

If You Move, You Lose: The Interstate Medicaid Obligation to Special Needs Adopted Children

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This Article presents the history of the adoption assistance programs of the United States and analyzes state Medicaid practice related to the federal statutory provisions that established the benefit and the Constitutional guarantees of the freedom of travel. It argues that the state practice of denying Medicaid to a child based on the state from which the child is adopted clashes with the Supreme Court's decision in Saenz v. Roe which held that the Equal Protection Clause "does not tolerate a hierarchy of 45 subclasses of similarly situated citizens based on the location of their prior residence." This Article posits that children adopted with special needs who have been found to be Medicaid eligible remain Medicaid eligible regardless of the state from which they were adopted and the state in which they presently reside.

INTRODUCTION	348
I. MEDICAID AND ADOPTION ASSISTANCE.....	349
II. CONGRESSIONAL INTENT, MEDICAID AND ADOPTION ASSISTANCE	353
III. STATE PRACTICE, MEDICAID AND ADOPTION ASSISTANCE	357
IV. A LEGAL ANALYSIS OF STATE PRACTICE, MEDICAID AND ADOPTION ASSISTANCE	358
A. DISTINGUISHING BETWEEN IN- AND OUT-OF-STATE STATE ADOPTION ASSISTANCE AGREEMENTS GOES AGAINST THE CONGRESSIONAL INTENT OF THE COBRA OPTION AND ASFA AND VIOLATES THE SUPREMACY CLAUSE OF THE CONSTITUTION....	358
1. Courts Should Follow Well-Established Supreme Court Precedents.....	361
B. THE STATE PRACTICE OF DISTINGUISHING AMONGST RESIDENTS WITH A STATE ADOPTION ASSISTANCE AGREEMENT VIOLATES THE EQUAL PROTECTION CLAUSE	363

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C. CURRENT STATE PRACTICE PUNISHES CHILDREN WHOSE FAMILIES HAVE EXERCISED THEIR CONSTITUTIONAL RIGHT TO TRAVEL	364
D. CURRENT STATE PRACTICE DOES NOT UPHOLD THE CONSTITUTIONAL IDEAL OF A COOPERATIVE UNION OF STATES	367
CONCLUSION	368
APPENDIX A.....	370
APPENDIX B.....	372

INTRODUCTION

This Article analyzes the issue of interstate Medicaid receipt for adoption assistance recipients through two lenses—the law and state practice. Federal law declares that all eligible youth adopted with special needs are Medicaid eligible¹ and the Constitution protects the right to travel interstate² under the Privileges and Immunities Clause and declares that differentiations in the receipt of public benefits based on state residency are intolerable.³ However, state practice routinely denies Medicaid to adoption assistance recipients when the youth moves or is placed for adoption interstate.⁴ How and why does this happen?

Adoption assistance acknowledges the life obstacles faced by youth formerly in out-of-home care by providing financial and medical support to families who decide to give a waiting child a permanent home.⁵ Medicaid is the medical assistance of choice by states and is recognized as a vital adoption support. And though Medicaid eligibility accompanies virtually all adoption assistance, Medicaid eligibility and Medicaid receipt are two very different things.⁶ Medicaid law mandates that all eligible children adopted with special needs receive Medicaid. However, both populations of adop-

1. 42 U.S.C. § 671(a)(21) (2000); Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2215 (1997).

2. U.S. CONST. art. IV, § 2, cl. 1. *See* Paul v. Virginia, 75 U.S. 168 (1868); Zobel v. Williams, 457 U.S. 55, 79 (1982); Saenz v. Roe, 526 U.S. 489, 500 (1999).

3. U.S. CONST. amend. XIV, § 1, cl. 2; Slaughter-House Cases, 83 U.S. 36, 80 (1872); *Saenz*, 526 U.S. at 489.

4. The author, Sharon McCartney, personally learned this information through her work at the non-profit organization, The Association of Administrators of the Interstate Compact on Adoption and Medical Assistance [hereinafter AAICAMA].

5. 42 U.S.C. § 670 et seq. (2000); Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500 (1980).

6. 42 U.S.C. §§ 670, 1396a(a)(10)(A)(i)(I) (2000); 42 C.F.R. §§ 435.115(e)(1), 435.145, 435.909; 45 C.F.R. § 1356. Comments to regulations by the Department of Health and Human Services [hereinafter HHS] can be found at 65 Fed. Reg. 4020-4088 (Jan. 25, 2000) (to be codified at 45 C.F.R. pt. 1355).

tion assistance youth routinely lose Medicaid interstate.⁷ What applicable federal, child welfare, and Medicaid laws are being ignored, and what case law is there that illuminates these issues? And how do these practices square with the Constitution?

The Article is presented in four parts. *Part I: Medicaid and Adoption Assistance* provides the federal and state frameworks of the two adoption assistance programs and the Medicaid benefit that accompanies them. *Part II: Congressional Intent, Medicaid and Adoption Assistance* explores the legislative intent behind the federalization of adoption assistance under title IV-E and the repeated efforts of Congress to secure Medicaid for eligible, special needs adopted children. *Part III: State Practice, Medicaid and Adoption Assistance* presents state practice in the provision of Medicaid to non-title IV-E (state) adoption assistance recipients and discusses its legalities and ramifications. And, finally, the Article presents case law and the Constitutional implications of state practice in the interstate provision of Medicaid to state adoption assistance recipients in *Part IV: A Legal Analysis of State Practice, Medicaid and Adoption Assistance*.

The Article presents the history and constructs of the title IV-E and the non-title IV-E state adoption assistance programs and their relationship to Medicaid and asserts that all Medicaid eligible children adopted with special needs remain Medicaid eligible interstate. It explores the contractual, legislative, regulatory, policy, case law, and constitutional bases for this assertion and analyzes the legal implications of state practices that deny Medicaid to adoption assistance recipients to conclude that *all eligible children adopted with special needs must remain Medicaid eligible and receive benefits regardless of the state in which they live*.

I. MEDICAID AND ADOPTION ASSISTANCE

The Adoption Assistance and Child Welfare Act of 1980 (AACWA)⁸ encourages the adoption of children from out-of-home care. Importantly, the AACWA federalized a program begun by the states to incentivize the adoption of children with special needs by removing financial barriers to the adoption of children from state foster care.⁹ The AACWA created a

7. AAICAMA, *supra* note 4.

8. 42 U.S.C. § 670 (2000). Note: Children who have not been in state custody may be eligible for adoption assistance. Additionally, an eligibility criterion of all adoption assistance programs includes a determination that the youth have a defined special need(s) that makes adoption assistance necessary to secure their adoption placement and support their permanency. To receive adoption assistance is to be a child with special needs. *See* 42 U.S.C. § 673 (2000) (discussing federal adoption assistance eligibility).

