

Health-Related Welfare Rules

November 1996

Douglas J. Besharov
Kristina Tanasichuk White
Mark B. Coggeshall

November 15, 1996

INTRODUCTION

Before welfare reform at the federal level, many states had moved ahead with reform programs of their own to reduce the caseloads and the expenditures of their social welfare programs. In doing so, states requested and received waivers from the rigid requirements of federal welfare laws. Through this waiver process, states created numerous models for reform that share two common goals: To encourage recipients (1) to become self-sufficient and (2) to engage in responsible behavior toward themselves and their children.

Most attention has been paid to those waivers that seek to encourage work, but 21 states also applied for federal waivers to allow them to add rules to their welfare programs that focus on the family's behavior toward health care. This report describes these "health-related welfare rules."

Health-Related Rules: Section 1115(a) of the Social Security Act authorizes states to request waivers from specific provisions that govern the Aid to Families with Dependent Children (AFDC) and Medicaid programs. Twenty-one states have requested waivers to impose health-related behavioral requirements on welfare recipients; eighteen such waivers have been approved as of this writing.

Twenty of the waivers (and all 19 of the approved waivers) require parents to have their children immunized as a condition of receiving their full cash benefit. Most states are imposing these requirements on preschool children because of low immunization rates among children under two, and the absence of other mechanisms to assure that these children receive proper immunizations.¹ Florida, for example, requires welfare mothers to provide proof that their preschool children have received their vaccinations. Two states, Maryland and North Dakota, require that recipients keep their children in compliance with Medicaid's early and periodic screening, diagnosis, and treatment (EPSDT) schedule, a program that provides medical check-ups for children from birth to age 18. Three states, Mississippi, Montana, and Texas,² require that parents keep both their children's immunizations and EPSDT screens up-to-date. Some states, such as South Carolina, have adopted a somewhat different approach--requiring mothers

¹All school districts require immunizations as a precondition of school attendance.

²The Texas requirement that recipients have their children immunized and keep their EPSDT screens up-to-date took effect June 1, 1996, under a new waiver entitled "Achieving Change for Texans (ACT)," approved in March 1996. Formerly, Texas operated under a waiver entitled, "Promoting Child Health in Texas," approved in June 1995. This earlier waiver, now subsumed under ACT, only required that recipients immunize their children.

on AFDC to attend health and parenting classes. While several states require such classes in addition to requiring preschool immunizations or EPSDT screens, South Carolina is one of the few states to require the classes but not the preschool immunizations.³

Sanctions: To encourage parental compliance, these new waivers authorize a reduction in AFDC payments for noncompliance. In Michigan, for example, recipients lose \$25 per month for each of their nonimmunized children. In Colorado, if all children under two years of age are not immunized, the adult's portion of the grant is eliminated; in Georgia, the child's portion of the grant is eliminated.

Several states, including Montana and Delaware, increase the size or duration of the sanction when noncompliance continues. In Montana, a first-time failure to have a child immunized is subject to a one-month penalty equal to the adult's portion of the grant. If a second sanction is applied, the adult's portion of the benefit is eliminated for three months; a third sanction removes the benefit for three additional months. The fourth (and any subsequent) sanction results in the cancellation of the adult's portion of the benefit for 12 months. If recipients comply with the immunization requirement at any time during the sanction period, their benefits are not restored until the sanction period has expired. Similarly, Delaware reduces the benefit to its recipients by \$50 for the first month they do not comply and increases the sanction by \$50 for each subsequent month of noncompliance. Thus, the first month's sanction is \$50, the second month's is \$100, and so on.

Most states authorize specific "good cause" exceptions to these requirements or the imposition of sanctions. These usually include exemptions for families whose religious beliefs prohibit medical interventions or when a physician certifies that the child may suffer adverse reactions to the vaccine. States generally require families to provide a written letter from either a church or physician explaining why they should be granted an exception. It appears that Oklahoma, in its pending waiver, is the only state that provides no exemptions. Up to now, however, the U.S. Department of Health and Human Services (HHS) has not approved waivers that do not provide good cause exemptions.

The waivers generally require states to ensure that immunizations, or other required health care services, are accessible and available to all the families that

³Among the states that require only the classes, South Carolina alone is included in this survey as an example of this approach to encouraging AFDC recipients to live healthier lives.

are subject to the health-related mandate. Also, sanctions are not to be applied until the reason for noncompliance has been identified and any barriers to access have been addressed.

Judging from the few states that can provide data, it appears that most recipients are complying with the health rules. Some states report almost universal compliance: Texas, for example, reported that, as of August 1996, 158,036 children under age 6 were subject to its immunization requirement.⁴ Of these, 151,155 (95.6 percent) were in compliance, 1,648 (1.0 percent) were sanctioned, 1,203 (0.8 percent) were exempt, and 4,030 (2.6 percent) were subject to an alternate schedule. Michigan reported that, in June 1996, it sanctioned 153 cases out of a total caseload of 174,176.⁵

Implementation: All 19 of the states that have received waivers have started implementing their programs. In July 1992, Maryland became the first state to do so, followed by Georgia in January 1993. Three others (Michigan, Florida, and Colorado) began implementation in 1994, and an additional seven states began in 1995.⁶ The rest began implementation in 1996.

It usually takes a year or more for a program to become fully operational. Most of the states have adopted statewide programs, often slowly phasing in counties or recipient groups. Massachusetts, for example, adds families to its program as they apply for AFDC or when their eligibility is redetermined. Between November 1995 and May 1996, approximately 62,000 of the state's 86,000 AFDC cases were brought into the program.

A few states do not plan to implement their reforms statewide. Instead, a group of counties is usually selected as the site of the program. Some states will use the experiences in these sites in order to determine whether to implement the program statewide or to modify the program before doing so.

⁴Some eligible children were still being phased into the program and were not included in this total.

⁵The high reported rate of compliance in Michigan may be an overstatement of actual compliance. Sanctions are levied against only those parents who acknowledge that their children are not being immunized. Since the admission of noncompliance is followed by a sanction, the number of sanctions does not represent the actual rate of noncompliance; parents are sure to underreport. Moreover, caseworkers often do not want to impose sanctions either; so as long as parents tell them they will have their children immunized, the caseworkers may look the other way. In addition, the 174,176 cases cited represent the state's total caseload, including clients without preschool children who would not be subject to the sanction in any case. Similar means of verification and reportage are also used by other states.

⁶This figure includes the state of Texas, which implemented its first health-related waiver entitled, "Promoting Child Health in Texas," in 1995. Their second waiver was implemented on June 1, 1996.

For the most part, the state programs work something like this: At their first meeting with applicants, caseworkers (or eligibility workers) explain the rules of the program, including the sanctions for noncompliance. The worker then tells the family what documentation is needed to verify compliance. When recipients return for a reassessment of their eligibility, they must provide documentation of their compliance with all the requirements. If the family is not in compliance, and there is no good cause for the noncompliance, its benefit is cut by the specified amount.

At first blush, it might appear that elaborate new staff and management information systems would be needed within state agencies. However, it appears that the administrative burden associated with these health-related waivers has been relatively small. It may be that these requirements are not burdensome to implement or it may be that the states are not far enough along in the process to determine their need for additional resources.

Implementation can be more elaborate, however, as illustrated by Florida's experience. When state officials began implementing their program, they decided to co-locate many agency staff in the same building that staff for the new welfare reform would be housed. Each county established a health clinic and hired a public health nurse, case managers, eligibility workers, and counselors to help recipients comply with the program. The on-site nurse provides immunizations, primary care, and performs minor procedures. When AFDC recipients come to these sites and have not had their children immunized, they are simply referred to the nurse. To be sanctioned, the family would have to refuse to use the nurse.

Evaluation: How well do these programs work? Are parents, for example, immunizing their children more than they would have if they were not required to do so? To answer such questions, HHS requires states to submit a detailed evaluation plan with each waiver request. In response, some states have put extensive evaluations in place. Some have hired large, national firms, such as Abt Associates, Inc. or the Manpower Demonstration Research Corporation (MDRC). Others have hired local evaluators, often from a nearby university.

To determine whether an immunization requirement is successful, one may be tempted to simply observe changes in immunization rates over time. The problem with this approach, however, is that a number of factors unrelated to the requirement (for example, a media campaign to encourage immunizations) may affect immunization rates. To determine net impact, evaluators need to determine what would have happened in the absence of the new requirement.

While there are numerous evaluation methodologies, the federal government has insisted (until the signing of the 1996 federal welfare reform bill) that states evaluate their demonstration programs using an experimental design which randomly assigns recipients and applicants to either a control group (whose members are not subject to the new provisions) or an experimental group (whose members are subject to the new provisions).⁷ The random assignment assures that the two groups are comparable, differing only in their participation in the new "treatment"; any differences in outcomes can be attributed to the effects of the intervention. In theory, random assignment has a major advantage over other evaluation methods: the need for statistical modelling is minimized, since members of the experimental and control groups have similar demographic characteristics and are exposed to the same economic conditions.

Despite the federal guidelines requiring a rigorous evaluation, the existing state welfare reform demonstrations are generally not well-suited for evaluating the impact of immunization and other health-related requirements. First, most state demonstrations involve multiple program changes, such as time limits, expanded earnings disregards, and family caps, to name just a few. It is virtually impossible to disentangle the impact of any one provision in such cases. Non-health-related provisions may indirectly affect immunization rates. Thus, David Fein, Senior Associate at Abt Associates, Inc., cautions against simplistic extrapolations:

It can be dangerous to assume that only policy changes that are deliberately focused on a given outcome are likely to have caused observed impacts. Imagine that an intervention combining greatly intensified education and training efforts, strong incentives for school attendance and a cap on benefits for children conceived on AFDC is found to reduce birth rates by 10 percent. Although it may be tempting to attribute the impact to the family cap, the effect may really originate revised life priorities tied to new skills and occupational opportunities.⁸

The same problem can arise with an immunization requirement. For example, an intervention imposing stringent work requirements and an immunization

⁷The experimental and control groups together constitute the research sample. In most states, the research sample may be drawn from a limited number of sites and is not necessarily representative of the broader population subject to the new provisions. Also, as long as minimum sample size requirements are met, the research sample need not include all of the cases within the research sites.

⁸David Fein, "Waiver Evaluations: The Pitfalls--and the Opportunities," Public Welfare, Fall 1984, p. 29.

requirement may be found to increase immunization rates. This welcome increase should not be attributed only to the immunization requirement. It may be, for example, that the work requirements increased the employability of recipients and, thereby, induced them to behave more responsibly overall. This new sense of responsibility may have prompted them to have their children immunized in greater numbers, even in the absence of the immunization requirement.

