsured come from families living below 100 percent of the federal poverty level. Mothers in families with incomes below 200 percent of the poverty line are uninsured at particularly high rates and account for nearly three of every four uninsured mothers in the United States (Guyer et al. 2001).

Numerous studies link health coverage to better access to care, better quality care, and improved personal and population health status. For example, studies have shown that uninsured individuals receive fewer preventive services and are less likely to have regular care for chronic conditions, such as hypertension and diabetes, which can lead to expensive and disabling complications (Institute of Medicine 2001). Uninsured adults, particularly those in poor health, are more likely to report they cannot see a physician when needed, due to cost (Ayanian et al. 2000). In addition, uninsured children who are eligible for but not enrolled in Medicaid encounter greater obstacles to care than their Medicaid-covered counterparts (Davidoff et al. 2000). A study comparing eligible adults enrolled in Medicaid with those who are not found that the uninsured were less likely to have a physician or dental visit, less likely to have a usual source of care, and more likely to incur out-of-pocket medical expenses (Davidoff et al. 2001).

Food Stamps: Declining Caseloads in the Midst of Substantial Food Insecurity

Trends in the food stamp caseload and program participation. From December 1996 to December 2001, the number of participants in the Food Stamp Program fell by 5 million, or 22 percent. The 18.7 million persons participating in the FSP in December 2001 represented a rise of about 1.6 million persons over the December 2000 level. The recent increase in the food stamp caseload is most likely being driven by improved access to the program in some of the states as well as growing numbers of layoffs (Food Research and Action Center 2002a). The overall caseload change between December 1996 and December 2001 varied substantially across the states. For example, participation declined by 42 percent in California but increased by 30 percent in Oregon and 11 percent in Indiana (Food Research and Action Center 2002b).

Some decline in food stamp participation was expected because of eligibility changes in the 1996 welfare law and the continued strength of the economy. While these two factors together explain some of the decline, they do not explain all of it. Last year, USDA reported to Congress that about a third of the total decline occurred because rising income and assets lifted people above the program's eligibility limits, just under 10 percent reflects the direct effect of welfare reform's change to eligibility rules, and a bit more than half occurred because of declining participation rates among eligibles (USDA 2001). Results of a recent

study using multivariate analysis to explore the effects of the economy and cash assistance policies on food stamp participation found that the economic growth during the middle to late 1990s explains 47 percent of the decline and welfare reform accounted for about 30 percent (Gleason et al. 2001).

Progress in reducing food insecurity and hunger; substantial unmet needs still exist. Between 1998 and 2000, food insecurity³ fell by 11 percent and hunger by 16 percent. Still, in 2000, 36.8 percent of poor households and 31 percent of households with children headed by a single mother were food insecure compared to 10.5 percent of all households. Similarly, at 12.7 and 9.0 percent respectively, the prevalence of hunger was much greater among poor and single parent households with children than among all households (3.1 percent). Only 23 percent of food-insecure households and 27.4 percent of food insecure-with-hunger households participated in the Food Stamp Program during the previous 30 days (Nord et al. 2002). America's Second Harvest, the nation's largest organization of emergency food providers, served 23.3 million people in 2001, an increase of 9 percent from 1997. Only 30 percent of clients received food stamps, though many more are likely to be eligible (Kim, Ohls and Cohen 2001).

FEDERAL FRAMEWORK AND STATE OPTIONS

Medicaid, SCHIP, and food stamps are authorized by different federal laws and administered by different federal agencies—the Department of Health and Human Services for Medicaid and SCHIP, and the Department of Agriculture for the FSP. Different federal requirements govern eligibility, enrollment, and retention policies and procedures for each program. Certain policy and procedure options are left to the state.

As Table ES-1 shows, for Medicaid, states have considerable latitude in setting eligibility policies such as income levels. States also have flexibility in setting procedures governing enrollment and re-determination processes. States have much less flexibility in the Food Stamp Program; because program benefits are federally financed, program rules are set largely by the federal government. There are, however, some options for establishing eligibility and procedures governing enrollment and retention. The ease with which working families can participate in these programs will depend on two key factors: (1) the amount of flexibility states have to ease the application and ongoing enrollment burden for families and (2) the extent to which they take advantage of the flexibility they have.

Prior to welfare reform, most families applied for Medicaid, food stamps and cash assistance through a joint process using a joint application. Thus, when families weighed the opportunity costs of applying for benefits against the value of the benefits they would receive, they most likely were considering the value of the full package of benefits available

³ Families are defined as food insecure if at some point during the previous year they were uncertain of having, or unable to acquire, enough food to meet basic needs of all their members because they had insufficient money or other resources.

Table ES-1
State Flexibility on Selected Medicaid and Food
Stamp Eligibility Policies and Enrollment/Retention Procedures

	Medicaid (Section 1931 and Children's Medicaid)	Food Stamps
Income Eligibility Levels	Federally required minimum levels; state has flexibility to set higher income cut-offs.	Federally established eligibility level at 130% federal poverty line.
Asset Limits	Federally required minimum limits; state has flexibility to set higher limits or to eliminate asset tests.	Federal limits: \$2,000 (\$3,000 if elderly) and vehicle valued at \$4,650; state has options to expand categorical eligibility to eliminate asset tests for some families and to substitute vehicle limit used in a TANF or MOE-funded assistance program.
Frequency of Recertification	Must be at least annual and can be more frequent.	Must be at least annual and can be more frequent.
Verification Requirements	States required to verify immigrant status of non-citizens applying for benefits. Any additional verification is state option.	States are required to verify identity, child support obligations and payments, residency, immigration status of aliens, income, SSN, and information that the state considers questionable (as defined by the state). Any additional verification is state option. On review, states shall not verify information that has not changed unless questionable.
Interview Requirements	State option.	Face-to-face interview required at application and recertification unless waived on a case-by-case basis due to hardship. State has the option (through waiver) to eliminate some face-to-face reviews, as long as one interview occurs annually.

to them. Now that fewer families are receiving cash assistance and may have the option to apply for some benefits (e.g., children's Medicaid, SCHIP and Section 1931 Medicaid) through a much simpler process, it is likely that families will begin to consider the costs and benefits of applying for each program separately. Since the opportunity costs of applying for benefits are highest for the Food Stamp Program, it may require a more concerted effort to convince families that it is worthwhile for them to apply for them, especially if their work schedules make it more difficult for them to go to the welfare office. In addition, the programs' varying eligibility criteria and procedural requirements for application and retention are likely to make it more complicated for workers to determine eligibility, for systems staff to develop automated eligibility determination systems, and for program managers to organize workers in a way that is efficient and productive.

KEY FINDINGS

The experiences of the study sites suggest the need for diverse strategies to increase participation in programs that support working families. These strategies focus on three different themes: (1) awareness, (2) simplification, and (3) reduction of risk points. Strategies aimed at increasing awareness of the availability of public benefits reach families who may otherwise never apply for benefits because they do not think they are eligible for them or who may simply be unaware of their availability. Strategies focused on simplifying the application or renewal process aim to reach families who choose not to apply because they believe the opportunity costs outweigh the benefits and families who fail to complete the application or renewal process because the process is too cumbersome. Finally, strategies focused on reducing potential risk points emphasize the importance of developing explicit procedures for addressing points where families are at heightened risk for not initially obtaining or retaining benefits. Below, we discuss our key findings related to each of these themes.

Increasing Program Awareness

- **A carefully designed public information campaign combined with locally based outreach activities appears to be a promising strategy for increasing program awareness and enrollment.**

The information we have on the role of public information campaigns and locally based outreach activities in increasing awareness and program participation comes from efforts to enroll children in Medicaid and SCHIP. Most of the study states reported great success with radio and TV campaigns that make program information routinely available to families. Outreach strategies that aim to provide information in locations where families congregate for other purposes (e.g., PTA meetings, church fairs, parades) extend the reach of these campaigns by providing information and enrollment opportunities to families who may not apply for benefits on their own. Several of the study sites indicated that their offices were flooded with applications or requests for applications after launching their information campaigns and local outreach activities. The overall success of these outreach efforts is difficult to measure because many of them were implemented at the same time as program expansions that broadened the pool of eligible recipients. In addition, they were implemented along with simplified procedures that may have independently increased the number of families interested in applying for benefits. Still, the available evidence suggests that carefully designed outreach strategies can reach families who may not otherwise know about or apply for benefits and are worthy of further exploration and expansion to other programs and other locations.

Program Simplification

- **The ease of applying for benefits depends on which benefits a family is seeking. In all the study sites, working families applying for and retaining children's Medicaid and SCHIP can do so through a relatively simple process; with a few exceptions, it is more complicated to apply for**

and retain Medicaid for the whole family (including parents) and substantially more burdensome to apply for food stamps.

Simple and short applications and renewal forms, no requirements for a face-to-face interview and limited verification requirements all reduce the burden of applying for assistance. In all the study sites, families can apply for children's Medicaid and SCHIP through a very simple process. The application form is short, in part because they do not need to report or verify assets and they never have to go to the welfare office. Five of the study states have simplified the application process even further by allowing self-declaration of income. Renewal of benefits occurs once a year and in half the states, changes in circumstances during the year do not affect eligibility.

Only a few of the study states have achieved the same level of simplification for Section 1931 Medicaid as for children's Medicaid and SCHIP. Nearly all of the study states use a simple application and do not require a face-to-face interview, however, only four states completely eliminate the asset test (an additional four exclude the value of one or more vehicles) and only three allow self-declaration of income. Renewals for Section 1931 Medicaid are generally quite simple; in most states they occur every 12 months and do not require a face-to-face interview.

Largely owing to more stringent federal requirements and concerns about quality control errors, the study states have taken fewer steps to simplify the food stamp application and retention process. Families interested in applying for food stamps or being recertified for them must appear at the welfare office for an interview and declare and document their income and assets, among other things. In most of the study states, families can apply for food stamp benefits using an application that is shorter than ten pages. In addition, several study states have eased the burden of retaining food stamps by waiving the face-to-face interview for recertifications that occur more than once a year. While retaining food stamps is sometimes less burdensome than initially applying for them, it is substantially more burdensome than retaining Medicaid and SCHIP. At the time of our visits, states were just beginning to decide whether they would take advantage of some of the new options for simplifying the renewal and change reporting requirements. Thus, our findings most likely understate the extent to which the recertification process for food stamps has been simplified.

To the extent that families want to apply for or continue to receive both food stamps and Medicaid, because they must still comply with the more burdensome application requirements for food stamps their overall burden is not eased by Medicaid's more simplified procedures. In the absence of a cash benefit, which is frequently accompanied by other benefits such as child care, transportation assistance and extensive casework support, it

Practices That Simplify the Enrollment or Renewal Process

- Applications and information on eligibility broadly available in locations outside the welfare office
- Applications initiated (and sometimes completed) in settings outside of the welfare office
- Submittal of application or renewal form through the mail or fax, via the internet or through a call center
- Short application
- Short renewal forms; pre-printed renewal forms with family specific information; combined form for food stamp and Medicaid reporting/renewal
- Elimination of face-to-face interview requirement
- Elimination of asset tests (Medicaid and SCHIP) and vehicle limits (Medicaid, SCHIP and Food Stamps)
- Reduce verification required (e.g., self-declaration of income in Medicaid and SCHIP); provide checklist of required verification prior to application or renewal appointment; provide assistance to obtain verification; use on-line information for verification; use document imaging systems to maintain documentation on file
- Limit denials for incomplete applications by providing reminder notices or reopening application if information provided after denial
- Longer renewal periods (i.e., 12 months); use food stamp report or renewal to automatically renew Medicaid (i.e., reset the Medicaid renewal clock)
- Continuous eligibility for children in Medicaid and SCHIP
- Semiannual or quarterly reporting in food stamps; for change reporting limit changes that must be reported (e.g., \$100 or greater)
- Share information reported for one program to other programs
- Client education about availability of benefits and importance of renewal process

Practices That May Discourage Families from Applying for Assistance or Retaining Benefits

- Perception that food stamps and Medicaid are “welfare” rather than supports for working families
- Process of applying for benefits is too burdensome (real or perceived – long applications; face-to-face requirements; rigid verification requirements; long waits for appointments)
- Practices to divert or discourage TANF applicants may discourage applications for all benefits
- More burdensome processes in some programs may encourage families only to apply for least burdensome program (i.e., children’s Medicaid or SCHIP) and forego other benefits (i.e., family Medicaid and Food Stamps)
- Completely separate food stamp and Medicaid application and renewal processes
- Delays in appointment scheduling
- Short certification periods
- Client confusion due to different application and reporting requirements for different programs

is possible that complying with burdensome application and retention requirements for food stamps may present unacceptable opportunity costs for working families, particularly when the food stamp benefit is small. Moreover, our focus group findings suggest that beleaguered families' willingness to comply with relatively simple retention procedures for Medicaid may be undermined by their experiences in retaining food stamp benefits.

