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# **MEDICAID ADVOCACY GUIDE**

Strategies for Increasing Access to Coverage

**A MANUAL FOR STATE-BASED ADVOCATES**

Northwest Health Law Advocates  
&  
Northwest Federation of Community Organizations



July 2001

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# **MEDICAID ADVOCACY GUIDE**

A Guide to Addressing Medicaid Access Issues

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## **INTRODUCTION**

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For the past three years, hundreds of thousands of families have had their Medicaid benefits illegally cut off by state governments across the country. Before 1997, Medicaid was a benefit that families eligible for Aid to Families with Dependent Children (AFDC) automatically received. Under federal “welfare reform,” AFDC was replaced by Temporary Assistance to Needy Families (TANF) and the Medicaid program was “de-linked” from the cash assistance program. This “delinkage” meant that many of the restrictive rules and time limits for receiving cash benefits which were imposed as part of “welfare reform” would not restrict eligibility for Medicaid. As a result, the vast majority of families going off TANF still qualified (and continue to qualify) for Medicaid.

Unfortunately, most states failed to implement these changes smoothly. Consequently, many families who left TANF were illegally removed from the Medicaid rolls at the same time. Communities across the country responded by demanding that these families have their Medicaid benefits reinstated and that the families be compensated for medical expenses they accrued while they were illegally denied Medicaid coverage.

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## **CASE STUDY – Washington State’s Experience: from Tragedy to Triumph**

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In Washington State alone, more than 100,000 individuals receiving TANF and medical assistance had their Medicaid benefits illegally cut off after Washington implemented “welfare reform.” This happened because the state failed to change the computer program and other practices that automatically terminated both sets of benefits when a person became ineligible for cash assistance.

As reports of these illegal terminations filtered down to the advocacy community, a coalition of community groups and legal services organizations began to investigate the problem. These groups obtained welfare caseload data from the state, as well as copies of the procedures the state used in deciding when to terminate families’ benefits. This information confirmed the anecdotal reports the groups had received, indicating that families were having their medical benefits cut off illegally on a systematic basis. Armed with this data, the groups demanded that Washington stop the illegal Medicaid terminations and implement a raft of corrective measures. These remedies included:

- Identifying and reinstating individuals who had had their medical benefits illegally cut off, and maintaining their Medicaid if eligible
- Changing the State’s computer and administrative procedures for terminating individuals’ Medicaid benefits
- Training state workers charged with administering benefits programs
- Compensating individuals who paid out of pocket medical expenses, were billed by health providers, or hounded by collection agencies after having their medical benefits wrongfully withdrawn
- Auditing the implementation of these changes.
- After extensive negotiations, the state agreed with the coalition of advocates’ above-listed demands. Under this agreement, the state found and reinstated almost 30,000 families’ Medicaid benefits, regardless of their current eligibility for Medicaid, beginning in May of 2000. The state further guaranteed that any other family whose benefits were illegally terminated who contacted them by November 15, 2000 would also be reinstated.

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## **PURPOSE – A Guide to Identifying and Addressing Medicaid Access Issues**

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This guide describes a successful campaign for Medicaid reinstatement that was conducted by community and legal advocates. The strategies for research, organizing and negotiating used by this coalition – as well as the lessons learned – may serve as a model for advocates around the country who are fighting to increase access to Medicaid in their communities. The Appendices contain background information that will help you understand these strategies in greater depth as well as examples of the informational materials we used in the campaign.

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## **STEP ONE – Determine the Nature and Scope of the Problem in Your State**

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In order to persuade the state agency to address the problem, you will first need to determine whether residents of your state are having trouble enrolling in, remaining on, or getting health services with their Medicaid benefits. You also need to understand the scope of the problem. To do this, you will need to cast a wide net in your research.

Start out by reviewing sources of information such as:

- local welfare records, state procedures and computer programs that determine how public benefits are approved or distributed
- research reports on how your state's benefits programs have been administered or changed since "welfare reform" went into effect
- government agencies' orders affecting Medicaid and TANF distribution
- recipients' personal histories, and information on low income population as compared to persons enrolled.

In conducting your research, it will be important to take the following steps:

- **Find the Right Agencies:** Find out which agencies have the records. In some states, a separate agency handles cash assistance from the one handling Medicaid. In some, Medicaid and Children's Health Insurance Program are run by different agencies. Records may be found at the state level, the county level, or both.
- **Get the Numbers:** Your state's records document the local TANF and Medicaid caseloads. These statistics are often published by the agencies. If these figures are not distributed by agencies, you can often obtain them by making a request under the authority of your state's "Freedom of Information Act" (FOIA) or similar public disclosure law (most states have them). *Appendix AA* contains instructions on making information requests under federal and state laws and sample request letters. In Washington, it was helpful to see charts of the decline in Medicaid family recipients against the decline in TANF recipients from the date when "welfare reform" was first implemented in the state until the present. Data showed that during this period, state Medicaid rolls decreased at approximately the same rate as the decline in TANF enrollment, indicating that illegal Medicaid terminations were taking place.
- **Understand "reason coding" in your state:** State welfare records usually include "reason codes" which provide the reason(s) why individuals had their benefits denied or terminated. Understanding these codes can play a key role in helping you demonstrate that families were illegally or improperly removed from the Medicaid rolls. See *Appendix BB* for a more detailed discussion of how to obtain and interpret your state's reason codes to advance your research.

→ Review studies that follow families who left TANF: Some of these “leaver” studies may have already addressed the very questions you will want to answer to determine whether Medicaid terminations have been happening in your State. For example: What were families’ health care coverage and needs during the period after they ceased to receive TANF? Did they continue to receive Medicaid after leaving the TANF program? How many families remained uninsured or underinsured, after losing TANF?

→ A good place to start is Jocelyn Guyer’s report, *Health Care After Welfare: An Update of Findings From State Level Leaver Studies*, Center on Budget and Policy Priorities, 8/16/00, (available at <http://www.cbpp.org/pubs/health.htm>) This report provides a listing as well as a thorough summary and analysis of the “leaver” studies compiled by various states to date.

→ Learn whether your state’s computer systems comply with the law: Some states have used computer programs that automatically remove families from Medicaid when they stop receiving cash assistance, or when they no longer qualify for one of the many categories of Medicaid.[1] This is illegal. Instead, when a family is removed from the TANF program, they are not automatically ineligible for Medicaid (see Introduction above). This is also true if someone with Medicaid becomes ineligible for a particular category of Medicaid – they may still qualify for another category. In all of these situations, computerized eligibility systems should keep Medicaid benefits “on” - not automatically shut them off. The computer can then be programmed to automatically analyze the person’s eligibility for every category of medical assistance to determine their ongoing eligibility.

→ Find out what role your state’s computer systems play in determining a family’s eligibility for and termination from TANF and Medicaid. You can probably obtain information on these computer systems through a state public disclosure law/FOIA request. See *Appendix AA*, section 2, and *Appendix BB* for more details of what information to request from the state about its welfare computer systems. It may also be useful to request a meeting with technical staff who work with the agency to explain the computer logic.

→ Learn about other factors that may exclude people from Medicaid incorrectly: This may include people who chose to terminate TANF without knowing that Medicaid benefits could be continued, or that receiving Medicaid does not affect welfare time limits. In some states, people request termination from TANF because of work requirements that may not apply to Medicaid.