A second issue concerning the measurement of the impacts of health-related interventions is related to data collection. For an immunization requirement, readily available AFDC or Medicaid records may include immunization status. However, to determine the net impact of an intervention, data on the outcome of interest, *e.g.*, immunization rates, must be collected on all cases assigned to the research sample, regardless of whether they still receive AFDC or Medicaid.⁹ This means alternative data sources are needed, because the AFDC and Medicaid records of inactive clients may not accurately reflect their immunization status. To assess the impact of immunization and other health requirements, most evaluators will rely on a survey. However, surveys have several problems. Respondents may not accurately recall their children's immunization status. Parents may remember whether their children have had any immunizations, but they are less likely to know if they are up-to-date on all immunizations.

In addition, low response rates on surveys, a common problem in this area of research, can introduce bias. If respondents differ in important ways from nonrespondents, then impact estimates generated by respondents may not accurately represent the population as a whole. Finally, while federal requirements mandate minimum sample sizes, these are for the demonstration as a whole. For immunization-related provisions, the number of families in the relevant subgroup, *e.g.*, those with preschool children, may be too small to detect modest differences in immunization rates.

In short, it is quite possible that the existing evaluations will not produce conclusive findings. However, this does not mean that the demonstrations are not having their intended effect, only that alternative evaluation approaches may have

⁹Although the immunization requirement applies only to active AFDC cases, many of the demonstrations may significantly affect the incidence of AFDC receipt (increased earnings disregards, for example, may allow working poor families to remain on assistance longer than they would have been able to in the absence of the intervention). This means that the characteristics of the subset of active AFDC cases within the experimental group is likely to be different than those receiving AFDC in the control group. To simply restrict the analysis to active AFDC cases, thus, would introduce bias. Moreover, such an evaluation approach would not permit over-time comparisons, since the cohorts would be constantly changing as clients exited and entered AFDC.

to be employed to reach more definitive conclusions about the impact of health-related waivers.

Of the 19 states with waivers, 14 have entered into contracts to evaluate their programs.¹⁰ Georgia released its first impact report in July 1996. Maryland and Delaware are expecting impact reports in December 1996; Utah expects to release the final impact report on its entire demonstration in March 2002. Florida expects to release its final report in September 1999, and Michigan is scheduled to release its first impact report with immunization data in 1998. Colorado expects to release an interim implementation report in September 1996; North Carolina expects to release one in September 1997. Montana expects to release some baseline data in early 1997 but has not scheduled the release date for its first impact report. Other states, such as Indiana, Louisiana, and Mississippi, have not scheduled any release dates. Virginia, Texas, North Dakota, South Carolina, Massachusetts, and states with waivers pending, have not engaged evaluators yet.

Difficulties with program implementation and data collection have delayed many of these evaluations. Georgia, for example, implemented its program in January 1993, but because of problems with the evaluator's contract and with data collection efforts, its first report with any impact data on the immunization requirement was delayed from its original due date of December 1995 to July 1996.

As of this writing, only Georgia and Maryland have released reports that begin to evaluate the impact of their programs. Although both reports are far from definitive, they are encouraging.

In Maryland, initial administrative data suggest that the health-related rules do not seem to pose a significant burden on recipients. Since January 1993, about 9 percent of the families in the program were sanctioned each month--and less than 1 percent of the families were out of compliance for seven to nine months.¹¹ In addition, the Maryland Department of Health and Mental Hygiene (DHMH) has reported a 42 percent increase in EPSDT screens since the program began. An actual impact evaluation is in process.

Although state officials attribute much of this increase to Maryland's new

¹⁰Tennessee and Maine have hired evaluators, but their recently approved waivers are not described in the state-by-state summaries that follow.

¹¹Maryland Department of Human Resources, Replication Study of PPI Clients Disallowed 7-9 Months (Baltimore, January 1995).

AFDC rules, embodied in its Primary Prevention Initiative (PPI), other factors also seemed to play a role. The Maryland Access to Care (MAC) project, for example, implemented in 1991, required all AFDC recipients to have a health care provider. In addition, a change in how data was coded made it easier to identify AFDC recipients who had gotten EPSDT screens. Moreover, the MAC and PPI projects both increased awareness of the value of preventive care in general, and of EPSDT screens in particular, which likely translated into sustained increases in their use.¹²

Georgia's Preschool Immunization Project (PIP) also is showing early promise. After the first two years of a four-year evaluation, an interim report by Abt Associates, Inc. concluded that the program was imposing only a "moderate" administrative burden on Georgia Division of Family and Children Services staff and "very little" burden on AFDC recipients. Abt also reported, for all five categories of immunizations targeted by the program, statistically significant increases ranging from 3.1 percentage points to 9.8 percentage points (described in greater detail below). While encouraging, this finding should be examined cautiously because only about half of the AFDC families in the treatment and control groups granted permission for evaluators to examine their children's immunization records. Consequently, the data indicating significant increases in all categories of vaccinations were probably distorted by self-selection biases. Families in the treatment group that were in full compliance with the immunization requirements were probably somewhat more likely to open their children's records to evaluators.¹³

* * *

Since the initial data for this report were gathered, four additional states have applied for health-related welfare waivers. Two of those waivers have already been approved, one is pending, and one has been withdrawn. Tennessee's Families First program requires AFDC recipients to assure that their children receive regular immunizations and medical examinations. The Department of Health and Human Services approved Tennessee's waiver on July 25, 1996, and program implementation began September 1, 1996. Maine's Welfare to Work waiver application was approved on June 10, 1996. The demonstration requires that children receive timely immunizations and regular check-ups. Implementation

¹²Joyce Underwood, Welfare Reform Program Manager, Maryland Department of Human Resources, telephone interview with Mark B. Coggeshall, August 30, 1996.

¹³Larry C. Kerpelman, David B. Connell, Michelle Ciurea, Nancy McGarry, and Walter Gunn, Preschool Immunization Project Evaluation: Interim Analysis Report, DHR Contract No. 427-93-51994, Abt Associates, Inc., May 1, 1996, p. 5-1.

began on August 1, 1996. Idaho applied for a waiver for its proposed Temporary Assistance for Families in Idaho program, which requires child immunizations, on August 9, 1996. Its waiver is pending HHS approval.

On July 2, 1996, West Virginia submitted a waiver for its West Virginia Works program, which would require child immunizations and apply progressive cash sanctions against the benefits of recipients who refuse to comply.¹⁴ However, the waiver has since been withdrawn.

The programs implemented by Tennessee and Maine, and Idaho's waiver application, are not described in the state-by-state descriptions that follow. However, these two programs and one waiver application were included in the figures cited in this introduction, *e.g.*, the total number of states with approved or pending health-related waivers. West Virginia was excluded from these figures because it withdrew its waiver application.

The 1996 federal welfare reform authorized the disbursement to the states of federal AFDC funds through Temporary Assistance for Needy Families (TANF) blockgrants. By rolling back federal oversight of state welfare agencies, this new law allows states to proceed with many programmatic changes without obtaining waivers. Those states that intend to implement such changes after the TANF authority takes effect have no reason to secure waivers from HHS. Consequently, it is anticipated that other states will follow West Virginia's lead and withdraw their waiver applications. In addition, after enactment of the new federal welfare law in August 1996, HHS began informing states with approved waivers that they could drop the control groups from their evaluations. HHS continues, however, to encourage states to use control groups in the expectation that more rigorous evaluations will yield more useful data. Nonetheless, South Carolina has recently dropped its control group, and it is likely that other states will also decide that a less rigorous evaluation will be more affordable and easier to carry through.

¹⁴Nancy Campbell, Program Analyst, Administration for Children and Families, Office of Planning, Research and Evaluation, U.S. Department of Health and Human Services, telephone interview with Mark B. Coggeshall, August 26, 1996.

This summary was compiled over an extended period of time from numerous written reports and telephone interviews. Every effort was made to ensure that the summary is accurate and current, but readers who wish to offer corrections and updates are invited to write the authors at:

Douglas J. Besharov
American Enterprise Institute
1150 17th Street, N.W.
Washington, DC 20036

STATE-BY-STATE DESCRIPTIONS

The following are detailed descriptions of each state program, including the actual health-related rules; the status of its implementation and evaluation; and any data available on compliance rates, sanctions imposed, and costs incurred by the agency to implement the program.

Colorado: Personal Responsibility and Employment Program

Waiver status: Approved January 13, 1994.

Rule: All AFDC recipients with children 24 months of age or under must report on a Monthly Status Report (MSR) that the child's immunizations are current.

Sanction: The adult portion of the AFDC grant.

Implementation status: Implementation for the five pilot counties (Jefferson, Adams, Mesa, Logan, and El Paso) began April 1, 1994.

Evaluation: The University of Colorado at Denver is conducting the state's evaluation. As yet, no data on immunizations are available.

Contacts: Maynard Chapman, Project Manager for Welfare Reform, Department of Human Services (303)866-2054.

* * *

Additional Information

Sanction administration: Recipients are required to report on an MSR that their children's immunizations are current. If the recipient fails to report that immunizations are current or in process, the adult portion of the AFDC payment will be withheld until appropriate verification is provided (unless good cause can be shown for failure to comply). After the determination is made that the immunizations are not current, parents have 60 days in which to start the vaccinations.

A face-to-face redetermination is not required, but a yearly redetermination via the MSR is required. Monthly status reports are sent to all families participating in the

program. Families with a change in circumstances return the monthly status report to the Department of Social Services.¹⁵ Immunizations are covered as a mandatory service under the state medical assistance program. No sanctions may be imposed without providing the recipient with an opportunity for a fair hearing in accordance with the "State Administrative Procedure Act."¹⁶

Delaware: A Better Chance: Contract of Mutual Responsibility

Waiver status: Approved May 8, 1995.

Rule: Requires children to be immunized as part of a contract of mutual responsibility.

Sanction: For all activities related to responsibility contracts, clients are subject to a \$50 grant reduction, increasing \$50 each month until compliance.

Implementation status: Statewide implementation began on October 1, 1995.

Evaluation: David Fein, Project Director at Abt Associates, is evaluating the program but no reports have been released. Abt estimates that the first interim report will be released in November or December 1996, but it will not include information on the individual activities, such as immunizations, in the responsibility contracts.¹⁷

Contacts: Jack Holloway, Executive Assistant to the Director, Division of Social Services (302)577-4880 x196.

* * *

¹⁵Colorado Department of Human Services, Special Projects, Staff Manual, Volume 12 (Denver, 1994).

¹⁶General Assembly of the State of Colorado, Personal Responsibility and Employment Demonstration Program, Senate Bill 93-129 (Denver, 1993), p. 7.

¹⁷Jack Holloway, Executive Assistant to the Director, Division of Social Services, State of Delaware, telephone interview with Kristina Tanasichuk White, April 18, 1996.

Additional Information

Additional staff requirements: No additional staff was hired. There was no major reorganization of workers' duties.

Sanction administration: Families eligible for the program are required to sign a Contract of Mutual Responsibility. Each contract is tailored to the individual family to specify which self-sufficiency requirements will be in the contract. Examples include employment activities, cooperation in securing child support, school attendance requirements, family planning, parenting education classes, substance abuse treatment, and immunizations. Families can object to certain provisions in the contract, but all are subject to the employment-related activities, school attendance, and immunization requirements. If the family does not have its children vaccinated according to the schedule recommended by the Advisory Committee on Immunization, the American Academy of Pediatrics, and the American Academy of Family Physicians, the staff will sanction the family until proof is provided that the immunization schedule has begun.