9. 42 U.S.C. § 673.

permanent federal funding stream under title IV-E¹⁰ and provided mandatory Medicaid eligibility under title XIX¹¹ to increase permanency and decrease the time a waiting child spent in care. All fifty states and the District of Columbia operate a federal adoption assistance program under title IV-E¹² and a non-title IV-E, state-funded adoption assistance program for youth ineligible for the federal program.¹³

There are two adoption assistance programs in the United States—one is federal (known as title IV-E adoption assistance) and one is state (non-title IV-E, referred to as state-funded or state adoption assistance). The AACWA requires that all states accepting title IV-E funds create a program of entitlement to subsidize children adopted with special needs and to assess all children known to the state for eligibility.¹⁴ For special needs youth ineligible for federal adoption assistance, all states operate a state adoption assistance program.¹⁵ For both populations of youth, medical assistance is a benefit that accompanies eligibility for adoption assistance.¹⁶ For title IV-E, Medicaid is the medical assistance and eligibility is mandatory.¹⁷ For state adoption assistance, medical assistance is also Medicaid, but eligibility is optional.¹⁸ This option is memorialized in the Medicaid State Plan¹⁹ and in a contractual agreement known as an adoption assistance agreement. The adoption assistance agreement is a contract entered into by the state and the adoptive family prior to adoption finalization and remains enforceable by both parties for the life of the agreement.²⁰

Federal law outlines the requirements of the Medicaid program and all states choosing to operate a Medicaid program must follow these require-

10. 42 U.S.C. § 671 (2000); 45 C.F.R. pts. 1355-57, §§ 1356.20(a), 1356.21(a).

11. 42 U.S.C. § 1396a(a)(10)(A)(i)(I) (2000).

12. EMILIE STOLTZFUS, CONG. RESEARCH SERVS., R42794, CHILD WELFARE: STATE PLAN REQUIREMENTS UNDER THE TITLE IV-E FOSTER CARE, ADOPTION ASSISTANCE, AND KINSHIP GUARDIANSHIP ASSISTANCE PROGRAM, (2012).

13. See, e.g., CAL. WEL. & INST. CODE § 16120, available at <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=16001-17000&file=16115-16125> (last visited Mar. 23, 2015). See also *Adoption Assistance by State*, CHILD WELFARE INFO. GATEWAY, <https://www.childwelfare.gov/topics/adoption/adopt-assistance/> (last visited March 4, 2015) (providing information regarding all jurisdictions' adoption assistance programs).

14. 42 U.S.C. §§ 671(a), 673; 45 C.F.R. §§ 1356.40(a), (f).

15. See, e.g., *Adoption Assistance by State*, supra note 13; CAL. WEL. & INST. CODE § 16120, supra note 13.

16. 42 U.S.C. §§ 671(a)(21), 1396a(a)(10)(A)(i)(I).

17. 42 U.S.C. § 1396a(a)(10)(A)(i)(I).

18. 42 U.S.C. § 1396a(a)(10)(A)(ii)(VIII); Note: AAICAMA: New Mexico informs AAICAMA that it has chosen to provide an alternative medical assistance comparable to Medicaid.

19. 42 U.S.C. § 1396a.

20. 42 U.S.C. § 675(3) (2000).

ments.²¹ Known by various names state to state, all states operate a federally-defined, state-administered Medicaid program.²² If a child meets the eligibility requirements of federal title IV-E assistance, the child must receive Medicaid benefits in the state in which the child lives.²³ For youth who do not meet the criteria of the title IV-E program and are found eligible for the state adoption assistance program, federal law allows states to elect to provide Medicaid under the “optional categorically needy” provision.²⁴ Once a state elects to cover members of an optional class, it must cover all members of that class.²⁵ Federal regulations allow states to cover “[i]ndividuals under age twenty-one (or, at State option, under age twenty, nineteen, or eighteen) or reasonable classifications of these individuals.”²⁶

For individuals under age twenty-one who have a state adoption assistance agreement, the agency may provide Medicaid to youth:

(aa) [F]or whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,

(bb) [W]ho the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) [W]ho was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State’s foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State’s [A]id to [F]amilies with [D]ependent

21. 42 U.S.C. § 1396a.

22. ELICIA J. HERZ, CONG. RESEARCH SERVS. RL33202, MEDICAID: A PRIMER (2005).

23. 42 U.S.C. §§ 673(b)(1) (2000), 1396a(a)(10)(A)(i)(I); 42 C.F.R. §§ 435.145, 435.403(g).

24. 42 U.S.C. § 1396a(a)(10)(A)(ii)(VIII); 42 C.F.R. § 435.201(a).

25. 42 U.S.C. § 1396a(a)(10)(B); 42 C.F.R. § 435.201(b).

26. 42 C.F.R. § 435.201(a)(4); Medicaid State Plan Attachment 2.2-A, Part B, Optional Groups Other Than the Medically Needy. *See infra* App. A for a copy of this attachment.

[C]hildren program under part A of subchapter IV of this chapter.²⁷

This Medicaid category of eligibility is referred to in the adoption assistance field as the COBRA option, and every state except New Mexico has elected this option since its introduction in 1985.²⁸ Youth are assessed for state adoption assistance eligibility and, if found eligible, are promised all or a combination of financial, medical, and post adoption support service benefits.²⁹ These promises are part of the state adoption assistance agreement entered into by adoptive families and state agencies that outlines the obligations of the parties and benefits of the agreement.³⁰ Medicaid is a benefit of virtually all adoption assistance agreements, both federal and state.³¹

The state holding an adoption assistance agreement with the adoptive family is known in the adoption field as the adoption assistance state or the agreement state.³² An adoption assistance agreement is a contract and both parties mutually agree to its terms and are bound by them. Both parties give something in consideration of the contract. A family agrees to give a child a permanent home and a state agrees to provide benefits to help secure permanency such as a monthly financial payment known as a maintenance payment, Medicaid, and post adoption services to support the family and child after finalization.³³ The inclusion of Medicaid in any adoption assistance agreement obligates states to provide Medicaid to the eligible youth *as long as the adoption assistance agreement is in effect*.³⁴ The federal law establishing the Title IV-E Adoption Assistance Program and subsequent amendments to the law have worked to define and strengthen this obligation.³⁵ However, children eligible for adoption assistance routinely lose

27. 42 U.S.C. § 1396a(a)(10)(A)(ii)(VIII); 42 C.F.R. §§ 436.224, 435.227.

28. AAICAMA, *supra* note 4 (explaining how New Mexico informed AAICAMA that it has chosen to provide an alternative medical assistance comparable to Medicaid).

29. 42 U.S.C. § 675(3) (2000).

30. *Id.*

31. *Id.*; EMILIE STOLTZFUS, CONG. RESEARCH SERVS., R42792 CHILD WELFARE: A DETAILED OVERVIEW OF PROGRAM ELIGIBILITY AND FUNDING FOR FOSTER CARE, ADOPTION ASSISTANCE AND KINSHIP GUARDIANSHIP ASSISTANCE UNDER TITLE IV-E OF THE SOCIAL SECURITY ACT, 2012); AAICAMA, *supra* note 4.