→ Collect stories: Find families who left or were terminated from the TANF program and who lost their Medicaid benefits as a result. Document the specific events that led to and followed their loss of benefits as well as the personal impact that the loss of medical coverage has had on their lives. See *Appendix CC* for a checklist of elements of a model story.

→ Familiarize yourself with relevant Health Care Financing Administration (HCFA) Directives: The Department of Health and Human Services oversees numerous

federal social programs. HCFA is the division of HHS that administers the Medicaid program. State agencies that participate in federal programs are required to comply with HHS guidelines with regard to those programs. The agencies under HHS (such as HCFA) often issue guidance letters outlining requirements for states and some of these apply to Medicaid. Explore the HHS website at [www.hhs.gov](http://www.hhs.gov), and the HCFA website in particular at [www.hcfa.gov](http://www.hcfa.gov).

On April 7, 2000, HCFA issued a letter mandating that states identify and reinstate families illegally terminated from Medicaid and review and correct their administrative and computer systems for determining families' Medicaid eligibility. Review this letter to see whether it applies to your state's practices and whether it can be used as a tool in your negotiations, public actions, and/or litigation. The letter is available at <http://hcfa.gov/medicaid/smd/40700.htm>. Additional guidance on what this letter requires of states was provided by HCFA in three series of Questions About the April 7, 2000 Letter to State Medicaid Directors, last updated on 10/13/00:

<http://www.hcfa.gov/medicaid/q&a40700.htm>;  
<http://www.hcfa.gov/medicaid/q&a4700a.htm>;  
<http://www.hcfa.gov/medicaid/q&a4700b.htm>.

Note: At the time of this writing, it is still unclear what the status of HCFA guidance is with the change in Presidential Administration.

Investigate other resources: Start by checking out your state welfare or Medicaid agency's and HCFA's websites (<http://www.hcfa.org>). Then, branch out to research the specific issues confronting your state. Here are a few reports produced by the government and community groups and think tanks with useful more detailed information on various aspects of this problem.

→ Your state agency's website

→ Cindy Mann, The Ins and Outs of Delinking: Promoting Medicaid Enrollment of Children Who are Moving In and Out of the TANF System- Center on Budget and Policy Priorities March 1999, Adobe Acrobat file available at <http://www.cbpp.org/pubs/health.htm>

→ TANF \$500 Million Fund Expenditures as of 12/31/99, FamiliesUSA, 12/31/99, <http://www.familiesusa.org/pubs/tanfup.htm>, hereinafter "FamiliesUSA, \$500 Million Fund Expenditures"

→ Go Directly to Work, Do Not Collect Health Insurance: Low Income Parents Lose Medicaid – Families USA, June 2000 – <http://www.familiesusa.org/pubs/gowrk.htm>

- What Did Welfare Reform Do to Medicaid in Your State and What Can you Do About it? An Action Kit for Advocates – Families USA, January 2000, available in Adobe Acrobat format at <http://www.familiesusa.org/actkit.htm>.
- Liz Schott, Issues for Consideration As States Reinstate Families That Were Improperly Terminated from Medicaid Under Welfare Reform, Center on Budget and Policy Priorities, May 2000, Adobe Acrobat file available at <http://www.cbpp.org/pubs/health.htm>
- Donna Cohen Ross, Jocelyn Guyer, Congress Lifts the Sunset on the “\$500 Million Fund” Extends Opportunities for States to Ensure Parents and Children Do Not Lose Health Coverage, 12/1/99, Center on Budget and Policy Priorities, <http://www.cbpp.org/12-1-99wel.htm>, hereinafter “Ross & Guyer, \$500M Fund.”
- HCFA, Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World, March 22, 1999, <http://hcfa.gov/medical/wrdl3229.htm>, hereinafter “HCFA, Expanding Coverage.”
- Websites for advocacy organizations such as:
  - National Health Law Program (NHeLP) at [www.healthlaw.org](http://www.healthlaw.org)
  - Access Project at [www.accessproject.org](http://www.accessproject.org)
  - Community Catalyst at [www.communitycatalyst.org](http://www.communitycatalyst.org)
  - Families USA at [www.familiesusa.org](http://www.familiesusa.org).

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## STEP TWO – Building Your Campaign

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Family Outreach – Locate and conduct outreach to families who have been affected by the access problem you have identified. In addition to identifying families with stories that illustrate the problem, you can simultaneously build your membership base of families who have been impacted by this issue.

See *Appendix CC* (checklist of elements of model stories). Find people at food banks, community centers, childcare centers, health clinics, housing projects, welfare rights programs.

Build Local Alliances –

→ Community and advocacy groups can help you identify individuals who have been affected by the Medicaid access problem you have identified and assist you in planning and implementing your action plan. In building these campaigns, legal services agencies have been strong allies, as they understand the laws and players which control the distribution of public benefits on a federal and local level.

→ Local bar associations, the National Health Law Program [(202)-289-7661; contact Steve Hitov], Northwest Health Law Advocates [(206) 325-6464; contact Janet Varon], and the Northwest Federation of Community Organizations [(206) 586-5400; contact Leeann Hall] can also provide referrals to legal advocates who specialize in this field. Welfare rights organizations, children’s advocates, health care access projects and outreach groups are valuable allies that can help find and tell the stories of families who are victims of the state’s illegal practices.

Highlight the Problem of Barriers to Medicaid Coverage - Organizations should consider how a press release, public demonstration and/or legal action will best draw attention to the problems you have identified in your State and most effectively assist in attaining your goals. See *Appendix FF* for a press release issued by Washington state advocates in the midst of negotiations with the state.

Contact the Decision-Makers, Set an Initial Meeting Date, Prepare for Negotiations.

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### **STEP 3 – Negotiating To End the Problem & Help Families Who Already Suffered**

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Consider prospective and retrospective remedies: In preparing for negotiations, you need to consider remedies which:

→ Correct the problem for the future, AND Help people that have experienced the barrier already.

→ Formulate your demands - When compiling your list of demands, address the source of the problem. In Washington we considered the following, many of which may apply to any Medicaid barrier campaign:

- Computer and process fixes: Our state welfare agency’s computer systems were a principal cause of illegal terminations, so we demanded that those systems be changed to:
  - ⌚ identify which families have already been illegally terminated by the computer
  - ⌚ ensure that families are not illegally terminated by the computer in the future
  - ⌚ ensure that the state looks at all information they have access to (such as income information provided for Food Stamps eligibility), and look at all potential categories of Medicaid eligibility.

**Worker Training:** Here, our goal was to make sure that state workers who have control over the computer and over the distribution of public benefits are aware of the procedures they must follow and are giving out correct information about Medicaid as families are transitioning off welfare.

**Internal Audits** of the State Agency Administering Benefits Programs: We also wanted to ensure that the state agency reviewed the following:

→ During the time lag before computer fixes can be achieved, each family moving off welfare must have its case reviewed or “audited” at the supervisory level to ensure that incorrect computer determinations are avoided or promptly canceled, that caseworker determinations are thorough and correct, and that families get the appropriate Medicaid benefits. An alternative approach used in Maryland is to have a centralized committee, educated in the changes in eligibility procedures and regulations, review all new Medicaid terminations during the interim period before final corrective systems are in place.