Florida: Family Transition Program (FTP)

Waiver status: Approved January 27, 1994.

Rule: Requires newly approved AFDC recipients with preschool children to begin state-mandated immunization; within one year recipients must submit verification from Department of Health or begin an immunization program at the redetermination site.¹⁸

Sanction: The portion of the AFDC grant attributable to any nonimmunized child.¹⁹

Implementation status: The state began implementation in two pilot counties, Escambia and Alachua, in February 1994. In Escambia County, participation in the Family Transition Program is mandatory; all eligible families are automatically enrolled. In Alachua County, participation is voluntary; eligible families are given information on the program and encouraged to enroll by signing an FTP

¹⁸Don Winstead, Welfare Reform Administrator, Department of Health and Rehabilitative Services, State of Florida, telephone interview with Kristina Tanasichuk White, March 14 and April 17, 1995.

¹⁹George Washington University's Center for Health Policy, Health Policy and Child Health (Washington, D.C.: George Washington University's Center for Health Policy, Spring 1994).

Participant's Agreement. Recipients are given up to one year to sign the agreement. Once signed, the family has a three-day grace period to withdraw from the program.²⁰

Evaluation: Barbara Goldman, Senior Vice President of Manpower Demonstration Research Corporation, is conducting the state's evaluation. The first interim report is due in October 1997, and the final report is due September 1999.²¹ MDRC's first report, "The Family Transition Program: An Early Impact Report on Florida's Time-Limited Welfare Initiative," was released in November 1995 but does not contain any information on the immunization component.

Contacts: Don Winstead, Welfare Reform Administrator, Health and Rehabilitative Services (904)921-5567; Barbara Goldman, Senior Vice President, Manpower Demonstration Research Corporation (212)532-3200; Dan Bloom, Senior Research Associate, Manpower Demonstration Research Corporation.

* * *

Additional Information

Additional staff requirements: Florida has located these new AFDC services in the same offices. Each pilot site has a health clinic on-site as well as case managers, eligibility workers, and a public health official. In Escambia County, the case manager's responsibilities include eligibility work. Escambia also hired one advanced nurse practitioner. In Alachua County, the state hired a physician's assistant, case managers, eligibility workers, and employee counselors.

Technological investments: In 1991, the state began to phase-in a statewide management information system, called FLORIDA, for all of its welfare programs. In 1994, when officials began to implement their welfare reforms (of which the immunization requirement is but a small component), they decided that the statewide system was too complex to adapt to the two pilot sites. Instead, the counties developed Local Area Networks (LANs), which are personal-computer based systems. As a result, staff must manually perform many key tasks, such as tracking the family's time limit and filling out the paperwork generated by the program's requirements. MDRC reports that, "Although staff thought that the

²⁰Dan Bloom, The Family Transition Program: An Early Implementation Report on Florida's Time-Limited Welfare Initiative, Manpower Demonstration Research Corporation, November 1995, p. 4.

²¹Barbara Goldman, Senior Vice President, Manpower Demonstration Research Corporation, telephone interview with Kristina Tanasichuk White, April 18, 1995.

LAN might improve their day-to-day lives by, for example, producing reports that they now produce manually, there were many complaints about duplicative work because the LAN is not directly linked to the FLORIDA...information system."²²

Sanction administration: In order to be sanctioned, recipients would have to refuse to have their children immunized. The eligibility worker at the site would impose the sanction. As of May 1996, only two persons had been sanctioned for noncompliance with the immunization requirement: one person for one month, another person for three months.²³

Evaluation status: A report scheduled for release in October 1997 will contain the first impact data, but the report data will provide little information about the impact of the immunization requirement. MDRC's first implementation report, however, provides early information on how staff in the pilot counties were adjusting to the new requirements and how well welfare recipients were informed about the new requirements. In these early stages of the evaluation, MDRC reports that the staff was having few difficulties with the new program. Staff at the two sites reported only one problem: Some staff were mistakenly applying the immunization mandate to all AFDC recipients with preschool children instead of applying the new requirement only to new AFDC applicants.

MDRC also conducted a small client survey to determine how familiar AFDC families were with the new requirements. In Escambia County, 55 experimental cases were interviewed, and 78 percent of respondents were aware of the immunization mandate.²⁴ In Alachua County, 45 experimental cases were interviewed, and 69 percent of respondents were aware of the immunization requirement.²⁵ MDRC concluded that the considerable number of respondents who were unaware of the requirement was not a cause for concern: "One would expect lower rates for these mandates because they do not apply to all FTP participants."²⁶ The sample of clients interviewed included some who are not subject to the requirement because they have no preschool children and, thus, have

²²Dan Bloom, The Family Transition Program: An Early Implementation Report on Florida's Time-Limited Welfare Initiative, Manpower Demonstration Research Corporation, November 1995, pp. 26 and 44.

²³Don Winstead, Welfare Reform Administrator, Department of Health and Rehabilitative Services, State of Florida, telephone interview with Kristina Tanasichuk White, May 13, 1996.

²⁴Dan Bloom, The Family Transition Program: An Early Implementation Report on Florida's Time-Limited Welfare Initiative, Manpower Demonstration Research Corporation, November 1995, pp. 46-47.

²⁵Dan Bloom, The Family Transition Program: An Early Implementation Report on Florida's Time-Limited Welfare Initiative, Manpower Demonstration Research Corporation, November 1995, pp. 56-57.

²⁶Dan Bloom, The Family Transition Program: An Early Implementation Report on Florida's Time-Limited Welfare Initiative, Manpower Demonstration Research Corporation, November 1995, p. 48.

no need to be aware of it.

Georgia: Georgia Preschool Immunization Project (PIP)

Waiver status: Approved November 17, 1992.

Rule: Immunizations are required for all children on AFDC who are age six and under and who are not yet enrolled in school.

Sanction: The child's portion of the AFDC payment. If an only child is sanctioned, the client is not eligible to receive AFDC.²⁷

Implementation status: Statewide implementation began in January 1993.

Evaluation: Larry Kerpelman, Vice President of Abt Associates, is conducting the state's evaluation. The annual report, entitled "Preschool Immunization Project Evaluation: First Annual Report," was released June 12, 1995. An interim report was submitted to Georgia officials on May 1, 1996, entitled "Preschool Immunization Project Evaluation: Interim Analysis Report." The report concludes that PIP's first two years of implementation resulted in substantial increases in vaccination rates. The final report is due March 1, 1999.²⁸

Contacts: Nancy Meszaros, Consultant, AFDC/FS Policy Unit, Division of Family and Children Services, Department of Human Resources (404)657-3608; Diane Simms, Consultant, AFDC/FS Policy Unit, Division of Family and Children Services, Department of Human Resources (404)657-3603.

* * *

Additional Information

Sanction administration: Caseworkers in the Department of Family and Children Services are required, at application, to explain the immunization requirement, the Early Periodic Screening, Diagnosis and Treatment (EPSDT) services available through the Public Health Department, and how the client can obtain these

²⁷Georgia Department of Human Resources, Georgia AFDC Immunization Requirements Program Manual.

²⁸Larry Kerpelman, Ph.D., Vice President, Abt Associates, Inc., telephone interview with Kristina Tanasichuk White, April 18, 1995.

services. (The state is also required to explain the immunization requirement to clients already receiving AFDC during each review of their eligibility.) Caseworkers then give clients the Appointment Letter and Verification Checklist (See Attachment A) to request an original, photocopy, or computer generated version of Department of Human Resources Form 3227, the Child Care Immunization Certificate. The certificates are available to the applicant from the health care provider who immunizes the child.

Caseworkers must then inform clients of their obligation to continue the immunization series and that their adherence will be verified at each standard and alternate review of eligibility.²⁹

If proof of compliance is not provided, the caseworker eliminates the child's portion of the AFDC grant. The caseworker also sends a notice indicating the reason for the sanction, the action necessary to make the child eligible, and information about AFDC-related Medicaid (ARM). The client is given a 10- day grace period during which the state holds the sanction action. If the client has not taken the necessary action within 10 days, a sanction is imposed.³⁰

Current recipients were notified of the immunization requirement in an insert to the envelop containing their December 1992 AFDC check (See Attachment B). Recipients were advised to provide proof of immunization for preschool age children at the next review of eligibility.

In the first two years of implementation in Muscogee County, 20 warnings were issued to experimental group clients threatening to impose sanctions for noncompliance, including three erroneously issued to control group families. Eleven of these warnings (all issued to treatment group families) were followed by sanctions affecting a total of 18 children. Eight of the 11 sanctioned families complied and were reinstated to full benefits after periods ranging from one to six months. Thus, over two years, only 1.5 percent of treatment families were warned and slightly less than 1 percent were sanctioned.³¹

²⁹When the program was first implemented, the state accepted the client's statement that the child was continuing the immunization program. However, the state later changed the verification policy to require staff to monitor immunizations more carefully and to request verification at every standard and alternate review of eligibility. The client's statement was no longer acceptable verification.

³⁰Nancy Meszaros, Consultant, AFDC/FS Policy Unit, Division of Family and Children Services, Department of Human Resources, State of Georgia, telephone interview with Kristina Tanasichuk White, March 8, 1995.

³¹Larry C. Kerpelman, David B. Connell, Michelle Ciurea, Nancy McGarry, and Walter Gunn, Preschool Immunization Project Evaluation: Interim Analysis Report, DHR Contract No. 427-93-51994,

Evaluation status: The immunization rules are statewide in scope. For purposes of evaluation, however, a control group of 1,000 families and an experimental group of 1,500 families have been established in Muscogee County. The evaluation design is as follows: Members of the control group were encouraged to immunize their preschool children but were not told that they would be sanctioned if they did not comply. All other families were told that they would be sanctioned if they did not immunize their preschool children. The state's evaluation seeks to answer three questions: (1) Will there be a statistically significant difference in the age-appropriate and timely vaccination rates among preschool children in the experimental but not in the control group? (2) Will the program be an unreasonable burden (financial and otherwise) for the client families? and (3) Will the program be an unreasonable burden on the administration of AFDC?

In the first year, Abt focussed on becoming familiar with the welfare program waiver, the administration of services in Muscogee County, the electronic and paper files of welfare recipients, and the health care provider network in Muscogee County. Abt also started to collect and review the case files of the experimental and control families in the study from the welfare office and from the medical providers in the county.

There were two set-backs in the first year of Abt's study. First, Georgia canceled the evaluation contract with Abt for five months. During this time, all activities stopped. Second, the Centers for Disease Control (CDC) initially requested that Abt collect some data on health services while they were collecting data from immunization records. The CDC withdrew its request "just at the point when this additional data collection was about to be instituted."³²

Evaluators also had difficulty with the case files of clients on welfare. When they first began data collection, researchers were told to identify relevant client forms by numbers printed across the bottom of the forms. Quality control checks on a sample of files, however, found that 30 percent of the sample files were missing forms needed for accurate data reporting. The numbers of the necessary forms had been cut-off when the forms were copied so the researchers were not able to identify them correctly. Researchers re-reviewed 1,422 of the 1,700 files, and the quality of the data improved.

