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# Transitional medical assistance: A classical policy analysis

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**Transitional Medical Assistance: A Classical Policy Analysis**

Submitted in partial fulfillment of the  
requirements for the degree of  
Master of Public Service Management  
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## **Abstract**

This study provides a policy analysis of Missouri's Transitional Medical Assistance (TMA) Program to determine if TMA helps reduce the number of uninsured Missourians. To evaluate implementation of TMA, this analysis follows Patton and Sawicki's model of policy analysis. Trends in TMA enrollment, Medicaid budget, unemployment rates, number of uninsured Missourians, eligibility requirements and benefits, and information on surrounding state's Medicaid and TMA eligibility, controls to prevent fraud, waste, and unnecessary spending and enrollment, reporting requirements, and guidelines for alerting and transitioning participants to TMA provide a basis for evaluating the goals and constraints identified. Interviews with caseworkers and supervisors provide additional information on the identified goals and constraints. This research indicates that the TMA policy is designed to reduce the number of uninsured Missourians but the constraints prevent successful implementation. The study concludes that Missouri's TMA program does not reduce the number of uninsured Missourians based upon available data but if Insure Missouri and universal healthcare have successful implementations, TMA will achieve its intended results.

## **Acknowledgements**

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## Chapter One



## Introduction

*In June 2008, a client brought a letter from Missouri Division of Social Services (DSS) to her scheduled community support visit. She brought it because she was unable to understand what it meant. In reading, the letter, as her community support worker (CSW) for the day, I found myself unable to understand the purpose of the letter except for the part where DSS wrote that her healthcare coverage changed to Transitional Medical Assistance (TMA). I had never heard of Transitional Medical Assistance before this client receiving this letter. I asked the client if I could have a day to research what this meant and later in the week, someone would explain the letter to her. As a natural instinct, I went to the DSS website to gather more information. The only information I found was that TMA is a program of Medicaid. This information left me in the same place before except with more frustration. The next step resulted in a phone call to my client's caseworker at the Medicaid office. In our conversation, she explained the purpose of TMA, how it works, and the intended result—participants would receive healthcare coverage through their employer or be able to purchase private insurance. I asked her what my client's options were because she worked in a job that offered no health benefits and was not financially stable to purchase her own insurance. The caseworker told me that my client's options were "to quit her job or become pregnant to receive Medicaid again."*

### Introduction to Medicaid and Transitional Medical Assistance

The Medicaid program is part of Title XIX of the Social Security Act Amendment signed into federal law by President Linden B. Johnson in July 1965. Low-income families received Medicaid through welfare programs, such as Aid to Families with Dependent Children (AFDC). The federal government decided to allow states to operate individual Medicaid programs because states could determine necessary coverage, eligibility requirements, and additional healthcare needs depending on the population. A typical welfare benefit package included cash, food stamps, and Medicaid. In 1965, the federal government expanded Medicaid eligibility to individuals with incomes at or below 36% of the federal poverty line thus beginning the separation of Medicaid and welfare into two programs. As the separation between Medicaid and welfare continued, the federal government instituted work support benefits to encourage employment among low-income families, such as Earned Income Tax Credit, child tax credit, minimum wage standards, and state income supplement programs. The benefits of employment and work support exceeded the income a family would receive if only relying on welfare. As a result of this, low-income parents and individual's income exceeded eligibility requirements

making Medicaid inaccessible to them and no alternative options for healthcare coverage (Weil 2001). The work support benefits began to affect state-run, federal Medicaid programs because individuals and families began losing Medicaid coverage but not obtaining alternative healthcare coverage. To address this situation, the federal government saw an opportunity to provide an unavailable service to employed low-income individuals and families by continuing healthcare coverage.

In 1988, the federal government instituted the Transitional Medical Assistance (TMA) program to provide individuals on Medicaid 6-12 additional months of healthcare coverage after they obtained employment as part of the welfare to work program under the Family Support Act of 1988. The federal government mandated minimum eligibility requirements and provided a list of optional eligibility requirements for state governments to use at their discretion (Patchias 2005). The federal government provides a percentage of money to cover the operating cost of the TMA program and requires states to cover the remaining percent. The amount of financial coverage from the federal government and required of states varies from state to state. If a state is unable to budget their required percentage of money for TMA, they run the risk of losing federal government financial support for Medicaid programs. Since TMA is a state-based program, it is beneficial to evaluate the program on a state-level. Each state has varying eligibility requirements, state changes to Medicaid, different financial support amounts from the federal government, and different operating procedures.

### **Introduction to Missouri Medicaid**

The state of Missouri began offering healthcare assistance in 1959. The healthcare assistance covered inpatient hospital care with a maximum reimbursement amount of \$5.00 per day, 100 days per year per patient. In 1963, Missouri received federal funds to cover limited prescription drug and dental programs for adults. In October of 1967, Missouri passed legislation that enacted medical services under Title XIX of the Social Security Act Amendment.

Under Missouri's Medicaid legislation, Missouri's Title XIX, eligible recipients could obtain outpatient hospital care, physician services and nursing home care. Missouri also included the blind, permanently and totally disabled, and expanded services to families on AFDC in its Title XIX legislation. Missouri recognized a need to provide medical care to children and blind persons who did not meet eligibility requirements for federal Medicaid. This limited medical assistance program covers medical care costs for Child Welfare Services recipients and Blind Pension recipients. Missouri funds this limited medical assistance program from the General Revenue and Blind Pension funds.

The next change in federal and state Medicaid programs took place in 1996 with the passing of the Personal Responsibility Work Opportunity and Reconciliation Act (PRWORA). This legislation eliminated AFDC—officially delinking welfare cash assistance and Medicaid. The PRWORA created Temporary Assistance for Needy Families (TANF) as the welfare cash recipient program and Medical Assistance for Families (MAF) as the healthcare assistance program for families since welfare programs no longer guaranteed Medicaid coverage. Since the PRWORA is a piece of federal legislation, all states had to adopt the legislation and make necessary changes to their welfare and Medicaid programs. However, states retained power to determine eligibility requirements, as well as the option to petition the federal government for a research and demonstration waiver, which allows states to expand Medicaid coverage to new groups.

Missouri began to see its Medicaid expenditures and program participants increase each year. The growth in Medicaid expenditures and program participants initiated a Medicaid reform as Missouri watched the number of uninsured Missourians steadily climb from 7% in 1999 to 12.1% in 2005, with a slight dip in 2003 (Missouri Citizen Education Fund 2007). Many factors attribute to the increase in Medicaid expenditures and program participants. Many Missourians depended upon their employer to provide healthcare benefits but during 1979-2005, this benefit declined. In 1979, 69.1% of employees received health insurance through their employer. By

2005, this percentage decreased to 59.6%. Another factor contributing to an increase in uninsured Missourians and increasing eligibility for Medicaid is the decline in wages and household income. From 2000-2005, the average Missourian's income decreased by \$4,904—leading to the inability to afford private insurance premiums or co-pays. The decrease in incomes is no surprise to Missourians because incomes began steadily to decrease starting in 1999. In 1999, the median income was \$51,427. By 2006, the median household income dropped to \$44,487—a 13.5% drop, representing the second steepest drop of any state in the United States. The decline in median household income caused Missourians to fall below poverty level, increasing their eligibility to claim welfare and Medicaid benefits. By 2005, 24.8% of people earned less than the poverty wage in Missouri—a 3.5% increase since 2000. “In 2006, the poverty threshold for a family with one adult and three children was \$20,516” (Missouri Citizen Education Fund, 2007). This increase in those living at or below the poverty wages affects an individual or family's ability to access healthcare because of the struggle to make basic ends meet such as paying rent, utilities, food, clothing and so on (Missouri Citizen Education Fund 2007). As Medicaid expenditures and program participants grew the need to reform Medicaid became apparent.

In 2005, Missouri embarked on this endeavor to reform, redesign, and restructure its Medicaid system with the overall goal to reduce the number of uninsured Missourians—as of 2005, the Census Bureau reported an estimated 691,000 uninsured Missourians. This Medicaid reform sought to transform Missouri's state Medicaid program, which remained untouched for almost 40 years, excluding PRWORA, into an innovative state healthcare system. This new Medicaid program would focus on wellness, prevention, improved health outcomes, individual responsibility, evidence-based practice, technology, and efficient program operations (Departments of Social Services, Health and Senior Services and Mental Health 2006).

A part of Missouri's 2005 Medicaid reform changed the eligibility requirements of Medicaid and TMA. A change in income limits for Medicaid and elimination of a second year of

coverage for TMA affect Missourians enrolled in Medicaid and Transitional Medical Assistance program (Smoucha 2005). By July 2005, 23,000 Missourians lost Medicaid coverage because their incomes exceeded the eligibility level with the number increasing to 104,000 Missourians during 2005-2006. These changes eliminated complete Medicaid coverage for about 100,000 Missourians and 300,000 Missourians lost services—such as dental coverage and wheelchair batteries (Missouri Citizen Education Fund 2007). Along with Medicaid reform, Missouri decided to rename the Medicaid division to represent the new healthcare approach Missouri committed itself too. The creation of MO HealthNet was a part of the 2005 Medicaid Reform. The Missouri Medicaid Reform Commission choose MO HealthNet as the new name for the Division of Medical Services with the intention that it recognized the start of a “new healthcare system that strives to provide access to quality healthcare for Missourians with the greatest needs” (Medicaid Reform Commission 2005).

### **Introduction to Methodology**

As our society moves towards reforming healthcare, it is important to look at current programs to understand the causes that lead to decreased access to healthcare. Previous researchers attribute politics and leadership, policy reform, and changes in eligibility as avenues that lead to either decreased or increased access to healthcare. The focus of this research was to evaluate Missouri’s Transitional Medical Assistance program to determine if the TMA program assists in reducing the number of uninsured Missourians.

The researcher used Patton and Sawicki's model of quick basic policy analysis.

*The Classical Rational Problem-Solving Process*

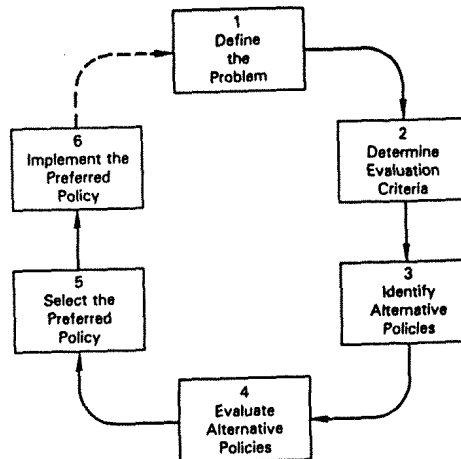


Figure 1  
(Patton 1993)

The six-steps of this policy analysis model include defining the problem, determining evaluation criteria, identifying alternative policies, evaluating alternative policies, selecting the preferred policy, and implementing the preferred policy (Patton 1993). This policy analysis used a backward-mapping approach to determine if TMA aids in achieving MO HealthNet's overall goal of reducing the number of uninsured Missourians while providing quality healthcare because implementation already occurred. This research looked at the policy implementation based upon four criteria—economic, political, social, and administrative. The researcher identified the policy goals with regard to the four criteria to direct the analysis of the policy implementation. The Instead of identifying constraints of the policy, the researcher identified constraints that developed over time to consider how they affected implementation. Using the goals and constraints identified, the researcher evaluated if the implementation of Missouri's TMA addressed the identified problem.

This model of policy analysis allowed the researcher to evaluate Missouri's TMA policy addressing the identified goals and constraints of implementation with the knowledge of the

policy development, and intended outcomes. Interviews with eligibility specialists (caseworkers) and county supervisors clarified policy decisions and program operations, which addressed the identified goals and constraints. The researcher gathered data and information on TMA enrollment, unemployment, Medicaid budget changes, Medicaid and TMA eligibility requirements and benefits, the number of uninsured Missourians, reporting requirements, guidelines for alerting and transiting to TMA coverage, controls in place to prevent fraud, waste, and unnecessary spending and enrollment. The combination of qualitative and quantitative data allowed the researcher to evaluate the implementation of TMA program in relation to the identified goals and constraints. The researcher attempted to gather program specific data but was unable to access these from Missouri Researcher and Evaluation Unit or locate in any previous publications.