→ After the computer problem is solved, a systematic program of case record review should be instituted to make sure that agreed-upon changes have actually taken place and that they have been effective.

→ Clarification of Medicaid Eligibility Rules and Procedures:

- The state agency should clarify and rewrite in easily understood language its rules and procedures governing eligibility for the state's TANF and Medicaid programs. Areas which will likely require clarification include:
  - 🕒 rules defining families' eligibility for benefits
  - 🕒 procedures for determining a family's eligibility for benefits or for terminating a family's benefits under those definitions
  - 🕒 training and reference manuals provided to state workers to educate them about these rules and procedures
  - 🕒 benefits application and appeal forms
  - 🕒 notices of eligibility, and, flyers or other materials distributed to the public to give them guidance about their rights to benefits.

These clarifications will help minimize any difficulties state workers or members of the public may have in determining how the new rules and procedures affect a particular person or family's eligibility.

→ Incorporation of HCFA Guidance: The revisions should reflect HCFA directives, such as prohibiting a state from requiring duplicate paperwork from people who have already submitted a food stamps review.

→ Identification, Notification and Reinstatement of families illegally terminated from the Medicaid rolls: The state should immediately identify individuals who lost Medicaid since "welfare reform" was implemented. Any of these persons whom the state can easily and quickly determine would certainly have lost their Medicaid benefits, even under the new laws, can be removed from the list of illegally-terminated persons. The remaining families are presumed to have had their medical benefits cut off illegally because federal law requires a full pre-termination review which you have shown is not occurring. To remedy this violation, the state should provide these families with at least three months of new Medicaid eligibility, regardless of their current eligibility status. States are required to maintain Medicaid coverage until a valid adverse redetermination of Medicaid eligibility has been completed.

→ Requiring our state to provide at least three months of renewed Medicaid benefits allowed many people to get an additional six to twelve months of coverage under the "Transitional Medical Assistance" (TMA) program. TMA is only available to families who have been on Medicaid for at least three months. As a result, getting three months of benefits through our agreement with the state actually enabled many to get Medicaid for 9-15 months.

→ Compensation to people for medical expenses accrued during the period they were illegally terminated from Medicaid. This may be reimbursement for some people, and payment of bills, collection agency fees and court costs for others. The state will need to have a claims process to allow people to submit their expenses or bills.

→ Negotiating Tips - In order to represent your constituents' interests effectively you must be thoroughly prepared for and deliberate in your actions throughout your negotiations. See *Appendix DD* for general information about conducting negotiations. In preparing for and conducting negotiations, it will be helpful to remember the following:

- Organize your negotiating committee and maintain solidarity: Although different community and advocacy groups will each have their individual constituencies, all of you will likely want basically the same thing out of this process – to identify individuals affected by the problem, to ensure their access to Medicaid, and to compensate them for any loss. By negotiating together and resisting the temptation to reach separate settlements with the state, your leverage and likely success in achieving your objectives will increase. The negotiating committee representatives should speak for the people affected and reflect community diversity.
- Know the decision-makers on the other side: Find out what governmental officials have authority over Medicaid program administration, policy-making and budget. Try to ensure that you are negotiating with individuals who have maximal authority to make commitments on behalf of the state Medicaid agency. Find out which people will be on their negotiating committee, and learn about their backgrounds.
- Make a negotiating plan: Meet with your negotiating committee to choose your joint baseline requirements, objectives, proposed solutions as well as which concessions would be flatly unacceptable.
- Decide who will play what role at each stage of the negotiations: Make an explicit agreement among the committee members about what roles each will play at each stage of the negotiations. Without such an understanding, you risk having one or more parties unintentionally usurp or undermine the committee's broad-based authority in dealing with the state.
- Keep your members and coalition partners informed as negotiations progress: Although a small bargaining team may enable more efficient negotiations, your organization's members and your coalition partners can provide a more inclusive perspective on issues which arise unexpectedly in the course of negotiations. And, by keeping your members/partners informed and seeking their feedback, you increase their ownership in any resultant deal.
- Keep lines of communication open with your opponents: Although it may be necessary to break off or sponsor public actions during the course of negotiations, make sure that the state officials with whom you are working understand the reasoning for your actions. Also, during protracted negotiations, make certain that you and your opponents have a mutual understanding of the current stage of negotiations, the next step to be taken, and by when that will take place.

→ Paying for the Needed Corrections – The \$500 Million Federal Fund.

To remedy the problems associated with delinking of Medicaid and TANF, your state will need to develop and implement a comprehensive set of programs that are likely to be quite costly. Fortunately, those programs can be financed by a \$500 million fund created by Congress to help states pay the costs associated with delinking cash benefits from Medicaid and preventing/remediating the resultant illegal Medicaid terminations. Each state was allocated a share of the \$500 million from which they can seek matching funds for a wide variety of activities.

It is very important that you have someone look closely at the federal rules outlining what this fund pays for and at what matching rates. To do this, you should consult HCFA guidance letters and other relevant sources of federal law (see generally HCFA, Expanding Coverage; Federal Register, 5/14/97, Vol.62, No.93, pp.26545-50). Then find out how much of this money is still available in your state.

Also, research what projects the fund has paid for in other states to help determine whether it would finance the remedies you are seeking (see Ross and Guyer, \$500Million Fund). When you consider what project expenses the fund might cover, you should ask the following questions:

→ How can you use the \$500 million fund to finance projects with effects beyond TANF/Medicaid delinkage?: Federal guidelines for funding delinkage remediation projects are somewhat liberal and often permit financing programs which have an overlapping effect in non-delinkage areas. For example, federal matching funds would likely be available to pay for public education concerning eligibility for several medical benefit programs (e.g., SCHIP, Transitional Medical Assistance), as long as the program was “primarily” oriented towards education concerning Medicaid benefits to families who were dropped from TANF. See HCFA Report, 3/22/99, Section 4. In this way you may be able to access funding for projects to expand awareness of and coverage under other benefits programs, which might otherwise be impossible to secure under the current political and fiscal climate.

→ What matching funding rate applies to your project?: Depending on what delinkage-associated activities for which your state is seeking funding, it will be reimbursed at either a 75% or 90% rate. See Ross and Guyer, \$500M Fund, Table 2 for a listing of which activities are funded at which rate.

→ How much money is left in your state’s share of the fund?: Ross and Guyer, \$500 Million Fund, Table 1 and Families USA, \$500 Million Fund Expenditures list the amount of the fund remaining in each state’s allocation as of the end of 1999. Contact HCFA to get an updated figure.

→ How can your state’s share of the \$500M fund go further?: Under previously existing Medicaid law, your state could be reimbursed by the federal government for up to 50% of the costs they incurred in the types of remedial activities covered by the \$500M fund. That money is still available. As a result, your state’s share of the \$500M fund will only be diminished by any amount reimbursed above the first 50% of project

expenses. [\*\*\*For example, suppose your state was allocated \$1 million from the fund and implemented a program to identify families whose benefits had been illegally terminated costing \$100,000. That project would likely qualify for federal reimbursement at a 90% rate, i.e. \$90,000. However 50% of the project expenses (\$50,000) would be funded through regular Medicaid reimbursement. Consequently, your state's share of the \$500M fund (\$1 million) would only be diminished by the difference between the total reimbursement (\$90K) and the regular Medicaid reimbursement (\$50K), or \$40,000. Your state would thus have \$960,000 of federal matching funds left.]