Abt Associates, Inc., May 1, 1996, p. 3-11.

³²Larry Kerpelman, David Connell, Nancy Burstein, and Walter Gunn, Preschool Immunization Project Evaluation: First Annual Report, DHR Contract No. 427-93-51994, Abt Associates, Inc., June 12, 1995, p. 2-1.

Two other problems with the files eventually surfaced. When the files were re-reviewed, 207 of the files were missing 647 forms which had been found and copied on the earlier review. Abt looked into this discrepancy and found that the DFCS office had only provided Abt's staff with the most recent files on recipient families, meaning that if there were multiple files on the family, Abt was only given the most recent one. Abt also found that between 50 and 100 of the case files provided to its staff in their second review were not originally listed as part of the study.

In May 1996, the first report on the program's impact, "Interim Analysis Report," was released by Abt. According to the report, the administrative burden PIP placed on Division of Family and Child Services (DFCS) requires a "moderate level of effort."³³ Abt measured the added staff burden associated with these requirements in Muscogee County, for the period January 1, 1993 through October 17, 1995. Abt found that intake workers spent an extra 27 minutes per client on activities related to PIP; most of this time was spent completing extra forms and reviewing and documenting immunizations. Ongoing case workers spent an extra 7.25 minutes per client on activities related to the immunization requirement at each recertification. There were generally two recertifications per year per client. Abt's report indicated that about half the clients failed to provide proof of immunization at the time of recertification, and that it took workers about one minute to deal with this matter. Other staff were also affected by the immunization requirement, but to a much smaller degree. The report's bottom-line conclusion is that "the administrative burden on DFCS, on an annualized basis, to administer the PIP is moderate (roughly one full-time equivalent)."³⁴ It is not clear whether this burden was met by actually hiring an additional staff person, or whether existing staff compensated by spending less time on other activities.

Abt also concluded that PIP imposed "very little burden" on the clients.³⁵ To measure client burden Abt selected 50 active clients for brief interviews. Abt was unable to contact 27 of the 50 clients selected; two others were no longer AFDC recipients or had no children under seven years of age. Thus, only 21 interviews were successfully conducted, and these form the basis for Abt's analysis of client burden.³⁶ Twelve of the interviewees obtained written proof of their children's immunizations during a regularly-scheduled physician or clinic visit and, thus, had

³³Preschool Immunization Project Evaluation: Interim Analysis Report, p. 5-1.

³⁴Preschool Immunization Project Evaluation: Interim Analysis Report, p. 5-3.

³⁵Preschool Immunization Project Evaluation: Interim Analysis Report, p. 5-1.

³⁶Preschool Immunization Project Evaluation: Interim Analysis Report, p. 4-16.

no compliance burden. The remaining nine respondents had to make a special trip to the physician or clinic, requiring an average of two hours and minimal transportation costs, to obtain the required proof. Eighteen of the 21 clients interviewed reported "hearing or seeing additional information" about childhood immunization.³⁷

Abt's interim report also suggests that the program successfully raised immunization levels. Abt found significant increases in all five categories of required vaccinations: (1) diphtheria, tetanus, and pertussis (DTP); (2) polio; (3) measles, mumps, and rubella (MMR); (4) hemophilus influenza type b (Hib); and (5) hepatitis B.³⁸ However, a number of problems undermine the confidence that can be placed in these findings.

First, using data only from the experimental group, Abt found the following increases after two years of the program's operation: DTP (from 54.6 percent to 61.6 percent), polio (from 59.4 percent to 77.7 percent), MMR (from 72.5 percent to 82.7 percent), Hib (from 15.2 percent to 20.5 percent), hepatitis B (from 1.8 percent to 16.9 percent). However, as described below, these changes do not necessarily reflect the net impact of the demonstration. One would expect a gradual increase over time, even in the absence of the demonstration, since children have to be immunized by the time they enroll in school. Since the evaluation follows the initial cohort, more and more of the children reach school age in each successive year. This, in itself, could explain the increasing trends.

Furthermore, these data are only from about half the experimental group, since cooperation was voluntary and only 48.1 percent of the recipients granted the evaluators permission to examine their children's immunization records.³⁹ This may introduce two forms of bias. First, the impact for the 51.9 percent of recipients whose immunization records are not included may be very different than the impact for those whose records are available. It is not clear how large, or in which direction, this possible nonresponse bias may distort the data. Selection bias arises if the characteristics of those for whom immunization records are available differ systematically from those in the control group. For example, it may be that those who were in compliance were more likely to open their records to the evaluators--a reasonable assumption, since those who are behind may hesitate to participate for fear of being sanctioned. The data suggest the occurrence of one or both of these biases: for three of the five types of vaccines,

³⁷Preschool Immunization Project Evaluation: Interim Analysis Report, p. 4-17.

³⁸Preschool Immunization Project Evaluation: Interim Analysis Report, p. 5-1.

³⁹Preschool Immunization Project Evaluation: Interim Analysis Report, p. 4-3.

there were statistically significant differences in initial vaccination rates between the experimental and control groups.⁴⁰

Finally, there was a problem in how workers implemented the program. Although the report concludes that PIP has been implemented "diligently" in Muscogee County, it also notes significant deviations from prescribed procedures. For example, there were instances in which clients were not issued warnings about potential sanctions when they should have been, which had the effect of weakening the "warning-sanction process."⁴¹

Some ongoing caseworkers said that they do not discuss immunization requirements with members of the control group even though control families are supposed to be encouraged to have their children immunized (although not threatened with sanctions if they do not). Conversely, another ongoing caseworker stated that he had been requiring members of both groups to have their children immunized. However, Abt concluded that "any failure to follow prescribed procedures works, on the whole, to dilute the impact of the PIP on immunizations, either through inadvertently bringing the 'treatment' to the control group families, through clouding the warning-sanction process, or through making it less clear what immunizations are being received."⁴²

To deal with some of these problems, especially the lack of comparability between the control and experimental groups, Abt measured the change in the relative differences in vaccination rates between the two groups. Thus, for example, the percentage up-to-date for DTP immunizations in the experimental group was 54.6 percent on the date of implementation as compared to 49.3 percent in the control group, a difference of 5.3 percentage points. The evaluators used that figure as a baseline against which to compare the widening of the margin of difference over the subsequent two years. Abt found that, for all vaccines, PIP led to a statistically significant widening of the differences at baseline between the experimental and control groups. Abt concludes that in 1995, as a result of PIP, DTP immunizations among experimental group children increased 5.8 percentage points more than would otherwise have been the case. The increases for other immunizations were: 9.8 percentage points for polio vaccinations; 6.9 percentage points for MMR vaccinations; 3.1 percentage points for Hib immunizations; and 8.1 percentage points for Hepatitis B vaccinations.

⁴⁰Preschool Immunization Project Evaluation: Interim Analysis Report, p. 5-1.

⁴¹Preschool Immunization Project Evaluation: Interim Analysis Report, p. 3-9.

⁴²Preschool Immunization Project Evaluation: Interim Analysis Report, p. 3-9.

Subject to the methodological and implementation problems discussed above, these are impressive results.

Indiana: Indiana Manpower Placement and Comprehensive Training Program

Waiver status: Approved December 15, 1994.

Rule: Recipients are required to submit proof that all children for whom they receive benefits have all standard childhood immunizations up-to-date.⁴³

Sanction: \$90 per adult, per month. If there are two parents in the household, the sanction can reach up to \$180 per month.

Implementation status: Statewide implementation began May 1, 1995.⁴⁴

Evaluation: Abt Associates, Inc. (David Fein, Project Director), in conjunction with the Urban Institute, has been under contract since December 1995. Abt has submitted a design for the evaluation of the entire program, including the immunization component. Indiana randomly assigned a total of 12,000 families to either the treatment (8,000 families) or the control group (4,000). Abt plans to collect data from: (1) a client survey, (2) a new statewide database monitoring system that, by late 1996 or early 1997, will record data on all children immunized by public health providers, and (3) Medicaid reimbursement records. There is no specific schedule for when reports will be released.

Contacts: Tom Reel, Director, Indiana Manpower Placement and Comprehensive Training Program (IMPACT), Family and Social Services Administration, Division of Family and Children (317)232-7098; Charlene Burkett-Simms, Manager, Family Independence Section, Family and Social Services Administration, Division of Family and Children (317)232-4923.

* * *

⁴³State of Indiana Family Social Services Administration, Immunizations for Children of AFDC Recipients Assigned to the Treatment Group, Operational Directive Manual of Policies and Procedures (Effective May 1, 1995).

⁴⁴Tom Reel, Director, IMPACT, and Jim Martin, Program Manager, State of Indiana, conference call interview, March 10, 1995.

Additional Information

Sanction administration: Recipients must show proof of immunization for all eligible children at application and redetermination. *At application:* If recipients (who are not in the control group) provide medical documentation which clearly establishes that all the AFDC children have received their scheduled immunizations, the caseworker may accept this documentation and not require the recipient to secure additional information from the immunization provider. The caseworker then completes the Indiana Immunization Certificate (IIC) (See Attachment C) and maintains it in the recipient's case file. If the recipient's documentation is not clear, the caseworker gives the client the IIC and the Indiana State Department of Health (ISDH) Immunization Record (See Attachment D). Within ten days, the client must go to an immunization provider for review and signature and then return the completed forms to the caseworker. The immunization record is placed in the client's file and the caseworker tells the client to keep the completed record for future use. *At redetermination:* The caseworker will review the IIC. If a child was due to receive an immunization, the caseworker will ask the recipient for documentation. If the recipient cannot provide proof of immunization, she must take the ISDH Immunization Record and the original IIC to the immunization provider for updated information. If the recipient does not have the Immunization Record, the caseworker re-issues both the Immunization Record and the IIC to the recipient. Within ten days, the recipient must return with proof of immunization. The Immunization Certificate is filed and the Immunization Record card is returned to the recipient. If, for any reason, the immunization records cannot be obtained, the child, no matter what age, must start the immunization schedule from the beginning.

Within ten days, if the AFDC adult recipient (1) fails to provide proof of immunization, or (2) fails to return the IIC and the Immunization Record, or (3) does not provide signed waivers based on religious or medical reasons, the eligibility caseworker in the local office of the Division of Family and Children will review the information and determine whether a sanction will be imposed. If a sanction is imposed, the family's AFDC benefits will be reduced by \$90 per adult recipient, per month, until documentation is produced. If the family is not sanctioned, a grace period of not more than ten calendar days can be granted to comply. Under no circumstances will the recipient "earn back" the \$90 per adult recipient per month once the child receives immunizations. The \$90 will not be prorated if the recipient brings records in during the month.