### **Significance and Limitations**

This research is significant because it aides MO HealthNet determining if TMA assists in achieving its overall goal—reducing the number of uninsured Missourians. It is also significant in its review of the implementation of the TMA policy. It provides a model for other states to use if they choose to analyze individual TMA policies. Previous research refrains from looking at the actual outcome implementation of the policy and focuses on other issues that affect implementation.

With all research, limitations are present. This research faced the limitations of time, and access to data and interviewees. The limitation of time was present because research did not commence until mid-March and had a completion date of June 2010. The limitation to data and interviewees was present because program specific data was unavailable and individuals on the 2005 Medicaid Reform Commission declined interviews. The researcher conducted interviews over the phone but there was a limitation to completing the desired number of interviews because individuals were not willing or able to schedule time to complete an interview.

## Chapter Two



## **Literature Review**

Healthcare access is a topic that researchers in the healthcare field continually study because of the frequent changes in policies, the economy, and ways in which professionals administer healthcare. Healthcare developed as a commodity in our society. It was a good on the free market and available to anyone willing to pay for it. From wars, the Great Depression, and economic changes, the government saw an opportunity to step in and provide a service that its people needed but could not access. From this recognition, the government created the welfare system including healthcare, with the original thought that assistance was a temporary program. As the American population became dependent upon welfare, it became evident that there needed to be a separation between monetary assistance and healthcare assistance. The federal government dissected the welfare system into two parts—Medicaid for healthcare and welfare for income assistance (Weil 2001).

### **History of Medicaid**

(See Appendix I, Part I for a history timeline of Medicaid)

In 1965, the federal government created Medicaid to provide low-income families with health services. The federal government defined eligibility requirements as “families that met a deprivation standard, meaning the death, continued absence, incapacitation, or unemployability of at least one adult in the family” (Centers for Medicare and Medicaid Services Nov 2009) and set an income level of eligibility. The income level of eligibility varied by state and the median state set income eligibility levels at 36% of the federal poverty level. The federal government defines the poverty level based upon an individual’s financial ability to obtain food (Willis 2000). If a family met eligibility requirements, they received cash, food stamps, and Medicaid. The federal government created new services, such as the early and periodic screening, diagnostic, and treatment comprehensive health services, and expanded Medicaid eligibility to more individuals as the need for access to healthcare continued to rise. The federal government

created additional benefits for individuals and families to control the growing Medicaid enrollment and expenditures.

The creation of work support benefits encouraged employment in the American public, including the Earned Income Tax Credit, child tax credit, minimum wage standards, state income supplement programs, food stamps, health insurance, and childcare. The creation of these benefits led to an increase in employment among the typical one-parent family with children who would otherwise qualify for welfare and Medicaid because the family had more benefits and income working than it would relying on Medicaid. The government saw a significant decrease in the numbers of individuals relying on Medicaid and welfare due to increases in employment and work support benefits (Weil 2001).

During the 1980s, Medicaid and welfare began to separate with the development of new eligibility groups and the Family Support Act of 1988. With this expansion of coverage, states received the authority to set their own income disregard policies—allowing expansion of eligibility beyond the federal government income levels. In 1981, freedom of choice waivers and home and community-based waivers became available under the Omnibus Budget Reconciliation Act. The waivers provided states the flexibility to create alternative healthcare plans for individuals needing care rather than placing them in hospitals, nursing facilities, or intermediate care facilities. This flexibility created the concern that states would use this flexibility to decrease Medicaid payments to hospitals—especially those which treated a disproportionate share of low-income patients. In response to this concern, states paid hospitals that treated a disproportionate share of low-income patient's additional payments to avoid decreased Medicaid payments (Work World 2009).

The split between Medicaid and welfare began when the federal government decided to continue health care coverage when families lost AFDC eligibility. With the creation of the Family Support Act of 1988, government controlled healthcare became available to individuals without requiring them to be eligible for welfare. This was due in part to the creation of the

eligibility groups of the medically needy and the option for states to obtain research and demonstration waivers in their Medicaid and welfare programs—allowing them to expand coverage to new groups (Weil and Holahan 2001).

In 1991, the federal government developed Disproportionate Share Hospital (DSH) spending controls, banned provider donations, and capped provider taxes. DSH payments assisted hospitals that provided care to Medicaid participants and uninsured individuals. States requested more than \$9 billion a year for DSH payments, which led to spending controls, bans, and tax caps (Guyer 2000). To counteract the excessive spending, the Balanced Budget Act of 1997 established new managed care options and revised DSH payment limits. DSH funds now covered initiatives that promoted access to hospitals; created sliding fee scales for primary care services; and extended publicly funded health coverage programs. The amount of federal DSH matching funds available decreased to a cap of \$25.7 million per state and new restrictions prevented states from diverting federal DSH funds to their general revenue. The changes in DSH spending and new restrictions affected the growth of state and federal Medicaid budgets. During 2003-2004, DSH payments declined by an annual rate of 1% per year while Medicaid grew at an estimated 6% per year (Guyer 2000). Before the Balanced Budget Act of 1997, the federal government embarked on the most comprehensive Medicaid and welfare reform in the history of the welfare program in 1996.

In July 1996, the federal government signed the Personal Responsibility Work Opportunity Reconciliation Act (PRWORA) into law. The PRWORA was the most comprehensive Medicaid reform to take place since the creation of Medicaid. Before 1996, low-income parents and children received Medicaid through cash welfare such as Aid to Families with Dependent Children (Weil 2001). With PRWORA, Temporary Assistance for Needy Families replaced AFDC—delinking welfare and Medicaid into two separate programs. This change meant that Medicaid was no longer a welfare benefit—families had to meet separate eligibility requirements to receive Medicaid. Another change that occurred with PRWORA was

the requirement for every adult on welfare to work with a five-year limit on cash welfare for families. These stipulations responded to the American public's opinion that welfare benefits contributed to a decline in working parents and the number of low-income children living in two parent families. The federal government gave states the power to modify eligibility requirements for Medicaid in three ways: 1) lower income standards but not below those of AFDC in effect on May 1, 1988; 2) increase income and resource standards that do not exceed the percentage increase in the Consumer Price Index; 3) "enact less restrictive income and resource methodologies than those in effect on July 16, 1996" (Grady 2008).

In response to the separation of welfare and Medicaid in July 1996, some states made eligibility requirements for TANF and Medicaid the same while using less restrictive income and resource methodologies to allow individuals and families with higher incomes to qualify for Medicaid by disregarding certain amounts or types of income or assets. By July 2006, 21 states eliminated the requirement of parents to report assets and 47 states eliminated the requirement for children (Grady 2008).

With the change to TANF and continuation of work support benefits, the federal and state governments saw a decline in the amount of cash welfare going to eligible families. The Congressional Research Service reported, "By fiscal year 2000 only half of the total federal and state spending under Temporary Assistance to Needy Families (TANF) was devoted to cash assistance compared to 70 percent in fiscal year 1995. However, the report warned that if a recession induced increase in caseloads requires states to reallocate these funds to pay basic benefits, these investments will almost certainly decline" (Sawhill 2002).

### **Transitional Medical Assistance Program**

The Family Support Act of 1988 created Transitional Medical Assistance requiring states to extend Medicaid coverage for a minimum of six months after an individual lost Medicaid coverage due to increase in income with the option to extend to a total of 12 months. In addition

to income eligibility requirements, a family has to receive Medicaid benefits for a total of three months out six months before the month in which they lose Medicaid eligibility to qualify for six months of TMA coverage.

The Social Security Act in 1988 expanded TMA coverage to families and individuals who lost Medicaid because of work-related issues, such as increase in hours of work or income from employment or time-limited earned income disregard. The time-limited earned income disregard allows families to qualify for Medicaid for a set time even when income is above the eligibility requirements. As of January 2008, the federal government requires states to provide four months of coverage for families with an increase in income because of child or spousal support and six month for families affected by work-related issues, with the option to extend coverage for six to twelve months (Grady 2008).

States avoid federal requirements by using earned income disregards. “For example, a family whose earnings are low enough to qualify for Section 1931 Medicaid may see an increase in earnings immediately (in months two or three) after receiving coverage. This increase in earnings may mean that they no longer qualify for Section 1931 Medicaid, and they would not qualify for TMA because they did not receive Medicaid in three of the immediately preceding six months. Some states would allow this family to remain eligible for Medicaid by disregarding all earnings for two months, and as a result, also meet the three of six months requirement for TMA. Other states would conduct look-back reviews to provide retroactively coverage to low-income families who would have qualified under Section 1931 Medicaid had they applied” (Grady 2008, p. 9).

Additional TMA coverage continues when a family meets certain requirements or through other state modifications. Families who have dependent children in the home can receive additional months of TMA coverage pending they meet reporting requirements and their average gross month income is below 185% of the federal poverty line. The federal government requires families to report gross monthly earnings and childcare costs on a quarterly basis for

extended coverage. The federal government gives states the authority to impose premiums, limit benefits, and use an alternative service delivery system if a family receives an additional six months of coverage (Grady, 2008).

States are eligible to extend TMA coverage for families through a variety of ways. States can apply for waivers of federal requirements; make state amendments that expand eligibility through modified income and resource eligibility standards; use only state funds to cover expenses of TMA coverage and or use income disregards to extend Medicaid coverage. According to the CRS report, several states extended Medicaid coverage by allowing a 12-month income disregard when increase in income would eliminate eligibility. This decision allows states to offer Medicaid coverage for an additional 12 months before the family becomes eligible for TMA. Once on TMA, states usually provide 12 months of coverage and then extend coverage by using state funds.

A Congressional Research Service report conducted in July 2002 found that 12 states provide more than 12 months of TMA coverage, 17 states extend the monthly coverage requirement; 19 states changed reporting requirements; and 20 states allowed families to self-declare earnings and childcare costs. The Congressional Research Service report also found that no states limit benefits after the initial six months, and three states impose a premium. A family's TMA coverage may terminate during the second six-month period if a family meets the following: 1.) The family ceases to include a dependent child; 2.) The family's average gross monthly earnings exceed 185% of the FPL; 3.) The caretaker relative had no earnings in one or more of the three previous months; 4.) The family fails to file a quarterly report; and 5.) The family fails to pay any required premiums (Grady 2008).

The Congressional Research Service surveyed state Medicaid directors during the summer of 2002 about their TMA policies, expenditures, and monthly enrollment. The CRS report found that the majority of TMA participants received TMA benefits because of work-related reasons—all states reported less than 10% of participants lost Medicaid eligibility

because of an income increase related to child or spousal support. In December 2001, 32 states reported 682,800 individuals enrolled in TMA. By June 2006, 15 states, whose Medicaid enrollment accounted for about 18% of total U.S. Medicaid enrollment, reported 351,300 participants enrolled in TMA. The CRS report roughly approximates that the total U.S. TMA enrollment in June 2006, would be 2.0 million.<sup>1</sup> Research also found that 18% of people under the age of 65 with qualifying incomes received healthcare coverage through employment whereas 34% of people under the age of 65 with qualifying incomes went without healthcare coverage. Twelve-percent of individuals with incomes double the poverty threshold went without healthcare coverage while 79% of individuals with incomes double the poverty threshold received healthcare coverage. There is a lack of research showing if TMA effectively provides access to healthcare. While it continues coverage for individuals for six months to one year after losing healthcare coverage, it appears that beyond TMA coverage, low-income families, who are ineligible for Medicaid due to eligibility requirements, become uninsured once their TMA coverage expires because they cannot afford insurance and or employers do not offer coverage (Grady 2008).

### **History of Missouri Medicaid and Transitional Medical Assistance Program**

(See Appendix I, Part II for a history timeline of Missouri Medicaid)

In October 1967, Missouri passed legislation enacting their Medicaid program expanding the limited medical assistance the state began providing in 1959 to cover outpatient hospital care, physicians' services, and professional nursing home care. This legislation extended coverage to blind persons, permanently and totaled disabled persons, and expanded services to AFDC recipients. The limited medical assistance program became available to Child Welfare Services recipients and Blind Pension recipients who do not meet eligibility requirements for

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<sup>1</sup> "This rough estimate may be inaccurate if the states without TMA data differ systematically from the 15 states with TMA data (e.g., if they have a higher or lower percentage of TMA enrollees in their Medicaid populations. Grady, CRS Report, January 2008.