→ What other potential funding sources are there? As the \$500 Million fund diminishes, advocates will need to explore other state and federal resources. If these funds are not already dedicated to improving Medicaid access, you'll need to brainstorm policy reasons to support your goal. Working in coalition with health providers can highlight the human need and cost-effectiveness of dedicated general funds to improving Medicaid access.

***Making the Deal – GET IT IN WRITING:*** If you are able to negotiate an agreement with the agency, it is very important to codify the agreement through some combination of: published administrative rules, a court-approved consent order, agency memoranda providing instructions to staff, and/or a letter of agreement between the government agency and the community. If you offer to draft it, you may be able to improve the outcome. The more detailed, the better. In Washington, advocates drafted and/or reviewed improvements in the worker training curriculum, the notices sent to reinstated clients, and the agency memos to staff, and the request from the Medicaid staff to the computer programmers.

The documents should specify how success in implementing the agreed-upon remedies will be measured and on what timeline. For example: tracking the number of families reinstated, number of medical bills reimbursed, number of families who retained Medicaid after the reinstatement period, etc.

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## **STEP 4 – Getting the Word Out About the Problem & the Solution You Have Forged**

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***Publicizing the Deal*** – In addition to any provisions for public and/or worker education you have secured as part of your agreement with the state, you should strongly consider publicizing the deal to the public at large and to the advocacy community. See *Appendix EE* - sample flyer informing families of the problem of illegal Medicaid terminations and the availability of reinstatement; *Appendix FF* - sample press releases distributed in Washington state by advocates in the midst of negotiations with the state and after the advocates reached an agreement with the state on a remedial plan. This achieves four goals:

- It provides additional education to the public about both the problem itself and what steps families can take under the plan you have established with the state to get reinstated on Medicaid and compensated if they had their benefits illegally terminated.
- It provides favorable publicity to your organization and your coalition partners for the active role you have taken in identifying this widespread crippling injustice and bargaining hard to reach a workable corrective solution.
- It creates a public expectation that the agreed upon plan will actually be implemented and the problem solved. This can be crucial in holding the state's feet to the fire, should they prove sluggish or reluctant to implement the plan.
- Lastly, it will educate the organizing and advocacy community to enable them to serve as an additional force for publicizing the plan to their constituencies and as watchdogs for ensuring that it is implemented fairly and expeditiously. See *Appendix GG* - memo distributed to Washington state advocates after formalization of community/state remedial agreement.

### ***Monitoring the Deal***

Reporting on the plan's implementation:

- Establish a timetable for implementing the different parts of the remedial plan and for reporting on its results both to the state and to the advocacy/community partners to the agreement. This information should also be publicly available and distributed. Optimally, the timetable should be part of the original agreement itself, although including it in an independent written side-agreement may be sufficient.

Ongoing communications:

- Set up a formal process for meeting with and/or exchanging information between the state, negotiating coalition partners and the public about the plan's implementation and its effectiveness at meeting its goals. The state's mere distribution of its monitoring reports is not sufficient.

→ Make certain that all sides have the expectation that there will be an actual exchange of concerns about how the plan is being implemented at agreed upon dates or intervals preferably at scheduled meetings, though possibly through written exchanges or some combination of both.

→ Create expectations that all written materials relating to policy and procedure changes, training of staff, communication with Medicaid clients, and instructions to computer programs needs to be reviewed by you, and that you will be given a reasonable time frame to complete your review.

Independent monitoring by coalition partners:

→ Community organizations will probably wish to establish their own procedures for independently monitoring the plan's implementation. Such practices might vary in degrees of formality from surveys of members and/or state workers concerning their experiences under the new Medicaid regime to systematic testing programs analyzing the actual implementation of the agreed-upon changes to the administration of public medical benefits.

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## **STEP 5 – Holding the State’s Feet to the Fire: Following Through with the Plan**

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### ***Enforcing the Deal***

If the state fails to implement the agreed upon plan, you will need to consider what action you wish take to make them live up their side of the agreement. Your options will likely range from informal negotiations, to media/action campaigns publicizing the state’s failures, to legal actions to compel enforcement. In weighing your options, you should remember to consider:

- **Act Early:** It will be important for you to respond quickly to any unwillingness on the state’s part to follow through with the agreement. Implementation of the plan will likely be a complex and costly enterprise. The state will thus have the opportunity to show substantial efforts at compliance before implementation is complete. Consequently, the more work the state has done to implement the agreement, the less likely a campaign to force them to comply in full is likely to garner public or political sympathy, even if a particular aspect of the agreement you consider to be crucial has not been put into effect.
- **Is Legal Action an Option?:** If you formalized your agreement with the state in some sort of court settlement or consent order, a legal action to compel the state’s compliance will likely be an option. However, the lack of a court sanctioned agreement in the first place will not necessarily foreclose this method of enforcement. Consult with your legal advocate partners to determine your full range of options.

### ***What if the Agreement Isn’t Doing its Job?***

Unfortunately, an agreement you make with the state might not effectively fulfill its goals, even when fully implemented. For example, a substantial percentage of the individuals whose benefits were illegally terminated might never be contacted by letters sent to their last known addresses or through a state-funded media campaign, because the families moved and don’t have access to the media publicizing the problem and agreement. However, it may well be difficult to persuade the state to expand/change the agreement you made with them partly through or after its implementation because you are unsatisfied with how well it has fulfilled its goals or spirit.

To minimize this problem:

- **Build ongoing monitoring mechanisms into the agreement.** This will ensure that you know how effective the plan is at meeting its broader aims well before its implementation is complete.
- **Try to anticipate problems and build back-up plans into the agreement to address predictable difficulties.**
- **Bring your concerns to the state’s attention early and often.** Again, the further along you are in the process of implementing the plan, the immeasurably more difficult it will be to secure additional action from the state on behalf of your constituents.

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## **CONCLUSION**

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We hope that this guide will be helpful to you in your efforts to identify the extent of barriers to Medicaid coverage in your state and organize your community to reverse these barriers. In addition, in states where a portion of the \$500 Million fund is still available, you have the opportunity to seek significant changes to your state's medical benefits programs with effects extending beyond remedying TANF/Medicaid delinkage, all at little expense to your state government.

Already, advocates and community groups in Montana, Ohio, Pennsylvania, Washington and other states have successfully sponsored campaigns resulting in reforms which made reinstatement available or expanded medical benefits for hundreds of thousands of individuals.