Differences in the application processes for food stamps and Medicaid make it difficult to predict systematic effects on participation. Some families may not apply for Medicaid no matter how simple the procedures because they don't currently perceive themselves as needing healthcare services (i.e., they are not sick). In contrast, the Food Stamp Program provides an immediate tangible benefit that may make a substantial difference in a working family's ability to make ends meet. Whether or not a family applies will depend upon whether they believe the opportunity costs of applying for the benefit exceed its cash value.

Historically, even though eligibility for Medicaid and food stamps has never been technically linked, families applying for one program often ended up enrolling in both. In fact, part of the increase in the food stamp caseload during the early 1990s is attributed to the expansion of Medicaid (Rosso 2001). Since most families applied for Medicaid benefits at the welfare office, they were considered for food stamps at the same time. As more families take advantage of the opportunities to apply for Medicaid and SCHIP benefits without ever going to the welfare office, it is possible that some families who may have previously received food stamps because they could apply for them at the same time they applied for Medicaid will no longer find the benefits provided by the Food Stamp Program worth the additional opportunity cost of applying for them.

- **Efforts to change the culture and structure of the welfare office were important components of some sites' efforts to increase participation in food stamps, Medicaid and SCHIP.**

Simplified application and renewal procedures do not necessarily provide a complete picture of the costs families consider when deciding whether or not to apply for benefits, especially when families must go to the welfare office to apply for benefits. Other factors that matter to families include (1) how they are treated at the welfare office; (2) how long they must wait to see a caseworker; (3) how many trips they need to make to complete the application process; and (4) how convenient it is to get to the welfare office or other locations where they can apply for assistance. The study sites implemented a variety of strategies to address these concerns, including:

- A "one worker, one family" approach to casework to provide more seamless and personalized service
- Training for caseworkers that emphasizes the importance of making sure families receive all the benefits to which they are entitled
- Same-day services that allow families to complete the application process in one visit

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- Edicts that require families to be seen within 10-20 minutes of arrival
 - Decentralized office structures that create more neighborhood-based service centers
 - “Call centers” that provide recipients with a convenient way to report changes in their circumstances
 - Outreach units that provide application assistance and eligibility determination in places working families frequent for other purposes (e.g., child care centers, health fairs, food banks, etc.)
 - Use of staff in community-based organizations to provide application assistance

It is difficult to gather more than anecdotal evidence on how these changes affect families' choices regarding whether or not to apply for or renew their benefits. Participants in our focus groups indicated that these changes mattered to them. Families like having a worker with whom they have a relationship and who can answer questions about their benefits. Participants indicated that same-day service worked well for them because they knew they could go to the welfare office on a day that was convenient for them and not have to return. Families who applied for benefits in a location other than the welfare office liked the convenience of being able to do so and appreciated the assistance they received in completing the application.

Mitigating Potential Risk Points

- **In an environment where each program has its own eligibility, application and renewal requirements, sophisticated automated systems, well-trained staff and explicit case processing procedures help to reduce the risk of families not having their benefits determined properly.**

Because of the low-income eligibility requirements for TANF, non-working families who qualify for TANF almost always qualify for food stamps and Section 1931 Medicaid. The situation for working families (including those receiving TANF in states with generous earned income disregards) is much more complex. While nearly all poor children qualify for both food stamps and children's Medicaid or SCHIP, eligibility for Section 1931 Medicaid and food stamps often diverge quite substantially for parents. In a small number of states, families (including parents) are eligible for Section 1931 Medicaid at higher income levels than for the Food Stamp Program. But, in many states, eligibility for Section 1931 Medicaid is substantially lower. In several of the study states, eligibility levels for Section 1931 Medicaid are so low that virtually any employment makes a family ineligible. Families who lose eligibility for Section 1931 should be eligible for Transitional Medical Assistance for 12 months in all states. Consequently, initial and ongoing eligibility must be determined independently for each program. Furthermore, differences in the application and reporting requirements for each program mean that an application that is incomplete for one program

may be complete for another. Similarly, while a change in circumstances might render a family ineligible for one benefit, it may have no bearing on their eligibility for another.

Staff training has been critical to assuring proper eligibility determination for all programs. When Medicaid eligibility was linked to cash assistance and fewer children and family coverage groups existed, it was relatively simple for workers to determine Medicaid eligibility for families. Now, even though the application process itself may be quite simple, a worker must be knowledgeable about Medicaid policy to know which Medicaid groups to consider and when a transition should and should not affect continued eligibility. This change, combined with more complex TANF eligibility requirements, requires workers to be knowledgeable about several complicated programs. In addition, because an independent eligibility determination must now be made for each program, the time required to process each case is greater than it used to be. Although it is difficult for local welfare offices, especially those in or near large urban centers, to maintain a cadre of well-trained staff who are knowledgeable about all programs, most of the sites have decided that it is preferable to train staff in all programs than to have staff specialize in one program. In the few sites where workers are specialized, the process of applying for and retaining benefits is sometimes substantially more burdensome for the family.

Because eligibility determination is so much more complex than it used to be, the need for automated support is far greater. However, because of the difficulty states have in keeping their automated systems up-to-date with current policy and procedures, automated systems can and do pose risks for families at some critical transition points. In some sites, sophisticated automated systems simplify the application process for families, reduce the workload for caseworkers and reduce the risk of benefits not being determined properly. In others, the eligibility determination process remains a manual process and is cumbersome for both clients and workers. Systems features that help mitigate risk points for families include automated eligibility determination, automatic consideration of eligibility for all programs, cascading eligibility determination routines for various Medicaid groups, integrated information sharing among all programs, and independent eligibility determination. Even though sophisticated automated systems can make eligibility determination simpler and more efficient, automation is not a substitute for well-trained staff. All of the sites with the most sophisticated information systems had implemented policy changes that could not immediately be accommodated by their automated systems. When these situations arise, a worker needs to understand the details of program eligibility well enough to be able to override the automated system and make the correct decision regarding eligibility.

Finally, in an effort to be proactive about mitigating risk points, the study sites implemented a number of explicit case processing strategies to ensure families receive the benefits to which they are entitled. These strategies include educating families early and often about the availability of benefits separate from TANF and about reporting requirements; providing families with pre-printed renewal forms with family-specific information; using food stamp reports to renew Medicaid or reset the Medicaid renewal clock; requiring written “informed consent” letters to close Medicaid; prohibiting TANF workers from closing a Medicaid case; avoiding reviews or requests for information that are not necessary; conducting any Medicaid reviews on an “ex parte” basis, without contacting

the family to the greatest extent possible; conducting special reviews of closed cases to catch erroneous food stamp or Medicaid closures; and considering information that is sufficient to take action on a TANF case sufficient to determine ongoing Medicaid and food stamps.

- **While TANF families previously were at high risk of not having their benefits determined accurately during critical transitions, the study sites have largely addressed these issues.**

Because large numbers of TANF recipients inappropriately lost Medicaid benefits when their TANF cases closed shortly after the implementation of TANF, we closely examined how these transitions were handled in the study sites, focusing on what strategies were being used to avoid improper case closures. Most of the staff members we interviewed were well aware that when a TANF application is denied, an independent eligibility determination should be conducted for food stamps and Medicaid. Frequently, even though enough information may not be available to make a determination for TANF or food stamps, the case can be processed for one of the Medicaid groups that require less information to determine eligibility. Similarly, when an ongoing TANF case closes, workers were aware that independent reasons for reviewing and/or closing Medicaid or food stamp cases must exist.

Strategies in place to reduce the risk of inappropriate case closure are similar to those in place to ensure independent eligibility determinations occur for all program applications. Strategies specific to TANF cases include not permitting a TANF worker to close a Medicaid case and requiring TANF workers to process eligibility for all programs before transferring the case to another worker. In addition, once TANF and Medicaid eligibility were de-linked in states' automated eligibility determination systems, the risk of inappropriate case closures was reduced substantially. While this risk point is not entirely ameliorated and ongoing vigilance is required, the risk of losing Medicaid upon closure of TANF has been substantially reduced in almost all of our study states.

RECOMMENDATIONS AND NEXT STEPS

Low participation rates and retention problems among working families were evident for working families before PRWORA for both Medicaid and the Food Stamp Program. While participation rates have worsened since welfare reform, these dynamics may have less to do with families losing food stamp and Medicaid benefits simply because they lost cash assistance, and more to do with working families not getting or retaining these benefits because they do not know they are eligible for them or they believe the process for obtaining or keeping them is too cumbersome. Our recommendations emphasize the importance of focusing on each of these aspects to increase program enrollment.

Practices Supporting Initial or Continued Receipt of Benefits at Potential Risk Points

- Informing clients early and often that food stamps and Medicaid are separate from TANF; use multiple methods
- Ensuring TANF eligibility requirements (such as job search) are not applied to food stamp or Medicaid application
- Ensuring that TANF or food stamp procedures (such as a face-to-face interview) are not erroneously applied to Medicaid
- Requiring written “informed consent letter” to close food stamps or Medicaid if client requests general case closure
- Training staff, especially on Medicaid de-linking
- Avoiding reviews or requests for information that are not necessary; treat TANF closure as a non-event
- Treating programs independently; consider eligibility separately (if at all) at transitions
- Conducting any Medicaid reviews on an “ex parte” basis
- Programming automated systems to continue, adjust or trickle benefits to other ongoing Medicaid coverage group (e.g., TMA)
- Conducting special reviews of closed cases to identify erroneous food stamp or Medicaid closures
- Ensuring that ongoing food stamps and Medicaid is determined before transferring a case to a non-TANF worker or have TANF worker maintain case longer
- Considering information that was sufficient to take TANF action as sufficient to determine ongoing food stamps and Medicaid (e.g., self-declaration of income for TMA)

Practices Creating a Risk to Initial or Ongoing Receipt of Benefits

- Applicants not apprised of all benefits available
- Applicants not considered for benefits not explicitly requested
- Incomplete application process due to client not completing a TANF requirement
- Delaying Medicaid or food stamp interview or eligibility determination pending completion of TANF requirement, such as orientation
- Caseworkers not fully aware of Medicaid or TMA availability for non-TANF families or importance of placing families in Section 1931 coverage for access to TMA
- Requiring families to provide additional information or complete paperwork to continue food stamps or Medicaid when no basis for review other than TANF closure
- Automated systems link eligibility (e.g., TANF and Medicaid) requiring manual workaround to avoid erroneous closure of Medicaid
- Setting food stamp and Medicaid renewals to occur at anticipated transitions such as when a family reaches a time limit
- Linking of Medicaid and food stamp reviews in the automated system when review periods are different
- Automatic Medicaid closure when eligibility review not completed without first checking if state already has current information to renew benefits (i.e., without conducting “ex parte” reviews).

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- **Use the lessons learned from public information and local outreach campaigns for children’s Medicaid and SCHIP to inform families about the availability of Section 1931 Medicaid and the Food Stamp Program.**

In recent years we have learned a lot about how to conduct successful public information campaigns for programs that offer benefits to children. States, localities, the federal government and foundations interested in the improving the circumstances of working families should use this information to increase people’s awareness about the full range of benefits available to working families. Any barriers to coordinating these efforts should be eliminated (e.g., any restrictions that require outreach efforts to be targeted to a single program) as it may be more efficient to launch one campaign aimed at educating working families about the benefits available to them rather than launching several program-specific campaigns. Efforts to expand outreach to working families should be accompanied by a concerted effort to evaluate the cost-effectiveness of these efforts. As more information becomes available on the overall effectiveness of these campaigns, including the particular features of campaigns that seem to have the most impact on enrollment, this information may help to determine how to target limited financial resources most effectively.

- **Expand efforts to provide families with opportunities to apply for and renew benefits outside of the welfare office and evaluate the relative effectiveness of alternative strategies.**

For some families, the simple act of having to go to the welfare office will keep them from initially applying for or renewing the benefits for which they are eligible. Even though some welfare offices are attempting to change their culture and operational procedures to better serve the needs of working families, many families perceive the welfare office to be a place where they will be treated poorly and be required to jump through numerous hoops to receive assistance. For some families, the stigma associated with receiving “welfare” is enough to deter them from applying for benefits. Others have work schedules that make a trip to the welfare office difficult. In an effort to overcome these barriers to enrollment, states and local welfare offices should continue to explore ways to provide families with options to apply for and renew their benefits outside of the welfare office.