Medicaid. All other changes to Missouri Medicaid occurred with federal mandated changes—including the enactment of the Transitional Medical Assistance program in 1988.

In July 2002, Missouri reported offering 24 months of TMA coverage, no modification to the three out of six month requirement, and no change to reporting requirements; allowed self-declaration of earnings and or child care costs; did not impose a premium during the second six-month period; did not limit benefits in the second six month period; and provided wrap-around coverage. Missouri did allow caseworkers to issue retroactive Medicaid coverage to families who qualified for Medicaid but did not apply if they do not meet the three out of six-month Medicaid coverage requirement for TMA. Missouri's Medicaid program remained unchanged by the state until 2005 when the Missouri General Assembly passed Senate Bill 539 to reform Missouri's Medicaid program (Missouri Department of Social Services 2007).

Missouri's decision to reform their Medicaid program stemmed from multiple factors including an increase in operating costs, increase in participants, healthcare inflation, and increase in healthcare needs. Missouri began to see its Medicaid expenditures and program participants increase each year. The growth in Medicaid expenditures and program participants initiated a Medicaid reform as Missouri watched the number of uninsured Missourians steadily climb from 7% in 1999 to 12.1% in 2005, with a slight dip in 2003 (Missouri Citizen Education Fund 2007). Many Missourians depended upon their employers to provide healthcare benefits but during 1979-2005, this benefit declined. In 1979, 69.1% of employees received health insurance through their employer. By 2005, this percentage decreased to 59.6%. Another factor contributing to an increase in uninsured Missourians and increasing eligibility for Medicaid was the decline in wages and household income. From 2000-2005, the average Missourian's income decreased by \$4,904, leading to the inability to afford private insurance premiums or co-pays. The decrease in incomes was no surprise to Missourians because incomes began steadily to decrease starting in 1999. In 1999, the median income was \$51,427. By 2006, the median household income dropped to \$44,487, a 13.5% drop, representing the second steepest drop of



any state in the United States. By 2005, 24.8% of people earned less than the poverty wage in Missouri—a 3.5% increase since 2000. “In 2006, the poverty threshold for a family with one adult and three children was \$20,516” (Missouri Citizen Education Fund 2007). This increase in those living at or below the poverty wages affected an individual or family’s ability to access healthcare because of the struggle to make basic ends meet such as paying rent, utilities, food, clothing and so on (Missouri Citizen Education Fund 2007). As Medicaid expenditures and program participants grew, the need to reform Medicaid became apparent. The purpose of reforming Missouri’s Medicaid program was to develop a program that achieved eight objectives developed by the Missouri Medicaid Reform Commission. These eight objectives focused on improved health status, maximizing available resources, eliminating fraud and waste, and better identifying participants needs and most effective method of service delivery. (See Appendix II, Part I for a list of the eight objectives.)

In developing a reformed Medicaid program, the Commission focused its plan on five areas including access to care, rising costs of healthcare, program structure, participation guidelines, and health status and prevention that address the eight objectives. The General Assembly gave the Commission a July 2005 start date to reform, redesign, and restructure a new and innovative Medicaid program for Missouri. The Commission had until June 30, 2008 to review the current program and make recommendations for reform (Medicaid Reform Commission 2005). The Commission submitted their report by December 7, 2006—17 months after the legislation enacted the start of this reform.

Based upon the Medicaid Reform Commission report, Missouri’s new Medicaid program changed its focus to provide services that promote wellness, prevention, improved health outcomes, individual responsibility, evidence-based practice, technology, and efficient program operations. The new Medicaid Program proposed 14 recommendations for Missouri to adopt to reform its current Medicaid program by June 30, 2008. (See Appendix II, Part II for a list of the fourteen recommendations.) The fourteen recommendations aim to safeguard Missouri’s

Medicaid program while increasing access to healthcare and improved health status for Missourians.

Senate Bill 539 also included a shift in the eligibility requirements of Medicaid and TMA with four major changes to Missouri Medicaid: 1) change in income limits for Medicaid from 75 percent of the FPL to 20 percent of the FPL for parental eligibility; 2) change in income limits for elderly and disabled from 100 percent of the FPL to 85 percent of the FPL; 3) elimination of Medical Assistance for Workers with Disabilities program (Chase 2008); and 4) elimination of a second year of coverage for TMA (Smoucha 2005). By July 2005, 23,000 Missourians lost Medicaid coverage because their incomes exceeded the eligibility level with the number increasing to 104,000 Missourians during 2005-2006. These changes eliminated complete Medicaid coverage for about 100,000 Missourians and 300,000 Missourians lost services—such as dental coverage and wheelchair batteries (Missouri Citizen Education Fund 2007). In 2006, Missouri's annual expenditures for Medicaid were over \$6.1 billion and covered more than 826,000 Missourians. The changes that occurred with Medicaid eligibility proved to sustain the Medicaid program, evident through a change in the direction of expenditures, and the fourteen recommendations aimed to increase access to healthcare and improve health status. However, senate Bill 539 contradicts itself because it decreased the income levels to qualify for Medicaid, eliminated a second year of TMA coverage, yet created the Missouri Medicaid Reform Commission, which proposed a program to decrease the number of uninsured Missourians and improve their health status. The changes of eligibility requirements and services by Senate Bill 539 have yet to produce the intended results expected from this legislation

In their study, Chase et al (2008) found that 15% of adult respondents lost their Medicaid coverage because of the 2005 reform. Of the 15% of adults who lost coverage, 62% reported having no insurance at the time of the survey. Within their findings, Chase et al found that loss of Medicaid coverage coincides with the ability to obtain medical care and there is a relationship between health status and productivity with health insurance. One in five adults reported a need

for medical care within the past year but did not receive it and 53% of adults who lost Medicaid coverage reported a need for medical care but an inability to access it. Over fifty percent of those surveyed reported that a change in their Medicaid coverage affected their health status. Chase et al demonstrated that the changes to Missouri Medicaid in 2005 have not produced positive results for Missourians. Their study demonstrates that finding alternative coverage once an individual or family loses Medicaid is difficult for low-income Missourians

### **Current Research and Suggestions**

Many suggestions on how to address issues of access to Medicaid arose out of various studies focused on making Medicaid more accessible to uninsured low-income individuals and families. Cheng (2005) researched the effect of welfare reform on individual's access to physicians, hospital care, prescription medication, and dentists. This research displays how healthcare policies can restrict access to healthcare and the effect race and ethnicity play in an individual's ability to access physicians, hospital care, prescription medication, and dentists. This study found that welfare policy, health insurance, race, and ethnicity affected an individual's access to healthcare. Cheng found that "restrictive welfare policies tended to reduce current or former recipients' utilization of some health services" (Cheng 2005, p. 597). Cheng recommends extension or elimination of time limits for work requirements to increase access to healthcare coverage.

Lee and Donlon (2009) researched the effect a state's political identity had on its Medicaid policies. They found that political factors play a role in a state's policies regarding healthcare for the poor. States that expressed higher level of support for Democratic Party ideology showed higher level of total Medicaid expenditures. Lee and Donlon suggest that to standardized healthcare coverage the federal government will need to assume responsibility and remove state level government influence from the development of programs to ensure that there are no disparities in basic healthcare coverage. They also suggest that advocates for

healthcare should learn more about their states political party affiliation to understand how political and social cultures affect states healthcare policy development. Sparer (2003) directed his research to understanding states capabilities to provide healthcare leadership resulting in quality healthcare. From this research, Sparer found that creating an intergovernmental partnership to deliver healthcare leadership is effective because the federal and state government push each other to provide more services; therefore, resulting in innovative healthcare leadership. With innovative leadership, states develop and sustain programs that meet their constituent's needs and reduce the number of uninsured individuals.

The federal government created the welfare system with the expectation that it was temporary. Families became dependent upon the assistance the government provided and eventually expecting the government to increase services. In response to the needs of Americans, the government expanded services and did so by creating the welfare to work program. Individuals, without documented disability, received welfare and Medicaid assistance with the requirement to obtain work within 6 months of receiving benefits. The goal of this requirement was to encourage individuals to become financially stable and responsible for their needs (Sawhill, 2002). Garrett and Holahan explored the type of coverage individuals retained once leaving welfare—whether Medicaid, private coverage or becoming uninsured. As individuals and families worked their way off welfare and remained employed, they kept insurance coverage. However, there is a group of women and children who did not have coverage because of eligibility requirements for Medicaid and unavailability of insurance coverage through employment. This study demonstrated that current healthcare policies do not aid in preventing individuals from becoming uninsured. This analysis supports the idea that current extensions of Medicaid do not aid in reducing the number of uninsured individuals; these extensions prolong an individual from eventually becoming uninsured—usually within one year of leaving welfare (Garrett 2000).

As the United States battles to develop a comprehensive healthcare plan to address the

issues of decreasing health status, access to healthcare, and increasing healthcare expenditures, it is most beneficial to evaluate current programs to determine the factors that caused the implementation outcomes. Medicaid in itself is too large of a program to evaluate as a whole because of its unique characteristic of being state run but federally funded. Therefore, there is something to learn from evaluating the policy implementation of state-specific programs and begin to understand the outcomes of Medicaid policy implementation on a state level before broadening it to a national level.

## Chapter Three

## Methodology

### Introduction

This research used Patton and Sawicki's model of quick basis policy analysis to assess Missouri's Transitional Medical Assistance program. Patton and Sawicki base their model of quick basic policy analysis on the rational model. The rational model uses six steps to guide the policy process as pictured on page seven of Chapter 1. These six steps include 1) problem identification; 2) determining evaluation criteria; 3) identifying alternative policies; 4) evaluating alternative policies; 5) implementing the preferred policy; and 6) evaluating the preferred policy implementation (Patton 1993).

### Using Patton and Sawicki's Model

This model enabled the researcher to take a comprehensive look at the implementation of Missouri's Transitional Medical Assistance program which addressed steps five to six of the process and identified goals and constraints that affected the policy outcomes, which addressed steps one through four of the process. This research evaluated Missouri's TMA program by using a backwards mapping approach because it evaluated an implemented policy but only as the outcomes traced to the policy goals. This analysis began at step one of Patton and Sawicki's model by identifying the problem.

**Problem:** There is a need to assess if Missouri's Transitional Medical Assistance program assists in achieving Missouri's goal of delivering a healthcare system that reduces the number of uninsured Missourians.

The second step identified the evaluative criteria used to assess the alternative policies in selecting the most appropriate solution to the problem. The evaluation criteria focused on the economic, political, social, and administrative goals and constraints of the preferred policy alternative: Missouri's Transitional Medical Assistance program. The tables below outline these goals and constraints.

<b>Goals</b>	
Economic	<ol style="list-style-type: none"> <li>1. Provide participants with extended healthcare coverage in the beginning stages of employment to avoid uninsured Missourians</li> <li>2. Ensure the sustainability of Missouri Medicaid Program</li> </ol>
Political	<ol style="list-style-type: none"> <li>1. Prevent fraud, waste, and unnecessary participant enrollment</li> <li>2. Create a program that does not encourage an influx on individuals and families from other states leading to an increase in Medicaid participants</li> </ol>
Social	<ol style="list-style-type: none"> <li>1. Encourage Missourians to seek employment by continuing Medicaid coverage after obtaining employment</li> <li>2. Encourage Missourian's to assume financial responsibility</li> </ol>
Administrative	<ol style="list-style-type: none"> <li>1. Require reporting requirements to continue TMA coverage that ensure an individual's eligibility for TMA</li> <li>2. Ensure coverage transition when an individual becomes ineligible for Medicaid but eligible for TMA</li> </ol>

<b>Constraints</b>	
Economic	<ol style="list-style-type: none"> <li>1. Need to decrease Medicaid spending</li> <li>2. Increase cost of healthcare coverage</li> </ol>
Political	<ol style="list-style-type: none"> <li>1. Pressure to reform MO Medicaid System</li> <li>2. Legislative expiration of funding for MO TMA program</li> </ol>
Social	<ol style="list-style-type: none"> <li>1. Decrease in jobs offering healthcare coverage</li> <li>2. Change in TMA eligibility requirements</li> </ol>
Administrative	<ol style="list-style-type: none"> <li>1. Reporting requirements</li> <li>2. Enrolling families in Medicaid</li> </ol>

### **Economic Goals and Constraints**

To evaluate the economic goals and constraints for Missouri's TMA program, this research looked at the following factors:

1. Trends in enrollment
2. Eligibility requirements
3. Average length of TMA coverage
4. TMA budget
5. Trend in the number of uninsured Missourians



## 6. Cost of healthcare

By gathering data around these factors, the researcher used the information to analyze and evaluate if Missouri's TMA program achieved the economic goals, overcame the economic constraints, and addressed the problem identified.