If you have any questions about this guide or if you would like advice on researching and planning a campaign to eliminate barriers to Medicaid coverage in your state please contact

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## Appendices

### Appendix AA: Sample Information Requests under the U.S. Freedom of Information Act (FOIA) and State Public Disclosure Law

#### ***FEDERAL FOIA REQUEST***

##### General Information

Instructions on making a FOIA request to the U.S. Health Care Finance Administration (HCFA) along with their procedures for responding to such a request are available at <http://www.hcfa.gov/foia>. General information on your rights under FOIA are available in the United States House of Representatives House Rpt. 106-50 - A CITIZEN'S GUIDE ON USING THE FREEDOM OF INFORMATION ACT AND THE PRIVACY ACT OF 1974 TO REQUEST GOVERNMENT RECORDS, which is available at <http://thomas.loc.gov/cgi-bin/cpquery/z?cp106:hr50.106>. You may also be able to obtain this information by contacting the HCFA Regional office in your area.

##### Sample Information Request Letter

ATTENTION: FREEDOM OF INFORMATION ACT REQUEST

October 31, 2000

Health Care Financing Administration  
Office of Information Services  
Division of Freedom of Information  
Room N2-20-16 7500  
Security Boulevard  
Baltimore, Maryland 21244-1850

To Whom It May Concern:

On behalf of the United Families for Democracy in Anystate (UFDA), this is a request for information on HCFA site visits of Anystate's practices and procedures for citizens' retention of Medicaid benefits when TANF is terminated.

Please consider this a request under the Freedom of Information Act, U.S. Code Title 5, Sec. 552, as amended in Public Law 104-231 (FOIA). HCFA is a federal agency to which FOIA applies, and the above-described information is by law available to the public.

The information can be emailed as an attachment to the following email address: [lboyle@ufda.org](mailto:lboyle@ufda.org). If it is impossible to provide any or all of the requested information in electronic form, please send hard copies of any such documents to the below-listed

address. In the event that some materials must be provided in hard-copy format, we request a waiver of the fees for the costs of their location and production. Pursuant to FOIA, we are eligible for the fee waiver because the disclosure of the record(s) is in the public interest, as they: (a) are likely to contribute significantly to public understanding of the operations or activities of the government, and, (b) are not primarily in the commercial interest of the requester.

UFDA is a nonprofit membership organization devoted to public education and organizing to promote the health and well-being of Anystate's citizenry. UFDA is the largest consumer organization in Anystate, with a membership of 25,300 citizens. UFDA is a 501c3 corporation, and our tax identification number is 44444-8888. We are requesting this information to investigate reports we have received from our membership that Anystate has unlawfully terminated numerous families from the Medicaid program administered by your agency when the families' TANF benefits were discontinued. UFDA shall receive no direct commercial compensation for this information, and may only indirectly benefit to the extent that it may receive public or private grants to publicize the results of its investigations including information provided in response to this request.

If you require further information to process the request for information, application for fee waiver or anything else concerning this letter, please call me immediately at 206-555-1234. Thank you for your attention to this matter.

Sincerely,

Liesel Boyle,  
Policy Director  
United Families for Democracy in Anystate  
444 Holstein Ave., Tricorn, Anystate 98000

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## ***STATE PUBLIC DISCLOSURE REQUEST***

### *General Information*

Most states have a public disclosure law similar in purpose and effect to the FOIA. This law typically allows you to freely inspect and/or get copies of public records at a fee. States will often charge fees for the location and copying of public records, although there may be exemptions for nonprofit, educational, news media or other public interest organizations or purposes. Precisely what information will be available, the fee schedule and exemption criteria for document production, as well as the required format for the request will vary between states. Your legal advocate partners will likely be familiar with the proper format and procedure for making such requests and fee waiver applications.

This information will also likely be available from the state itself by viewing the state's website or simply by calling the state agency from which you are requesting information.

Sample Letter

The Honorable Denise Broadoak, Secretary  
Anystate Department of Health and Social Services  
P.O. Box 8888  
Tricorn, Anystate 98888-5888

Dear Secretary Broadoak:

As authorized under the state Public Disclosure Act, RCA 42.17.250 et seq., I am writing to request copies of public records in the possession or control of your agency concerning the administration of Medicaid benefits in Anystate. Pursuant to this request, please provide the following information pertaining to the period from 1997 to the present time:

- Any and all memoranda, reports, policies and procedures compiled, created, or employed by or otherwise in the possession of your agency, its divisions, their staff, its contracting agencies and other agents (hereinafter "Department staff") concerning
  - Determining of individuals' eligibility for Medicaid benefits
  - Terminating of individuals from receiving Medicaid benefits
  - Reassessing of an individual's eligibility for Medicaid benefits upon her/his or her/his parent's determination of ineligibility for benefits funded under the federal Temporary Aid for Need Families (TANF) program.
    - Documentation on any computer software employed by Department staff, in the assessment of individuals' eligibility for Medicaid and/or termination of Medicaid and/or TANF benefits, specifying which codes apply to Medicaid terminations.
    - Reports, summaries or other records of errors made by such software and/or Department Staff in the determination of individuals' eligibility or ineligibility for Medicaid, or termination of Medicaid and/or TANF benefits.
    - Any and all reports, memoranda or other materials provided to the United States Health Care Financing Administration concerning its site visits of Washington state's practices and procedures for citizens' retention of Medicaid benefits when TANF is terminated.

Any and all reports, memoranda, documentation or other materials listing and/or explaining the "reason codes" employed by your department in keeping records of the reason for the termination of individuals' TANF and/or Medicaid benefits.

A frequency distribution chart of how many combined TANF/Medicaid terminations occurred for each reason code. Please send whatever documents may be sent in electronic format via email [lboyle@ufda.org](mailto:lboyle@ufda.org). . If it is impossible to provide any or all of the requested information in electronic form, please send hard copies of any such documents to the below-listed address. If the charge for copying these documents will total more than \$50.00, please contact me at 206-555-9999. Thank you very much for your time.

Sincerely,

Liesel Boyle, Policy Directory  
United Families for Democracy in Anystate  
444 Holstein Ave., Tricorn, Anystate 98000

## Appendix BB: Reason Coding – Finding the Tracks of Illegal Medicaid Terminations in the Forest of State Welfare Data

If your state uses “Reason codes” in classifying reasons for TANF termination, it can be useful in your advocacy to understand how many people were terminated for what reasons. Request the following information from your state agency:

- A list of the reason codes used for TANF/Medicaid terminations (code numbers and definition of the reason)
- A frequency distribution chart of how many combined TANF/Medicaid terminations occurred for each reason code, for the period you are interested. This may be available separately for children and adults.

An excerpt of Washington State’s response looks like this:

Frequency Distribution of  
Terminated F01[2] and F04[3] AUs[4] and reasons [excerpt]  
Aug. 1997 – June 1999

Month	Coverage Group	Reason Code	Count
199708	F01	331	486
199708	F01	557	123
199708	F01	599	86
199708	F01	551	79
199708	F01	204	66
199708	F01	552	63
199708	F01	508	53
199708	F01	301	49
199708	F01	248	40

Reason code information can be used to probe more deeply into the systems problems that cause people to be terminated incorrectly from Medicaid, and determine which problems affect the largest numbers of people. For example:

- Reason codes are not specific enough to explain the basis for termination. (In Washington, 30% of TANF terminations sampled were terminated under the reason code “Other.”)
- Reason codes that resulted in combined TANF/Medicaid terminations were for reasons that only apply to TANF (such as nonparticipation in Workfirst, expiration of a time limit, or excess earnings). This may expose flaws in the state’s computer system, showing that it does not automatically consider transitional Medicaid, for example.