If a parent indicates an inability to obtain immunizations, the local health

department can be contacted to obtain a "Nurse/Clinic Technician Master Schedule." These are teams which visit specific local sites in counties to provide health services. Clients are to be referred to these locations. The caseworker also provides the "ISDH Address List for Local Health Department and Local Health Offices," which identifies free or low-cost immunization clinics.⁴⁵

Sanction administration: Agency records include some information about the number of sanctions for failure to comply with immunization policy. Indiana officials estimate approximately 500 to 600 sanctions (not an unduplicated count per child) had been imposed as of March 1996. Their monthly sanction reports should provide a more accurate count.⁴⁶

Louisiana: Family Independence Project

Waiver status: Approved February 5, 1996.

Rule: Parents must immunize all children under 18 years of age, according to the schedule from the Office of Public Health in the Department of Health and Hospitals. Evidence that the children are in the process of completing their immunization series is also admissible.

Sanction: The child's portion of the grant is eliminated for each child who is not immunized. The grant is restored as soon as the child is immunized or, in the case of a series of inoculations, as soon as the child has begun the series.

Implementation status: Statewide implementation will begin January 1997.

Evaluation: The state has selected Louisiana State University (LSU) to conduct the evaluation. However, the formal evaluation design has not been finalized. The immunization requirements will be implemented statewide, but their impact will be evaluated in only two parishes (probably Livingston and East Baton Rouge). Throughout the first month of implementation, some active AFDC cases in the two evaluation parishes will be randomly assigned to either a control group, members

⁴⁵State of Indiana Family Social Services Administration, Immunizations for Children of AFDC Recipients Assigned to the Treatment Group, Operational Directive Manual of Policies and Procedures (Effective May 1, 1995).

⁴⁶Tom Reel, Director, Indiana Manpower Placement and Comprehensive Training Program (IMPACT), Family and Social Services Administration, Division of Family and Children, State of Indiana, telephone interview with Kristina Tanasichuk White, March 29, 1996.

of which will be encouraged to immunize their children but will not be sanctioned, or an experimental group, members of which will be sanctioned for failing to comply with the immunization regulations. AFDC recipients in the evaluation parishes who are not assigned to the control or experimental groups will be subject to the immunization requirements and the sanctions, but their cases will not be tracked for purposes of program evaluation. At the conclusion of the first month of implementation, the state will cease assigning active AFDC recipients to the control and experimental groups. Thereafter, throughout the remainder of the five-year evaluation period, only new AFDC applicants will be assigned to the evaluation groups.

State officials have yet to decide whether to adopt the stratified sampling mechanism LSU has recommended. If the stratified sampling mechanism is adopted, 750 cases will be assigned to each of the two evaluation groups during the first month of the evaluation period, and 750 additional cases (all new AFDC applicants) will be assigned to the evaluation groups during the remaining years of the evaluation period. The sample size will then total 3,000 cases.⁴⁷

Contacts: Christine Sutton, Director of the Assistance Payments Program, Office of Family Support, Department of Social Services (504)342-2890; Garry Russell, Coordinator-Supervisor, Family Support Program, Office of Family Support, Department of Social Services (504)342-2507.

Maryland: The Maryland Primary Prevention Initiative (PPI)

Waiver status: Approved July 1, 1992.

Rule: Rules cover preventive health care for all family members.

Preschool children. Except for 5,000 control cases, the heads of AFDC case units must show proof that their preschool children have met the following schedule of health check-ups: for children 0-18 months, at least one check-up by a doctor every six months; for children 19 months-6 years, at least one check-up by a doctor every year. Preventive health check-ups must include immunizations, unless contraindicated due to the child's medical condition or religious restrictions.

School-Aged Children and Adults. All families on AFDC are given a \$20 bonus

⁴⁷Garry Russell, Coordinator-Supervisor, Family Support Program, Office of Family Support, Department of Social Services, State of Louisiana, telephone interview with Mark B. Coggeshall, August 22, 1996.

per year for each school-aged child or adult who provides proof of an annual preventive health check-up. (Check-ups at family planning clinics meet this criteria.)

Pregnant Women. Any pregnant women in an AFDC family who shows proof of pregnancy and of regular prenatal care receives a monthly bonus of \$14 to cover nutritional needs. Any pregnant woman applying for AFDC during the third trimester of her pregnancy, and who has no other children, receives both the nutritional allowance and an additional pregnancy needs allowance of \$33.

Sanction: \$25 per month for each preschool child who does not meet the preschool health criteria without good cause. These sanctions are called "disallowances." Health rules for school-aged children and adults are not considered requirements and carry no sanctions. They provide clients with opportunities for earning bonuses.

Implementation status: Statewide implementation began July 1, 1992.⁴⁸

Evaluation: Larry Thomas, Director, Schaefer Center for Public Policy, University of Maryland at Baltimore, is conducting the state's evaluation. With the exception of 5,000 cases in a control group, all of the state's 75,000 AFDC cases are subject to PPI rules, with 10,000 of these in an experimental group for which data is being collected. The experimental and control groups were selected from cases in Baltimore City (3 offices), Prince George's County (1 office), Wicomico County, and Allegheny County.⁴⁹

Contacts: Katherine Cook, Director, Office of Policy Administration, Family Investment Administration (410)767-7113; Larry Thomas, Director, Schaefer Center for Public Policy, University of Maryland at Baltimore (410)837-6188.

* * *

Additional Information

Additional staff requirements: The state hired 50 Targeted Case Managers (TCMs) for special support services (discussed in further detail below).

Sanction administration: The PPI rules are explained to clients at each application

⁴⁸Department of Human Resources, State of Maryland, The Primary Prevention Initiative Fact Sheet.

⁴⁹Department of Human Resources, State of Maryland, Welfare Reform in Maryland: The Primary Prevention Initiative (Baltimore, December 1994), p. 7.

and at each redetermination. The rules are explained again, with an offer of service after a family has been sanctioned for three months, and again after nine months of sanctions.

The main vehicle for communicating with clients about PPI is the face-to-face meeting between the client and the income maintenance worker. Such meetings occur when the client applies for AFDC, and again every six months when the client's AFDC grant comes up for redetermination. At these meetings, workers are required to explain the PPI programs and its rules and ask clients if they would like to be referred for services to help improve their children's health care.

Whereas some states accept the client's statement as sufficient verification of compliance, Maryland requires official verification that health care check-ups have been completed. Applicants for AFDC are required to sign a form declaring that they understand their responsibilities under PPI and will make sure that their preschool children are up-to-date on health check-ups. Then, at the biannual redetermination meetings, clients are required to submit documentation of their children's health visits, signed by a doctor. Such documentation may include either the Department of Human Resources' (DHR's) special PPI Preventive Health Care form; a statement on doctor's stationery or a prescription pad signed by the doctor; or information contained on the "Healthy Kids Card," a separate program of the Maryland Department of Health. The income maintenance worker gives the applicable verification forms to the client at the time of application for AFDC and mails them out in advance of each scheduled redetermination. Documentation with a doctor's signature is also required to qualify for any of the health care bonuses.

The income maintenance worker is responsible for making changes to the client's AFDC grant to reflect the imposition of new disallowances, removal of old disallowances (when proof of compliance is provided or good cause is claimed), and qualification for bonuses. Such changes are accomplished by updating the state's automated files. The computer automatically recalculates the client's grant based on new information about disallowances.

Since January 1993, most clients have been in compliance with the PPI requirements. Fewer than 10 percent of cases are out of compliance each month; fewer than 1 percent are out of compliance for 7 to 9 months; but more than two-thirds of even these hard core cases achieved compliance within 12 months.⁵⁰

⁵⁰Department of Human Resources, State of Maryland, Replication Study of PPI Clients Disallowed 7-9 Months (Baltimore, January 1995).

Because most clients achieve compliance quickly, Maryland (including DHR and the legislature) has focused special attention on those few clients who experience long-term, continuous disallowances. To learn more about these cases, DHR conducted three studies of cases with long-term disallowances: an initial study based on a random sample of 295 cases with disallowances of 7 to 9 months as of October 1993; a follow-up study of the clients from the 1993 study that were still being disallowed in March 1994 (97 cases); and a replication of the 1993 study using a new random sample of 320 cases with 7 to 9 month disallowances as of March 1994. All of these studies looked at compliance with both the health and education requirements of PPI. Key findings from this research include:⁵¹

- The typical long-term disallowed client was a single, African-American mother in her late 20s or early 30s whose only child had a preschool health disallowance.
- Preschool health disallowances are more common than school-aged education disallowances. However, the ratio seems to be evening out with time.
- Most of these cases came into compliance by the twelfth month of sanctioning. Thus, the imposition of sanctions seems to have an effect on behavior sooner or later.
- Long-term disallowances are geographically concentrated in a few Baltimore City districts.
- Few clients with long-term disallowances take advantage of the opportunities for health bonuses.
- Workers' communication with clients about PPI improved significantly over the two years between the first and third studies.
- Nonetheless, the three studies found misapplications of PPI policy ranging from 8 percent to 20 percent of study cases. This may mean that income maintenance workers still do not understand the policy as well as they should or that some other factors hinder them from applying it correctly in all cases.

⁵¹See Department of Human Resources, State of Maryland, Replication Study of PPI Clients Disallowed 7-9 Months (Baltimore, January 1995).

Of those with long-term sanctions (exceeding three months) most are disallowed for preschool health requirements (77 percent) rather than for school attendance requirements (23 percent); and 88 percent are concentrated in three districts in Baltimore City.⁵²

The approximately 5,000 active AFDC cases in Baltimore City (the largest number of active cases in the study) may be one of the reasons for the high concentration of long-term disallowances.⁵³ But there may be other reasons as well. On average, client families in Baltimore City, for example, are larger and receive higher payments. The average number of adults in a case is .9533 versus .7972 in other experimental sites; the average number of children is 2.2289 versus 1.4259. Since assignment, the total AFDC grant amount per case in Baltimore City is \$7,940.97 versus \$3,639.02 in other experimental sites.⁵⁴ Children in these families may not be in compliance with PPI requirements because, as some studies suggest, children in larger families tend not to be immunized on time regardless of AFDC reciprocity.⁵⁵ It is also possible that, because families in Baltimore receive larger payments, they may not feel the bite of the sanction as much as other families in the study. Whatever the reasons for the long-term disallowances, the interim evaluation report shows a 50 percent decrease in the number of long-term disallowances in Baltimore from December 1994 to June 1995.⁵⁶

Special support services: The Maryland Department of Human Resources makes various services available to assist families in making full use of preventive health care. Every client is offered services at application and at each redetermination. The PPI services are voluntary.

Outreach is defined as a contact with the client in which the client is offered service and good cause is explained.⁵⁷ Outreach activities may include letters,

⁵²Department of Human Resources, State of Maryland, Replication Study of PPI Clients Disallowed 7-9 Months (Baltimore, January 1995).

⁵³The Schaefer Center for Public Policy, University of Maryland at Baltimore, Maryland's Primary Prevention Initiative: An Interim Report, November 22, 1995, p. 266.