### **Political Goals and Constraints**

To evaluate the political goals and constraints for Missouri's TMA program, this research looked at the following factors:

1. Controls in place to prevent fraud, waste, and unnecessary enrollment
2. Eligibility requirements
3. Surrounding states eligibility requirements
4. Trends in number of uninsured Missourians

By gathering data around these factors, the researcher used the information to analyze and evaluate if Missouri's TMA program achieved the political goals, overcame the political constraints, and addressed the problem identified.

### **Social Goals and Constraints**

To evaluate the social goals and constraints in Missouri's TMA program, this research looked at the following factors:

1. Eligibility requirements
2. Healthcare coverage status: employer-sponsored or private coverage, uninsured, lost employment to retain Medicaid
3. Average length of TMA coverage
4. Trend of unemployment in Missouri

By gathering data around these factors, the researcher used the information to analyze and evaluate if Missouri's TMA program achieved the social goals, overcame the social constraints, and addressed the problem identified.

## **Administrative Goals and Constraints**

To evaluate the administrative goals and constraints in Missouri's TMA program, this research looked at the following factors:

1. Eligibility requirements
2. Number of individuals who receive extended TMA coverage through reporting requirements
3. Number of individuals who lose extended TMA coverage through reporting requirements
4. Guidelines and process for alerting participants of a change in their coverage and what that change means
5. Efficiency and effectiveness of reporting requirements

By gathering data around these factors, the researcher used the information to analyze and evaluate if Missouri's TMA program achieved the administrative goals, overcame the administrative constraints, and addressed the problem identified.

Interviews with eligibility specialists (caseworkers) and county supervisors qualitatively enhanced the analysis of Missouri's TMA program. The research aimed to interview 10-15 individuals. The interviews aided in clarifying the policy decisions, program operations, and program changes by providing an understanding on how the TMA program developed into the current program. The information in the interviews addressed the goals and constraints identified in this research. The interviewees for the research were recruited by the research liaison from the Missouri Department of Social Services. The researcher provided the liaison with a desired list of interviewees and through the liaison made initial contact about participating in this research. The researcher completed all interviews by phone as requested by the Missouri Department of Social Services. See Appendix III for interview tool and interview responses.

## **Analysis Plan**

To complete the analysis, the researcher gathered quantitative and qualitative data. The quantitative data allowed for trend analysis and comparisons to provide descriptive data assessing the goals and constraints. The qualitative data were interviews with individuals providing additional information about Missouri's TMA program. The information from interviews allowed for a content analysis to assess the goals and constraints.

## Chapter Four

## Results

This research focuses on the economic, political, social, and administrative goals of Missouri’s Transitional Medical Assistance program and the constraints that developed over time affecting the implementation of the TMA program as identified in chapter three. This research uses the identified goals as parameters to evaluate the implementation of the TMA program and how the identified constraints affect implementation.

### Economic Goals

#### *Ensure the sustainability of Missouri Medicaid*

Interviews revealed that the parameters in place to ensure sustainability are the eligibility requirements for the TMA program. Table 1 displays the eligibility requirements for TMA from 2000-2009.

**Table 1 Income Eligibility for Medicaid and TMA and length of TMA Coverage**

Year	Income Level	TMA FPL: Federal Poverty Line	Initial Coverage	Total Additional Coverage (submit quarterly reports)	Total additional coverage available through waivers
2000		<185% FPL	6 Months	6 Months	12 months
2001		<185% FPL	6 Months	6 Months	12 months
2002	≤100% of FPL	<185% FPL	6 Months	6 Months	12 months
2003	≤77% of FPL	<185% FPL	6 Months	6 Months	12 months
2004	≤75% of FPL	<185% FPL	6 Months	6 Months	12 months
2005	≤21% of FPL	<185% FPL	6 Months	6 Months	Eliminated
2006	\$556.00	<185% FPL	6 Months	6 Months	Eliminated
2007	≤21% of FPL	<185% FPL	6 Months	6 Months	Eliminated
2008	≤20% of FPL	<185% FPL	6 Months	6 Months	Eliminated
2009	\$234.00	<185% FPL	6 Months	6 Months	Eliminated

(Source: Kasier Medicaid reports, interviews, and TMA CRS Report 2008)

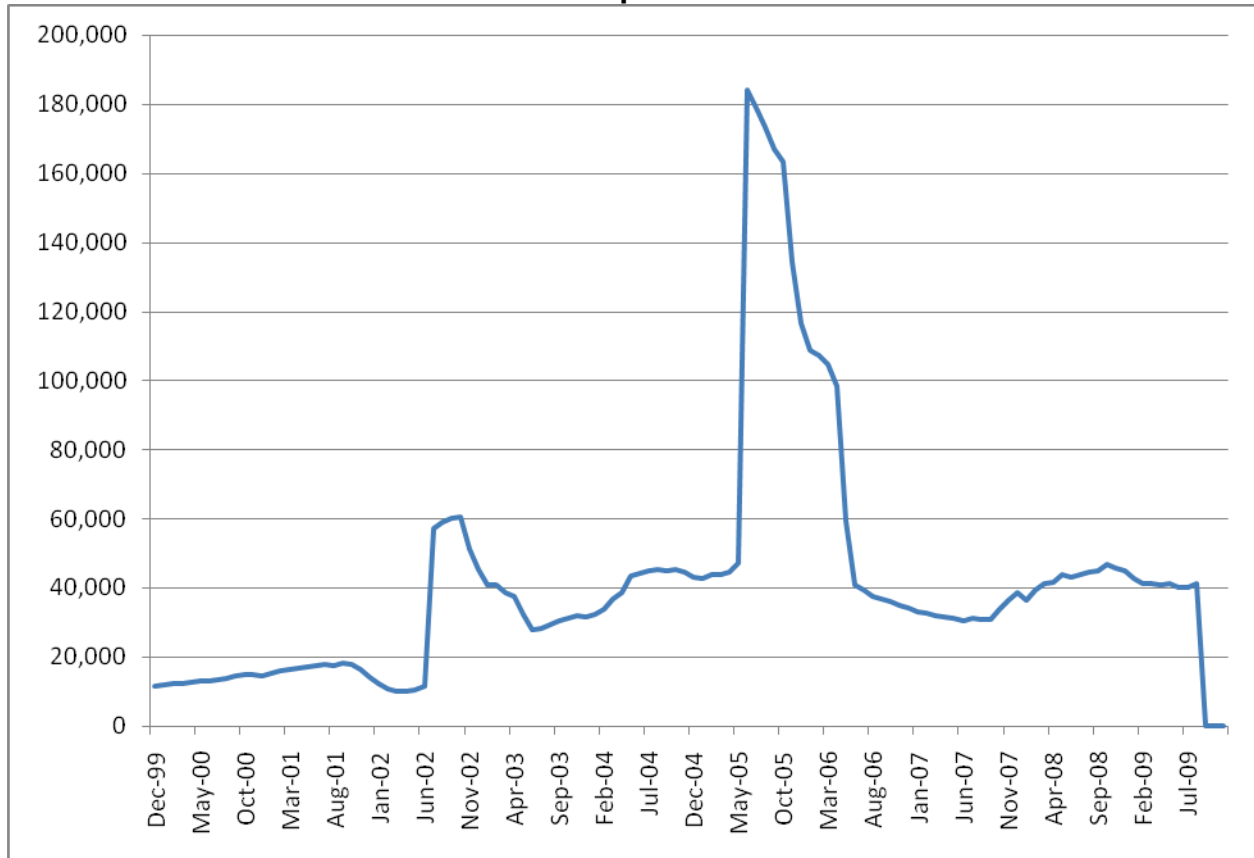
The TMA program helps ensure the sustainability of the Missouri Medicaid program because it is time-limited and income-limited coverage. Once an individual becomes eligible for TMA coverage, their Medicaid coverage will continue for six months. If the individual continues

to meet eligibility and reporting requirements, TMA coverage extends for an additional six months, totaling to a potential of 12 months of coverage. For an individual to receive TMA, their income must exceed the Medicaid income eligibility requirements but not exceed 185% of the FPL and have 3 out of 6 eligible months of Medicaid. When an individual's income exceeds 185% of the FPL, they are no longer eligible for TMA, even if their initial 6-month coverage period has yet to expire. These two eligibility requirements are important to the TMA program because they contribute to ensuring the sustainability of Missouri Medicaid. These limits create a turnover in enrollment and act as a control for spending. "These eligibility limits provide cost-savings to Missouri because individuals do not stay on TMA for more than 12 months, and sometimes become self-sufficient, no longer needing other benefits" (Interview 1).

The Monthly Management Reports provide the total monthly enrollment for TMA each month from January 2000-September 2009. October 2009 through December 2009 Monthly Management Reports were unavailable because "the data is not yet publically available since Missouri started a transition in October 2009 to a new computer system" (Email from Research and Evaluation Unit Employee). Figure 2 displays the changes in the monthly TMA enrollment with enrollment drastically increasing during 2005 and by 2006 beginning immediately to drop. The increase in enrollment numbers for 2005 is consistent with the eligibility changes made with Missouri's Medicaid reform. For space purposes, the graph displays the monthly enrollment numbers in six-month increments. See page 32 for Figure 2.

Figure 2 displays the effect the income and time limits have on the monthly enrollment for TMA. This figure shows that TMA is temporary coverage and relies on the income and time limits to aid in sustainability of Missouri Medicaid. It is unclear which limit, time or income, affects individuals enrollment on TMA because limited data were available. Caseworkers reported that, "most often times an individual loses TMA because of the time limit, not the income limit" (Interview 2).

**Figure 2: TMA Monthly Enrollment Totals  
Jan 2000-September 2009**



(Source: Missouri Monthly Management Reports)

*Provide participants with extended healthcare coverage in the beginning stages of employment to avoid uninsured Missourians*

The goal of the TMA program is to “provide clients with health insurance coverage after obtaining employment, to avoid losing Medicaid coverage for six-twelve months, and potentially lead to client self-sufficiency and ability to afford health insurance” (Interview 5).

The TMA program bridges the gap between an individual losing Medicaid coverage and obtaining employer-sponsored or private insurance. The TMA program achieves this goal by offering individuals six months of Medicaid coverage, when they come eligible for TMA, and an opportunity to extend coverage for an additional six months, if they abide by the reporting requirements and income remains at or below 185% of the FPL. The eligibility requirements and

TMA length of coverage in Table 1 display that the TMA program meets this goal by providing an initial 6 months of coverage. “There is nothing in place to determine if the 6-12 months of coverage actually helps prevent uninsured Missourians. Short-term, this program reduces the number of uninsured Missourians for 6-12 months. But, long-term an individual’s TMA coverage expires and they usually fall through the cracks and become uninsured” (Interview 1).

**Economic Constraints**

*Need to decrease Medicaid spending*

The changes in Missouri’s Medicaid budget from 2000-2009 create a constraint on the implementation of Missouri’s TMA program, evident in the budget fluctuations, the trend of TMA enrollment, and the number of uninsured Missourians from 2000-2009. To address this constraint, the researchers obtained the yearly Medicaid budget for 2000-2009. FSD reported that “exact specifics of the TMA budget are unavailable because there is no differentiation in the Medicaid budget on the amount of money each program receives” (Email from FSD Employee). Interviewees voiced that the “Medicaid budget became a major concern because it is the state’s largest expense. Missouri legislature needed to control Medicaid spending. Therefore the budget changed with the aim of lowering it each year” (Interview 4). Table 2 displays the yearly budget for Missouri Medicaid from 2001-2009.