32. AAICAMA, *supra* note 4.

33. 42 U.S.C. § 675(3) (2000).

34. CTRS. FOR MEDICARE AND MEDICAID SERVS., THE STATE MEDICAID MANUAL § 3506, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html?DLPage=1&DLSort=0&DLSortDir=ascending> (last visited Mar. 23, 2015).

35. 42 U.S.C. § 673 (2000).

Medicaid when they move interstate, despite the terms of the adoption assistance contract.³⁶

It is important to note that this Article focuses on the denial of Medicaid to youth eligible for state adoption assistance. However, it is noted that interstate moves also affect the federal, title IV-E adoption assistance population. Title IV-E eligible youth over the age of eighteen who reside outside the assistance state are denied Medicaid by some states who do not extend their own title IV-E adoption assistance program past the age of eighteen.³⁷

II. CONGRESSIONAL INTENT, MEDICAID AND ADOPTION ASSISTANCE

Under the initial AACWA, Medicaid funds were received through services provided by Medicaid providers in the adoption assistance state for title IV-E adoption assistance recipients.³⁸ However, the difficulty of implementing this obligation is apparent. In an ever increasingly mobile world, adopted families were moving from the adoption assistance state with a Medicaid card that could not be used outside the state. Interstate realities made the term “mandatory Medicaid” meaningless for title IV-E recipients.

Congress addressed this oversight five years later in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).³⁹ Congress mandated that all states provide Medicaid to all residents who were title IV-E eligible.⁴⁰ Most children adopted from state care are eligible for title IV-E adoption assistance and have this interstate Medicaid protection.⁴¹ Most children are eligible, but not all.⁴²

Approximately sixty-six percent of all youth adopted from state care are eligible for federal, title IV-E adoption assistance; however, thirty-five percent of youth are not.⁴³ For these children, state adoption assistance pro-

36. AAICAMA, *supra* note 4.

37. *Id.*

38. 42 U.S.C. § 670 (2000); Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500 (1980).

39. Consolidated Omnibus Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986).

40. *See id.* at § 9529 (Section 9529 made this residency stipulation applicable to any child receiving Title IV-E assistance (whether foster care or adoption assistance)). *See also* 42 C.F.R. § 435.403(g).

41. STOLTZFUS, *supra* note 31; AAICAMA, *supra* note 4.

42. STOLTZFUS, *supra* note 31.

43. *Id.* The percentage of youth eligible for title IV-E adoption assistance has declined in the last decade. *See infra* App. B for a graphic depiction of eligibility from FY2000 (74.8%) to FY2011 (65.9%). Subsequently, the number of youth placed for adoption *without* the support of title IV-E and mandatory Medicaid has increased in the same years from 13% to 24.2%.

grams work to incentivize the adoption of children ineligible for the federal program. Approximately twenty-four percent of those ineligible for the federal program are eligible for the state program.⁴⁴ However, Medicaid historically was not available to these children. Not until 1985 were states given the option of providing Medicaid to children receiving state adoption assistance. This option came in the same COBRA legislation that made Medicaid mandatory in all states for title IV-E recipients.⁴⁵ The Federal Medical Assistance Percentages (FMAP) became available to states opting to provide Medicaid to this population as an optional, categorically needy youth under age twenty-one.⁴⁶ However, children holding state adoption assistance agreements experienced the same Medicaid delivery difficulties that met title IV-E eligible youth interstate after the AACWA.⁴⁷

Congress responded to this problem by including a Medicaid provision in the Adoption and Safe Families Act of 1997 (ASFA). With the goals of safety, permanency, and well-being of children in state custody, the law established adoption incentive payments for states that increase their adoption numbers and tied eligibility for these incentive dollars to the provision of Medicaid or its equivalent to all children adopted with special needs living in the state.⁴⁸ The ASFA also mandated that welfare plans under title IV-E include ways to use cross-jurisdictional resources to secure permanency.⁴⁹ Congress promoted interstate placement in the law and created the legal provisions to access the Medicaid necessary to strengthen those placements.

To achieve this, Congress again worked to clarify legislative intent regarding state obligation to provide Medicaid to adopted children. The provision lifts, verbatim, the language of the Medicaid provision in the COBRA that grants states the option of providing Medicaid to youth receiving state adoption assistance.⁵⁰ The inclusion of the COBRA language in the ASFA strengthens the earlier AACWA by clarifying state obligation to provide Medicaid in all cases to all children eligible for adoption assistance who meet the COBRA provisions.⁵¹ This intent is further clarified by two

44. STOLTZFUS, *supra* note 31.

45. 42 U.S.C. § 1396a(a)(10)(B) (2000); Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986); 42 C.F.R. § 435.201(b).

46. 42 U.S.C. § 1396a(a)(10)(A)(ii)(VIII).

47. AACAMA, *supra* note 4.

48. 42 U.S.C. § 670 (2000); Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2215 (1997); ACYF-CB-IM-01-03, issued Mar. 7, 2001.

49. 42 U.S.C. § 671(a)(21) (2000); Adoption and Safe Families Act of 1997.

50. 42 U.S.C. § 670 (2000); Adoption and Safe Families Act of 1997; ACYF-CB-IM-01-03, issued Mar. 7, 2001.

51. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, § 201; 42 U.S.C. § 673b (2000).

federal agencies in two, separate issuances. The first is from the Congressional Research Service (CRS) and the second is from the Centers for Medicare and Medicaid Services (CMS).

The first federal agency is the CRS. The CRS is the public policy research arm of Congress whose analysis and products are considered authoritative.⁵² CRS's "highest priority is to ensure that Congress has [immediate] access to the nation's best thinking" on public policy issues and its analyses are self-described as "authoritative, confidential, objective, and nonpartisan."⁵³ The issuance of the CRS report, *Child Welfare: Implementation of the Adoption and Safe Families Act (P.L. 105-89)* was provided in 2004 at the request of Congress and is excerpted below. The section entitled *Eligibility for Adoption and Medical Assistance* is short and specific. It makes very clear that all states must provide Medicaid to all adopted children with special needs for medical, mental health, or rehabilitative care regardless of the state in which the youth lives.⁵⁴

Children who are eligible for federal adoption assistance are also deemed eligible for Medicaid. States have the option to provide Medicaid coverage to special needs adopted children who do not meet the income eligibility criteria for federal adoption subsidies. However, ASFA requires states to provide health insurance coverage to these children if they have special needs for medical, mental health, or rehabilitative care. This health coverage may be through Medicaid or another program, as long as benefits are comparable. . . .

In addition, to be eligible for adoption incentive payments . . . in FY2001 or FY2002, states were required to provide health coverage to *any* special needs child living in their state whose adoptive parents had entered into an adoption assistance agreement with *any other* state. (When Congress

52. CONG. RESEARCH SERVS., *Congressional Research Service Careers*, <http://www.loc.gov/crsinfo/> (last visited Jan. 24, 2015).