⁵⁴The Schaefer Center for Public Policy, University of Maryland at Baltimore, Maryland's Primary Prevention Initiative: An Interim Report, November 22, 1995, p. 266.

⁵⁵Stanley Schaffer and Peter Szilyagi, "Immunization Status and Birth Order," Archives of Pediatrics and Adolescent Medicine Vol. 149, No. 7 (American Medical Association, July 1995), p. 792.

⁵⁶The Schaefer Center for Public Policy, University of Maryland at Baltimore, Maryland's Primary Prevention Initiative: An Interim Report, November 22, 1995, p. 266.

⁵⁷Good cause is a grace period from a disallowance which can be in effect up to three months while the client works with the local Department of Social Services or another service provider to improve preventive health care and school attendance behaviors.

telephone calls, or face-to-face visits, either at the client's home or at the local Department of Social Services office. Clients who are disallowed for three consecutive months and who do not request services are automatically referred for outreach contact by a TCM worker. If the case is actively involved in another DHR service such as Child Protective Services or Intensive Family Services, the assigned worker may perform the outreach. A second outreach contact should occur after nine consecutive months of disallowance. A client can request help from a TCM worker at any time.

As of March 1994, a letter alone will not be considered outreach; the letter must be followed by a phone call, home visit, or meeting. At least three attempts must be made to reach the client before the outreach case is closed, with priority given to families with the largest grant reductions. Cases with three or more disallowances and those disallowed for nine consecutive months receive a home visit.

The decision to claim good cause is up to the client. Clients can only claim good cause in two instances during the five years of the project.

Other services connected with PPI include a Targeted Case Management Program that provides up to 90 days of counseling and case management (renewable for another 90 days) focused on helping clients make long-term changes in their health and school behavior. TCM workers meet with clients to develop a service agreement that specifies tasks to be completed by both the worker and client and, in some cases, other members of the family. TCM tasks range from supportive counseling and simple reminders to the client to submit missing documentation, to calling HMOs to make appointments, making contact with schools, and arranging for "flex" funds to help with special financial needs. Note that TCM services are not intended to resolve deep-seated problems, such as substance abuse or child abuse. Clients needing help for these problems are referred to more experienced, trained DHR staff or other agencies, as appropriate.⁵⁸

A representative random sample of 247 cases was collected to survey how clients perceived the program's services. The survey found that only 209 of these cases received outreach from a service worker; the other 38 cases either requested services without outreach or responded to offers made by an Income Maintenance worker. Just under one-third of the clients accepted an offer of TCM services.

Beyond TCMs, 21 of the study cases were referred to another community service,

⁵⁸Maryland Department of Human Resources, Welfare Reform in Maryland: The Primary Prevention Initiative (Baltimore, December 1994), p. 5.

including six to the Baltimore Health Department, two to Child Protective Services, and two cases referred to the housing authority among others. Service case reviewers made notes in 23 cases attributing compliance directly to the efforts of TCMs. In three of these cases, the TCMs identified and sought to remove an incorrectly applied disallowance.

Barriers to compliance:

Income maintenance cases: Case reviewers found nine cases (3 percent) in which problems/barriers were identified. These included the failure to understand PPI policies and procedures, no reminder letter sent regarding requirements, family situation, client needs service referral, client unable to obtain permanent housing, caretaker relative not making much effort, and alleged neglect (Child Protective Services cannot find client).

Social Services Administration (SSA): SSA service case reviewers found problems/barriers in 45 cases (15 percent). Twelve cases listed multiple barriers.

Child Protective Services: The study population included 12 active CPS cases (4 percent). Ten of the active cases involved child neglect; three also involved abuse. Six cases (50 percent) involved parental drug abuse. This is roughly equivalent to the proportion of all AFDC cases active in Child Protective Services.

Evaluation status: Since May 1993, 91 to 93 percent of AFDC families have met the PPI requirements. (This includes the education requirements not discussed here).⁵⁹ Ninety-five percent of the families meet the requirements within three months.⁶⁰ The Department of Health and Mental Hygiene (DHMH) reports a 42 percent increase in EPSDT screens since PPI began. Health Maintenance Organizations (HMOs) have expanded access to health care services by opening additional appointment times for AFDC clients and providing appointments to disallowed clients within 15 days (and all other clients within 45 days). A new HMO, Optimum Choice, added 1,200 providers for AFDC clients.

The DHR's evaluation of PPI also includes a special addendum to focus only on preventive health and immunization status. The Schaefer Center for Public Policy,

⁵⁹Maryland Department of Human Resources, The Primary Prevention Initiative Fact Sheet.

⁶⁰Department of Human Resources, State of Maryland, Welfare Reform in Maryland: The Primary Prevention Initiative (Baltimore, December 1994), p. 2.

the Johns Hopkins School of Hygiene and Public Health, and the Maryland Department of Maternal and Child Health are collaborating to evaluate what effects PPI has had on immunization levels and whether or not the program should be recommended to other states.

Data collection for this addendum began in July 1995. The Schaefer Center for Public Policy sent letters to providers explaining the study and requesting permission to review immunization records. Because this initial request did not include a letter of parental consent, many providers denied the request. In August 1995, evaluators began including a letter from DHR and DHMH, signed by the Secretary of DHR and the Secretary of DHMH, that stated that the PPI research team was authorized by the state to access the records and that parental consent was not required.⁶¹ Providers now cooperate fully with the research team. Data that may clarify PPI's impact on immunization rates will not be available until December 1996.

The Schaefer Center for Public Policy has also conducted a survey of both AFDC clients and staff of DHR to assess how they view the PPI program. The survey found that the overall reaction to PPI was positive. More than 73 percent of AFDC clients supported sanctions for parents who do not immunize their children, and almost 70 percent of clients believed that sanctions motivated parents to fulfill the health requirements.⁶²

Staff of the DHR were also supportive of the program, although many said that the program's ability to change behaviors was limited. Approximately 13 percent of staff thought the "threat of disallowance" was a "very powerful" incentive for compliance, and only 27 percent of staff agreed that such threats motivated "only some" clients to comply.⁶³ A total of 27 percent indicated that benefits must actually be reduced to motivate "some clients" to comply.⁶⁴ Almost 60 percent of DHR staff believed that the program was helpful to clients, while 10 percent believed the program harmed some clients.⁶⁵

⁶¹The Schaefer Center for Public Policy, University of Maryland at Baltimore, Maryland's Primary Prevention Initiative: An Interim Report, November 22, 1995, p. 298.

⁶²The Schaefer Center for Public Policy, University of Maryland at Baltimore, Maryland's Primary Prevention Initiative: An Interim Report, November 22, 1995, pp. 212-214.

⁶³The Schaefer Center for Public Policy, University of Maryland at Baltimore, Maryland's Primary Prevention Initiative: An Interim Report, November 22, 1995, p. 222.

⁶⁴The Schaefer Center for Public Policy, University of Maryland at Baltimore, Maryland's Primary Prevention Initiative: An Interim Report, November 22, 1995, p. 223.

⁶⁵The Schaefer Center for Public Policy, University of Maryland at Baltimore, Maryland's Primary Prevention Initiative: An Interim Report, November 22, 1995, p. 225.

Massachusetts: Welfare Reform 1995

Waiver status: Approved October 31, 1995.

Rule: All dependent children must receive all immunizations recommended by the Department of Public Health. Clients are considered in compliance when they provide verification that the child has been immunized or is scheduled to begin the immunization series. Either form of verification must be signed by a physician.⁶⁶

Sanction: The adult's portion of the AFDC grant (approximately \$90). In two-parent households, both adults' portions of the grant are withheld.

Implementation status: Statewide implementation began November 1, 1995. The policy is being phased-in for each client as they apply for AFDC, or as they come up for redetermination. As of May 1996, approximately 62,000 recipients, out of a caseload of 86,000, were in the program.⁶⁷

Evaluation: The Department of Transitional Assistance has not selected an evaluator but has released a Request for Proposals.

Contacts: Dick Powers, Director of Communications, Department of Transitional Assistance (617)348-8405.

* * *

Additional Information

Additional staff requirements: No additional staff was hired.

Sanction administration: At application, at the birth of a child, and when a child turns two years old, caseworkers in the Department of Transitional Assistance are required to verify that parents on AFDC have had their children immunized. Since immunizations are required for school enrollment, verification of school enrollment satisfies the immunizations verification requirement for a school-age

⁶⁶Department of Transitional Assistance, State of Massachusetts, "Immunizations," A Starter's Kit: Part I, pp. 56-57.

⁶⁷Dick Powers, Director of Communications, Department of Transitional Assistance, State of Massachusetts, telephone interview with Kristina Tanasichuk White, May 10, 1996.

child.

If the family has preschool children, the caseworker explains the immunization requirement, gives the parents a written description of the immunization requirements (the "Immunization" form), and tells them that they have 60 days to comply with the requirement. (The instructions for filling out the form and for complying with the requirement are also on the reverse side of the Immunization form.) For these 60 days, the family is eligible for AFDC benefits.

The caseworker then establishes a reminder file for 60 days from the date the Immunization form was given to the parent. If the verification arrives on time, or the caseworker receives notification of a good cause exemption, the form or letter is filed in the case records with no consequence for the family's benefit. If the form is not returned within 60 days, the caseworker eliminates the adult portion (or the portion for both adults in the case of two-parent families) of the AFDC benefit until the form is received.

If the family fulfills the requirement by providing verification of an appointment with a health care provider, the caseworker contacts the recipient by mail or in person to give them another copy of the Immunization form--to be returned within 30 days. If the form is returned within the allotted time frame, it is filed in the case record with no consequence for the family's benefit. If it is not returned within 30 days due to delays with the health care provider, the caseworker extends the deadline to allow the family to reschedule and complete their appointment. If the delay is due to the recipient, the caseworker applies the sanction mentioned above.⁶⁸

Michigan: Amendment to "To Strengthen Michigan Families"

Waiver status: Approved October 6, 1994.

Rule: Each eligible child under age 6 must receive all immunizations recommended by the Department of Public Health. Clients are considered in compliance when immunizations have begun for all children subject to the requirement. The client's statement is acceptable verification.

⁶⁸Department of Transitional Assistance, State of Massachusetts, "Transitional Aid to Families with Dependent Children: Nonfinancial Eligibility, Section 203.800: Immunizations," Department of Transitional Assistance Policy Manual, 106 code of Massachusetts regulations, Chapter 203, Section 203.800.

Sanction: \$25 per month, if one or more eligible children are not immunized and there are no unresolved barriers to immunizations.

Implementation status: Statewide implementation began January 1, 1995.

Evaluation: Abt is conducting the state's evaluation. It has produced several annual reports but none has addressed the immunization requirement.⁶⁹ Results from a random sample survey are expected in 1998.

Contacts: Bob Lovell, Director of Staffing and Program Evaluation, Department of Social Services (517)373-1989; Bill Boersema, Financial Assistance and Child Support Division (517)373-9204.

* * *

Additional Information

Additional staff requirements: No additional staff was hired.