**Table 2 Missouri Medicaid Budget**

Year	Budget
2000	Unavailable
2001	\$4.1 Billion
2002	Unavailable
2003	\$4.5 Billion
2004	\$4.8 Billion
2005	\$6.3 Billion
2006	\$4.7 Billion
2007	\$4.9 Billion
2008	\$5.4 Billion
2009	\$5.8 Billion

(Source: Medicaid Basic Reports 2001, 2003-2009)



The Medicaid budget for 2000 and 2002 was unavailable. As Missouri's Medicaid budget steadily rose from 2001-2005, an urgent need to control Medicaid spending developed to ensure sustainability of Missouri's Medicaid program. "When the budget needs to be cut, they look at programs and categorize their priority based on the program participants. For the TMA program, this led to decreasing eligibility requirements, especially income eligibility, to reduce the number eligible for TMA to meet the new budget" (Interview 4). Income eligibility decreased from 75% of FPL to less than 21% of the FPL from 2004-2005—a 54% decrease in income eligibility levels. "The immediate change of eligibility requirements in 2005 forced a lot of individuals on Medicaid to TMA and individuals on TMA to have no coverage" (Interview 5). Caseworkers explained that this immediate change, especially for individuals on TMA at the time, "left people with few options for healthcare coverage and most of the individuals had no other access to healthcare coverage or were not in a financial position to purchase private insurance" (Interview 1). Interviewees stated that the enrollment numbers for TMA continually decreased after 2005 because of Missouri's Medicaid reform to ensure sustainability. Figure 2 (see p. 32) displays the fluctuation in enrollment numbers that occurred with the eligibility requirement changes.

"Income eligibility requirements decreased to make it more difficult for individuals to qualify for Medicaid or TMA—saving the state money in the Medicaid budget" (Interview 2).

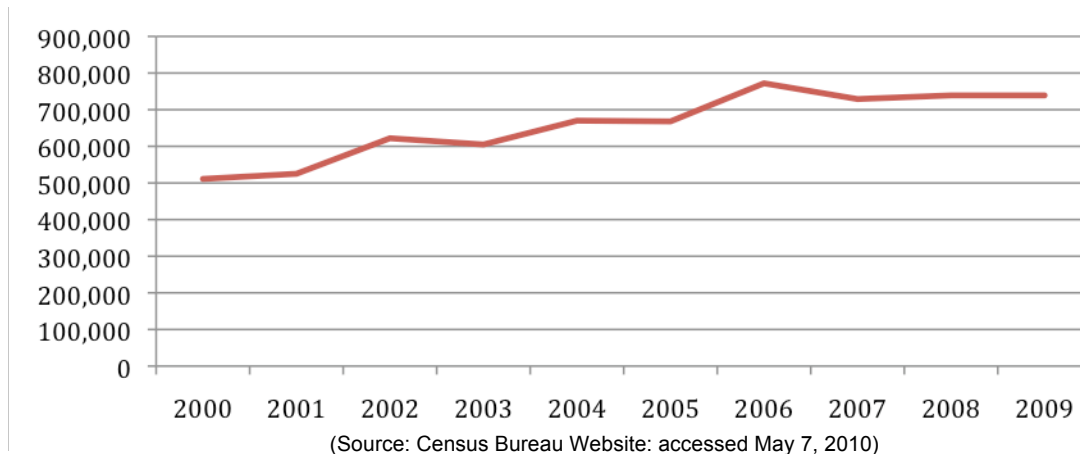
The number of uninsured Missourians supports the effect this constraint had on the implementation of the TMA program. Table 3 and Figure 3 provide information on the number of uninsured Missourians from 2000-2009.

**Table 3 Yearly Totals of Uninsured Missourians**

Year	Total People
2000	511,000
2001	525,000
2002	622,000
2003	605,000
2004	670,000
2005	668,000
2006	772,000
2007	729,000
2008	739,000
2009	739,000

(Source: Census Bureau Website: accessed May 7, 2010)

**Figure 3 Yearly Totals of Uninsured Missourians**



From 2000-2005, the number of uninsured Missourians increased by an average of 31,000 individuals, with two years having a decrease in the total number. The number of uninsured individuals increased by 104,000 from 2005-2006. Even though the number of uninsured Missourians decreased from 2006-2009, the number of uninsured Missourians is still significantly higher than 2000-2005. Caseworkers communicated that even though the number of uninsured Missourians decreased in 2007 and reached a plateau in 2008-2009, they believe the “majority of the uninsured are individuals who cannot afford coverage or do not work in jobs

providing coverage. Therefore, they will continue to remain uninsured for a longer time, potentially never accessing healthcare coverage” (Interview 5).

### *Cost of healthcare coverage*

This research considers how the cost of healthcare from 2000-2009 affects the implementation of the TMA program based on the goals identified. In addressing this constraint, this research draws conclusions about how the rising cost of healthcare places constraints on the Medicaid budget, ability of individuals to afford healthcare coverage, and how it affected employer-sponsored coverage. Information regarding the cost of healthcare in Missouri came from familiesusa.org and statehealthfacts.org. From 2000-2005, the cost of healthcare rose from \$6,371.00 to \$9,948.00. The cost of healthcare in 2006 was \$10,864.00; 2007-\$11,852; 2008-\$11,557.00; 2009-\$12,285.00. The researcher found no explanation for this decrease in the cost of healthcare in 2008. One possible explanation is that the 2008 cost of healthcare was available from Kaiser State Health Facts and the remaining years were from familiesusa.org. Depending on how each gathered their datum and obtained these numbers could explain the slight decrease from 2007-2008.

The increase creates a constraint on the implementation of the TMA program and for reducing the number of uninsured Missourians because after the 6-12 months, an individual needs to be able to afford coverage or receive it through their employer. The rising cost of healthcare makes it difficult for an individual coming off Medicaid to afford employer or private coverage within 6-12 months. “The cost of insurance shocked individuals causing them to abstain from purchasing coverage and with the rising cost, employers began to scale back coverage or offer no coverage with employment because of the cost” (Interview 4). This constraint affects the implementation of TMA. It created a need to scale back Medicaid expenses, which led to a decrease in the Medicaid budget and change eligibility requirements, affecting TMA enrollment and the number of uninsured Missourians.

## **Political Goals**

To address the political goals of the TMA program, this research evaluates the controls in place to prevent fraud, waste, and unnecessary enrollment and compares Missouri's TMA eligibility with surrounding states.

### *Prevent fraud, waste, and unnecessary enrollment*

The TMA program helps prevent fraud, waste, and unnecessary enrollment because it is income and time limited and the state of Missouri has controls that prevent fraud, waste, and unnecessary enrollment. The income and time limits help achieve this goal because they require a review each month of an individual's eligibility to determine if they meet the requirements to continue TMA coverage. The controls in place through the program integrity office and the Family Support System provide a method for Missouri Medicaid to prevent fraud, waste, and unnecessary enrollment. The audit of an individual's enrollment and Medicaid usage, such as doctors, prescriptions, and pharmacies, is important to the implementation of the TMA program because there needs to be a system of checks and balances that address the spending and enrollment since Medicaid is a federal and state funded program. There is a need to demonstrate to the public that the money spent is accounted for and individuals are not abusing the Medicaid system.

The Program Integrity Office that oversees fraud, waste, and unnecessary spending for MO HealthNet and the Family Support Division has an office that oversees fraud, waste, and unnecessary spending in regards to individuals accessing TMA. An interview with a program integrity specialist provided information about the controls in place.

All providers and recipients must submit an application and meet criteria to either provide Medicaid services or receive them. After submitting an application, providers and recipients must meet eligibility requirements. Providers undergo a background check and survey of the need for Medicaid providers in their practicing area. Recipients must meet eligibility requirements as outlined by Family Support Division to receive Medicaid. Once a provider or recipient receives Medicaid, they are subject to monitoring and audits by either the

Program Integrity Office or Financial Service Division in the Family Support Division. The offices will look for red flags in provider and recipient's files such as the use of deceased individual's information, performing unnecessary medical services, billing anomalies, use of multiple doctors, use of multiple pharmacies, and inconsistent reporting of income for eligibility purposes. If any of these red flags or potential others appear, the provider or individual faces potential restrictions or punishment such as a surprise medical record audit or limitation to only seeing one doctor and using one pharmacy for services (Interview 6).

Because of the unavailability of data, it is uncertain how effective or efficient these controls are and how effective or efficient the TMA program is in aiding the prevention of fraud, waste, and unnecessary enrollment.

*Create a program that does not encourage an influx of individuals and families from other states, leading to an increase in Missouri Medicaid participants*

To evaluate this political goal, this research considers the relationship between Missouri's eligibility and surrounding states eligibility. "Federal Government determines the overall eligibility requirements and states may file a waiver to change income eligibility requirements. Missouri's eligibility requirements change because of available funding, change in administrative priorities, political pressure, and to maintain enrollment" (Interview 4).

To achieve this political goal Missouri has more stringent eligibility requirements or fewer benefits for individuals to discourage an influx of individuals into the state to receive Medicaid. The researcher identified Illinois, Iowa, Kansas, and Arkansas as the surrounding states for Medicaid and TMA eligibility. Eligibility information from Kansas was unavailable on the state website, staff answering phones about Kansas Medicaid did not know the requested information, and the eligibility office operates using a voicemail system and states that all messages will be returned in 24-48 hours. All messages left by the researcher went unreturned. Table 2 displays the eligibility information for these states and Table 1 displays the eligibility information for Missouri.

**Table 4 Medicaid and TMA Eligibility for Illinois, Arkansas, and Iowa**

State			
Illinois	County Group	Medicaid Income	TMA Income
	Group I	\$435	<185% FPL
	Group II	\$423	<185% FPL
	Group III	\$408	<185% FPL
Arkansas			
	Family Size	Medicaid Income	TMA Income
	1	\$902.50	\$1,669.63
	2	\$1,214.17	\$2,246.21
	3	\$1,520.83	\$2,820.79
Iowa	4	\$1837.50	\$3,339.38
	Family Size	Medicaid Income	TMA Income
	1	\$183.00	<185% FPL
	2	\$361.00	<185% FPL
	3	\$426.00	<185% FPL
	4	\$495.00	<185% FPL

(Information gathered from State's website: accessed May 13, 2010)

Table 4 shows the similarities and differences between four states surrounding Missouri. The major difference between the four states is the Medicaid income eligibility requirement. To receive TMA, an individual must first qualify for Medicaid. When their income exceeds the Medicaid limit because of employment, an individual is eligible for TMA. Once receiving TMA, an individual cannot exceed the TMA income limit during their coverage period. If an individual exceeds the TMA income limit, they become ineligible for coverage even if it is before the mandatory time limit expires. This information allows the researcher to compare these eligibility requirements with Missouri's eligibility requirements to determine if there would be an influx of individuals coming to live in Missouri to receive benefits.

By comparing Missouri to surrounding states, it is evident that Missouri's eligibility requirements are more stringent than Iowa, Illinois, Kansas, and Arkansas. This detracts individuals from assuming residency in Missouri to receive Medicaid benefits—creating an expectation that Medicaid enrollment will remain steady or even drop because Missouri's income eligibility is currently \$234.00 for a family's monthly income whereas the other states

range from \$183-\$902 for a family of one, making it easier to obtain Medicaid benefits in the surrounding states.

## **Political Constraints**

### *Pressure to reform MO Medicaid system*

The pressure to reform the MO Medicaid system laced a political constraint on the implementation of the TMA program. There was “political pressure to reform Medicaid because of the increased amount of spending, enrollment, and the rising cost of healthcare” (Interview 4). The State legislature is responsible for determining the budget and eligibility requirements for Medicaid, including TMA. The pressure to reform Missouri’s Medicaid system and bring Medicaid spending under control forced the state legislature to reduce the Medicaid budget and change the eligibility requirements.