The study sites used two different strategies to encourage families to initially apply for benefits that are worthy of expansion and evaluation, but other strategies should be considered as well. Using staff in community agencies to help families apply for benefits allows welfare offices to tap into a large network of agencies that come into regular contact with potentially eligible families. The downside of this approach is that because enrolling families in public benefit programs is usually added to existing responsibilities, success is dependent on an agency’s or worker’s individual commitment to increasing enrollment and whether the application process can be closely integrated with their current work. Simple application procedures are key to the success of this strategy.

An alternative strategy that may hold even greater promise, especially for the Food Stamp Program is the creation of outreach eligibility determination units such as those developed in Georgia and Oklahoma for Medicaid and SCHIP. The advantages of such

units are many. First, their sole purpose is to enroll families in public benefit programs. Second, because they are mobile, they can conduct outreach in locations where and when families congregate. By not being stationed in one place, they do not run the risk of not enrolling enough families to justify their existence as is sometimes the case when workers are permanently outstationed in one location. Finally, because staff are trained eligibility workers, they have far greater knowledge of how to ensure applications are completed accurately and processed efficiently. While more complicated application procedures are likely to make it more difficult for an outreach strategy to work, trained eligibility staff can be expected to deal more effectively with complicated application procedures than staff in community agencies. While it is not absolutely necessary for outreach workers to be able to link to the automated system remotely to be successful, when it is possible for them to do so, it simplifies the eligibility determination process and makes it possible for workers to determine eligibility on-site.

As a part of identifying ways to provide families with alternatives to apply for benefits outside the welfare office, special consideration should be given to strategies that allow families to apply for multiple, rather than individual programs. For example, states that already have Medicaid eligibility workers outstationed in health facilities may want to consider how these efforts could be expanded to include outreach for the Food Stamp Program.

The options that make it possible for families to renew their benefits outside of the welfare office are relatively simple and low-cost. The simplest strategy is allowing families to handle all renewals through the mail. Call centers provide an efficient way to handle renewals and changes over the phone. While call centers involve initial start-up costs, those costs may be easily recouped through efficiency gains over time. Finally, the internet provides another easy and efficient way for families to both apply for benefits and report changes. In the short-term, web-based strategies may be more helpful to community groups, but as internet access becomes more widespread, more families will be able to take advantage of these options at their own convenience.

- **Continue to encourage states to take advantage of the flexibility they have to simplify application and renewal requirements and identify key program requirements that make simplification difficult.**

States currently have considerable latitude to simplify the application and renewal process for children's Medicaid, SCHIP and Section 1931 Medicaid. Efforts should continue to encourage more states to take advantage of this flexibility. More documentation of the ways in which simplification reduces the burden for families and workers may help states that have not yet simplified their application and renewal processes to move in this direction. Careful analysis of the circumstances of families who receive benefits under simplified procedures such as elimination of the asset test and self-declaration of income may reduce concerns about ineligible and "non-deserving" families receiving benefits. Additionally, states may want to develop quality control pilots or phase in changes by geography or population to be sure they are comfortable with changes as they proceed. On

verification issues, they might want to initially adopt streamlined requirements at renewals then expand them to applications.

Because the options for simplifying the food stamp application and recertification requirements are relatively new and just being implemented, there is less information available on states' experience with these new procedures. To encourage greater use of these options, it may be worthwhile to document the experiences of states that have successfully implemented them. Emphasizing the ways in which these new options protect states against quality control errors is likely to be key to getting states to adopt them. In addition, because eligibility workers have been so strongly influenced by the emphasis placed on avoiding quality control errors, it may take some time for these more simplified procedures to be fully implemented at the front line.

- **Explore options for aligning eligibility requirements and application procedures for Medicaid and food stamps.**

Prior to welfare reform, there was considerable attention paid to trying to align food stamp and cash assistance policies. Now that more families are working, it may be worthwhile to shift this emphasis and consider ways in which policies and procedures for food stamps and Medicaid may be better aligned. Currently, the complex array of requirements makes it difficult for families to understand which benefits they are eligible for and when they are eligible for them. Under existing federal regulations, states are constrained from simplifying food stamp enrollment and retention procedures to the extent that they can for Medicaid. Although some of the study states were preparing to take advantage of existing and new opportunities to simplify reporting requirements, food stamp eligibility procedures must include annual face-to-face interviews and reporting and verification requirements that are not mandated for Medicaid and SCHIP. Given that some of these constraints follow from federal rules or regulations, some efforts to better align the Food Stamp and Medicaid programs will require action at the federal level, but some things can be done now.

- **Explore options, including providing increased funding, to help states maximize their use of technology to increase enrollment and promote retention in food stamps, Medicaid and SCHIP.**

State capacity to take advantage of the technology available to help simplify the application and renewal processes and to reduce the risk of inaccurate eligibility decisions for food stamps, Medicaid and SCHIP is quite varied. While some states have very sophisticated information systems in place and are exploring ways to use new technology such as document imaging systems and the internet to reduce the burden for families and the workload for caseworkers, other states have information systems in place that can do little more than calculate eligibility. Given the complexity of determining eligibility for multiple programs for working families, information systems are key to ensuring families receive the benefits to which they are entitled. As information systems age, it becomes critical to consider how to best help states take full advantage of the technology available to them and to update their information systems to meet the demands of a reformed public assistance

system. The federal agencies may want to consider providing technical assistance to states on how to implement strategies such as paperless application systems and document imaging systems. They may also want to consider working with states to explore ways in which they can efficiently link to new and existing databases that provide information that can be used to determine eligibility.

- **Redesign the food stamp quality control system to account for the complex circumstances of working families.**

Federal food stamp quality control procedures have a significant influence on how states manage and operate their Food Stamp Programs. As currently implemented, the food stamp quality control system acts as a barrier to simplifying the food stamp application and recertification requirements. Because cases with earnings are especially prone to errors, the quality control system also discourages states from actively encouraging participation by working families. The use of short certification periods is a case in point. Although short certification periods create a substantial burden for families, states use them because changes in families' circumstances, especially fluctuations in wages that are not reported to the agency, are likely to result in a quality control error. Under the current QC system, states are held accountable for making accurate determinations based on a family's circumstances, not on making accurate determinations based on information that is known to them. Thus, to avoid QC errors, states require families whose circumstances change often to be recertified often. The reason the new reporting options are attractive to states is that they allow states to simplify the reporting requirements while protecting them from quality control errors; the options states have to freeze benefit amounts between quarterly and semiannual reports will mean that there are no errors arising from any changes in the family's income and therefore no need to know it between reports.

- **Encourage states to set enrollment goals for food stamps, Medicaid and SCHIP and reward them for their accomplishments.**

Local program administrators commonly reported that they focus their efforts most closely on outcomes for which they are held accountable. Because they are responsible for a broad range of programs and tasks, specific goals help them to set priorities and measure their progress against some benchmark. When Indiana launched its effort to increase participation in children's Medicaid and SCHIP, the state articulated its vision and priorities statewide and set specific enrollment goals for each county office. The state granted local officials the authority to determine how to achieve the goals and gave them financial support to put their plans into action. Arkansas has set a goal of having 80 percent of families leaving TANF continue on food stamps and Medicaid. Officials note that the rate of retaining families increased once they set a specific retention target. The federal agencies may want to work with states to set similar enrollment and retention targets and reward them for their performance.

WHAT THE FUTURE HOLDS

Welfare offices are in a state of transition. Whereas in the past they focused almost exclusively on determining eligibility for public benefits, now, they are focused on determining eligibility *and* developing strategies to help TANF recipients make the transition from welfare to work. In the rush to implement welfare reform, few states initially paid close attention to the challenges inherent in discouraging families from receiving cash assistance while simultaneously promoting continued receipt of benefits that can support them while they are working. However, as welfare reform efforts mature, more states and local welfare offices are looking for ways to support working families. The strategies they have adopted aim to increase awareness about the availability of benefits, simplify the process for applying for or continuing to receive benefits and establishing procedures to assure families receive all the benefits to which they are entitled.

Although the future holds promise for improving the circumstances of working families, it also holds a great deal of uncertainty. Public awareness about the reported success of welfare reform has created strong public support for using government funds to support low-income working families. This support has made it possible for many states to simplify the requirements for Medicaid and SCHIP, and in some states, to expand eligibility to allow more families to take advantage of the benefits these programs provide. Unfortunately, the progress made in simplifying eligibility procedures for Section 1931 Medicaid and children's Medicaid/SCHIP, and in promoting enrollment may be stalled or even reversed due to the current budget crises faced by many states. Since states bear as much as half of the cost of providing Medicaid benefits to families, expanding participation in Section 1931 Medicaid has not received the same level of political support as enrolling children in SCHIP. In the short-term, it is probably unlikely that states will undertake additional efforts to simplify their application and retention requirements as such efforts would be expected to increase enrollment and costs.

On the other hand, there currently appears to be widespread support for simplifying the food stamp program and for making changes in the food stamp quality control system that will make it easier and less risky for states to serve working families. Because states do not bear little of the financial cost of increased enrollment in the Food Stamp Program, states' current fiscal crises may not stall these efforts in the same way they may stall efforts in Medicaid. Since we conducted our site visits, many states have already decided to take advantage of the options they have to make it easier for working families to obtain food stamps. The nutrition provisions of the 2002 Farm Bill also support and expand recent efforts to simplify the Food Stamp Program and to reduce states' risk of having quality control financial penalties imposed upon them.

Technology is already playing a critical role in increasing participation in food stamps, Medicaid and SCHIP and is likely to continue to do. While the current range of systems and technologies used in most states appears to be somewhat of a mixed bag, a number of nascent efforts and trends have the potential to significantly improve program access and participation. Technology innovations are occurring at an unprecedented rate, and hold promise to enable states to create new system components that offer additional functionality for workers and clients, and can be easily added onto existing information systems. This

would allow states to maximize the benefits of new technology, while still retaining the eligibility core systems in which they have heavily invested.

Finally, the outcome of TANF reauthorization could influence how much progress states make in increasing participation in food stamps, Medicaid and SCHIP and how quickly they make it. At any one time, welfare offices have many competing priorities they are trying to address. Because they do not have unlimited resources and often face serious staff shortages, they cannot always address all of their priorities. When welfare offices are required to implement major new initiatives, all other priorities often fade into the background, at least for a time. If TANF reauthorization requires states to shift their focus or makes additional demands on them, increasing participation in food stamps, Medicaid and SCHIP may not receive the same attention it might if states were able to simply continue on the path they are currently on. Alternatively, because welfare reform has raised awareness about the needs of working families, TANF reauthorization could provide the catalyst states need to focus even more effort on increasing participation in food stamps, Medicaid and SCHIP.

CHAPTER I

INTRODUCTION

During recent years, the nation has witnessed unprecedented changes in the circumstances of low-income families. In the past, the primary means of support for many single-parent families was cash assistance; for many of those families, it is now income from their own earnings. Since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), cash assistance caseloads have declined by more than half. Studies of families who have left the welfare rolls show that about 60 percent are working at any point in time (Acs and Loprest 2001). Changes in the work participation rates of never-married mothers further demonstrate the extent to which work has become a key means of support for many single-parent families with children. Between 1994 and 1999, the employment rate for never-married mothers increased from 47 to 65 percent (Moffit 2002).

The increase in employment among former welfare recipients has been accompanied by strong support for providing “work supports” to low-income working families, including nutritional assistance through the Food Stamp Program, health insurance through Medicaid and the State Children’s Health Insurance Program (SCHIP) and child care and transportation assistance through a broad array of federal and state initiatives. However, low levels of participation among former recipients in the Food Stamp and Medicaid programs have raised concerns about whether welfare offices are organized and equipped to deliver these benefits to working families, and whether federal regulations constrain their ability to do so. In response to these concerns, the federal government and some states have started to reassess the way eligibility for these benefits is determined, and to implement new strategies to reach more working families. Unlike other benefits that might be made available to working families, food stamps and Medicaid are entitlements, meaning that receipt of program benefits is not subject to the same state and local constraints that may affect benefits such as child care and transportation.

This study, conducted by Mathematica Policy Research, Inc. and its subcontractors, American Management Systems, Inc. and the George Washington University Center for Health Services Research and Policy, was commissioned by the U.S. Department of Health

and Human Services and the U.S. Department of Agriculture to (1) identify state and local strategies for increasing participation in the Food Stamp Program, Medicaid, and the SCHIP; (2) examine ways in which the procedures used to determine eligibility support or impede access to benefits; and (3) identify the ongoing challenges faced by the organizations charged with administering these programs at the state and local level. In this report, we synthesize our findings from visits to 15 sites in 12 states. This introductory chapter provides further detail about the study's context and methods. First, we summarize the research on Medicaid and food stamp caseload trends, and how lack of benefits can affect family well-being. The second section presents the study design, key research questions, and the framework for both our analysis and the synthesis of our research presented in this report. The final section outlines the organization of the remainder of the report.