Sanction administration: At application, field staff informs each client with a non-exempt child about the immunization requirement and the penalty for noncompliance, which may be imposed at redetermination. Michigan Department of Social Services (DSS) staff must review the requirement with clients until the client fully understands their obligation. Staff also refers clients to their health provider or to the local Health Department for more information. Inserts describing the new immunization policy were mailed to clients along with their checks in October, November, and December 1994. Exceptions are allowed for children under two months of age, medically inappropriate immunizations, and immunizations that are contrary to the family's religious beliefs.

As of June 1995, DSS field staff applied sanctions to 101 cases. Sanctions last until immunizations have begun for all children under age six. At that time, the number of sanctions was increasing, since the number of recipients subject to the sanction was increasing as more cases came up for redetermination.⁷⁰ As of June 1996, roughly 150 families per month were sanctioned. The sanction is \$25 per

⁶⁹Alan Werner and Robert Kornfeld, Evaluation of "To Strengthen Michigan Families": Fourth Annual Report: Third Year Impacts (Boston: Abt Associates, Inc., 1996).

⁷⁰Linda Rose, Policy Analyst, Department of Social Services, State of Michigan, telephone interview with Kristina Tanasichuk White, April 19, 1995.

month (regardless of the number of children not in compliance). Because the program seeks to encourage immunizations, and not to sanction clients, no emphasis has been placed on developing a precise reporting system.⁷¹

⁷¹Bill Boersema, Financial Assistance and Child Support Division, Department of Social Services, State of Michigan, telephone interview with Kristina Tanasichuk White, March 25, 1996; and Bob Lovell, Director of Planning and Evaluation, Department of Social Services, State of Michigan, telephone interview with Keturah Sawyer, June 6, 1996.

Mississippi: Mississippi New Direction Demonstration Project (MNDDP)

Waiver status: Approved October 6, 1994.

Rule: Children under age 6 must receive required immunizations and EPSDT screens on a regular basis (i.e., two per year for infants 0 to 18 months and one per year for children 18 months through age 6).

Sanction: \$25 per month until compliance.

Implementation status: Statewide implementation began October 1, 1995.

Evaluation: Bill Brister, Ph.D., Project Director at the Center for Applied Research at Millsaps College, is conducting the evaluation. Evaluators decided to look at three cities in three counties.⁷² They selected 1,500 families for the control group, and 1,500 families for the experimental group. Families in the control group were notified of the program but were told that they would not be subject to sanctions. The families in the experimental group were notified of the requirements and that they would be sanctioned if they did not comply. The evaluation will focus on whether or not there is a statistically significant improvement in the immunization rates of the experimental group in comparison with the control group.

Contacts: Larry Temple, Deputy Director, Department of Human Services (601)359-4476; Zenothia Robinson, Project Director of Welfare Reform (601)359-4749; Jo Ann Coleman, Bureau Director of State Operations (601)359-4823; Dr. Bill Brister, Project Director, Center for Applied Research, Millsaps College (601)974-1271.

* * *

Additional Information

Additional staff requirements: No additional staff was hired.

Montana: Families Achieving Independence (FAIM)

⁷²Vicksburg in Warren County, Lexington in Holmes County, and Meridian in Lauderdale County.

Waiver status: Approved April 18, 1995.

Rule: Families sign a Family Investment Agreement that requires them to immunize their children and keep them up-to-date on their EPSDT screens.

Sanction: The adult's portion of the AFDC grant is removed for at least one month if children are not immunized or up-to date on their EPSDT screens. When the family is sanctioned a second time, the adult's portion is eliminated for at least three months. The third time, the family is sanctioned for at least six months. For the fourth and subsequent sanctions, the adult's portion is removed for at least 12 months. The sanction continues for the full term regardless of whether or not the family has complied.

Implementation status: The statewide program is being phased-in, with it taking about six months for a county to become fully operational. In February 1996, the state implemented the program in its first eight counties. On May 1, 1996, another eight counties became operational.⁷³

Evaluation: Rick Offner, Director, Department of Community and Government Studies, University of Montana, is conducting the state's evaluation. Recipients from seven counties in Montana⁷⁴ will be randomly assigned to treatment and control groups. By 1998, they expect to have 2,400 families in the control group and about 7,200 in the treatment group. Each year, all families in the control group and an equal number of families from the treatment group will be surveyed by mail, first to develop baseline data on immunization status and later to collect data on the immunization status of the children. The evaluators plan to double check the parent surveys with the state's welfare database and its related Medicaid data.

The first report with baseline data on immunizations is expected to be released in early 1997.⁷⁵ After the baseline data is released, evaluators will report

⁷³The term "operational" refers to sites where all of the current and new cases are converted to the new policy.

⁷⁴The sites are Missoula County, Silver Bow County, Yellowstone County, Park County, Phillips County, Valley County, and Blaine County. Montana has a large population of Native Americans who live on reservations in some of these counties. The evaluation excludes Native Americans who live on a reservation that has a tribal JOBS program.

⁷⁵Susan Skinner, FAIM Evaluation Specialist, Program Integrity Unit, Child and Family Services Division, Department of Public Health and Human Services, State of Montana, telephone interview with Mark B. Coggeshall, October 17, 1996.

immunization data in a monthly extract.⁷⁶

Contacts: Kim Brown, Child and Family Services Division, Department of Public Health and Human Services (406)444-6676; Rick Offner, University of Montana (406)243-6011.

* * *

Additional Information

Additional staff requirements: Because it was politically unpopular to hire more full-time employees to help implement the program, the state hired a consulting firm to study the management and work techniques of current employees. BDM Technologies, an international time management and computer consulting firm, submitted a report entitled, The Eligibility Process Evaluation (EPE): Final Report and Recommendations, in December 1994, that outlined techniques the department could use to improve work skills and to free up more time to implement the program.⁷⁷ BDM suggested short-term changes that could save the department 65,000 to 70,000 hours of staff time per year. Some of the short-term recommendations included standardizing across county offices the format of client files, prospectively budgeting all AFDC and food stamp cases, and transferring the responsibility of scheduling interviews to the client. The long-term changes were estimated to save "in the range of 67,000 to 130,000 hours per year."⁷⁸ They included establishing on-line policy documentation and referral information, establishing a computer network, and creating new job descriptions.⁷⁹

North Carolina: Work First Program

Waiver status: Approved February 5, 1996.

Rule: Requires parents to immunize their children and bring them in for regular medical check-ups under the terms of a Personal Responsibility Contract agreed to

⁷⁶Rick Offner, Director, Department of Community and Government Studies, University of Montana, telephone interview with Kristina Tanasichuk White, April 16, 1996.

⁷⁷Kim Brown, Child and Family Services Division, Department of Public Health and Human Services, State of Montana, telephone interview with Kristina Tanasichuk White, April 9, 1996.

⁷⁸BDM Technologies, State of Montana County Offices of Human Services: Eligibility Process Evaluation, Final Report and Recommendations, December 1994, p. 5.

⁷⁹BDM Technologies, State of Montana County Offices of Human Services: Eligibility Process Evaluation, Final Report and Recommendations, December 1994, pp. 4-6.

by the parents.

Sanction: Failure to comply with the terms of the Personal Responsibility Contract results in a \$50 reduction in benefits for three months. A second sanction prompts a \$75 reduction for three months, a third sanction is \$75 for six months, and a fourth sanction is \$75 for 12 months. Even after a recipient who has been sanctioned complies, full benefits are not restored until the expiration of the most recent sanction.

Implementation status: Statewide implementation began on July 1, 1996.

Evaluation: The state's evaluation will be conducted by MAXIMUS, Inc. However, the evaluation plan has not been approved by either the state or federal governments. According to the draft evaluation plan submitted by MAXIMUS, the demonstration period is scheduled to run from July 1, 1996 through June 30, 2001. The evaluator's draft final report is due December 29, 2001.

The sampling plan calls for the creation of treatment and control groups of approximately 4,000 AFDC cases each, to be accomplished in two stages. In the first stage, 2,000 active cases will be randomly assigned to each of the two groups; in the second stage, 2,000 new AFDC applicants will be assigned to each of the two groups over three years. The cases are expected to be drawn from two counties (Northampton and Forsythe).

Contacts: Mark Benton, Consultant, Planning and Evaluation Section, Division of Social Services, (919)733-3055.

* * *

Additional Information

Sanction administration: The Work First program requires adult caretakers to have preschool children under age 7 immunized according to a fixed schedule. Five types of vaccinations are required: oral polio vaccine, diphtheria, tetanus, and pertussis (DTP), measles, mumps, and rubella (MMR), bacterial meningitis, and Hepatitis B. Preschool children are also required to have "regular" medical examinations, that is, seven examinations between birth and the child's second birthday, and annual physicals thereafter.

Good cause exemptions from these requirements will be granted for medically

inappropriate immunizations and immunizations that are contrary to the family's religious beliefs.⁸⁰

North Dakota: The Training, Education, Employment and Management Project (TEEM)

Waiver status: Approved September 28, 1995.

Rule: Recipients sign a Social Responsibility Contract that requires them to keep all dependent children in the household up-to-date on their EPSDT screens. Substitutes for the EPSDT (i.e., health care check-ups from other providers) must be approved by the county public health EPSDT worker. Children must have their EPSDT screens completed by the date set in their Social Responsibility Contract.⁸¹

The EPSDT worker determines whether or not the recipient is in compliance and reports to the eligibility worker.

Sanction: The adult's share of the AFDC cash grant (but not of the other elements of the TEEM grant)⁸² until all children in the household have had their EPSDT screen or are exempted for good cause.

Implementation status: On November 1, 1996, the state plans to implement the program in 11 of its 53 counties: Adams, Cass, Morton, Stark, Sargent, Steele, Stutsman, Trail, Ransom, Richland, and Williams. The counties will be phased into the program in groups of three, with all of the counties converted in four months.

Evaluation: A Request For Proposals was released in June 1996. The deadline for the receipt of proposals was September 1996. State officials hope to enter into a contract by the time the program is implemented in November 1996.⁸³

⁸⁰Mark Benton, Consultant, Planning and Evaluation Section, North Carolina Division of Social Services, telephone interview with Mark B. Coggeshall, September 4, 1996.

⁸¹Kevin Iverson, Project Director, The Training, Education, Employment and Management Project (TEEM), Department of Human Services, State of North Dakota, telephone interview with Kristina Tanasichuk White, May 13, 1996.

⁸²The TEEM benefit is issued as a cash payment constituting the households' AFDC, food stamp, and Low-Income Heating Energy Assistance Program (LIHEAP) benefits. Thus, a sanctioned recipient would continue to receive the food stamp and LIHEAP portions of their cash benefit.

⁸³Kevin Iverson, Project Director, The Training, Education, Employment and Management Project

Contacts: Kevin Iverson, Project Director, The Training, Education, Employment and Management Project (TEEM), Department of Human Services (701)328-2729.