53. *Id.*

54. KAREN SPAR & MATTHEW SHUMAN, *CHILD WELFARE: IMPLEMENTATION OF THE ADOPTION AND SAFE FAMILIES ACT (P.L. 105-89)*, CONG. RESEARCH SERVS. DOCUMENT NO. RL30759, 8 (Nov. 8, 2004), http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2012/RL30759_gb.pdf. HHS reminded states of this obligation in the information memorandum, Administration on Children, Youth and Families, Administration for Children and Families ACYF-CB-IM-01-03 (Mar. 7, 2001).

reauthorized the adoption incentives program in 2003, this requirement was extended through FY2007.) States also must comply with this provision to be approved for a child welfare demonstration project (or waiver).⁵⁵

The second federal agency is the Centers for Medicare and Medicaid Services (CMS). CMS oversees state implementation of the Medicaid program.⁵⁶ Adding strength to the ASFA Medicaid mandate to provide Medicaid to all eligible youth adopted with special needs is the directive of the federal government found in the CMS State Medicaid Manual. The State Medicaid Manual is created by the CMS to provide state guidance and public understanding in the implementation of the Medicaid program, offering “day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives.”⁵⁷

The language of the State Medicaid Manual, in chapter three, section 3506, *Children Under State Adoption Assistance Programs* makes clear that, “[o]nce initial [Medicaid] eligibility has been established, that determination is binding as long as an adoption agreement is in force and the child is within the age limitation.”⁵⁸

Medicaid eligibility for adoption assistance recipients was begun under the *Adoption Assistance and Child Welfare Act*, mandated under the COBRA of 1985, clarified by the *Adoption and Safe Families Act*, confirmed by the CRS, and mandated by CMS, the federal agency that oversees the Medicaid program. How, then, is it possible that adoption assistance recipients found Medicaid eligible do not receive Medicaid in all states in all circumstances?

55. KAREN SPAR & MATTHEW SHUMAN, CHILD WELFARE: IMPLEMENTATION OF THE ADOPTION AND SAFE FAMILIES ACT (P.L. 105-89), CONG. RESEARCH SERVS. DOCUMENT NO. RL30759, 9 (Nov. 8, 2004), http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2012/RL30759_gb.pdf.

56. ELICIA HERZ ET AL., HOW MEDICAID WORKS: PROGRAM BASICS, CONG. RESEARCH SERVS. DOCUMENT NO. RL32277, 1 (Mar. 16, 2005), <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3227703162005.pdf>. See *CMS covers 100 million people...*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov> (last visited Jan. 24, 2015).

57. MANUALS, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html> (last modified Nov. 5, 2013).

58. CTRS. FOR MEDICARE AND MEDICAID SERVS., *The State Medicaid Manual*, § 3506, TITLE 45, CHAPTER 3, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html> (last visited Mar. 23, 2015).

III. STATE PRACTICE, MEDICAID AND ADOPTION ASSISTANCE

Currently, in every state but New Mexico, if an adopted child resides within the state that executed the state adoption assistance agreement, the state will provide the child with Medicaid.⁵⁹ If the child has a state agreement issued by a different state than its state of residence, however, state practice determines whether the child will receive Medicaid. Most states (forty-one) provide Medicaid to all resident children with state-funded adoption assistance agreements (AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, ID, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, NJ, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY).⁶⁰ Five states only provide Medicaid to resident children with whom they have a state-funded adoption assistance agreement (HI, IL, NH, NM, NV).⁶¹ A third group of five states provides Medicaid to all resident children who have a state-funded adoption assistance agreement, unless the agreement was executed by one of the five states that categorically denies Medicaid to children with out-of-state, state-funded adoption assistance agreements (IA, ND, NE, NY, PA).⁶² This practice results in children who are in similar positions of adoption assistance eligibility and medical need receiving differential treatment by the state in which they reside, based on the state that holds the adoption assistance agreement.

This practice indicates a misunderstanding amongst the states regarding “reasonable classifications” of Medicaid eligibility. State policies and practices sometimes add eligibility criteria that delays or denies the receipt of Medicaid. The assumption appears to be that, if these types of state-of-origin restrictions on Medicaid benefits are included in the state Medicaid plan or implemented through state policy or practice, then the restrictions must be legitimate. This assumption, of course, is unjustified. There is no federal authority permitting states to impose additional criteria on Medicaid eligibility under the COBRA option. The Supremacy Clause of the Constitution, in fact, precludes it.⁶³

The state practice of denying Medicaid either to all children with out-of-state adoption assistance agreements or to children who have an adoption assistance agreement with a state that categorically denies assistance may

59. EVELYNE P. BAUMRUCKER ET AL., CHILD WELFARE: HEALTH CARE NEEDS OF CHILDREN IN FOSTER CARE AND RELATED FEDERAL ISSUES, CONG. RESEARCH SERVS. DOCUMENT No. RL42378, 24 (July 24, 2012), http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2012/R42378_gb.pdf. See *infra* note 91.

60. See “AAICAMA, COBRA Option/Reciprocity as of May 2012.”

61. *Id.*

62. *Id.*

63. U.S. CONST. art. VI, § 2.

be unlawful. At issue is the definition of “reasonable” and whether the state practice of determining Medicaid eligibility for this population based, in part, on the state with which a child holds an adoption assistance agreement is reasonable. This method of eligibility determination is likely unconstitutional under the Privileges and Immunities Clause of the United States Constitution and, therefore, in violation of 42 C.F.R. § 435.901, *Consistency With Objectives and Statutes*, which requires that all state Medicaid agency standards and methods for determining eligibility are consistent with the rights of individuals under the United States Constitution.

To support this legal conclusion, we turn to a legal analysis of this practice with respect to the federal Medicaid statute and the congressional intent behind its enactment. We will present the Constitutional arguments that make this state practice impermissible, beginning with the Supremacy, Equal Protection, and Privileges and Immunities Clauses, and, finally, the foundational ideals of the United States Constitution.

IV. A LEGAL ANALYSIS OF STATE PRACTICE, MEDICAID AND ADOPTION ASSISTANCE

A. DISTINGUISHING BETWEEN IN- AND OUT-OF-STATE NON-TITLE IV-E ADOPTION ASSISTANCE AGREEMENTS GOES AGAINST THE CONGRESSIONAL INTENT OF THE COBRA OPTION AND ASFA AND VIOLATES THE SUPREMACY CLAUSE OF THE CONSTITUTION

Seemingly, some states have added unreasonable eligibility criteria to the federal Medicaid statute. Congress clearly outlined three requirements that a child with a state adoption assistance agreement must meet to be eligible for Medicaid under the COBRA option.⁶⁴ Additionally, Congress allowed states to set two “targeting criteria.”⁶⁵ The first narrows the class by limiting the option to an age less than twenty-one.⁶⁶ The second allows states to expand, not reduce, the class of children by permitting a state to ignore income or resources when determining eligibility.⁶⁷ These two factors are the only areas in which Congress left the states any discretion.⁶⁸ Any additional criteria is unauthorized and in violation of the federal statute. Further, such additions would violate the Supremacy Clause in Article VI of the Constitution that holds federal laws supreme over state laws.⁶⁹ A

64. 42 U.S.C. § 1396a(a)(10)(A)(ii)(VIII) (2000).