THE CAUSE FOR CONCERN: DECLINING PARTICIPATION AMID CONTINUED NEED

For many families, increased employment does not always translate into improved financial circumstances. Parents leaving the welfare rolls usually work full time, earning between \$7 and \$8 per hour, leaving many of them well below the poverty line (Moffit 2002). Since the implementation of welfare reform, poverty rates for families have been declining steadily. In 2000, the overall poverty rate reached its lowest level since 1979 and poverty rates for female-headed families hit an all-time low. However, a recent Urban Institute study indicates that when all types of income are taken into account (including earnings, cash assistance and food stamps) about 300,000 more single-parent families lived in extreme poverty (below 50 percent of the poverty line) in 1998 than in 1996. Although many single parent families left welfare for work during this time period, their income from earnings was not sufficient to offset the income loss resulting from lower rates of participation in government programs. The authors note that if families with children took full advantage of the government programs for which they qualified, 3.8 million fewer persons would have been poor and 2.0 million fewer would have been extremely poor in 1998 (Zedlewski et al. 2002).

Food stamps, along with the Earned Income Tax credit, can bring a family with a full-time minimum wage worker close to the poverty level. Health coverage through Medicaid or SCHIP may be the route to medical care for many uninsured working families. Participation in these programs can help increase a family's ability to make and sustain the transition to self-sufficiency, as well as provide important benefits for the health and well-being of each family member. However, an increasing number of eligible families are not taking advantage of the benefits available to them.

Medicaid: Expanding Eligibility for Children but Slowing Rates of Enrollment for Families and Continued High Levels of Uninsurance for Low-Income Families

Trends in Medicaid enrollment. Total Medicaid enrollment grew throughout the early 1990s, declined between 1996 and 1998, but began rising again in 1999.⁴ Total Medicaid enrollment grew throughout the early 1990s, declined between 1996 and 1998, but began rising again in 1999.⁵ Between June 1996 and June 2000, total Medicaid enrollment in the 50 states and District of Columbia rose 1.7 percent, but trends in enrollment varied significantly across states. For example, Ohio's enrollment grew by 51.1 percent, while Georgia's enrollment declined 13.0 percent (See Appendix A-1). The growth in the Medicaid program in the early 1990s was fueled primarily by federal and state policies designed to expand Medicaid eligibility for poverty-level children and pregnant women, and by an economic downturn that increased the number of people in need. The enrollment rate slowed in the mid-to-late 1990s; this is often attributed to both the strong economy and federal welfare reform, which moved families from cash assistance to work and created confusion about Medicaid eligibility (Ku and Bruen 1999). The most recent rise in Medicaid enrollment can be largely attributed to SCHIP, created by the Balanced Budget Act of 1997. By 2001, about 4.6 million children were enrolled in SCHIP at some point during the year, up from less than 2 million children in FY 1999 (Centers for Medicare and Medicaid Services 2002 and Health Care Financing Administration 2001).

Low Medicaid enrollment among TANF leavers and nonelderly adults. Among families interviewed in the 1997 National Survey of America's Families, only slightly more than half of the women who left Temporary Assistance to Needy Families (TANF) were still on Medicaid or other state health insurance in the first six months after leaving, and one-third had no health insurance at all. One year after leaving welfare, less than one-quarter received Medicaid benefits, and about one half were uninsured (Garret and Holahan 2000). The most recent analyses of Medicaid participation rates for eligible non-elderly adults (parents) indicate that slightly more than half of these individuals (51.4 percent) were enrolled, and 27 percent of them were uninsured (Davidoff et al. 2001).

Continued high rates of uninsurance and associated costs. Between 1994 and 1998, rates of uninsurance for persons under 65 rose steadily from 17.1 percent to 18.4 percent. Between 1998 and 1999, the uninsurance rate declined to 17.4 percent (National Center for Health Statistics 2001). In the wake of September 11 and the recession, the number of uninsured is rising. Two-thirds of the 42 million uninsured Americans are in working families with incomes less than 200 percent of the federal poverty level; more than one-third of the uninsured come from families living below 100 percent of the federal poverty level. Mothers in families with incomes below 200 percent of the poverty line are

⁴ Total Medicaid enrollment includes these main categories of enrollees: elderly, blind and disabled persons, pregnant women, children, and families.

⁵ Total Medicaid enrollment includes these main categories of enrollees: elderly, blind and disabled persons, pregnant women, children, and families.

uninsured at particularly high rates and account for nearly three of every four uninsured mothers in the United States (Guyer et al. 2001).

Numerous studies link health coverage to better access to care, better quality care, and improved personal and population health status. For example, studies have shown that uninsured individuals receive fewer preventive services and are less likely to have regular care for chronic conditions, such as hypertension and diabetes, which can lead to expensive and disabling complications (Institute of Medicine 2001). Uninsured adults, particularly those in poor health, are more likely to report they cannot see a physician when needed, due to cost (Ayanian et al. 2000). In addition, uninsured children who are eligible for but not enrolled in Medicaid encounter greater obstacles to care than their Medicaid-covered counterparts (Davidoff et al. 2000). A study comparing eligible adults enrolled in Medicaid with those who are not found that the uninsured were less likely to have a physician or dental visit, less likely to have a usual source of care, and more likely to incur out-of-pocket medical expenses (Davidoff et al. 2001).

Health insurance coverage for parents is particularly important because children are more likely to receive care if they are enrolled in the same health plan as their parents (Medical Policy Institute 2001). In addition, a study of changes in children's coverage comparing states that extended coverage to low-income parents to those that did not found that allowing the family to apply for coverage all at once raises the likelihood that children will be covered (Ku and Broaddus 2000).

Food Stamps: Declining Caseloads in the Midst of Substantial Food Insecurity

Trends in the food stamp caseload. From December 1996 to December 2001, the number of participants in the Food Stamp Program fell by 5 million, or 22 percent. Food stamp caseloads declined further in the first four years of welfare reform and have recently begun to increase. The 18.7 million persons participating in the FSP in December 2001 represented a rise of about 1.6 million persons over the December 2000 level. The recent increase in the food stamp caseload is most likely being driven by improved access to the program in some of the states as well as growing numbers of layoffs (Food Research and Action Center 2002a). The overall caseload change between December 1996 and December 2001 varied substantially across the states (see Appendix A-2). For example, participation declined by 42 percent in California but increased by 30 percent in Oregon and 11 percent in Indiana (Food Research and Action Center 2002b).

Declining rates of participation. Some decline in food stamp participation was expected because of eligibility changes in the 1996 welfare law and the continued strength of the economy. While these two factors together explain some of the decline, they do not explain all of it. Last year, USDA reported to Congress that about a third of the total decline occurred because rising income and assets lifted people above the program's eligibility limits, just under 10 percent reflects the direct effect of welfare reform's change to eligibility rules, and a bit more than half occurred because of declining participation rates among eligibles (USDA 2001). Results of a recent study using multivariate analysis to explore the effects of the economy and cash assistance policies on food stamp participation found that the

economic growth during the middle to late 1990s explains 47 percent of the decline and welfare reform accounted for about 30 percent (Gleason et al. 2001).

An analysis of trends in rates of participation in the Food Stamp Program between 1994 and 1999 found that the number of participants decreased relative to the number of eligible individuals, that is, the rate of participation in the program declined (Rosso 2001). The overall rate of participation declined by more than 10 percentage points, from 74.3 to 57.4 percent. Among children, the participation rate declined from 89.5 to 67.7 percent and among individuals in single-parent households, the rate declined from 98.9 to 81.4 percent. Among households with earnings, a group already less likely to participate than other groups, the participation rate fell from 57.1 to 42.9 percent. Participation held steady or increased for elderly adults, the disabled, and individuals in households receiving TANF.

Low food stamp enrollment among TANF leavers. A 2001 Urban Institute study of food stamp participation among families leaving welfare found that about two-thirds of families who left TANF between 1995 and 1999 also left the FSP, even though few of these families reported incomes high enough to disqualify them for food stamps (i.e., greater than 130 percent FPL) (Zedlewski 2001). A synthesis of welfare leaver studies found that about half of leaver families received food stamps in the first quarter after exit (Acs and Loprest 2001).

Progress in reducing food insecurity and hunger; substantial unmet needs still exist. Between 1998 and 2000, food insecurity⁶ fell by 11 percent and hunger by 16 percent. Still, in 2000, 36.8 percent of poor households and 31 percent of households with children headed by a single mother were food insecure compared to 10.5 percent of all households. Similarly, at 12.7 and 9.0 percent respectively, the prevalence of hunger was much greater among poor and single parent households with children than among all households (3.1 percent). Only 23 percent of food-insecure households and 27.4 percent of food insecure-with-hunger households participated in the Food Stamp Program during the previous 30 days (Nord et al. 2002). America's Second Harvest, the nation's largest organization of emergency food providers, served 23.3 million people in 2001, an increase of 9 percent from 1997. Only 30 percent of clients received food stamps, though many more are likely to be eligible (Kim, Ohls and Cohen 2001).

Why Eligible Families Don't Participate

Recent research findings identify several reasons that welfare leavers may not have maintained Medicaid or food stamp benefits for which they were eligible, and why some families are unwilling to apply for these benefits (Ellwood 1999; Ellwood and Irvin 2000; Kenney and Haley 2001; McConnell and Ponza 1999). These include:

⁶ Families are defined as food insecure if at some point during the previous year they were uncertain of having, or unable to acquire, enough food to meet basic needs of all their members because they had insufficient money or other resources.

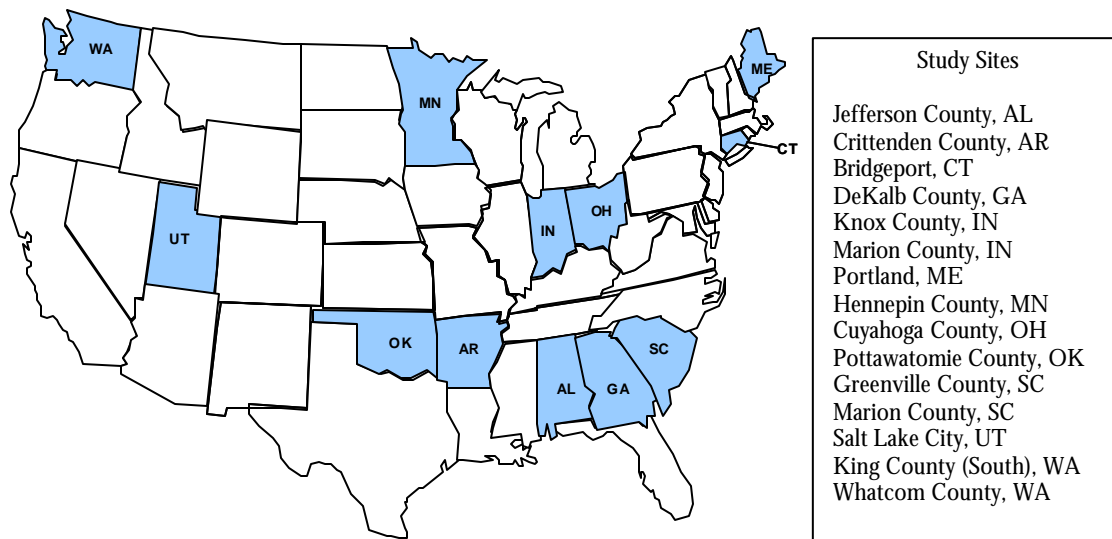
- The lack of knowledge that Medicaid coverage or food stamp benefits are available for working families
- The burdensome and often demeaning procedures associated with applying and retaining benefits
- Negative feelings about participating in the program
- For immigrants, fear of being a “public charge”
- Lack of perceived need for health care coverage or nutritional assistance when families are healthy, coupled with a belief that Medicaid will be available when needed
- The belief that cash assistance rules and constraints apply to Medicaid and food stamps
- The complicated eligibility rules for transitional Medicaid coverage for families with increased income
- The challenge for caseworkers of simultaneously moving families from welfare to work while increasing enrollment in Medicaid
- Poorly equipped management information systems

Although the relative importance/weight of these reasons is not definitely established by research and probably varies given particular recipient circumstances, one study of Medicaid for children and SCHIP found that lack of knowledge was the most common reason, followed closely by administrative hassles (Kenney and Haley 2001). A recent study examining factors affecting the receipt of food stamp and Medicaid benefits for TANF leavers concluded that the two main factors were caseworkers’ failure to inform the recipients, and recipients’ lack of knowledge (Quint and Widom 2001).