* * *

Additional Information

Additional staff requirements: The counties have hired four additional eligibility workers, but, according to state officials, their hiring was not a result of the relatively small administrative burden imposed by the immunization requirement.⁸⁴

(TEEM), Department of Human Services, State of North Dakota, telephone interview with Mark B. Coggeshall, August 26, 1996.

⁸⁴Kevin Iverson, Project Director, The Training, Education, Employment and Management Project (TEEM), Department of Human Services, State of North Dakota, telephone interview with Mark B. Coggeshall, November 8, 1996.

Oklahoma: Welfare Self-Sufficiency Initiatives

Waiver status: The Welfare Self-Sufficiency Initiatives were submitted in December 1995 and are still pending.

Rule: All children on AFDC would be required to be immunized according to the Oklahoma Department of Public Health schedule. There are no good cause exemptions--including no exemptions for religious beliefs or adverse reactions. Immunizations will be reviewed at application and at each review (approximately every six months).⁸⁵

Sanction: The adult's portion of the grant until all eligible children in the household are vaccinated.

Implementation status: The state is proposing to pilot the program in six counties, however, the specific counties have not yet been selected.

Evaluation: Not applicable.

Contacts: Beverly Brown, Program Supervisor (over welfare reform, AFDC, and day care), Division of Family Support Services, Department of Human Services (405)521-4391.

South Carolina: Program resulting from the Family Independence Act

Waiver status: Approved May 3, 1996.

Rule: Applicants are required to sign an Individual Self Sufficiency Plan that outlines a vocational goal. Under these plans adult and minor mothers are required to attend and complete health and parenting class as a condition of AFDC eligibility. The full curriculum of the classes includes 24 hours of parenting skills training, eight hours on household budgeting, and four hours on preventive health services (about half of which focusses on family planning, including detailed information about birth control, access to contraceptives, AIDS prevention, and sexually transmitted diseases). The remainder of the health class covers EPSDT

⁸⁵Beverly Brown, Program Supervisor (over welfare reform, AFDC and day care), Division of Family Support Services, Department of Human Services, State of Oklahoma, telephone interview with Kristina Tanasichuk White, May 14, 1996.

screens, and how to access Medicaid and other health care providers.⁸⁶

Sanction: Case managers determine on a case-by-case basis who will be sanctioned. The state assumes that recipients will attend class 100 percent of the time. If a client misses class, their case manager meets with them immediately to determine if the absence deems a sanction. Mothers who do not attend are sanctioned for the adult's portion of their AFDC grant. If they still do not comply, they are notified that after 60 days a full-family sanction will be applied.⁸⁷

Implementation status: The state implemented its program statewide on October 1, 1996.⁸⁸

Evaluation: A Request for Proposals was tentatively scheduled for release in October or November 1996. However, state officials, availing themselves of the new leeway afforded them as a result of the new Temporary Assistance for Needy Families blockgrants authorized by the 1996 welfare reform bill, have since decided not to conduct a formal evaluation of their reforms. Instead, they plan to propose a less rigorous evaluation design that would not involve a control group. Much of the data collection would be conducted by state agencies, and officials hope that the U.S. Department of Health and Human Services will agree to finance a portion of their evaluation costs. State officials are currently drafting a concept paper outlining the proposal.⁸⁹

Contacts: Bill Middleton, Director of Program Reform, Department of Social Services (803)737-5904; Leigh Bolick, Project Administrator, Department of Social Services (803)737-5916.

Texas: Promoting Child Health in Texas and Achieving Change for Texans (ACT)

Waiver status: "Promoting Child Health in Texas," approved in June 1995, was the first waiver requested by the state and approved by the federal government.

⁸⁶Leigh Bolick, Project Administrator, Department of Social Services, State of South Carolina, telephone interview with Kristina Tanasichuk White, May 13, 1996.

⁸⁷Bill Middleton, Director of Program Reform, Department of Social Services, State of South Carolina, telephone interview with Kristina Tanasichuk White, May 10, 1996.

⁸⁸Steven Pressley, Ph.D., Program Director, Office of Family Independence, Department of Social Services, State of South Carolina, telephone interview with Mark B. Coggeshall, October 8, 1996.

⁸⁹Steven Pressley, Ph.D., Program Director, Office of Family Independence, Department of Social Services, State of South Carolina, telephone interview with Mark B. Coggeshall, October 8, 1996.

Texas requested and received (in March 1996) a second waiver, "Achieving Change for Texans (ACT)," which includes many reforms to the entire welfare system. "Promoting Child Health in Texas" will be subsumed under the new waiver.

Rule: Under "Promoting Child Health in Texas," recipients were required to have their children immunized. On June 1, 1996, this rule was altered under ACT to require recipients to immunize all children and keep them up-to-date on their Medicaid Texas Health Steps (formerly EPSDT) screens.

Sanction: Under the first waiver, the sanction is \$25 per nonimmunized child, with no limit to the amount that can be deducted. The new waiver will limit the maximum total sanction to \$75.

Implementation status: "Promoting Child Health in Texas" began statewide implementation in October 1995. ACT began implementation on June 1, 1996.

Evaluation: The Planning and Evaluation section of the Client Self-Support Services Office has developed a research design, which was implemented in January 1996. In four sites across Texas, cases are randomly assigned to an experimental or control group based on the client's social security number. The state expects to have a sample size of over 10,000 cases in four sites by 1998.

Contacts: Rita King, Program Specialist, Client Self-Support Services, Planning and Evaluation Division (512)438-4148; Kent Gummerman, Director of Programs, Client Self-Support Services, Planning and Evaluation Division (512)438-3743; Nancy Smith, Evaluation Specialist, Client Self-Support Services, Planning and Evaluation Division (512)438-5043.

* * *

Additional Information

Additional staff requirements: No additional staff was hired for the first or second waiver.

Sanction administration: After October 1, 1995, all applicants for, and clients of, AFDC were told that they would need to bring current immunization records or proof of good cause for each child under age 6 to their next periodic review, and that failure to do so would result in a \$25 per month, per child sanction. All

offices were also required to display an immunization poster, give recipients the Texas Department of Health Immunization Hotline phone number (for immunization questions and local immunization sites), and provide immunization publications in the lobbies of the local offices. Caseworkers were also required to review the immunization requirements at the time of application and at periodic reviews.

If the parent does not comply, the caseworker enters a code into the computer that automatically signals a reduction in the family's first full month of benefits. The caseworker documents which child or children in the family are not immunized and sends the parents notification that the sanction will be imposed. If the sanction results in a monthly benefit of less than \$1, the grant will remain at \$1 so that the family can remain eligible for Medicaid. The sanction is removed the month the family provides verification of immunization.⁹⁰

As of August 1996, of the state's 158,036 children under age 6 who were subject to its immunization requirement, 151,155 (95.6 percent) were in compliance; 1,648 (1.0 percent) were sanctioned; 1,203 (0.8 percent) were exempt; and 4,030 (2.6 percent) were subject to an alternate schedule.⁹¹

Evaluation status: Control and experimental group members were encouraged to immunize their children but those in the control group were not told they would be sanctioned for not having their children vaccinated. Families in the experimental group must provide proof that their children are immunized at each complete review or face sanctions.

The state has begun data collection on its own but has not yet engaged an outside contractor to evaluate the program.⁹²

Utah: Amendment to The Single Parent Employment Demonstration Project

Waiver status: Approved July 25, 1996.

⁹⁰Burton Raiford, "Texas Department of Human Services Executive Letter," Department of Human Services, State of Texas, August 18, 1995.

⁹¹Kent Gummerman, Director of Programs, Client Self-Support Services, Planning and Evaluation Division, State of Texas, telephone interview with Peter Germanis, October 23, 1996.

⁹²Nancy Smith, Evaluation Specialist, Client Self-support Services, Planning and Evaluation Division, State of Texas, telephone interview with Kristina Tanasichuk White, April 10, 1996.

Rule: Applicants for, and families on, AFDC in one site would be required to have all of their preschool children immunized. Immunization status would be checked at application and at redetermination. Once the rule is explained, recipients have six months to comply.⁹³

Sanction: \$25 per month regardless of the number of children without immunizations. According to the waiver's Terms and Conditions, sanctions are to be lifted "as of the month of compliance."

Implementation status: Expected to begin statewide in November or December 1996.⁹⁴

Evaluation: The University of Utah will conduct the state's evaluation. The university's final impact report is due in March 2002.

Contacts: John Davenport, AFDC/RISE Program Specialist, Office of Family Support, Department of Human Services (801)538-3968.

Virginia: Virginia Independence Program

Waiver status: Approved July 1, 1995.

Rule: Applicants for, and recipients of, AFDC must provide verification that all otherwise eligible children have received the required immunizations. Those applicants unable to provide verification of immunizations at the initial determination of eligibility will have to provide either verification of immunizations received, or a plan for completing the immunization schedule prepared by a physician by the time of the scheduled redetermination. Compliance will be checked at all subsequent redeterminations.

Sanction: \$50 for the first child and \$25 for each additional child who is not immunized. Families receive a warning ten days before the sanction is imposed.

Implementation status: The immunization component was implemented statewide on July 1, 1995. At the time of implementation, AFDC recipients were required to

⁹³Bill Biggs, Coordinator, Single Parent Employment Demonstration Project, State of Utah, telephone interview with Kristina Tanasichuk White, May 13, 1996.

⁹⁴John Davenport, AFDC/RISE Program Specialist, Office of Family Support, Department of Human Services, State of Utah, telephone interview with Mark B. Coggeshall, August 22, 1996.

comply by the first scheduled redetermination of assistance after notification of the immunization guidelines. Applicants were required to provide verification by their first redetermination.

Evaluation: No evaluator has been selected yet, but the state does plan to evaluate the impact of the immunization requirement as a separate component in their evaluation.

Contacts: Marsha Sharp, Acting Program Manager for AFDC, Division of Benefit Programs, Department of Social Services (804)692-1730.

* * *

Additional information

Additional staff requirements: No additional staff was hired.

Sanction administration: On July 1, 1995, caseworkers began to inform applicants for, and recipients of, AFDC about the immunization requirement at application and redetermination. After being told about the immunization requirement, recipients are required to provide verification of immunization. Preferably, recipients will bring the AFDC Childhood Immunization Certification form provided by the vaccine provider. If they do not, and the child's status is unclear, caseworkers must contact the Immunization Action Plan Coordinator at the Health Department or call the Bureau of Immunization hotline. Children enrolled in school, Head Start, or a licensed family day care home or center are exempt from these verification requirements, presumably because of the immunization programs offered within these centers. Good cause exemptions are available to parents who raise religious objections and to children whose health may be endangered by vaccination.

If the recipient does not comply with the requirement and good cause for noncompliance is not shown, the caseworker must identify and remove any barriers over which the agency has control before imposing a sanction. If all barriers have been removed and the client is still not complying, the caseworker deducts \$50 for the first child who is not immunized, and \$25 for each additional child who is not immunized. If the sanction(s) result in a reduction to zero benefits, the family retains Medicaid coverage. When the recipient submits verification that the children have received their immunizations, the caseworker must try to remove the sanction before the next month.