The changes in income eligibility requirements (see Table 1) display the affect this pressure had on individuals being eligible for coverage displayed through the increases and decreases in enrollment (see Figure 2) and the number of uninsured Missourians (see Table 4 and Figure 3). The changes forced individuals to either TMA coverage or no coverage because of the new eligibility requirements set in 2005. “Even if an individual was receiving TMA at the time of the eligibility changes, once the new limit took those with eTMA automatically lost coverage and those who would have qualified for eTMA and planned to receive it, no longer had coverage once TMA expired” (Interview 2). Caseworkers stated that the changes in eligibility left a significant amount of individuals ineligible for TMA, especially if their income fell into the 21%-75% of FPL gap cut in 2005. These changes affected the implementation of the TMA program from successfully providing individuals with healthcare coverage in the initial stages of employment or increased income because it limited those eligible. This political constraint affects successful implementation of the TMA program because “it kicked TMA clients off coverage, especially those on eTMA and forced Medicaid clients on to TMA, whether or not they

had employment or a tangible increase in their income. The new income limits made it appear that individuals had an increase in income but in reality, actually did not.” (Interview 2). This constraint caused an increase in TMA enrollment, especially in 2005, a drastic decrease after eligibility requirements changed in 2005, and a significant increase in the number of uninsured Missourians from 2005-2006. Figure 2 displays the enrollment changes and Figure 4 displays the fluctuation in the number of uninsured Missourians.

## **Social Goals**

### *Encourage Missourians to assume financial responsibility*

A goal of the TMA program, while helping to reduce the number of uninsured Missourians, is to encourage Missourians to assume financial responsibility. It is important for Missourians to assume financial responsibility because it provides an individual with a “sense of ownership, dignity, and removes a form of dependence on the government to provide for their needs” (Interview 5). The TMA program seeks to achieve this goal by placing a time and income limit on the length of coverage. The time limit provides individuals an opportunity to plan for assuming financial responsibility for healthcare coverage because it gives them 6-12 months of Medicaid coverage at no cost to the individual while they are working and receiving an increased income. By changing income limits, it creates a “sense of urgency for the client to become prepared to assume financial responsibility” (Interview 5).

“The 2005 Medicaid Reform sought to benefit the TMA program because it became difficult to meet income eligibility requirements for Medicaid or TMA with the intention that it would encourage people to work and seek jobs offering employment to have healthcare coverage” (Interview 2). The change in income eligibility from 2000-2009 (Table 1) demonstrates Missouri’s effort at encouraging Missourians to assume financial responsibility along with the time limit of coverage. With the time limit and decreasing income eligibility levels,



“clients right at that cut-off line had to prepare to become financially responsible for their healthcare coverage” (Interview 2).

The unavailability of data prohibits evaluation of this goal to determine if Missourians do become financially responsible and independently accessing healthcare. It is unknown if Missourians access healthcare after TMA coverage expires, remain uninsured, or lose employment and reapply for Medicaid coverage. In 2005 Medicaid Reform, “Missouri designed a state-sponsored health insurance program where individuals whose TMA expired could have the option to buy-in to healthcare coverage. This program never came to fruition. One possible reason may be the lack of funding” (Interview 4).

*Encourage Missourians to seek employment by continuing Medicaid coverage after obtaining employment*

The TMA program seeks to reduce the number of uninsured Missourians because it encourages Missourians to seek employment without immediately retracting Medicaid benefits after obtaining employment. The design of the TMA program is to encourage individuals on Medicaid, who are capable of working, to obtain employment by allowing “individuals to keep insurance for a period of time after obtaining employment. Individuals coming out of poverty retain benefits while beginning work which is a benefit to them and their children” (Interview 1). Missouri’s eligibility requirements (Table 1) allow an individual to receive TMA coverage for an initial six months and continue coverage for an additional six months if their income stays at or below 185% of FPL and they file quarterly reporting requirements. The inaccessibility to data prevent the researcher from evaluating this social goal because it is not known beyond the 6-12 months of TMA coverage if an individual keeps employment and obtains healthcare coverage, keeps employment but becomes uninsured, or becomes unemployed and reapplies for Medicaid coverage. The researcher is unable to determine if the TMA program encourages employment or serves a vehicle for creating a turnover with Medicaid enrollment through reduction of income eligibility.

## Social Constraints

### *Rise in unemployment*

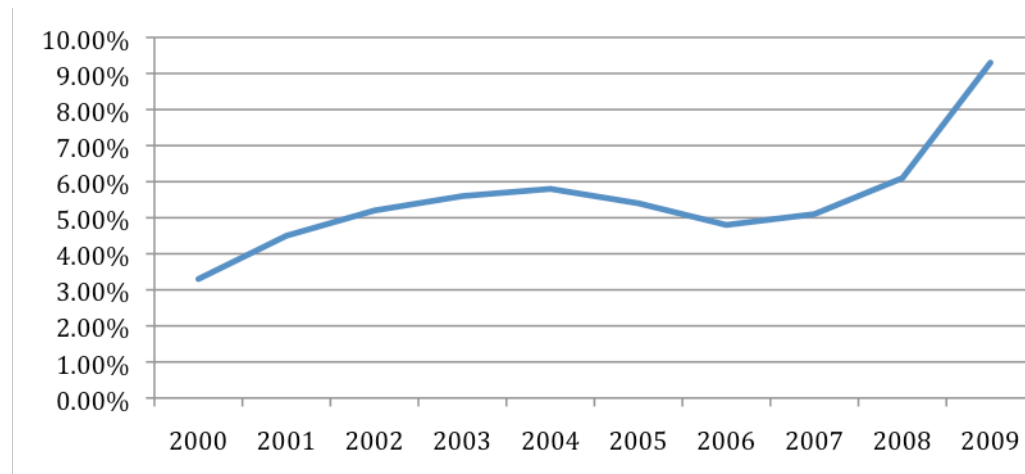
This research considers how the rise in unemployment and change in eligibility requirements affect the implementation of the TMA program. Table 5 and Figure 4 display the yearly unemployment rates for Missouri.

**Table 5 Unemployment Rates**

Year	Percentage
2000	3.30%
2001	4.50%
2002	5.20%
2003	5.60%
2004	5.80%
2005	5.40%
2006	4.80%
2007	5.10%
2008	6.10%
2009	9.30%

(Source: Census Bureau Website: accessed May 7, 2010)

**Figure 4 Unemployment Rates**



(Source: Census Bureau Website: accessed May 7, 2010)

Table 5 and Figure 4 show that the unemployment rate rose steadily from 2000-2006 where in 2006 it had a slight drop but then increased from 2007-2009. The high unemployment rate in 2009 is attributed to the collapse of the economic market.

The rate of unemployment in Missouri is a social constraint for the TMA program because it affects the two social goals identified in the research. An underlying expectation of TMA is that it encourages Missourians to assume financial responsibility because healthcare coverage eventually expires. An expectation is that individuals work in jobs offering healthcare coverage or are able to purchase private coverage. The unemployment rate in Missouri steadily increased from 2000-2005 and resumed increasing in 2007, eventually reaching 9.30% in 2009. This is a constraint for the TMA program because individuals need employment for income to assume financial responsibility. The rise in unemployment over the years affects the implementation of the TMA program because it detracts from individuals being able to assume financial responsibility and obtain employment.

#### *Change in eligibility requirements*

The change in eligibility requirements from 2000-2009 creates a social constraint in the implementation of the TMA program. Table 1 displays the eligibility requirements for TMA from 2000-2009. The main changes to eligibility requirements were the income eligibility limits and the elimination of the option to file a waiver for a second 12-month period of coverage, known as extended TMA. The change in income limits from 2000-2009 transitioned an influx of individuals off Medicaid to TMA and individuals on TMA to receiving no benefits. Figure 2 (see p 3) displays the effect the change in income limits had on TMA enrollment “The changes in eligibility requirements forced individuals to assume financial responsibility earlier than anticipated and many were not in a position to do this when income eligibility requirements changed causing individuals to become uninsured” (Interview 2). “Individuals who transferred to TMA because their income exceeded Medicaid limits, often did not understand that TMA is temporary, and did

not see a reason to obtain employment or plan to lose coverage because they still received the same benefits” (Interview 4).

## **Administrative Goals**

### *Require reporting requirements to provide six additional months of coverage*

The reporting requirements are the only way for an individual to continue coverage for an additional six months. The additional six months of coverage contributes to achieving Missouri’s goal of reducing the number of uninsured Missourians because it prevents an individual from losing Medicaid coverage when they experience an increase in their income through employment or other means such as child payments. Missouri achieves this goal by including quarterly reporting requirements in the eligibility requirements if a participant wants to continue coverage for an additional six months. Table 1 displays the eligibility requirements for Missouri’s TMA program. “The reporting requirements serve as a way for clients to assume responsibility for maintaining their healthcare coverage and as a vehicle for preventing fraud, waste, or unnecessary enrollment” (Interview 6). Data on the number of individuals who received an additional six months of coverage from meeting reporting requirements and the number of individuals who lost coverage from not meeting reporting requirements was unavailable. This constrains the evaluation of this goal because the research is unable to determine if the reporting requirements do benefit the participants. Interviews made it clear that “clients often do not understand the importance of the quarterly reports or the reports themselves so they tend to ignore them and lose TMA coverage after the initial six months” (Interview 2).

### *Ensure coverage transition when eligible for TMA*

Interviews from MO FSD show that the process for alerting an individual about a change in their Medicaid coverage is by sending a form letter and providing the IM-4TM, which further explains TMA to the recipient. A copy of the IM-ATM is in Appendix IV. The transition from

Medicaid to TMA is a “crucial step” (Interview 2) to ensure that individuals eligible retain TMA coverage for a minimum of six months instead of becoming uninsured. Interviewees stated that this transition includes “alerting an individual of a change in their Medicaid, what that change means, and new responsibility the individual needs to assume to continue coverage after the initial six-month period” (Interview 2). Missouri relies on a computer system to alert them when an individual transfers to TMA. The computer system changes their Medicaid status to TMA and generates a form letter to the recipient explaining the change in their Medicaid coverage and the additional eligibility requirements that take effect including income restrictions, reporting requirements, and the length of coverage. Caseworkers communicated “clients often do not understand this letter, ignore the letter, and lose TMA coverage after their initial six months because they did not submit quarterly reports” (Interview 2). Data on the number of individuals who maintained TMA once they transferred and the number who lost TMA because of a lack of understanding about TMA was unavailable.

## **Administrative Constraints**

### *Reporting requirements*

The reporting requirements to continue TMA coverage for an additional six months create an administrative constraint in the implementation of the TMA program. Interviews provided information regarding the effectiveness and efficiency of the reporting requirements. In 2005, Missouri changed to a new computer system for managing caseloads. “With this change communication about transition to TMA became computer generated whereas before the caseworkers were responsible for contacting clients about transition to TMA, reporting requirements, explaining benefits and how TMA works, entering quarterly reports, and following up with clients if they had not submitted reports. The current system generates a letter that clients often do not understand causing them to ignore the letter and lose healthcare coverage” (Interview 2). This affects the implementation of the TMA program because the reporting

requirements are in place to ensure coverage for six additional months but if an individual does not submit a quarterly report after the initial six months, they lose TMA coverage. Interview participants stated that they “observed more uninsured Missourians because individuals did not understand that TMA only lasted 6-12 months and to receive the full 12 month coverage, individuals had to complete quarterly reports” (Interview 5). “There is a gap between when the reports should send out and when the computer system actually sends them out. This creates a risk of an individual losing their TMA coverage for a period of time because the computer system sends reporting forms late to an individual or the individuals returned report was not entered in time. Caseworkers receive no notification when letters are sent out and, if a report is not entered into the computer system” (Interview 2).

## **Overall Research Constraint**

### **Unavailability of data**

The unavailability of data is a constraint to the overall research. The following program specific data was not available:

- Number of individuals who lost TMA coverage because of reporting requirements
- Number of individuals who lost TMA coverage because of continued employment
- Number of individuals who quit their job to reapply for Medicaid coverage
- Number of individuals who lost coverage because of receiving unemployment benefits after losing employment before TMA coverage expired
- TMA Budget
- Average length of TMA coverage for an individual
- The number of individuals who received back-dated Medicaid coverage to meet TMA eligibility requirements and receive coverage

This data was unavailable from Missouri’s Research and Evaluation Unit, Family Support Division, and no other publications contained this information. The unavailability of this data creates a constraint on evaluating the implementation of the TMA program. This specific data would allow a comprehensive evaluation of the TMA program based upon the goals identified in this research. It prohibits the research from confirming if the goals identified achieve their intended purpose and if the implementation of TMA helps reduce the number of uninsured

Missourians. However, in Chapter 5, the researcher looks at how the data gathered still allows for an evaluation of the implementation of Missouri's TMA program.