STUDY DESIGN AND METHODOLOGY

This study was designed with multiple purposes in mind: (1) to identify promising approaches to enhance and facilitate enrollment and retention in the SCHIP and Medicaid and Food Stamp programs; (2) to assess barriers to initial and ongoing enrollment among low-income families and those receiving cash assistance under TANF; and (3) to provide feedback to federal and state program administrators, with suggestions for facilitating increased enrollment and retention. We conducted extensive visits to 15 local sites in 12

states. Prior to completing this report we prepared a detailed summary report for each state.⁷



Research Questions

Three research questions provided the framework for our study:

- What “promising practices” are states implementing that facilitate and increase enrollment and retention in the Food Stamp Program and in the children’s and family coverage groups of the Medicaid program?
- How do local welfare offices determine initial and ongoing eligibility for food stamps and the children’s and family coverage groups of Medicaid? What policies, practices, procedures, and operational configurations promote enrollment and retention in these programs? Which ones create potential risk points to initial or continued participation?
- What lessons can be learned from the efforts and experiences in the study sites?

When it was possible to do so, we also examined these issues for state SCHIP programs.

⁷ These reports are available on the Mathematica Policy Research website, www.mathematica-mpr.com.

Selection of the Sites

Our goal was to include a range of states, including some that were interested in identifying ways in which they could change their policies and practices to increase program enrollment and retention, and some that had already implemented strategies to do so. To select the sites, we examined program participation data and consulted with experts in the field. In the end, the sites were selected based on one or more of the following criteria.

Self-selection by participating in the “Supporting Families Under Welfare Reform” project Four of the sites we studied—Alabama, South Carolina, Maine, and Cuyahoga County, Ohio—were chosen because these sites applied and were chosen to participate in an initiative of the Robert Wood Johnson Foundation, Supporting Families Under Welfare Reform. The project provided technical assistance to states and counties to analyze, assess, and improve enrollment of families in Medicaid, SCHIP and food stamps. Because of the substantial overlap of the goals and efforts of our study and the Supporting Families project, we worked collaboratively to avoid duplication and to benefit from joint efforts.

Implementation of specific promising practices of interest. We identified specific states that had implemented particular promising practices such as outreach or streamlined enrollment. Although many were not the only states to implement such practices, experts in the field helped us select sites particularly worthy of examination. Some examples of practices that contributed to our selection of particular states are: (1) streamlined Medicaid enrollment for parents and children, (2) expanded Section 1931 Medicaid for families, (3) use of community-based groups to assist with enrollment, (4) implementation of procedures to facilitate retention of program benefits, and (5) use of non-traditional organizational structures to provide public benefits to eligible families.

Demonstration of higher levels of program participation. Some of the states we studied demonstrated higher levels of participation in some benefits. For example, Arkansas, Connecticut, and South Carolina had food stamp caseload declines that were much lower than the national average and the state’s TANF caseload decline.

Regardless of our reason for selecting the site, we conducted a fairly parallel research process in each site, although we made sure to fully examine any particular practice that contributed to our selection of the site.

Data Collection

We collected data for this study primarily through three-day site visits, conducted by research teams of two or three persons. The objective of each site visit was to gain information from a wide variety of perspectives on the enrollment and retention policies and practices that may affect participation in Medicaid, SCHIP, and food stamps.

During each visit, the research team conducted 60- to 90-minute semi-structured interviews with administrators and staff of the state agencies, local welfare offices, and

community-based organizations that serve clients. We also conducted focus groups with clients who were recruited by staff from the welfare office or community agencies.

At each local welfare office, we conducted interviews to explore staff procedures and client interactions, work flow, the use of automated systems, the supervisory approach, and the local office environment. Whenever possible, we shadowed eligibility workers conducting initial or ongoing eligibility reviews with clients and observed the reception/front desk area and activities.

Data Analysis

Our analytic framework involved two foci. First, we considered how the opportunity costs or burden associated with applying for or retaining Medicaid and food stamps can be eased by state policies, procedures, and practices. For example, how simple or complex is the application and renewal process and how much time does it take to complete it?

Second, we considered points in the application and enrollment process where applicants may be at risk of not getting the benefits for which they are eligible. For example, we examined how the application process differed for families who do and do not apply for cash assistance. For retention, we examined both renewal processes and key transition points such as loss of TANF benefits. In particular, we examined retention policies and procedures that ensure families keep the benefits for which they are eligible when their circumstances change.

We analyzed the data collected from each study site by identifying whether and how the state addressed key factors that affect initial and ongoing participation (see accompanying box for a list of the factors we examined). We also focused on particular categories of applicants and recipients whose circumstances could present a heightened risk to becoming and staying eligible. These categories included families who: (1) are leaving or have left TANF cash assistance, (2) apply for but do not receive TANF cash assistance, and (3) want only to apply for Medicaid or food stamps, but not cash assistance.

In conducting this analysis, we followed the case flow processes from initial inquiry about benefits through program termination. We examined the application and retention processes for Medicaid and food stamps for TANF and non-TANF families. We paid special attention to barriers arising or intensifying because of welfare reform policies. We also examined how automated systems and organizational culture and structure can support or hinder enrollment and benefit retention.

**Factors That May Limit Participation in Public Benefit Programs
Due to Increased Burden or Heightened Risk**

Factors that keep families from initiating the application process

- Lack of information or misinformation about eligibility for benefits
- Lack of information on how to apply for benefits
- Perception that food stamps and Medicaid are “welfare”
- Process of applying for benefits is too burdensome or demeaning (real or perceived)

Factors that may affect completion of the initial enrollment process

- Complicated or lengthy application form
- Extensive verification requirements
- Burdensome application process (multiple trips or lengthy visits to the welfare office)
- Applicant not apprised of all benefits available, or that food stamps and Medicaid are available separate from TANF
- Additional TANF requirements that may affect completion of the application process for other benefits
- Inadequate procedures to ensure independent consideration of food stamp and Medicaid eligibility if TANF application is denied or withdrawn

Factors generally affecting retention of program benefits

- Frequent eligibility reviews (short renewal or certification periods)
- Burdensome review processes (trips to welfare office, repeat verification, lengthy forms)
- Confusing and multiple requirements on reporting changes of circumstances

Factors specifically affecting retention of food stamps or Medicaid when TANF is closed

- Lack of information or misinformation about continued eligibility for benefits separate from TANF eligibility
- Lack of effective processes to ensure ongoing Medicaid or food stamps when reason for TANF closure is not a basis for loss of other benefits

ORGANIZATION OF THIS REPORT

The remaining chapters in this report present our findings. To the extent possible, we follow the analytic framework of our analysis. Chapter II provides background on Medicaid, SCHIP, and the Food Stamp Program, detailing federal requirements and state options on policies and procedures affecting enrollment in and retention of benefits. Chapter III discusses state and local efforts to increase awareness of these benefits, including public information campaigns and community outreach initiatives. It also describes some of the notable activities and the factors that may contribute to their success. Chapter IV analyzes application and enrollment procedures, highlighting promising practices and identifying lessons learned about those that appear to promote enrollment. Chapter V analyzes benefit retention practices and procedures—particularly the overall processes for renewal or recertification and those that ensure continuation of food stamps and Medicaid when TANF benefits are closed. We also highlight promising practices in this area. Chapter VI analyzes automated eligibility systems and other supportive technology that states use to distribute and coordinate benefits. This chapter summarizes some of the significant promising practices in using Management Information Systems. Chapter VII presents overall conclusions of this report and of the study.

CHAPTER II

STATE POLICY AND PROCEDURAL OPTIONS

Medicaid, SCHIP, and food stamps are authorized by different federal laws and administered by different federal agencies—the Department of Health and Human Services for Medicaid and SCHIP, and the Department of Agriculture for the FSP. Different federal requirements govern eligibility, enrollment, and retention policies and procedures for each program. Certain policy and procedure options are left to the state. This chapter briefly reviews federal requirements and state options for setting eligibility policies and enrollment and retention procedures, and identifies the extent to which states have flexibility in determining working families' eligibility and the ease of application and benefit retention. In Appendix B, we provide detailed tables describing the choices made by the 50 states and the District of Columbia in areas where they have the flexibility to determine their own eligibility policies or procedural requirements.

For Medicaid and SCHIP, states have considerable latitude in setting eligibility policies such as income levels. States also have flexibility in setting procedures governing enrollment and re-determination processes. States have much less flexibility in the Food Stamp Program; they generally must follow federal guidelines. There are, however, some options for establishing eligibility and procedures governing enrollment and retention.

MEDICAID COVERAGE GROUPS FOR CHILDREN AND FAMILIES

The Medicaid program provides coverage to several groups of low-income individuals including children, pregnant women, families, and aged, blind, and disabled persons. Each coverage group has its own set of federal requirements and state options governing eligibility policies and procedures for enrollment in and renewal of benefits. Our study focuses on the three primary Medicaid coverage groups serving low-income families or children: Section 1931 Medicaid for families, Transitional Medical Assistance (TMA), and children's Medicaid. Many of the states we visited also serve low-income families through a Medically Needy coverage group or through a waiver of federal Medicaid requirements under Section 1115 of the Social Security Act.

Medicaid is jointly funded by state and federal dollars. State Medicaid spending is matched by the federal government in accordance with each state's federal Medicaid match rate, which is determined annually based on the state's per capita income for recent years. Current federal match rates range from 50 percent in more affluent states (\$1 of federal funds matches \$1 in state funds) to 76 percent in poorer states (slightly over \$3 in federal funds matches \$1 in state funds). Certain activities can receive a higher federal match. Because states pay up to 50 percent of the cost of Medicaid coverage, policies and processes that expand eligibility or increase enrollment will increase state Medicaid costs. Thus, budget considerations are likely to substantially influence states' choices in these areas.

Section 1931 Medicaid for Families (Parents and Children)

State Policy Options for Eligibility

The 1996 federal welfare law established a Medicaid coverage group for low-income families with children through a new Section 1931 of the Social Security Act. Prior to 1996, families receiving Aid to Families with Dependent Children (AFDC) automatically qualified for Medicaid, but often families—and, in particular, parents—not receiving welfare could not qualify for Medicaid. In replacing the AFDC program with the Temporary Assistance to Needy Families (TANF) block grant, Congress replaced the AFDC-linked Medicaid group with the Section 1931 eligibility group that is not linked to receipt of cash welfare. (This is often referred to as de-linking.) The primary purpose of establishing a separate Medicaid group was to assure that low-income families would not lose out on health coverage as a result of the changes in state welfare programs.

Medicaid eligibility under Section 1931 is based on certain rules and standards in effect under a state's AFDC plan on July 16, 1996. Specifically, states must provide Medicaid to families with children whose income and resources are below the state's AFDC income and resource standards in effect on July 16, 1996, and who meet certain AFDC family composition requirements as they were on July 16, 1996.

Under Section 1931, a state can vary from its July 16, 1996 rules in several ways, the most significant being the option to adopt "less restrictive methodologies" for consideration of income and assets.

Income and assets. Using less restrictive methodologies, a state can set Section 1931 eligibility policies that raise asset limits, or disregard assets altogether. They can also expand the amount of earnings disregarded in determining eligibility, as most states have done in their TANF programs. Many states have chosen to use less restrictive methodologies to align Section 1931 Medicaid policies with their TANF earnings disregard policies. Other states have expanded Section 1931 eligibility cut-offs beyond those used for TANF eligibility.

Generally, a state must use a single set of eligibility policies for its Section 1931 group. A state is permitted, however, to use different policies for earned income for all Section 1931 applicants than it uses for all Section 1931 recipients. For example, a state can have more

limited earnings disregards for Section 1931 applicants but use more generous earnings disregards for Section 1931 recipients. In addition, while nearly all states are required to use the same set of eligibility criteria for families whether or not they receive TANF, a few states can use different eligibility policies for TANF applicants and recipients than other Section 1931 families under prior AFDC waivers.

The national median income cut-off for a Section 1931 recipient with earnings is about three-fifths of the federal poverty line, but state eligibility limits range from 21 to 200 percent of the federal poverty line (see Appendix B). Fewer than 10 states use an income cut-off above the poverty line, while about one-quarter use an income threshold of below 50 percent of the poverty line. As shown in Table II-1, the 12 states we visited reflected the range in Section 1931 eligibility levels. A number of states, including some of the states we visited, use a higher income eligibility limit for recipients than for applicants. Some states also use a higher earnings disregard for a limited period of time for recipients.

Most states use less restrictive methodologies to raise Section 1931 asset tests from the July 16, 1996 levels, or eliminate them altogether. About half of the states set asset limits higher than \$1,000 (the July 16, 1996 level for most states), and another quarter have eliminated asset tests altogether (see Appendix B). The states in this study spanned the range of these choices; four—Connecticut, Ohio, Oklahoma, and South Carolina—eliminated asset tests (see Table II-1).