Many people are terminated from TANF/Medicaid using the reason code for “client requested” termination; it is likely many of these people wanted off TANF but had no idea they could stay on Medicaid without affecting the TANF time limit. If you get a separate breakdown for children terminated from TANF, the numbers may suggest whether they are being properly considered for children’s Medicaid or CHIP.

## **Appendix CC: Checklist for Collecting Model Stories About Your Constituents' Experiences with Illegal Medicaid Termination or Other Barriers**

Shows the person/family is poor, struggling, on the edge:

- the person's and family's hourly income, if any
- the person's and family's annual income, if any
- If income, source(s) of income (wages, SSI, child support, etc.)
- benefits received through job, if any, such as health care
- number of people depending on person's and family's wage, including children (include ages of children)
- highlight extra financial challenges, such as a
  - chronically ill child or spouse
  - job loss
  - lack of education and skills
  - other(s) \_\_\_\_\_

Shows the person/family is "deserving"

- If there are kids or other dependents they're responsible for, mention this.
- If the person is supporting their kids single handedly, highlight this;
- if the person is a single parent because they've been widowed or divorced (vs. never married), mention this.

Show how hard they work by pointing out the

- number of hours they work,
- how many jobs they're holding down.

Show anything that demonstrates they're a "good citizen" or "good person" as this is conventionally understood

- they volunteer,
- they go to church,

→ other(s) \_\_\_\_\_

Shows the negative consequences for the person/family of “X” (X is whatever the problem is. Examples of past problems we’ve written about include the person/family:

- not having health insurance;
- not being told about charity care;
- being given the wrong information about food stamps.

Explain the negative things that have happened to the person and the person’s family because the person had X happen (or not happen) to them and their family.

Examples:

- “I didn’t get food stamps [when I should have] and so my kids went to school hungry that whole month.”

Alternately, if the consequences of X have not been felt yet, the story should explain what could happen or what the person is worried will happen because X has occurred.

Examples:

- “I’ve been really sick because of my heart problem but I was afraid to go to the doctor because I don’t have insurance and I just can’t afford a big medical bill; now I’ve lost my job because I had to miss so many days from work.”

Maximizes the story's emotional impact on the reader

- The story is in the first person;
- The story includes statements from the person expressing their feelings about the problem.

Examples:

- “I’m angry...”
- “What they did was totally unjust ...”
- “What kind of a country/city/place is it where this kind of thing can happen? I’ve worked hard...”
- “When they told me, I just couldn’t believe it. I was so frightened about what would happen next...”

## Appendix DD: The Four Stages of Negotiation

A negotiation goes through four definite stages as it progresses:

- 1) preparation
- 2) information
- 3) proposal/counterproposal
- 4) agreement.

At each stage, you have various objectives and use different methods. You must achieve your objectives in one stage before moving on to the next. Moving too soon or without having achieved your aims for the stage on which you are working can cause serious problems later on.

**1) Preparation:** Before you begin negotiations, it's necessary to understand the range of your interests/objectives/demands. Start by thinking about what the possible resolutions of a negotiation are: optimal solution; acceptable possibilities; no deal. Use this to prioritize your range of objectives, from those which you would expect to achieve only under an ideal resolution to those without which no deal would be acceptable. Then, divide your objectives into groups corresponding with the three possible resolutions:

- Resolution -> Objectives
- Optimal results -> What you'd like to get
- Acceptable results -> What you intend to get and think reasonable to expect
- No deal -> What you must get, without which agreement is impossible

In formulating your objectives and setting their priorities, it will be helpful for you to think creatively about possible outcomes and gather information on existing practices.

**2) Information:** During this phase of the negotiation process, you investigate the other side's objectives and priorities and disclose information about your own.

Aims: The aims of informing are straightforward:

- To determine your opponent's objectives and how they are prioritized.
- To offer them some guidance about your own objectives and priorities.
- To set up links between the two sets of objectives so as to establish possibilities for proposals.

Methods: Informing consists of exchanging and assessing information about each other's positions

Exchanging information:

- Ask the other person to explain their positions on an item by item basis.

- State your objectives clearly, focussing on those you would Like and Intend to achieve, while being noncommittal about your Must Get requirements.
- Listen carefully to your opponent's disclosures. Besides asking questions you need to actually listen to the answers, and not just spend all of your time thinking of the next question. In this way you can more easily pick up clues about your opponent's priorities.

Assessing the information you gathered:

- Summarize issues neutrally to establish you're on the right track.
- Make disclosures of your own priorities to encourage your opponents to outline their objectives.
- Ask for interpretation and clarification, particularly if your opponents present something that you believe has hidden or confusing language.
- Watch and listen for signals of positive or negative responses as well as possible movement in their positions or descriptions thereof during the informational phase.

Stick to the point:

- Keep the exchange productive: Don't interrupt, try to score points, make personal attacks, shout, blame the other person, talk too much, be sarcastic, threaten, or give unintended signals.
- Don't get drawn prematurely into exchanging proposals. You need to be adequately informed before you are able to exchange proposals confidently. And your opponent needs to realize that you have moved from informational exchange to the next phase of negotiations or all sides are likely to begrudge statements unintentionally misconstrued as offers.

**3) Proposal/counterproposal:** This is the process of presenting your solutions, responding to solutions put forward, working as hard as possible to reach your 'like to get' objectives in the context of meeting your opponent's needs, and coming up with ideas for bridges between positions.

Aims:

- To signal areas of agreement and disagreement.
- To set up strings of conditions and concessions.
- To match them to your own.
- To make the trade. Methods:

→ Put forward concrete solutions: Proposals are not simply a means of indicating to your opponent, what you want. You should, if you've carried out the informing stage correctly, have a good idea of what are areas of common interests and concerns. You now need to move into the negotiating arena. In order to do this and to get out of the information stage, you or your opponent will have to put forward solutions. These solutions take the form of proposals.

→ Move from general to specific. Break down both your and your opponents' broader concerns into the specific problems they typify. Examine each problem in turn identifying the concrete difficulty and suggesting what your opponent must do to eliminate/mitigate it. Address one problem at a time, attempting to find a way to resolve each difficulty before moving on to the next problem. Finally, trade off specific concessions, remembering that they all must be connected and work together to provide a comprehensive solution.

#### Concessions:

All proposals must contain some attempts to reach your like to get objectives. However, in order to do so, you have to go some way towards meeting their like to get position. These gestures are your concessions. However, any time you make concessions, you must ensure that certain rules apply.

- Every concession must be given conditionally.
- You must value concessions in your opponent's terms.
- Never "give away" concessions as a good faith gesture.

#### Key points:

- Don't get drawn into exchanging proposals before you are ready. If your opponent makes a proposal that seems a bit premature, simply move back to the information stage by asking questions.
- Remember the key order of negotiating is moving from the general to general (broad concerns to overarching problems), then from the general to specific (overarching problems to the concrete difficulties); and finally specific to specific on each point (concrete difficulties to specific solutions, then on to the next difficulty).
- Everything must be linked – you want a full agreement; a settlement which only addresses certain aspects of the problem is likely to be of little value.
- Everything must be conditional – don't make good faith "free" concessions.
- Listen carefully to your opponent's propositions, and don't interrupt. It shows that you treat them seriously, and people often tag a concession onto the end.
- Don't offer alternatives too readily; that only encourages people to say "no" to your first proposal.