## Chapter Five



## **Discussion and Conclusion**

The researcher evaluated the implementation of the TMA program to determine if Missouri's TMA program assists in reducing the number of uninsured Missourians. The number of uninsured Missourians steadily climbed from 7% in 1999 to 12.1% in 2005. The decline in employer-sponsored healthcare and in wages and household income contributed to the rise in the number of uninsured Missourians. From 1979-2005, employers offering coverage dropped from 69.1% to 59.6%. In 1999, the median household income was \$51,427 and by 2006, it dropped to \$44,487—a 13.5% decrease. The average Missourian saw a \$4,904 decrease in their income from 2000-2005. As the number of uninsured Missourians grew and incomes dropped, Medicaid experienced an increase in expenditures and enrollment propelling Missouri to a Medicaid Reform in 2005. Missouri dedicated itself to creating a healthcare system that delivered innovative services while reducing the number of uninsured Missourians (Missouri Citizen Fund 2007). Using Patton and Sawicki's model of policy analysis, this research addressed how the TMA program assists in reducing the number of uninsured Missourians and what constrains the TMA program in reducing the number of uninsured Missourians.

The identified program goals served as the evaluative criteria. Instead of identifying constraints of the TMA program, this research looks at constraints that developed over time and how they affected implementation. Missouri's TMA program is designed to achieve the goals outlined in this research; however, the implementation of the TMA program is greatly affected by the constraints that developed over time and the unavailability of data prohibit a comprehensive evaluation of the TMA program.

The researcher is unable successfully to evaluate the implementation of Missouri's TMA program because the unavailability of program specific data prohibit the researcher from determining if the implementation of TMA achieves the goals identified in the research. The unavailability of data is a cause for concern because the data gathered and the interviews conducted allow the researcher to conclude that the TMA program does not assist in reducing

the number of uninsured Missourians for more than 6-12 months. If program specific data were available, the researcher would perhaps be able to determine the direct affect of the implementation of TMA. This unavailability caused the researcher to obtain broader data and rely on interview responses to evaluate the implementation of Missouri's TMA program.

Even though the program is designed to achieve the goals identified, the data gathered show that the implementation of the TMA program is unsuccessful because the goals counteract the achievement of one another. The economic goal of ensuring Medicaid sustainability and the political goal of creating a program that discourages an influx of enrollment affect the social goals because the Medicaid budget and eligibility requirements change and in this case, make it difficult for an individual to meet eligibility requirements and work towards assuming responsibility for healthcare coverage. This constrains individuals from assuming financial responsibility or seeking employment because they lose benefits before they are in a position to assume responsibility or refrain from seeking employment in hopes of retaining Medicaid benefits.

The administrative goals affect the economic goal of providing participants with extended healthcare coverage in the beginning stages of employment because individuals must file quarterly reports after initial six months to receive a full 12 months of coverage. Interviewees reported that most individuals usually do not understand the importance of the reports and do not submit there; therefore, they lose coverage after six months. This affects the implementation of the TMA program from achieving the goal of providing coverage in the beginning stages of employment to avoid uninsured Missourians because most individuals retain coverage for six months because they do not file the quarterly reports and become uninsured. This affects the social goal of providing extended coverage in hopes of the individual accessing healthcare coverage privately or through an employer. The unavailability of knowing the average length of TMA coverage and the number of individuals who lose coverage for various reasons prevent the

researcher from drawing any conclusions about the interaction of these two goals beyond what interviewees shared.

The constraints identified affect the implementation of the TMA program because they prevent the TMA program from achieving the goals. The constraints forced changes to the TMA program in budget, eligibility requirements, and benefits, and unemployment constrained the social goals and economic goal of sustaining Missouri Medicaid. The two major constraints, need to decrease the Medicaid budget and change in eligibility requirements, had the largest effect on the implementation of TMA because fewer individuals could receive benefits and those ineligible were often not in a position to assume responsibility for their healthcare coverage and remain uninsured. The rising cost of healthcare, pressure to reform Missouri Medicaid, rise in unemployment, and the reporting requirements contributed to the development of need to decrease the Medicaid budget and the change in eligibility requirements. As all of those constraints developed, Medicaid spending increased, resulting in the need to control spending. To control spending, Missouri legislature decreased the budget and changed eligibility requirements so fewer individuals met eligibility—allowing Medicaid and TMA to stay within their budget means. However, these constraints also affect the participants because individuals need to be able to afford healthcare coverage or obtain a job offering coverage, which many are unable to do and remain uninsured.

The collapse of the economy contributed to the constraints because they furthered the effects the constraints had on the TMA program. With the collapse of the economy, the rise in unemployment continued, more employers began cutting or scaling back healthcare coverage, and less funding for Medicaid programs was available, all of which provided no positive benefit to decreasing the number of uninsured Missourians.

As the economy collapsed and the 2005 Missouri Medicaid Reform changes took full effect, Missouri recognized that many Missourians were uninsured. The 2005 Medicaid Reform affected many Missourians and left them without insurance. The state legislature realized the

effects from the 2005 Reform and in 2007 developed a new healthcare initiative, *Insure Missouri*, to expand healthcare coverage to uninsured low-income Missourians—including those who lost coverage in 2005 or after. Besides expanding coverage to new individuals and providing coverage to individuals who lost it because of Medicaid cuts, Phase III of this initiative would provide assistance to small businesses that provide health insurance for their employees. Missouri planned to launch this program in January 2009. If all of the phases of Insure Missouri implement successfully, there is potential that Missouri's TMA program could have a long-term effect on reducing the number of uninsured Missourians. Insure Missouri "offers limited-benefits Medicaid coverage to working adults, ages 19-64." Phase I "covers working parents and other caretaker relatives age 19 and above with earned incomes below 100% of FPL, \$13, 690, for a family of 2. Phase II covers "all working adults—both those who are parents and those who are childless—with incomes up to 185% of FPL." Phase III covers employees of small businesses up to income levels set by the general assembly (Watson, 2008). The expanded coverage and addition of small business employer coverage creates the possibility of TMA bridging the gap between Medicaid coverage and individual responsibility by making healthcare coverage accessible to those who cannot afford it and do not meet Medicaid eligibility requirements. It would allow them to continue working and receive benefits after TMA expired, potentially leading to the individual affording healthcare coverage because they received longer coverage while receiving an increased income through employment.

With the recent developments of universal healthcare in the United States, the outlook for the TMA program contributing to reducing the number of uninsured Missourians is positive. There would be the availability of healthcare coverage for an individual to purchase at a reasonable price if they had no access to healthcare through their employer or could not afford private coverage. Missouri had plans to enact a state-sponsored healthcare package with the 2005 reform but never created this program. Missouri's idea for a state-sponsored plan now has the potential to become a reality because funding will be available.

Currently, the TMA program is a short-term solution to a long-term problem. The TMA program has the potential to be the bridge between Medicaid coverage and individuals assuming responsibility for healthcare coverage. However, the implementation appears to be unsuccessful and does not reduce number of uninsured Missourians because after 12 months most individuals have no access to healthcare and become uninsured.

#### *Weakness of Study*

A weakness to this research is the unavailability of program specific data. This is a weakness to the research because it prevents the researcher from comprehensively evaluating the TMA program and drawing specific conclusions to the goals identified in the research. Another weakness to this study was the lack of interviews from state representatives and senators who facilitated the 2005 Medicaid Reform. This lack of interviews prohibits the researcher from understanding the legislative changes to Medicaid and the reasoning behind the changes other than to control Medicaid spending.

#### *Directions for Future Research*

This research demonstrates the importance of evaluating specific programs within Medicaid because of the effects programs have on the Medicaid system. For Missouri, future research should focus on creating a system that will allow program specific data to be gathered to evaluate programs and how the implementation of Insure Missouri affects the TMA program and Missouri's goal of reducing the number of uninsured Missourians. When universal healthcare begins implementation, Missouri would benefit by researching the effect universal healthcare has on recipients of TMA coverage and how Medicaid, TMA, and universal healthcare work together to bridge the gap and reduce the number of uninsured Missourians. However, the researcher cautions any further research because of the unavailability of data. Missouri's Research and Evaluation Unit reported that to collect such data requires "a lot of time and money." Multiple requests from this researcher about the cost and willingness to underwrite some of the expense went ignored leading the researcher to believe that the unavailability of

data relate to the issue of time and not cost. This shows that there is not a concern for these data and that they only evaluation of implementation focuses on enrollment numbers and budget means. Missouri Research and Evaluation Unit reported that the Monthly Management Reports are the only available data. The researcher presents this caution because if data do not become available then there is no benefit for future research.

## **Appendices**

**Appendix I**

Part I  
Chronology of Medicaid

Part II  
Chronology of Missouri Medicaid



## Part I

### Timeline of Medicaid

1965—President Linden B. Johnson signed Medicaid and Medicare into law under Title XIX of the Social Security Act Amendment

1967—Federal government established early and periodic screening, diagnostic, and treatment (EPSTD) comprehensive health services for all children under 21 years of age and eligible for Medicaid. The creation of this program was a response to the American public's demand for testing and screening to eliminate or reduce factors that could lead to mortality, morbidity, and disabilities, such as testing PKU levels in blood that could lead to mental retardation if it went untreated (Tonniges, 2000).

1972—Creation of Supplemental Social Security Income providing access to Medicaid for elderly, blind, and disabled individuals.

1981—Freedom of choice waivers and home and community-based waivers became available under the Omnibus Budget Reconciliation Act.

1983—Expanded eligibility groups to include children under the age of 6 and pregnant women with incomes below 133 percent of the federal poverty level, and children under the age of 19 born after September 30, 1983 from families with incomes below the federal poverty level.

1986—Expanded state optional Medicaid coverage to pregnant women and infants, age one year or younger with a family income at or below 100% of the Federal Poverty Line.

1988—Qualified Medicare Beneficiary required states to provide Medicaid coverage to pregnant women and infants, age one year or younger with a family income at or below 100% of the Federal Poverty Line.

1989—Expanded EPSDT to include pregnant women and children under the age of six with a family income at or below the Federal Poverty Line.

1990—Created the Specified Low-Income Medicare Beneficiary program covering children ages 6-18 with a family income at or below 100% of the Federal Poverty Line

1991— Creation Disproportionate Share Hospital (DSH) spending controls, bans on provider donations, and caps provider taxes. States could request reimbursement under DSH for any service provided to Medicaid participants and uninsured individuals.

1996—Personal Responsibility Work Opportunity Reconciliation Act

1997—Balanced Budget Act of 1997 introduced the State Children's Health Insurance Program (SCHIP) and established new managed care options and revised DSH payment limits

## Part II

### Timeline of Missouri Medicaid

1959—Missouri offered limited medical assistance to low-income individuals with minimal access to inpatient hospital care. Missouri offered a maximum reimbursement of \$5.00 per day for a total of 100 days for inpatient hospital care per patient.

1963—Missouri provided limited prescription drug and dental programs for qualifying adults

1967—Missouri passed legislation enacting their Medicaid program providing outpatient hospital care, physicians' services, and professional nursing home care. This legislation extended coverage to blind persons, permanently and totally disabled persons, and expanded services to AFDC recipients.

1967-2005—All changes to MO Medicaid were federal mandated changes

2005—Missouri embarked on comprehensive Medicaid reform

2006—Missouri Medicaid Reform Commission completed its analysis and gave recommendations

2008—Missouri's goal to have in place its reformed Medicaid program

## **Appendix II**

### Part I

Eight Objectives of Missouri Medicaid Reform Commission

### Part II

Fourteen Recommendations from Missouri Medicaid Reform Commission

## Part I

### Eight Objectives of the Missouri Medicaid Reform Commission

- Improving the health status of Missourians by increasing access to basic healthcare, wellness, and prevention;
- Better identifying the needs of participants and develop services that meet those needs and results in the best outcomes at the best cost;
- Ensuring appropriate levels of statutory and administrative oversight to improve participation and efficiency by providers while improving access to quality care;
- Providing service options that will encourage the least restrictive setting for the delivery of care—especially as it relates to long term care;
- Ensuring the state budget lives within its means by controlling the financial growth of the public healthcare program and fully utilizing and encouraging the use of private financial resources and private insurance;
- Focusing resources to help those with the greatest needs and providing taxpayer resources only to those who cannot afford to provide for themselves;
- Identifying and making recommendations to eliminate waste, fraud, and abuse in Missouri's public healthcare system, as it relates to those getting services and those providing services; and
- Consolidating as appropriate and administering state medical assistance programs to achieve maximum efficiency and effectiveness.