65. 42 U.S.C. § 1396a(a)(17).

66. *Id.*

67. *See infra* App. A, § c.

68. *Id.*

69. U.S. CONST. art. VI, cl. 2.

state may not burden a federal law with state requirements.⁷⁰ When a state chooses to enact the COBRA option, it must limit its determination of Medicaid eligibility to the criteria enacted into law.

Congress reiterated its intent that the COBRA option covers all children adopted with special needs who hold a state adoption assistance agreement when it enacted the ASFA.⁷¹ By mandating that all eligible children with special needs receive Medicaid, Congress reinforced the fact that Medicaid benefits must be provided to all eligible children with state adoption assistance agreements.⁷² And, by specifically targeting children with special needs for Medicaid, the Act put Medicaid funding behind the child welfare goal of improving the health, safety, and well-being of these children.⁷³ Given the intent of Congress that all children adopted with special needs receive medical assistance, the states choosing to include the COBRA option in the Medicaid State Plan should comply.

In *Miller v. Youakim*, the United States Supreme Court emphasized that no state can depart from the Congressional intent behind a federal statute.⁷⁴ *Youakim* addressed the Illinois Department of Children and Family Services' (DCFS) practice of limiting Aid to Families with Dependent Children (AFDC) funds to relative placements while giving greater AFDC-Foster Care (AFDC-FC) funding to children placed with relatives.⁷⁵ The families of four foster children brought a class action challenging the payment distinction between related and unrelated foster care parents.⁷⁶ DCFS argued that this differential payment plan was appropriate because the State defined the term "foster family home" as a facility for children unrelated to the operator.⁷⁷ But, after carefully parsing through the text of the statute, the Court found that Congress did not intend to limit the term to include only non-relative caretakers, but to include all homes licensed and approved by the state agency.⁷⁸ The Court then looked to the legislative history of the statute and its subsequent amendments and determined that the fundamental purpose behind foster care was to care for neglected children.⁷⁹ Thus, the

70. *Id.*

71. KAREN SPAR & MATTHEW SHUMAN, CHILD WELFARE: IMPLEMENTATION OF THE ADOPTION AND SAFE FAMILIES ACT (P.L. 105-89), CONG. RESEARCH SERVS. DOCUMENT NO. RL30759, 25 (Nov. 8, 2004), http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2012/RL30759_gb.pdf.

72. *Id.* at §§ 306-07.

73. *Id.*

74. *Miller v. Youakim*, 440 U.S. 125 (1979).

75. *Id.* at 126.

76. *Id.* at 129-30.

77. *Id.*

78. *Id.* at 135.

79. *Miller v. Youakim*, 440 U.S. 125, 140-43 (1979).

Court concluded that Congress did not “intend[] to discriminate between potential beneficiaries, equally in need of the program, on the basis of their relationship to their foster parents.”⁸⁰ As a result, the Court’s holding prohibited Illinois from adding to the federal statute the requirement that a foster child live with a non-relative to receive the higher payment under AFDC-FC.

Similar to the facts in *Youakim*, many states have impermissibly added criteria to a federal statute.⁸¹ Just as Illinois could not support its distinction between relative and non-relative caregivers, a court will likely find that states limiting Medicaid to children who have state adoption assistance agreements with the state of residence cannot justify this limitation with the text of the statute. A proposed interpretation of the statute to mean that, because it reads that the child must have an adoption assistance agreement between “*the* state (instead of ‘*a* state’) and the adoptive parents” in order to trigger state Medicaid obligations, the agreement must be with the same state in which the child resides distorts the statute’s meaning and defies Congressional intent.

All children who meet the three eligibility criteria for the COBRA option have been deemed to be in need of medical assistance, and the purpose of the federal option is to provide aid to these needy children.⁸² The determination of need is referenced in the past tense in the law, meaning that determination only happens once, prior to adoption finalization and is made by the adoption assistance state that executed the agreement.⁸³ How else could a state determine that medical assistance was necessary to secure the placement?⁸⁴ A child’s need is, logically, not congressionally meant to be re-determined when he or she crosses state lines if the need must be established at adoption placement.

There is no indication that Congress intended to restrict this class of children eligible for Medicaid based on the arbitrary fact of with which state the family made the adoption assistance agreement. Allowing states to limit Medicaid based on this fact would not be a reasonable classification of children as required by the federal regulations clarifying the COBRA option. This classification is, therefore, in violation of federal law. Congress intended that a state that chooses the COBRA option provide Medicaid to all children with state adoption assistance agreements who meet the three federal requirements under Medicaid law, regardless of the state with which the agreement was made.

80. *Id.* at 142.

81. Janeen Newby, *Medicaid: Finding a Way Through the Maze of Non IV-E Eligibility*, available at <http://www.slideserve.com/ely/medicaid> (last visited Mar. 23, 2015).

82. See 42 U.S.C. 1396a(a)(10)(A)(ii)(VIII) (2000).

83. *Id.*

84. See 26 C.F.R. § 1.410(b)-4.

1. *Courts Should Follow Well-Established Supreme Court Precedents*

In defiance of the Supreme Court holding in *Youakim*, the Ninth Circuit decided in *Lipscomb v. Simmons* to allow Oregon to fund foster placements made only with non-relatives.⁸⁵ The court reasoned that, when faced with difficult fiscal considerations, “nothing in the Constitution prevents [the state] from taking advantage of those financially able and generous relatives.”⁸⁶ Throughout the opinion, however, the court emphasized that the state only had a duty to provide adequate, not optimal, care,⁸⁷ and that there was no evidence that the child’s placement with unrelated foster parents denied them adequate care.⁸⁸ The same cannot be true of the denial of Medicaid benefits. Children with state adoption assistance agreements have been determined to be children with special needs, invariably in need of medical assistance, and by denying them that assistance they are being denied adequate care. Unlike in *Lipscomb*, these adopted children are receiving no medical assistance from the state, not a suboptimal form of medical assistance. If the court does look to *Lipscomb* as an authority, it should find this difference to be determinative.

The *Lipscomb* court went on to state that there is “no affirmative right to governmental aid,” so denying payments to relatives was in line with the state’s legitimate interest in conserving limited funds.⁸⁹ By denying any affirmative right to governmental aid, this court also disregarded the Supreme Court opinion in *Goldberg v. Kelly*.⁹⁰ In *Goldberg*, New York residents challenged the state of New York and the city of New York’s practice of terminating welfare benefits without prior notice or an opportunity to be heard, alleging that such actions were in violation of the Due Process Clause.⁹¹ The Court noted “welfare entitlements [are] more like ‘property’ than a ‘gratuity.’”⁹² It, therefore, found that Constitutional restraints applied to the withdrawal of public assistance benefits and that the beneficiary is entitled to procedural due process before the benefit is rescinded.⁹³

The *Goldberg* Court cited 42 U.S.C. § 602(a)(4), which requires that a State afford a fair hearing to any recipient of aid under a federally assisted

85. *Lipscomb v. Simmons*, 962 F.2d 1374 (9th Cir. 1992).