**4) Agreement:** The purpose of agreement is to establish that the apparent solution is acceptable to both parties, that they both understanding the implications, and that there are no ambiguities. To avoid potential disputes about the content of your agreement, make certain you specify precisely to what you and your opponents have agreed, and have it recorded.

## **Appendix EE: Sample flyers distributed to Washington State families eligible for reinstatement to Medicaid**

### **Important Notice!**

Did you lose medical benefits when you went off welfare?

If this happened to you or someone you know, call:  
1-800-562-3022 (TDD only 1-800-848-5429)

DSHS is looking for families who lost Medicaid medical benefits when they stopped getting a Temporary Assistance to Needy Families (TANF) cash grant. These families lost benefits sometime between August 1, 1997, and August 31, 1999. DSHS will:

- give these families 3 months of free medical benefits
- help them apply for medical benefits beyond the 3 months
- pay past medical bills for some families.

Medical benefits do not have time limits and do not count toward the 60-month clock for cash grants. As long as a family qualifies, they can get medical benefits.

If it is hard to get to a phone, please send your name and address to:

Family Medical Project  
PO Box 45534  
Olympia, WA 98504  
Fax: (360) 664-0910  
E-mail: [FamilyMed@dshs.wa.gov](mailto:FamilyMed@dshs.wa.gov).

### ***What About Past Medical Bills?***

If you have paid or unpaid medical bills between August 1, 1997 and the date of your new family medical benefits, DSHS may be able to pay some of them.

Asking for a claims package is easy.

- MAIL the enclosed blue postcard
- CALL the Medical Assistance Customer Service Center at 1-800-562-3200 (TYY only 1-800-848-5429)
- FAX your request to Family Medical Project Claims at (360) 664-0910
- E-MAIL [FamilyMed@dshs.wa.gov](mailto:FamilyMed@dshs.wa.gov).

Begin gathering information now.

- Find copies of your bills. We need to know when you got the service, the type of service and how much it cost. Ask your doctor or pharmacist to help.
- If you have paid the bills, find receipts or cancelled checks. We need proof of payment before we reimburse you.
- If you have not paid the bills, we will mail you a Medical ID card if your claim is approved. You can give it to the medical provider to pay for the services.

## Appendix FF:

Sample press releases to publicize the problem and put pressure on the state in the midst of negotiations and to publicize the remedy after negotiations completed in Washington State Press Release Publicizing Negotiations and Pressuring the State Department Of Social And Health Services Agrees To Stop Improper Termination Of Health Coverage Cassie Sauer, The Children's Alliance, 206/324-0340, cassie@childrensalliance.org Many people across Washington state are celebrating the drastic reduction in the numbers of people receiving welfare. However, thousands of adults and children have lost health insurance as a result of welfare reform—perhaps as many as 100,000. Welfare and health coverage were mistakenly bundled—when families left welfare, they were cut off health coverage, even though this is a clear and direct violation of federal law.

Columbia Legal Services, the Children's Alliance, and Welfare Rights Organizing Coalition are pleased to be working with the Department of Social and Health Services to develop a solution to this problem. Changes to policies and systems have been negotiated that will ensure that every eligible family gets the health coverage it needs, and families who have been improperly terminated in the past are provided some relief.

The negotiations have resulted in a plan to:

- Stop improperly cutting off families from health care when they leave TANF.
  - Continue Medicaid for families who ask to stop their cash benefits, unless they confirm in writing that they also want health coverage stopped.
- Make significant changes to ACES, the state's computer system, that will stop the computer from automatically terminating families' health coverage.
  - Reinstate adults and children who were improperly terminated from health coverage since 1997 for a period of 90 days. These families' cases will be reviewed to see if they are eligible to continue to receive health coverage.
  - Reimburse families who were improperly terminated for their past medical bills.
- Stop repeated requests by the state for information from families that they have already provided, and stop requests for information and verification not necessary for Medicaid eligibility.

For welfare reform to work, people who move from welfare into low wage jobs need health coverage. Congress recognized this as essential to welfare reform's success when it placed safeguards in the federal welfare reform bill and provided \$500 million in funding to assist states to maintain health care for needy families. Washington state's share of these funds is about \$10 million. The state has only spent only \$2.1 million, according to the federal Health Care Financing Administration, but has until March 2000 to spend the rest.

The negotiations have been productive, and many agreements have been reached. Several key things remain to be done in order to ensure that families receive the health benefits to which they are legally entitled:

- The Governor and welfare administrators need to provide enough funding and staff to ensure that the plan is implemented fully and correctly.
- Some proposed changes are temporary. Welfare administrators need to ensure that these measures are made permanent through policy, system and computer changes.
- The Legislature and the Governor need to simplify eligibility for the state's health coverage for adults. Complex eligibility rules lead to caseworker error and family confusion.
- Washington's welfare policy makers should put equal value on making sure families have the tools they need to be self-sufficient as on reducing welfare caseloads. It is time to move beyond cutting caseloads as the sole measure of success of welfare reform. People need all the resources necessary to go to work and stay on the job.

"I did everything I was supposed to do—I found a job and turned in all the paperwork to continue my medical benefits—and I still lost Medicaid coverage for me and my two children," says Sandra Haddix-Hamilton, a former welfare recipient. Ms. Haddix-Hamilton had to make multiple contacts with state agencies in order to get her benefits reinstated. In Washington state, the loss of health insurance is a continuing problem for those leaving public assistance. State-conducted surveys of families who have recently left welfare show that 32-35% of adults and 18-20% of children have no health insurance, though most families are eligible for Medicaid. The median income of families moving off welfare is 113% of the federal poverty level, well below the eligibility cutoffs for Medicaid. At that level, all of the children and most adults are legally entitled to medical benefits.

Press Release Publicizing Remedy Created by Negotiated Accord Information:

Cassie Sauer, Health Policy Director  
206/324-0340 (w); 206/325-6433 (h)

Peter Berliner, Executive Director  
206/324-0340 (w); 206/764-9128 (h)



**FOR IMMEDIATE RELEASE**  
September 20, 2000

## **CHILDREN'S ALLIANCE**

### **Deadline for Second Chance for Health Coverage Approaching**

Just Ten Days Left; 2700 People in Spokane County Still Need to Call  
With a September 30 deadline just ten days away, thousands of families could still qualify for Medicaid coverage under the Department of Social and Health Services' effort to reinstate those incorrectly removed from the program. Families have until then to contact DSHS at a special toll free number (1-888-944-2892) to find out if they are eligible. "Now is the time to act," said Cassie Sauer, Health Policy Director at the Children's Alliance. "Anyone who has been cut off should call to re-enroll, whether they need health care now or might find it helpful later on."

Of the estimated 100,000 individuals whose Medicaid coverage was terminated either incorrectly or prematurely when their welfare grants ended between August 1997 and August 1999, a little over half have had their health insurance reinstated. In spite of state-wide publicity efforts by outreach workers, health care advocates, and DSHS, including development of the special toll-free phone line, tens of thousands of people have yet to be found.