Two-parent families. In setting Section 1931 eligibility policies, states have an option to treat two-parent families the same as single-parent families, or to make eligibility more restrictive for two-parent families. Specifically, a state can elect to continue or eliminate the AFDC family composition requirement limiting eligibility for two-parent families based on “unemployment” to those persons working fewer than 100 hours per month.⁸ This so-called “100-hour rule” often categorically excluded working two-parent families from qualifying for benefits, even when family earnings were so low that the family was financially eligible. Nationally, fewer than a dozen states (including Arkansas and Utah, which appear in this study) continue to impose the 100-hour rule in their Section 1931 Medicaid group (see Appendix B and Table II-1). The remaining states have eliminated the 100-hour rule and substantially treat two-parent families the same as single parent families for Section 1931 eligibility.

⁸ To the extent that a state had a statewide waiver of the AFDC “100-hour rule”—as 30 states had under the AFDC program—a state can extend Medicaid coverage under Section 1931 to all two-parent families. In addition, an HHS rule gives all states—including those that did not have 100-hour rule waivers—greater flexibility to extend coverage under Section 1931 to two-parent families with an employed parent.

Table II- 1
Policies Affecting Families' Initial and Ongoing Eligibility for Section 1931 Medicaid

Section 1931 Medicaid Eligibility Limits for a Family of 3: Maximum Monthly Earned Income					Eliminated Asset Test	Kept Asset Test But Disregards Entirely First Vehicle	Eliminated '100 Hour' Rule	Uses 1931 Disregards or Other Policy to Meet TMA Rules	Effectively Extends Transitional Coverage ^b
Applicant		Recipient ^a (limit after expiration of time-limited earnings disregard in parentheses)							
State	Dollars	Percent FPL	Dollars	Percent FPL					
U.S.					Yes: 16 No: 35	Yes: 18 No: 17	Yes: 42 No: 9	Yes: 19 No: 33	Yes: 13 No: 38
AL*	\$254	21	\$366 (\$254)	30 (21)		✓	✓		
AR	\$255	21	\$638	52		✓			
CT	\$1,918	157	\$1,918	157	✓	--	✓	✓	✓
GA*	\$756	42	\$756 (\$514)	62 (42)			✓	✓	✓
IN	\$378	31	\$378	31			✓		
ME	\$1,918	157	\$1,918	157		✓	✓	✓	
MN*	\$942	77	\$942 (\$638)	77 (52)		✓	✓		
OH	\$1,219	100	\$1,219	100	✓	--	✓		
OK	\$591	48	\$591	48	✓	--	✓		
SC*	\$1,219	100	\$1,136 (\$668)	93 (55)	✓	--	✓	✓	✓
UT*	\$673	55	\$995 (\$673)	82 (55)				✓	✓
WA	\$1,092	90	\$1,092	90			✓	✓	

Source: 1931 Medicaid eligibility criteria for applicants and recipients: Data were initially collected during Kaiser-supported study entitled *Making Medicaid Work for Low-Income Families* and are accurate to June 2001, along with supplemental information from site visits and state agencies. For purposes of this table, these data were updated using the Federal Poverty Level for 2001.

^aStates marked with asterisk have time-limited earnings disregard for recipients. These states have a second parenthetical entry in this column. The first entry is the eligibility level with the initial earnings disregard, and the parenthetical entry reflects the eligibility level after this disregard has ended.

^bUnder Section 1931, states have the option to disregard all earnings for a period of time at the point where a family would lose eligibility for Medicaid due to an increase in earnings and before the family enters TMA, thus effectively extending their transitional coverage. These four states provide 24 months of extended Medicaid, by disregarding earnings for 12 months after the family reaches the income limit shown in the column for recipient income limits.

Sanctions. Under Section 1931, states have an option to terminate the Medicaid coverage of a non-pregnant adult who loses TANF due to refusal to comply with TANF work rules. Only 12 states have elected this option, including three states visited in this study: Alabama, Indiana, and South Carolina (see Appendix B). States choosing this option cannot, however, deny or terminate Medicaid coverage of children or pregnant women. Moreover, states cannot deny or terminate Medicaid for failure to comply with other TANF requirements, such as an immunization requirement. For Section 1931 Medicaid, all states must require cooperation with medical support requirements (for child support cases) and must sanction a non-pregnant adult who fails to cooperate without good cause.

State Procedural Options for Enrollment and Retention

Each state has a great deal of flexibility in establishing the procedures it uses to determine initial and ongoing eligibility for Medicaid. The options identified below in the context of Section 1931 Medicaid typically are available for other Medicaid groups as well. State choices made under these options are discussed in more detail in Chapters III, IV, and V.

Applications. States can choose whether families applying for Medicaid use a separate Medicaid-only application or a combined form that also includes TANF and/or food stamps. (States are required to make separate Medicaid-only applications available for pregnant women and children.)

Interview requirements. States can choose whether to require an interview for application or renewal, and, if so, whether it must be face-to-face or can be conducted over the telephone.

Verification. States are required to verify the immigrant status of non-citizens seeking benefits. Otherwise, states can choose the eligibility factors a family must verify, and can accept self-declaration of any or all eligibility factors.

Renewal. Under federal law, states must review eligibility for Medicaid at least once a year, and can choose to review it more frequently. Most states review eligibility for Section 1931 annually, although about a dozen states do so every six months. Four of the states we visited—Georgia, Maine, Ohio, and Oklahoma—reviewed eligibility every six months. A review can and, to the greatest extent possible, should be based on information already known to the agency. A state need not require any action or paperwork from the family if it has information to renew Medicaid.

Reporting of changes. Between reviews, states must require families to report changes of circumstances that affect their eligibility. States can meet this requirement by requiring a family to file a periodic report (e.g., monthly or quarterly) about changed circumstances. States need not require reporting of changes that do not affect eligibility—for example, assets in a state that does not consider them. States can disregard small fluctuations in income between certifications.

Under federal law, only state or county government employees can determine Medicaid eligibility. In addition, many rules that have long governed Medicaid continue to apply to Section 1931 Medicaid. States must conform to salient federal requirements including: (1) individuals have a right to apply without delay; (2) applications must be processed promptly and within 30 or, in some instances, 45 days; and (3) Medicaid for any coverage group should not be denied or terminated until the state has considered eligibility for Medicaid under any other coverage group.

Transitional Medical Assistance (Parents and Children)

State Policy Options for Eligibility

Under federal law, states must provide Transitional Medical Assistance for up to 12 months to families losing Section 1931 Medicaid coverage due to earnings, and four months to families who become ineligible due to receipt of child support income. TMA due to earnings is available automatically for six months and may be extended for an additional six months if a family's gross earnings, without child care costs, are below 185 percent of the federal poverty line. To qualify for TMA, a family must have qualified for Medicaid under Section 1931 for three of the prior six months.

Before the 1996 welfare law, TMA eligibility was triggered by loss of AFDC eligibility. In de-linking cash and Medicaid, Congress changed the TMA trigger; loss of Section 1931 eligibility rather than loss of cash assistance triggers TMA. In fact, a family can receive TMA without ever having received TANF cash assistance.

While basic TMA eligibility policies are set by federal law, state options to use less restrictive methodologies for Section 1931 Medicaid effectively allow a state to increase access by disregarding income for at least three months and thus delaying ineligibility for Section 1931 Medicaid. In doing so, a state can help a family meet the “3 of 6 month rule” to qualify for TMA or can, in effect, provide extended medical coverage for longer than the 12-month TMA period.

Extended Medicaid. Prior to the 1996 welfare law, some states obtained waivers to provide Transitional Medical Assistance for longer than 12 months. Now all states can use less restrictive methodologies in their Section 1931 groups to achieve the same result without a federal waiver. A state can, for example, disregard all earnings for Section 1931 Medicaid for 12 months. The family continues to receive Section 1931 Medicaid for this 12-month disregard period. When the disregard expires, the family may lose eligibility for Section 1931 Medicaid once earnings are counted, thus triggering up to 12 months of federally required TMA. The combined effect of these two periods is that the family receives a 24-month extension of Medicaid. This is often referred to as extended Medicaid. About a dozen states, including four states we visited in this study—Connecticut, Georgia, South Carolina, and Utah—provide 24 months of extended Medicaid (see Appendix B and Table II-1).

Mitigating the “three of six month” rule. By disregarding all income for at least three months for Section 1931 Medicaid, a state can ensure that the family receives Section

1931 Medicaid for the minimum three months needed to qualify for TMA. This can eliminate the TMA access barrier posed by the “three of six month requirement” for recipients who get jobs immediately upon enrolling in Medicaid. About one-third of the states have devised strategies to effectively waive the “three of six month requirement” including several states we visited in this study—Connecticut, Georgia, Maine, South Carolina, Utah, and, since the site visit, Washington (see Appendix B and Table II-1).

State Procedure Options for Enrollment and Retention

Under federal law, states cannot require a family to apply for TMA. Instead, TMA is automatically made available to families losing Section 1931 Medicaid due to earnings or child support. A state may require that a family verify earnings, or it may accept the family’s self-declaration of employment and earnings. Under federal law, families receiving TMA must file quarterly reports.

Children’s Medicaid Coverage Groups

State Policy Options for Eligibility

Children have other bases of Medicaid eligibility if the family does not receive Medicaid under Section 1931 or TMA. Under a series of expansions enacted in the 1980s and 1990s, states must provide Medicaid coverage to children under age 6 in families with incomes under 133 percent of the federal poverty line, and children under age 19 in families below 100 percent of the poverty line.⁹ States can cover children beyond these minimum levels—over half do so, with about one-quarter of states covering at least some children at or above 200 percent of the poverty line. (In addition, nearly 30 states cover additional children at or above 200 percent of the poverty line through their separate state SCHIP programs, discussed below.) Similarly, federal law sets a floor for state asset tests that cannot be more restrictive than those used under the state’s IV-A plan. States may, however, raise asset limits or eliminate them altogether. Some 44 states, including all of the study states except Utah, have eliminated asset tests in the children’s Medicaid coverage group (see Appendix B and Table II-2).

State Procedure Options for Enrollment and Retention

States have a great deal of flexibility in establishing the processes to determine initial and ongoing Medicaid eligibility. As is the case for Section 1931 Medicaid, states can choose to use procedures for children’s Medicaid such as short application forms, mail-in applications with no interviews required, and self-declaration of income and other circumstances without

⁹ Mandatory coverage for children under the poverty line is required for children born after September 30, 1983, and thus is being phased in through passage of time. By September 30, 2002, states will be required to provide Medicaid for all children through age 18 in families with income below the federal poverty line.

Table II-2
Policies Affecting Initial and Ongoing Eligibility for Children's Medicaid and SCHIP

State	Medicaid Coverage for Children Including Medicaid Expansion & SCHIP Medicaid Expansion Eligibility as Percent FPL				Separate State SCHIP Eligibility as Percent FPL		
	Under 6 years	6 to 19 years	Eliminated Asset Test	Continuous Eligibility	Up to 19 Years	Eliminated Asset Test	Continuous Eligibility
AL	133	100	v	v	200	v	v
AR	200	200	v		--	--	--
CT	185	185	v	v	300	v	v
GA	133*	100	v		235	v	
IN	150	150	v	v	200	v	v
ME	150*	150	v	v	200	v	v
MN	275*	275	v		-- ^a	--	--
OH	200	200	v		--	--	--
OK	185	185	v		--	--	--
SC	150	150	v	v	--	--	--
UT	133	100			200	v	v
WA	200	200	v	v	250	v	v

Source: Center on Budget and Policy Priorities, survey of state Medicaid and SCHIP enrollment and renewal procedures for the Kaiser Commission on Medicaid and the Uninsured, forthcoming 2002.

*These states have higher eligibility limits for children under 1 year of age

^aMinnesota has a very small separate state SCHIP for 275 to 280% FPL but, due to its small size, this program is not routinely shown in Kaiser Commission on Medicaid and the Uninsured materials.

requiring verification. States must also meet requirements for timely processing and reviewing eligibility before denying or terminating benefits. There are also several additional options and requirements for children's coverage.

Outstationed enrollment. Federal law requires states to ensure that enrollment sites for Medicaid for children and pregnant women are available at certain locations, namely hospitals and community health centers. Beyond that, states can choose to enable enrollment at such locations as school-linked services centers, WIC clinics, child care programs, and other places frequently visited by families and children. States can also use outstationed workers to complete renewals.