86. *Id.* at 1377.

87. *Id.* at 1381.

88. *Id.* at 1382.

89. *Id.* at 1379.

90. *Goldberg v. Kelly*, 397 U.S. 254 (1970).

91. *Id.* at 292.

92. *Id.* at 262 n.8.

93. *Id.* at 262.

program before termination of that aid becomes final.⁹⁴ Title XIX Medicaid is a federally funded program that provides medical assistance to those in need.⁹⁵ Children with state adoption assistance agreements qualify for this program because they have a medical or rehabilitative need that would make it impossible for a potential adoptive parent to provide the care they need without Medicaid assistance.⁹⁶ When that child moves to a new state, however, some states terminate this assistance without any procedural protections for the child and the adoptive family.⁹⁷ This practice violates the due process rights articulated by the *Goldberg* Court.⁹⁸ Like the plaintiffs in *Goldberg*, these youth have come to rely on this governmental support.⁹⁹ In fact, it has been determined that they would not have been able to be adopted without such medical assistance and the adoptive parents were given this benefit for their child in exchange for providing a permanent home. This is a contractual, as well as a due process, violation.

Nevertheless, children with state adoption assistance agreements routinely face the loss and the possibility of losing Medicaid, without ever receiving any procedural due process, when only their residency, not their eligibility, has changed. It may be that families do not know their rights or do not seek to enforce them. If the right to a fair hearing were enforced, the practice of denying Medicaid based on a child's adoption assistance state would receive at least administrative review and, perhaps, court scrutiny. Presented with such cases, courts are likely to find that such arbitrary deprivation of a federal benefit to children adopted with special needs is an impermissible state practice.

The *Goldberg* Court then goes on to explain that the need to "protect the public's tax revenues" does not provide a strong enough consideration to outweigh an individual's "overpowering need" for assistance.¹⁰⁰ Fiscal constraints cannot justify the denial of due process.¹⁰¹ In the present case, as explained above, the children being denied Medicaid have been determined by the adoption assistance state to be in need of medical assistance and continue to meet statutory eligibility. Fiscal considerations cannot, therefore, prevent children and their families from having the opportunity to contest the denial of Medicaid benefits.

The Ninth Circuit holding in *Lipscomb* is hard to reconcile with the Supreme Court precedents in *Youakim* and *Goldberg*. It goes against the

94. *Id.* at 258 n.3.

95. *See* 42 U.S.C. 1396 §1901 (2000).

96. *See* 42 U.S.C. 1396a(a)(10)(A)(ii)(VIII) (2000).

97. *Goldberg v. Kelly*, 397 U.S. 254, 261 (1970).

98. *Id.*

99. *See* 42 U.S.C. § 670 (2000).

100. *Goldberg*, 397 U.S. at 261.

101. *Id.*

fundamental, and deeply established, principle that similarly situated residents must be treated equally. The court should follow the more weighty authority of the Supreme Court, not one aberrant Court of Appeal decision. In so doing, it will likely find that the current state practice of distinguishing amongst special needs adopted youth based on the state with which they have an adoption assistance agreement violates congressional intent and denies them constitutional due process.

B. THE STATE PRACTICE OF DISTINGUISHING AMONGST RESIDENTS WITH A STATE ADOPTION ASSISTANCE AGREEMENT VIOLATES THE EQUAL PROTECTION CLAUSE

Current state practice does not treat equally situated residents equally. Courts only rarely apply strict scrutiny to a classification of people within a law and youth receiving state adoption assistance is not one of them.¹⁰²

In the Supreme Court case most analogous to this population of children, *Saenz v. Roe*, the Court found that the “[s]tate’s legitimate interest in saving money provides no justification for its decisions to discriminate among equally eligible citizens.”¹⁰³ This statement prevents the state from relying on fiscal considerations to justify its policy, likely leaving it with little else on which to base the state practice. Even under a mere rational basis test, a court will likely find that the fact of which state holds a child’s adoption assistance agreement as a basis for Medicaid is not rationally related to the resident state’s legitimate interest in conserving state funds. The state that executed the agreement does not have a rational connection to the resident states’ decision to not provide Medicaid and classifying children on this criterion is an unreasonable state practice. It should be noted that states have never been made to assert any state interest, rational or otherwise, for which the current practice was a means of achieving. The court would likely find that there are other, less discriminatory ways to achieve the same fiscal goal.¹⁰⁴

The *Saenz* court also stated that the Equal Protection “Clause does not tolerate a hierarchy of 45 subclasses of similarly situated citizens based on the location of their prior residence.”¹⁰⁵ In *Saenz*, the Court disallowed Cali-

102. See *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985). Heightened scrutiny is required for race, national origin, and gender. See *id.* A legal classification based on mental retardation does not require strict review. See *id.*

103. *Saenz v. Roe*, 526 U.S. 489, 507 (1999).

104. See *Chem. Waste Mgmt. v. Hunt*, 504 U.S. 334, 344-45 (1992) (finding an in-state vs. out-of-state distinction unjustified because there were less discriminatory means of achieving the same public health goal).

105. *Saenz*, 526 U.S. at 506-07 (citing William Cohen, *Discrimination Against New State Citizens: An Update*, 11 CONST. COMM. 73, 79 (1994)).

ifornia's attempt to limit welfare benefits to new residents by paying only what the individual would have received from the previous state of residence for the first year of California residence.¹⁰⁶ It explained that new residents were entitled to the same benefits as more established residents and that distinguishing between these equally needy residents was a violation of Equal Protection as well as the Privileges and Immunities Clause.¹⁰⁷

This hierarchy is exactly what the states that have imposed additional restrictions on Medicaid to state adoption recipients have created. In states that deny Medicaid to all children with out-of-state adoption assistance agreements, two subclasses exist. At the top are those with state agreements with that same state who can receive Medicaid benefits, and below them are the children with agreements with other states who are denied those benefits.

In states that deny Medicaid to children with a state agreement from one of the five states that deny Medicaid to all children with out-of-state agreements, two slightly different subclasses are created. Children who have a state agreement that is not with one of those five states receive Medicaid and are at the top of the hierarchy. Children from one of the five states, however, are at the bottom of the hierarchy and are denied Medicaid benefits. All the children, however, who meet the definition of resident and were found Medicaid eligible by the adoption assistance state, are equally entitled to Medicaid benefits. Thus, such a hierarchy of resident children is unsustainable under the constitutional protections of equality among residents, and was clearly not the intent of Congress. Current state practice is, consequently, legally unjustifiable.