→ In Spokane County alone, DSHS has located and reinstated close to 4,000 people. An additional 2,700, close to 40% of all those eligible for reinstatement countywide, have not been located. These individuals could receive three months of free medical coverage, continued coverage under Medicaid, and payment or reimbursement of back bills under this one-time opportunity. During the three months, families will be reviewed for ongoing Medicaid coverage using a very simple process.

→ Last fall, The Children's Alliance, Columbia Legal Services, the Northwest Health Law Advocates, and the Welfare Rights Organizing Coalition reached an historic settlement with the Department of Social and Health Services to help families who had been wrongly terminated from Medicaid as a result of welfare reform. "While many states had similar problems, Washington State moved aggressively and made needed changes to get families the medical coverage they deserve. We are really pleased that the state is taking action to re-enroll families who were cut off from Medicaid coverage," said Sauer. "However, many families who were cut off don't know they are still eligible."

→ Families who want to see if they qualify for three months of free medical must contact the **Family Medical Project toll-free at 1-888-944-2892 before the September 30 deadline**. Those who only want help with past bills should call toll-free at 1-800-562-3022 before the September 30 deadline.

## **Appendix GG: Sample memo to advocates clarifying the agreement to reinstate families terminated illegally**

### **NORTHWEST HEALTH LAW ADVOCATES UPDATE**

June 8, 2000

#### **Reinstated Families Can Request Continuing Medicaid and Reimbursement for Past Bills Background on Reinstatement**

This memo contains updated information on the reinstatement of Medicaid for families terminated from TANF and Medicaid simultaneously between August 1, 1997 and August 31, 1999. Advocates successfully argued that many of these families lost Medicaid illegally, without a proper DSHS review of continuing eligibility for Medicaid.

DSHS has mailed information to all families terminated from TANF and Medicaid during the August 1997 through August 1999 period who are not currently on Medicaid. About 70,000 individuals were reached through the mailing. About 30,000 were not reached because there was no current address for the family.

#### **What Advocates Should Do**

- Continue to identify and inform these families of their eligibility for the following:
  - Automatic Medicaid coverage through DSHS for family members who were terminated, for a 3-month period determined by when they contact DSHS, so long as the contact is made by September 30, 2000. For purposes of this one-time coverage, they do not have to meet the Medicaid eligibility requirements;
  - An opportunity to have DSHS determine their eligibility, using a simplified process, for ongoing Medicaid eligibility after the 3-month reinstatement period; and
  - Reimbursement of medical expenses the family paid or incurred after leaving TANF, if the Medicaid termination was not clearly correct and if the services are covered under the Medicaid program.

If you encounter someone who is potentially in the reinstatement group:  
Provide the person with the information in this memo;

Encourage the person to contact DSHS's special Family Medical Project by telephone, fax, email or mail to report their current address and request reinstatement:

PHONE: 1-888-844-2892 (toll-free)

FAX: 1-888-706-6789 (toll-free) EMAIL: [FamilyMed@dshs.wa.gov](mailto:FamilyMed@dshs.wa.gov)

ADDRESS:  
Centralized Medical Unit  
PO Box 47986  
MS N55-1  
Seattle, WA 98146

- Assist them with requesting and completing a claims package if they have paid or unpaid past bills.
- Assist them with completing the Eligibility Review form in the booklet they receive.
- Maintain a list of such people (including name, address, phone, email), who wish to be contacted in the future to monitor implementation of this process.
  - Request an Outreach Packet from the Family Medical Project by emailing FamilyMed@dshs.wa.gov This packet contains information that can be posted and given to families, including a flyer, "Important Notice! Did you lose medical benefits when you went off welfare?" Packets are currently in short supply; there may be a delay in filling your request. Many agencies and advocates have received packets in the mail.

### **Process for reinstatement**

In early February, DSHS's "Family Medical Project" sent former TANF/Medicaid families a flyer with basic information about reinstatement, followed by personally addressed letters giving them more information about reinstatement. People still living at the address they had when their grant was terminated and those who had a forwarding address received a Notice of Reinstatement letter, a May 2000 Medicaid ID Card, and a blue Family Medical Project Booklet. The booklet contains a streamlined family Medicaid Eligibility Review form to request continuing Medicaid. Also included was a blue mail-back postcard to request information about claiming reimbursement for past medical bills. People in this group should now have gotten June medical ID cards.

People who did not get the notice, booklet or ID card should contact the Family Medical Project as described above and request reinstatement. See below for the website where updated information will be posted. Once it is confirmed that the family was terminated from TANF and Medicaid simultaneously during the relevant time period, they should be reinstated. Relatives, such as grandparents, who were on the TANF grant, as well as parents and children through age 21 who were on the grant, are eligible for reinstatement.

Requests for reinstatement will be accepted through **September 30, 2000**. Families requesting after that date should not expect to be reinstated, though they can always apply for ongoing coverage. Those requesting reinstatement past a cutoff date in April will be reinstated for later months, e.g., August-October. The last 3-month period will be October-December.

Requesting Continuing Medicaid after the 3-month Reinstatement Period

Reinstated individuals will have an opportunity to be evaluated for continuing Medicaid after the reinstatement period, using a simplified review process. They should complete and return the eligibility review form contained in the Family Medical Project Booklet.

Reimbursements and Payment of Unpaid Medical Bills Incurred after TANF termination  
The process for reimbursing clients in the reinstatement group for past bills they have paid, and the process for paying their providers for unpaid bills, is still being developed. A claims package should be mailed later this month to all who returned the postcard. (Packets will continue to be mailed as postcards are received, through September 30.)

People currently on Medicaid who had a gap in eligibility due to a TANF/Medicaid termination are also being offered an opportunity to submit past bills. The claims package consists of a cover letter, an instructional flyer, and a claims form with a business reply envelope.

To qualify for reimbursement, the bills must be for Medicaid-covered services after the date of termination from TANF/Medicaid. Reimbursement for collection agency fees related to the medical bills will also be available.

### **Updates and forms**

DSHS will provide updates through the Medical Assistance home page. The address is <http://maa.dshs.wa.gov/FamilyMedical/index.html>. MAA expects to issue Frequently Asked Questions for both clients and providers, and has issued Numbered Memo #00-09, the first of two to be sent to providers. The Family Medical Eligibility Review, a short reapplication form, will be available through a link to DSHS Forms and Publications. The form, exclusive to the project, offers identified families a quick way to apply for continued Medicaid benefits. Northwest Health Law Advocates will also provide periodic updates.

Questions? Need Help? Reports?

If you would like to be on an email list to receive these updates, or you have questions, problems, or need assistance, contact Cecilia Erin Walsh at the Children's Alliance, 206-324-0340, ext. 22. We are very interested in tracking any problems, as well as success stories, as this agreement is implemented.

[1] Examples of Medicaid eligibility categories include: Families with children under 19, Pregnant women, Children under 19, Persons with disabilities ("SSI-related"). Also, rules relating to income, resources and work requirements are generally less stringent for Medicaid than for cash assistance.

[2] Clients receiving TANF Cash assistance and Medicaid.

[3] Family Medicaid clients not receiving TANF cash.

[4] Assistance units (families)