Continuous eligibility. States must review eligibility for Medicaid at least once a year, and can choose to do so more frequently. Over 40 states review children's Medicaid annually; most of the remaining states review eligibility every six months. States have an

CHAPTER III

INCREASING AWARENESS ABOUT THE AVAILABILITY OF PUBLIC BENEFITS AND THE PROCESS OF APPLYING FOR THEM

In recent years, the number of low-income working families has risen, while the number of families receiving cash assistance has fallen sharply. This has led to new challenges for public agencies that deliver health and nutritional benefits to families—specifically, educating families about the Food Stamp, Medicaid, and SCHIP programs, and encouraging them to apply for appropriate benefits. Until recently, few states or local welfare offices conducted outreach for these programs, leaving interested states with little experience to draw upon. In order to be successful, outreach efforts need to reach families who are not aware they may be eligible, provide them with information on how to apply, and convince them that the benefits available are greater than the costs of application. This often means correcting misinformation about program eligibility requirements, reducing any discomfort families may have about receiving “welfare,” and reducing the opportunity costs of applying for benefits.

Many states have developed expansive public information and outreach campaigns to increase participation in children’s Medicaid and SCHIP programs. Although federal funds are available to offset the costs of these activities (see box), they have been slower to use outreach to increase participation in Section 1931 Medicaid and food stamps. We observed this pattern in the study states—the most extensive outreach efforts were focused on enrolling children in Medicaid and SCHIP, with more limited efforts to enroll parents in Medicaid and families in food stamps. In general, outreach efforts were focused on one, rather than multiple programs. When in place for more than one program at the same site, these outreach efforts generally operated independently of one another. Only Washington State had a campaign in place to make working families aware of all of the benefits available to them.

**Table IV-1
Provisions to Simplify the Application Process**

State	No Face-to-Face Interview Required Yes = ✓				Reduced Verification: Income Self-Declaration; No Asset Test or Vehicle Exclusion				Application Type: 1931 Can Use Children's Application ✓ Children's Medicaid/State SCHIP Use Same Form ✓ Food Stamp Application < 10 Pages ✓		
	Section 1931 Medicaid	Children's Medicaid	Separate State SCHIP	Food Stamp	Section 1931 Medicaid	Children's Medicaid	Separate State SCHIP	Food Stamp	Section 1931 & Children's Medicaid	Children's Medicaid & Separate SCHIP	Food Stamps
AL	✓ ^a	✓ ^a	✓		Vehicle exclusion	No asset test	Income self- declaration; No asset test	Vehicle exclusion		✓	
AR		✓	--		Vehicle exclusion	Income self- declaration; No asset test	--	Vehicle exclusion	✓	--	✓
CT	✓	✓	✓		Income self- declaration No asset test	Income self- declaration No asset test	Income self- declaration; No asset test		✓	✓	✓
GA		✓	✓		Income self- declaration	Income self- declaration; No asset test	Income self- declaration			✓	✓
IN	✓ ^a	✓	✓			No asset test	No asset test	Vehicle exclusion		✓	✓
ME	✓	✓	✓		Vehicle exclusion	No asset test	No asset test	Vehicle exclusion	✓	✓	✓
MN	✓	✓	--	^b	Vehicle exclusion	No asset test	--			--	
OH	✓	✓	--		No asset test	No asset test	--	Vehicle exclusion	✓	--	✓
OK	✓	✓	--		Income self- declaration; No asset test	Income self- declaration; No asset test	--		✓	--	✓
SC	✓	✓	--		No asset test	No asset test	--	Vehicle exclusion		--	✓
UT	✓	✓	✓				No asset test		✓	✓	✓
WA	✓	✓	✓			Income self- declaration; No asset test	Income self- declaration; No asset test			✓	✓

^aInterview is required, but can be completed over the phone.

^bIn its pilot outreach project, Hennepin County uses the hardship exemption to exempt families who apply for food stamps at community centers from the face-to-face interview.

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APPENDIX A
PROGRAM ENROLLMENT

TABLE A-1

CHANGES IN OVERALL MEDICAID AND TANF ENROLLMENT

State	Medicaid 6/96-6/98 Change (%)	TANF 6/96-6/98 Change (%)	Medicaid 6/98-6/00 Change (%)	TANF 6/98-6/00 Change (%)	Medicaid 6/96-6/00 Change (%)	TANF 6/96-6/00 Change (%)
U.S.	-6.7	-32.3	9.0	-30.1	1.7	-53.2
AL	2.6	-47.7	6.3	3.7	9.0	-45.8
AK	-24.7	-18.2	23.4	-20.1	-7.0	-34.9
AZ	-2.4	-41.2	10.6	-13.9	8.0	-49.4
AR	-10.3	-43.8	17.0	-12.3	4.9	-50.8
CA	-9.5	-22.9	2.8	-37.0	-7.0	-51.4
CO	-16.1	-43.2	29.2	-49.3	8.4	-71.2
CT	-1.5	-25.2	4.4	-46.4	2.8	-60.0
DE	9.5	42.4	17.8	-47.8	29.0	-25.6
DC	-10.0	-20.1	5.8	-17.6	-4.7	-34.1
FL	-7.8	-54.9	20.0	-44.1	10.6	-74.8
GA	-8.8	-47.3	-4.6	-24.3	-13.0	-60.1
HI	.4	-30.3	.5	-8.4	.9	-36.1
ID	4.8	-81.6	22.0	-42.9	27.8	-89.5
IL	-6.5	-25.9	6.4	-46.0	-.5	-60.0
IN	-6.6	-26.6	39.4	-8.7	30.2	-33.0
IA	-8.7	-22.9	-2.5	-21.8	-11.0	-39.7
KS	-10.6	-49.2	12.3	9.7	.4	-44.3
KY	-2.5	-30.7	11.0	-28.1	8.2	-50.2
LA	-6.1	-39.9	2.5	-42.5	-3.8	-65.5
ME	-3.1	-28.6	5.6	-31.7	2.4	-51.3
MD	-2.0	-39.2	4.8	-40.0	2.7	-63.5
MA	30.1	-27.6	7.1	-43.55	39.3	-59.1
MI	-3.6	-35.13	-3.9	-41.7	-7.4	-62.2
MN	-10.1	-15.1	8.6	-20.2	-2.3	-32.3
MS	-24.7	-59.5	45.5	-34.1	9.6	-73.3
MO	-4.8	-35.5	24.2	-15.0	18.2	-45.2
MT	-14.7	-42.0	2.8	-21.4	-12.3	-54.4
NE	5.3	-11.9	20.3	-20.3	26.7	-29.8
NV	40.0	-28.6	6.1	-35.4	48.5	-53.9
NH	1.2	-32.8	7.6	-13.4	8.9	-41.8
NJ	-9.0	-33.4	2.4	-33.7	-11.2	-55.8
NM	-26.7	-25.3	28.5	-8.4	-5.9	-31.6

State	Medicaid 6/96-6/98 Change (%)	TANF 6/96-6/98 Change (%)	Medicaid 6/98-6/00 Change (%)	TANF 6/98-6/00 Change (%)	Medicaid 6/96-6/00 Change (%)	TANF 6/96-6/00 Change (%)
NY	-22.2	-21.3	28.6	-24.5	.05	-40.6
NC	-4	-36.4	7.5	-43.9	7.1	-64.3
ND	-8.8	-34.3	-2.4	-.04	-6.6	-34.6
OH	39.2	-34.1	8.6	-30.3	51.1	-54.0
OK	-6.9	-29.5	30.2	-52.4	21.1	-66.5
OR	-11.8	-41.0	11.1	-12.9	-2.0	-48.6
PA	-17.8	-31.5	1.4	-35.4	-16.7	-55.8
RI	3.4	-5.3	28.5	-18.1	32.9	-22.4
SC	13.4	-47.8	21.5	-40.4	37.8	-68.9
TN	7.5	-43.0	4.3	-2.3	12.1	-44.3
TX	-13.4	-44.2	4.0	5.6	-9.9	-47.0
UT	9.4	-29.1	7.8	-13.1	17.9	-38.4
VT	30.6	-21.6	10.3	-20.9	44.0	-37.9
VA	-26.8	-36.4	-3.9	-31.9	-29.7	-56.7
WA	13.2	-24.5	1.5	-29.5	14.9	-46.8
WV	.5	-56.1	15.1	-22.3	-14.7	-65.9
WI	-14.2	-76.5	20.6	1.8	3.5	-76.0
WY	-9.3	-75.1	.4	-63.1	-5.5	-90.8

Sources: Health Care Financing Administration. *Medicaid Managed Care Enrollment Report*, www.hcfa.gov/medicaid/omc1996/2000.htm (column 1, total Medicaid enrollment).

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Calculations were done by staff of the Center for Health Services Research and Policy (CHSRP), School of Public Health and Health Services, The George Washington University Medical Center.

TABLE A-2

CHANGES IN FOOD STAMP ENROLLMENT

State	Food Stamp Participants December 1996	Food Stamp Participants December 2001	Percent Change December 1996 – December 2001
U.S.	23,920,683	1,874,286	-21.6
AL	492,478	441,060	-10.4
AK	15,651	41,832	167.3
AZ	388,374	357,847	-7.9
AR	273,742	279,453	2.1
CA	2,938,077	1,702,529	-42.1
CO	228,530	175,476	-23.2
CT	213,636	163,684	-23.4
DE	57,880	38,849	-32.9
DC	93,328	75,544	-19.1
FL	1,295,006	989,257	-23.6
GA	746,116	616,645	-17.4
HI	131,074	107,834	-17.7
ID	74,941	67,556	-9.9
IL	1,059,386	893,276	-15.7
IN	356,026	396,508	11.4
IA	167,446	138,604	-17.2
KS	157,751	136,656	-13.3
KY	459,433	439,305	-4.4
LA	610,840	579,500	-5.1
ME	126,823	109,030	-14.0
MD	354,647	222,382	-37.3
MA	353,910	236,677	-33.1
MI	870,229	730,455	-16.1
MN	270,236	210,696	-22.0
MS	423,956	328,097	-22.6
MO	522,146	505,186	-3.2
MT	68,052	63,243	-7.1
NE	98,088	85,054	-13.3
NV	89,028	93,413	4.9
NH	47,672	39,664	-16.8
NJ	510,583	319,666	-37.4

State	Food Stamp Participants December 1996	Food Stamp Participants December 2001	Percent Change December 1996 – December 2001
NM	222,484	166,447	-25.2
NY	1,966,399	1,318,618	-32.9
NC	610,383	565,048	-7.4
ND	37,928	36,352	-4.2
OH	918,303	722,426	-21.3
OK	326,181	291,928	-10.5
OR	268,898	350,555	30.4
PA	1,042,559	76,9745	-26.2
RI	94,449	69,711	-26.2
SC	358,353	370,536	3.4
TN	611,291	569,742	-6.8
TX	2,161,958	1,519,766	-29.7
UT	102,517	86,711	-15.4
VT	53,944	39,414	-26.9
VA	503,630	350,453	-30.4
WA	487,312	343,279	-29.6
WV	294,564	231,674	-21.4
WI	246,023	252,332	2.6
WY	30,476	22,724	-25.4

Source: Food Research and Action Center. "Food Stamp Program Participation Five Year Change."
<http://www.frac.org/html/news/fsp/01december5yr.htm>, March 2002b.