C. CURRENT STATE PRACTICE PUNISHES CHILDREN WHOSE FAMILIES HAVE EXERCISED THEIR CONSTITUTIONAL RIGHT TO TRAVEL

The *Saenz* Court articulated the three components embraced by the "right to travel," a right contained within the Privileges and Immunities Clause of the Constitution.¹⁰⁸ One of these components is the right to be treated like other citizens of the state if the traveler elects to become a permanent resident.¹⁰⁹ As discussed above, the Court switched its discussion from the right to travel to one of Equal Protection of residents, but the right to travel also applies to the current case. The *Saenz* opinion suggests that this right can be violated even if migration is not actually deterred.¹¹⁰ It

106. *Saenz*, 526 U.S. at 498.

107. *Id.* at 497.

108. *Id.* at 500.

109. *Id.*

110. *Id.* at 504.

further states that a policy of eliminating incentives is not more justifiable than one that imposes special burdens on new arrivals to deter them from moving into the state.¹¹¹ In so stating, the Court implied that the withholding of benefits, not just the imposition of penalties, could be found to implicate the right to travel.

Requiring the families of some children with state adoption assistance agreements to secure alternative medical assistance, alternative Medicaid delivery, or to go without may be interpreted as a special burden that cannot be imposed. Just as in *Saenz*, current state practice does not actually restrict the ability to travel.¹¹² Rather, federal benefits are restricted once the person enters into the state and establishes residency. The denial of Medicaid benefits to children with a state adoption assistance agreement that the host state will not honor, however, makes the present case even more compelling than the situation in *Saenz*. Unlike in *Saenz*, these children cannot receive the government assistance to which they should be entitled as residents of the state after a given period of time. They are not merely being treated differently for a year, but for their entire residence in the new state. Furthermore, rather than receiving less assistance from their new host state, they are receiving no assistance. Without this assistance, which they have been deemed to need and for which they remain statutorily eligible, they may go without adequate healthcare, leading to a less healthy, productive, and fulfilling life. The termination consequently does not just hurt these children for a year, but for the rest of their lives and at a time in their lives when adequate healthcare is developmentally crucial.¹¹³ For these reasons, a court will likely conclude that states impermissibly discriminate against citizens who have chosen to exercise their right to travel.

In a second case concerning the right to travel, *Edwards v. California*, the Court struck down a law prohibiting indigent people from entering California, finding that the law impermissibly hindered the free movement of

111. *Saenz v. Roe*, 526 U.S. 489, 509 (1999).

112. *See id.* at 500.

113. 42 U.S.C. § 1396d(r) (2000). The creation of the mandatory *Early and Periodic Screening, Diagnostic, and Treatment* (EPSDT) benefit under Medicaid was meant to provide “comprehensive and preventive health care services for children under age 21 . . . [which is] key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.” MEDICAID.GOV, *Early and Periodic Screening, Diagnostic, and Treatment*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html> (last visited Mar. 23, 2015). *See also* CTRS. FOR MEDICARE AND MEDICAID SERVS., *The State Medicaid Manual*, §§ 5010, 5121, 5310, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html> (last visited Mar. 23, 2015) (requiring states to “[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly”).

people across borders.¹¹⁴ The Court explained that the social interstate movement of people is a national concern that does not permit diverse treatment by the different states.¹¹⁵ The Court worried that such diverse treatment could lead to retaliatory measures by other states, leaving needy people with nowhere to live.¹¹⁶

The retaliation that the Supreme Court feared has come to pass with respect to Medicaid for children with state adoption assistance agreements. Five states have read the COBRA option's "the state" language versus "a state" language as permitting them to extend Medicaid only to children with agreements executed within the residence state. In response to the fact that children from other states were denied Medicaid upon moving to these five states, several other states have taken the position that they will not extend Medicaid to children with an agreement held by one of the five states.¹¹⁷ This retaliation limits the number of states to which adopted children with special needs can live and still receive the medical assistance they need and the Medicaid they were promised in the adoption assistance agreement. If the retaliation continues to expand, it may result in these children choosing between medical care and the family's need to move to a state that does not provide Medicaid that is otherwise optimum for other reasons. Something the constitutional line of cases regarding the right to travel clearly indicates is unsupportable.

The plurality in *Edwards* focused on the Commerce Clause, without ever turning to the right to travel.¹¹⁸ The concurrences, however, emphasized that the right of national citizens to cross state borders freely is protected by the Privileges and Immunities Clause of the Constitution, and rises to an even higher level of protection than that afforded to the movement of goods.¹¹⁹ One concurrence stated, "The mere state of being without funds is a neutral fact – constitutionally an irrelevance, like race, creed, or color."¹²⁰ This statement clearly indicates that laws that discriminate on the basis of wealth are invalid. The state practice of denying Medicaid to some children with out-of-state agreements, while not directly discriminating on the basis of wealth, has the largest potential impact on the poorest families who may have no alternative healthcare option for their child. Because of this discriminatory effect, this state practice may likewise be held to be invalid.

114. *Edwards v. California*, 314 U.S. 160, 177, 173 (1941).

115. *Id.* at 176.

116. *Id.*

117. THE ADVISORY BD. CO., *Where the States Stand on Medicaid Expansion* (Feb. 11, 2015), <http://www.advisory.com/daily-briefing/resources/primers/medicaidmap>.

118. *Edwards*, 314 U.S. at 176.

119. *Id.* at 177-78.

120. *Id.* at 184-85.

Several further comparisons can be made between *Edwards* and state practice regarding the provision of state adoption assistance. First, both involve federal assistance. California wanted to prohibit the entry of indigents to preserve limited resources, just as states likely justify the withholding of Medicaid benefits with fiscal concerns. Second, *Edwards* involved a man who did not choose to live in the state, but rather was forced to move there to be cared for by his brother.¹²¹ This is similar to a child who does not choose to move, but moves to wherever their family decides. This issue of volition is likely the reason the plurality looked to the Commerce Clause rather than to the Privileges and Immunities Clause, but the opinion shows how tightly linked the two constitutional protections are. An argument could easily encompass both, or transition from one to another. While *Edwards* concerned the prohibition of indigents from entering the state, and the present case concerns the termination of benefits once a child arrives, the similarities between the cases may persuade the court to find that current state practice impinges on privileges protected by the Constitution.

D. CURRENT STATE PRACTICE DOES NOT UPHOLD THE
CONSTITUTIONAL IDEAL OF A COOPERATIVE UNION OF
STATES

Justice Cardozo famously stated that the Constitution is “framed upon the theory that the peoples of the several states must sink or swim together.”¹²² This sentiment runs through many of the cases regarding welfare and travel. A state cannot isolate itself from the problems that face the Union. Healthcare and its provision is decidedly a problem facing this nation and the provision of healthcare to former foster youth is an on-going necessity. This need is evidenced by Congress once again recognizing and addressing the provision of healthcare to this population by creating a new, mandatory category of Medicaid eligibility for former foster youth under the *Patient Protection and Affordable Care Act of 2010*.¹²³

The states that deny Medicaid benefits either to all children with out-of-state adoption assistance agreements or to children with state adoption assistance agreements from one of the five states that categorically deny Medicaid are forcing the families of children adopted with special needs to seek alternative healthcare. For families faced with the many behavioral,

121. *Id.* at 170-71.