## Part II

### Fourteen Recommendations

1. Transform Missouri's Medicaid program to MO HealthNet;
2. Transform the Division of Medical Services to the MO HealthNet Division to become an authoritative leader in the provision of quality healthcare as well as healthcare financing;
3. Engage MO HealthNet participants with a healthcare home and healthcare home coordinator focusing on the health and wellness of individuals;
4. Engage MO HealthNet participants in a health risk assessment;
5. Develop a plan of care among the MO HealthNet participant, their healthcare coordinator, and allied health professionals to improve healthcare status and encourage healthy behavior;
6. Assist MO HealthNet parents who are not receiving temporary cash assistance to achieve independence. Modeled on Welfare Reform agreements, MO HealthNet independence agreements will be developed to help participants achieve improved health outcomes and self reliance;
7. Provide an opportunity for MO HealthNet participants to access other Medicaid-eligible services beyond the MO HealthNet benefit package. Participants may accrue credits by taking part in an approved list of health behaviors and use the credits for Medicaid-eligible services through MO HealthNet Plus;
8. Recognize the critical role of healthcare home providers who embrace the principles of the MO HealthNet program. Healthcare home providers are active contributors and integral to the success of MO HealthNet and the improved health status of participants. Healthcare home providers will have access to improved technology, incorporate evidence-based practice, engage participants in health risk assessments, and partner with providers. In recognition of the critical role of healthcare home providers, the working group recommends that physician-related reimbursement be increased;
9. Pay for performance measures be implemented to support providers for contributing to the health of MO HealthNet participants;
10. Expand strategies that reduce waste, fraud, and abuse and emphasize fiscal accountability through an efficient use of systems;
- 11-14. Reduce the number of uninsured Missourians. In 2005, the Census Bureau estimated 691,000 Missourians were uninsured. Strategies to increase health insurance availability include:
  11. Small employer premium offsets;
  12. Extending MO HealthNet Coverage to workers with disabilities;
  13. Extending MO HealthNet coverage to youth aging out of the foster care system; and
  14. Redefining affordability for MC+ for Kids (SCHIP).

(Departments of Social Services, Health and Senior Services and Mental Health, 2006)

**Appendix III**  
Interview Tool  
Interview Responses

Interviewee:  
Code number:

Interviewer:

### Questions

What is your involvement with the Transitional Medical Assistance (TMA) Program?

What is your understanding of the goals of the TMA Program?

What do you consider strengths of the TMA program?

What do you consider weaknesses of the TMA program?

What is the process for determining changes to the TMA Program?

How are changes in eligibility requirements determined?

Who determines what eligibility requirements need to change?

Why do eligibility requirements change for the TMA program?

What are some benefits of the TMA programs?

What are some constraints of the TMA program?

How did the TMA Program change with the 2005 Medicaid Reform?

What benefits arose out of the 2005 reform for the TMA program?

What constraints arose of the 2005 reform for the TMA program?

From your perspective, how have the changes in eligibility affected the TMA program and the number of uninsured Missourians?

What do you identify as the driving force(s) behind the changes that took place with the TMA program? Let me suggest a few among others: eligibility requirements, decrease of waivers for back-coverage, elimination of petitioning for a second year of coverage and such.

To what extent have these driving forces been beneficial?

To what extent have these driving forces been detrimental?

Considering all that has occurred, how has the TMA program helped MO HealthNet in achieving its goal of reducing the number of uninsured Missourians?

## **Interview Results**

### **1. What is your involvement with the Transitional Medical Assistance (TMA) Program?**

Interview participants consisted of eligibility specialists and area supervisors. State Representatives and Senators identified on the 2005 Medicaid Reform Commission Committee declined interviews. MO HealthNet Director declined an interview.

### **2. What is your understanding of the goals of the TMA Program?**

The interview participants communicated that the goals of the TMA program are to provide clients with health insurance coverage after obtaining employment, avoid losing Medicaid coverage for six-twelve months, and potentially leads to client self-sufficiency and ability to afford health insurance.

### **3. What do you consider strengths of the TMA program?**

The interview participants communicated that the strengths of the TMA program are that an individual does not lose insurance for becoming employed and covers the gap between an individual being able to enroll in employer-sponsored health insurance or obtaining private insurance.

### **4. What do you consider weaknesses of the TMA program?**

The interview participants communicated that weaknesses of the TMA program are: 1. Time-limited, only get coverage for 6-12 months; 2. If an individual quits their job, they cannot automatically receive Medicaid for Families, they must reapply; 3. If an individual loses job and receives unemployment, they lose TMA coverage and cannot qualify for Medicaid for Families; 4. Individuals often do not understand that TMA coverage is short-term; 5. If an individual has sporadic or seasonal work, they must explain the months with unearned income otherwise they face losing coverage; 6. Seasonal work income now applies to annual income to determine eligibility for MAF and TMA.

### **5. What is the process for determining changes to the TMA program?**

The interview participants communicated that all changes to the TMA program results from Federal legislative changes or by State waivers to the Federal Government to make changes.

### **6. How are changes in eligibility requirements determined?**

The interview participants communicated that the Federal Government determines the overall eligibility requirements and states may file a waiver to change income eligibility requirements. The interview participants communicated that Missouri's State Budget for Medicaid determines the income eligibility requirements.

### **7. Who determines what eligibility requirements need to change?**

The interview participants communicated that the Federal Government and State legislation determine what eligibility requirements need to change.



## **8. Why do eligibility requirements change for the TMA program?**

Interview participants communicated that eligibility requirements change because of available funding, change in administrative priorities, and political pressure.

## **9. What are some benefits of the TMA program?**

Interview participants communicated that benefits of the TMA are: 1. Individuals keep insurance for a period of time after obtaining employment; 2. States avoid uninsured individuals; 3. TMA can act as preventative care in that an individual is able to keep healthcare coverage and if any health issues arise, they are able to seek treatment; whereas, if an individual did not have healthcare coverage, they may avoid seeking care, causing the problem to worsen with potentially causing the State to provide more expensive healthcare coverage if disability results.

## **10. What are some constraints of the TMA program?**

Interview participants communicated that the constraints of TMA are: 1. Individual must have 3 months of eligible Medicaid for Families coverage to qualify for TMA; 2. Adult must remain employed to keep TMA; 3. Dependent child must remain in the household; 4. Individual must meet reporting requirements to extend TMA an additional 6 months; 5. Individual must remain in Missouri to receive coverage; 6. Individuals usually do not understand any correspondence sent to them regarding their coverage; 7. The computer system usually sends reporting forms late causing individuals to return forms late but computer system does not recognize this and terminates TMA coverage; 8. If an individual's report is not entered in the computer system on time, their TMA coverage automatically terminates whereas beforehand, caseworkers were responsible to overseeing this and terminating benefits.

## **11. How did the TMA Program change with the 2005 Medicaid Reform?**

Interview participants communicated that because of the 2005 reform, TMA experience the following changes: 1. An increase in the number of individuals eligible for TMA because individuals on Medicaid for Families became ineligible due to the new income eligibility restrictions; 2. Individuals who received TMA at the current time became ineligible for TMA because of income eligibility restrictions; 3. elimination of the extended TMA program and; 4. change in the budget for all Medicaid benefits

## **12. What benefits arose out of the 2005 reform for the TMA program?**

Interview participants stated that the benefits from the 2005 reform for the TMA program encourage people to work and seek jobs offering employment because it became difficult to meet income eligibility requirements for Medicaid or TMA. Interview participants communicated that the State benefited because there was a reduction in Medicaid spending and less adults on Medicaid for Families or TMA.

## **13. What constraints arose of the 2005 reform for the TMA program?**

Interview participants stated that the following constraints arose from the 2005 reform for the TMA program: 1. Income eligibility lowered to 20% of FPL; 2. Extended TMA, which offered coverage for up to 24 months, was eliminated; 3. The cost of insurance shocked individuals causing individuals to abstain from purchasing coverage

**14. From your perspective, how have the changes in eligibility affected the TMA program and the number of uninsured Missourians?**

Interview participants shared that they observed more uninsured Missourians because individuals did not understand that TMA only lasted 6-12 months and to receive the full 12 month coverage, individuals had to complete quarterly reports, fewer individuals eligible for TMA, and the new eligibility requirements restricted individuals from qualifying for Medicaid for Families and TMA.

**15. What do you identify as the driving force(s) behind the changes that took place with the TMA program? Let me suggest a few among others: eligibility requirements, decrease of waivers for back-coverage, elimination of petitioning for a second year of coverage and such.**

Interview participants stated that the State budget and the 2005 Medicaid Reform are the driving forces behind changes with the TMA program.

**16. To what extent have these driving forces been beneficial?**

Interview participants shared that the changes forced individuals to become more self-sufficient by finding own healthcare coverage; however, there is no system in place to follow up with individuals to determine if they have healthcare coverage—it is usually assumed. They also shared that the changes reduced Medicaid spending for the State.

**17. To what extent have these driving forces been detrimental?**

Interview participants shared that the changes take away coverage from individuals who need it and cannot afford it privately or obtain it through an employer; therefore, individuals become uninsured. Individuals who qualify for TMA had an opportunity to extend coverage for an additional 12 months, totaling 24 months, but the 2005 reform eliminated that opportunity.

**18. Considering all that has occurred, how has the TMA program helped MO HealthNet in achieving its goal of reducing the number of uninsured Missourians?**

Interview participants shared that from their observations, TMA is successful for the 6-12 months the individual has coverage; however, beyond that there appears to be no long-term effect. Missouri intended to create a state-sponsored health insurance program where individuals leaving TMA could purchase the same healthcare coverage if they could not afford private or employer-sponsored insurance or employer did not offer coverage. This program was never enacted.

**Appendix IV**  
IM-4TM Memo

## TRANSITIONAL MEDICAID

When your family loses eligibility for Medicaid for Families due to earnings, hours of employment, or loss of an income disregard, you are eligible for "Transitional Medicaid" coverage under Section 1925 of the Social Security Act. As long as there is an eligible child in your household, you can continue to receive a Medicaid card for six months after you are no longer eligible for Medicaid for Families. If you meet certain requirements you can receive a Medicaid card for an additional six months.

You need to tell us immediately if a child leaves your home. Additionally, during the full twelve month period, we will send you three reporting forms. If you do not return these reports by the due date, we will close your case and you will not be entitled to Medicaid for the remainder of the twelve months on this basis. **Save your wage stubs to send in with these reports.**

**REPORT #1:** At the end of the 3<sup>rd</sup> month, we will send you a reporting form. If you complete this form with all the information we ask about earnings and child care expenses for the 1<sup>st</sup> three months, you may be eligible for the additional six months. Be sure to return the completed form with wage stubs and child care receipts no later than the due date if you want the additional coverage.

**REPORT #2:** At the end of the 6<sup>th</sup> month, we will send you another reporting form. Complete this form with earnings and child care information and attach wage stubs and child care receipts for 2<sup>nd</sup> three months. We will use the information you report to decide if you are eligible for the next three months.

**REPORT #3:** At the end of the 9<sup>th</sup> month, we will send you another reporting form. Complete this form with earnings and child care information and attach wage stubs and child care receipts for the 3<sup>rd</sup> three months. We will use the information you report to decide if you are eligible for the next three months.

**For the 1<sup>st</sup> six months** you can lose Medicaid coverage only if:

- You no longer have an eligible child in the home
- We determined you received Medicaid for Families in any of the 6 months before closing by means of fraud.
- You are no longer a resident of the state of Missouri.

If you do not return the 1<sup>st</sup> report by the due date with required proofs attached, you will not be eligible for the 2<sup>nd</sup> six months.

**During the 2<sup>nd</sup> six months**, there are additional reasons you might lose Medicaid coverage. These are:

- Your income from earnings (less child care expenses you pay) is over 185% of the federal poverty limit.
- You have no earnings in at least one month of the 2<sup>nd</sup> or 3<sup>rd</sup> reporting period, unless we determine the loss of employment was beyond your control.
- You don't complete & return your report form by the due date.

**If you have any further questions regarding Transitional Medicaid, contact your caseworker.**

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