APPENDIX B
PROGRAM POLICIES

TABLE B-1

MEDICAID POLICIES AFFECTING FAMILIES' ABILITY TO ENROLL IN AND
RETAIN SECTION 1931 MEDICAID

State	Section 1931 Medicaid Eligibility for 3-Person Family with Earnings Disregard		Eliminated Asset Test Yes: 16✓ No: 35	Kept Asset Test But Disregards Entirely First Vehicle Yes: 18✓ No: 17	Eliminated '100 Hour' Rule Yes: 42✓ No: 9	Length of Review of Period (Months)	Uses 1931 Disregards or Other Policy to Meet TMA Rules Yes: 19✓ No: 32	Effectively Extends Transitional Coverage ^c Yes: 13✓ No: 38
	Maximum Monthly Earned Income in \$\$ and as Percent FPL	Applicant ^a						
U.S.								
AL*	\$254 / 21	\$366 / 30		✓	✓	12		
AK	\$1,208 / 79	\$1,827 / 120		✓	✓	6	✓	
AZ	\$641 / 53	\$641 / 53	✓	N/A	✓	12	✓	✓
AR	\$255 / 21	\$638 / 52		✓		12		
CA	\$1,309 / 107	\$1,826 / 150			✓	12		
CO	\$511 / 42	\$511 / 42		✓	✓	12		
CT	\$1,919 / 157	\$1,919 / 157	✓	N/A	✓	12	✓	✓
DE	\$1,491 / 122	\$1491 / 122	✓	N/A	✓	12	✓	✓
DC	\$2,438 / 200	\$2,438 / 200	✓	N/A	✓	12		
FL	\$806 / 66	\$806 / 66			✓	12		
GA*	\$756 / 62	\$756 / 62			✓	6	✓	✓
HI ^d	\$1,403 / 100	\$1,403 / 100		✓	✓	12		
ID*	\$407 / 33	\$597 / 49		✓	✓	12		
IL	\$686 / 56	\$1,131 / 93	✓	N/A	✓	12		
IN	\$378 / 31	\$378 / 31			✓	12		
IA	\$1,065 / 87	\$1,065 / 87			✓			
KS	\$493 / 40	\$762 / 63		✓	✓	6		
KY*	\$909 / 75	\$909 / 75			✓ ^e	12	✓	
LA	\$264 / 22	\$264 / 22				12		
ME	\$1,919 / 157	\$1,919 / 157		✓	✓	6	✓	
MD	\$523 / 43	\$523 / 43		✓	✓	12		
MA	\$1,621 / 133	\$1,621 / 133	✓	N/A	✓	12		
MI	\$774 / 63	\$809 / 66		✓	✓	12	✓	
MN*	\$942 / 77	\$942 / 77		✓	✓	12		
MS*	\$458 / 38	\$672 / 55	✓	N/A	✓	12		✓
MO	\$1,309 / 107	\$1,309 / 107	✓	N/A	✓	12	✓	✓
MT	\$836 / 69	\$836 / 69		✓	✓	12	✓	
NE	\$669 / 55	\$669 / 55		✓		12		✓
NV*	\$1,097 / 90	\$696 / 57		✓	✓	12	✓	
NH	\$750 / 62	\$1,200 / 98		✓			✓	

State	Section 1931 Medicaid Eligibility for 3-Person Family with Earnings Disregard		Kept Asset Test But Disregards Entirely First Vehicle			Length of Review of Period (Months)	Uses 1931 Disregards or Other Policy to Meet TMA Rules		Effectively Extends Transitional Coverage ^c	
	Maximum Monthly Earned Income in \$\$ and as Percent FPL		Eliminated Asset Test		Eliminated '100 Hour' Rule					
	Applicant ^a	Recipient ^b	Yes: 16 [✓] No: 35	Yes: 18 [✓] No: 17	Yes: 42 [✓] No: 9			Yes: 19 [✓] No: 32		Yes: 13 [✓] No: 38
NJ	\$1,711 / 140	\$1,711 / 140	✓	N/A	✓	12	✓	✓		
NM	\$704 / 58	\$704 / 58	✓	N/A	✓	12	✓			
NY	\$667 / 55	\$1,067 / 88			✓	12				
NC	\$750 / 62	\$750 / 62		✓	✓	12	✓	✓		
ND*	\$1,336 / 110	\$1,336 / 110	✓	N/A	✓	12				
OH	\$1,219 / 100	\$1,219 / 100	✓	N/A	✓	6				
OK	\$591 / 48	\$591 / 48	✓	N/A	✓	6				
OR	\$616 / 51	\$616 / 51			✓	6				
PA	\$677 / 56	\$806 / 66	✓	N/A	✓	12				
RI	\$2,345 / 192	\$2,345 / 192	✓	N/A	✓	12		✓		
SC*	\$1,219 / 100	\$1,219 / 100	✓	N/A	✓	12	✓	✓		
SD	\$796 / 65	\$796 / 65		✓	✓	12				
TN	\$990 / 81	\$990 / 81				6				
TX	\$485 / 40	\$395 / 32			✓	6	✓			
UT*	\$673 / 55	\$995 / 82				12	✓	✓		
VT	\$1,301 / 107	\$1,211 / 99		✓	✓	12		✓		
VA*	\$381 / 31	\$557 / 46			✓	12				
WA	\$1,092 / 90	\$1,092 / 90			✓	12	✓			
WV	\$343 / 28	\$343 / 28				12				
WI*	\$607 / 50	\$896 / 73				12				
WY	\$790 / 65	\$790 / 65		✓	✓	6				

Source: Data were collected during Kaiser-supported study entitled *Making Medicaid Work for Low-Income Families* and are accurate to June 2001. For purposes of this table, data for Section 1931 were updated using the Federal Poverty Level for 2001 by Jocelyn Guyer, Kaiser Commission on Medicaid and the Uninsured and Liz Schott, consultant, Mathematica Policy Research, Inc.

Footnotes:

^aThese columns reflect the earnings thresholds that apply to parents in the first month that they have earnings with the exception that they do not take into account the policies used by a few states of disregarding all earnings for an extremely time-limited period (i.e., 1 to 3 months) aimed at helping families qualify for TMA.

^bTwelve states marked with an asterisk have time-limited increased earnings disregard for recipients. The entries in the column reflect the eligibility levels before the disregard has ended. The eligibility cut-offs (income/percent of poverty) after the disregard has ended are as follows: AL: \$254/21; GA: \$514/42; ID: \$407/33; KY: \$616/51; MN: \$638/52; MS: \$638/38; NV: \$438/36; ND: \$892/73; SC: \$710/58; UT: \$673/55; VA: \$381/31 ; WI: \$607/50. These columns do not take into account the policies used by a few states of disregarding all earnings for a period of 12 months or more that are aimed at expanding the effective life of transitional coverage.

^cUnder Section 1931, states have the option to disregard all earnings for a period of time at the point where a family would lose eligibility for Medicaid due to an increase in earnings and before the family enters TMA, thus effectively extending their transitional coverage. Some states, however, have extended the duration of TMA through AFDC or Section 1115 waivers; these waivers will all expire by the end of 2005.

^dHawaii does not have a Section 1931 eligibility category, families are covered under the 1115 waiver program, QUEST.

^eKentucky has eliminated the '100 hour' rule for recipient families, but not for applicant families.

TABLE B-2

CHILDREN'S MEDICAID AND SCHIP ELIGIBILITY AS A PERCENTAGE OF POVERTY

State	Medicaid Coverage for Children						Separate State SCHIP		
	Including Medicaid Expansion & SCHIP Medicaid Expansion						Up to 19 Years	Eliminated Asset Test	Continuous Eligibility
	Up to 1 Year	1 to 5 Years	6 to 17 Years	18 to 19 Years	Eliminated Asset Test	Continuous Eligibility			
AL	133	133	100	100	v	v	200	v	v
AK	200	200	200	200	v		----	----	----
AZ	140	133	100	100	v		200	v	
AR	200	200	200	200	v		----	----	----
CA	200	133	100	100	v	v	250	v	v
CO	133	133	100	43			185	v	v
CT	185	185	185	185	v	v	300	v	v
DE	200	133	100	100	v		200	v	v
DC	200	200	200	200	v		----	----	----
FL	200	133	100	100	v	v	200	v	
GA	235	133	100	100	v		235	v	
HI	200	200	200	200	v		----	----	----
ID	150	150	150	150		v	----	----	----
IL	200	133	133	133	v	v	185	v	v
IN	150	150	150	150	v	v	200	v	v
IA	200	133	133	133	v		200	v	v
KS	150	133	100	100	v	v	200	v	v
KY	185	150	150	150	v		200	v	
LA	200	200	200	200	v	v	----	----	----
ME	200	150	150	150	v	v	200	v	v
MD	200	200	200	200	v		300	v	
MA ^a	200	150	150	150	v		200/400	v	
MI	185	150	150	150	v		200	v	v
MN ^b	280	275	275	275	v		----	----	----
MS	185	133	100	100	v	v	200	v	v
MO	300	300	300	300	v		----	----	----
MT	133	133	100	71			150	v	v
NE	185	185	185	185	v	v	----	----	----
NV	133	133	100	78			200	v	v
NH	300	185	185	185	v		300	v	
NJ ^c	200	133	133	133	v		350	v	
NM	235	235	235	235	v	v	----	----	----
NY	185	133	100	100	v	v	250	v	
NC	185	133	100	100	v	v	200	v	v

State	Medicaid Coverage for Children						Separate State SCHIP		
	Including Medicaid Expansion & SCHIP Medicaid Expansion								
	Up to 1 Year	1 to 5 Years	6 to 17 Years	18 to 19 Years	Eliminated Asset Test	Continuous Eligibility	Up to 19 Years	Eliminated Asset Test	Continuous Eligibility
ND	133	133	100	100	v		140	v	v
OH	200	200	200	200	v		----	----	----
OK	185	185	185	185	v		----	----	----
OR	133	133	100	100	v		170		
PA ^a	185	133	100	46	v		200/235	v	v
RI ^d	250	250	250	250	v		----	----	----
SC	185	150	150	150	v	v	----	----	----
SD	140	140	140	140	v		200		
TN ^e	---	---	---	---	v		----	----	----
TX	185	133	100	100			200	v	v
UT	133	133	100	100			200	v	v
VT	300	300	300	300	v		300		
VA	133	133	100	100	v		200	v	
WA	200	200	200	200	v	v	250	v	v
WV	150	150	100	100	v	v	200	v	v
WI ^f	185	185	185	185	v		----	----	----
WY	133	133	100	100	v	v	133	v	v

Source: Center on Budget and Policy Priorities, survey of state Medicaid and SCHIP enrollment and renewal procedures for the Kaiser Commission on Medicaid and the Uninsured, forthcoming 2002.

Footnotes:

^aMassachusetts and Pennsylvania provide state-financed coverage for children with incomes above SCHIP levels up to 400% FPL and 235% FPL respectively.

^bMinnesota does have a very small separate state SCHIP for 275 to 280% FPL, but, due to its small size, this program is not routinely shown in KCMU materials. Minnesota covers children under age 2 up to 280% FPL.

^cNew Jersey covers parents with incomes up to 200% FPL using SCHIP funds.

^dRhode Island covers parents with income up to 185% FPL using SCHIP funds.

^eUnder Tennessee's waiver, eligibility is based on the child's lack of health insurance. There is no upper income limit.

^fWisconsin covers applicants parents with incomes between 100% and 185% FPL using SCHIP funds, and recipient parents up to 200% FPL.

TABLE B-3

PERCENT OF HOUSEHOLDS WITH SHORT FOOD STAMP CERTIFICATION
PERIODS IN FY 2000 BY STATE

State	All Households	All Households with Children	All Households with Children and Earnings
Alabama	2.8%	2.6%	0.4%
Alaska	1.1%	0.0%	0.0%
Arizona	53.8%	65.5%	18.2%
Arkansas	1.8%	1.4%	0.3%
California	1.1%	0.8%	1.1%
Colorado	27.4%	46.2%	53.8%
Connecticut	1.9%	1.8%	1.1%
Delaware	30.3%	40.0%	19.1%
District of Columbia	0.7%	0.2%	0.0%
Florida	23.0%	37.9%	48.2%
Georgia	36.1%	51.7%	82.5%
Hawaii	0.1%	0.2%	0.0%
Idaho	9.1%	13.5%	11.6%
Illinois	4.1%	3.5%	2.3%
Indiana	12.2%	16.4%	27.1%
Iowa	1.1%	0.2%	0.4%
Kansas	0.3%	0.2%	0.4%
Kentucky	29.2%	40.6%	62.4%
Louisiana	42.4%	55.8%	76.1%
Maine	26.6%	52.3%	90.5%
Maryland	6.3%	8.1%	13.1%
Massachusetts	19.1%	25.5%	61.5%
Michigan	19.6%	29.2%	49.1%
Minnesota	0.1%	0.0%	0.0%
Mississippi	2.5%	1.4%	1.1%
Missouri	52.4%	76.3%	89.5%
Montana	1.0%	1.2%	0.0%
Nebraska	29.1%	50.3%	59.3%
Nevada	24.4%	36.7%	37.7%
New Hampshire	12.4%	15.7%	23.6%
New Jersey	5.0%	5.7%	10.1%
New Mexico	47.9%	64.5%	78.3%
New York	2.7%	2.6%	4.0%
North Carolina	40.6%	63.4%	79.6%
North Dakota	11.1%	14.2%	13.6%
Ohio	19.6%	34.0%	67.5%
Oklahoma	45.1%	70.1%	86.6%

State	All Households	All Households with Children	All Households with Children and Earnings
Oregon	10.5%	13.1%	17.8%
Pennsylvania	2.1%	2.0%	2.6%
Rhode Island	0.3%	0.3%	0.0%
South Carolina	0.3%	0.6%	0.8%
South Dakota	0.3%	0.0%	0.0%
Tennessee	39.2%	61.1%	82.6%
Texas	39.1%	45.7%	55.3%
Utah	34.0%	50.2%	71.1%
Vermont	1.9%	0.6%	1.6%
Virginia	28.8%	42.8%	57.8%
Washington	36.3%	51.2%	51.9%
West Virginia	28.9%	45.5%	84.5%
Wisconsin	44.1%	65.9%	74.6%
Wyoming	47.7%	62.4%	69.3%
Total	18.5%	26.0%	37.8%

Source: Center on Budget and Policy Priorities Analysis of USDA Quality Control Data for FY 2000.