122. *Baldwin v. G.A.F. Seelig, Inc.*, 294 U.S. 511, 523 (1935).

123. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (amending § 5000A of the Internal Revenue Code of 1986); 42 U.S.C. § 1396a(a)(10)(A)(i)(IX) (2000); 42 C.F.R. 435.150 (providing Medicaid to eligible, former foster care youth to the age of 26).

mental, and physical health needs common to children adopted from care, this additional hurdle may well feel like swimming alone.¹²⁴ Furthermore, this state practice has isolated some states from the responsibility of providing medical assistance to special needs adopted children. The *Edwards* Court prohibited such behavior, stating, “the relief of the needy has become the common responsibility and concern of the whole nation.”¹²⁵ States cannot impose healthcare costs on families based on the arbitrary classification of having an out-of-state non-title IV-E adoption assistance agreement.

The Supreme Court has emphasized that “the business of the State is not with the past, but with the present: to remedy continuing injustices, to fill current needs, to build on the present in order to better the future.”¹²⁶ A state should not focus its attention on the state from which the child came in the past, but rather on the needs of the child in the present. And the health care needs of children adopted from care continue in the present, regardless of the state with which the child holds an adoption assistance agreement.

CONCLUSION

Adoption assistance programs seek to promote adoption of children from state care and providing Medicaid is a vital component in support of that goal. All states operating adoption assistance programs must meet the Congressional intent of the *Adoption and Safe Families Act of 1997* to ensure the safety, permanency, and well-being of children entrusted to and adopted from state care. All states must comply with the Constitution of the United States and its principles of federal Supremacy, the right to travel, and the equal rights and privileges of all Americans.

States must also accommodate for the realities of a mobile society and meet their Medicaid obligation to children eligible for adoption assistance. They must work cooperatively across states and within states to meet this contractual obligation outlined in the adoption assistance agreement, mandated in federal law and protected by Constitutional principles. Current state Medicaid practice treats similarly situated citizen residents inequitably, is a disincentive to the practice of interstate adoption, and potentially leaves children adopted with special needs to suffer the ill effects of inadequate healthcare. This practice is clearly an unintended consequence of the interstate realities of Medicaid. Congress could not have intended for Medi-

124. U.S. DEP’T OF HEALTH AND HUMAN SERVS., Admin. for Children and Families, Office of Planning, Research and Evaluation, *No. 12: Estimates of Supplemental Security Income Eligibility in Out-of-home Placements*, NAT’L SURVEY OF CHILD AND ADOLESCENT WELL-BEING, 1, http://www.acf.hhs.gov/sites/default/files/opre/est_suppl.pdf (last visited Feb. 15, 2015).

125. *Edwards*, 314 U.S. at 175.

126. *Zobel v. Williams*, 457 U.S. 55, 70 (1982).

caid benefits to be lost interstate to children adopted with special needs who did not have the good fortune to qualify for title IV-E. If you move, you should not have to lose.

APPENDIX A

MEDICAID PLANS AT ATTACHMENT 2.2-A, PART B, OPTIONAL GROUPS OTHER THAN THE MEDICALLY NEEDY

State plans for Medicaid differ widely and plan contents are not all readily available to the public. The following is an example of a state plan, where the provision of Medicaid to state adoption assistance recipients is at number 8 and reads as follows:

“A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement-

- a. Was eligible for Medicaid under the State's approved Medicaid plan; or
- b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.
- c. Additional targeting: (specify, if any)

The State covers these individuals under the age of-

- 21
- 20
- 19
- 18

The agency does not consider income or resources when determining eligibility for this population.”

Source: Ohio State Plan Under Title XIX of the Social Security Act, TN 11-008 (effective date April 1, 2011), *available at* <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-11-008-Att.pdf>; Superseded by SPA TN 13-0025 (Attachment 2.2-A, Page 14, stricken through), *available at* <http://medicaid.ohio.gov/Portals/0/Medicaid%20101/Medicaid%20State%20Plan/Section%202/2.2-A.pdf>; State Plan Amendment TN 13-0025 (superseding pages of plan material, Attachment 2.2-A Complete Pages Re-

moved: Page 14, effective date Jan. 1 2014), *available at* <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-13-0025-TC.pdf>. *See also* Wyoming State Plan Amendment Under Title XIX of the Social Security Act, TN 13-006 (effective date Oct. 1, 2013), *available at* <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WY/WY-13-006-Att.pdf>; Wyoming State Plan Amendment Approval Document, SPA TN 13-006 (approval date Oct. 25, 2013), *available at* <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WY/WY-13-006-Ltr.pdf>.

APPENDIX B

The following chart is found at the top of page 50 in the CRS report, *Child Welfare: A Detailed Overview of Program Eligibility and Funding for Foster Care, Adoption Assistance and Kinship Guardianship Assistance under Title IV-E of the Social Security Act* by Emilie Stoltzfus (October 26, 2012).

The columns for “FY” and “Total Adoptions” are the first two columns on the left with no umbrella column; to the right of those two columns is the umbrella column of “Share of Total Adoptions” under which is found the remaining four columns. Link:

http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2012/R42792_gb.pdf (page 50, top of page)

Table 9. Total Adoptions with Public Child Welfare Agency Involvement by Receipt of Title IV-E Subsidy, Non-Title IV-E Subsidy or No Subsidy, FY2000-FY2011

Number of total adoptions shown excludes those for which data on receipt of subsidy were missing.

Fiscal Year	Total Adoptions	Share of Total Adoptions			
		Subsidy Provided with Title IV-E Support	Subsidy Provided without Title IV-E Support	No Subsidy Provided	Total
2000	50,975	74.8%	13.0%	12.2%	100%
2001	50,480	74.7%	13.1%	12.2%	100%
2002	52,810	73.3%	15.6%	11.1%	100%
2003	50,482	70.1%	18.6%	11.2%	100%
2004	50,839	71.9%	18.8%	9.3%	100%
2005	51,503	71.2%	19.5%	9.3%	100%
2006	50,364	67.4%	20.6%	12.0%	100%
2007	52,534	66.6%	21.1%	12.3%	100%
2008	55,083	65.7%	23.8%	10.5%	100%
2009	56,939	63.9%	24.0%	12.1%	100%
2010	53,502	67.1%	23.3%	9.6%	100%
2011	50,507	65.9%	24.2%	9.9%	100%

Source: Table prepared by the Congressional Research Service, based on AFCARS data provided by HHS, ACF, ACYF, Children’s Bureau in

March 2008 for FY2000-FY2003 and in August 2012 for all subsequent years.

Note: The total number of adoptions shown for a given fiscal year may not match the numbers of “total adoptions” for that fiscal year as shown elsewhere because the number here excludes a small number of public child welfare agency adoptions in each year for which data on receipt of subsidy were not reported.