



Managing Medicaid Take-Up

The Relationship Between Medicaid and Welfare Agencies

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Study Highlights

There is great variety across the states in organizing TANF, Medicaid, CHIP, and related programs.

- ❖ The administrative structures range from relatively simple separation of TANF and Medicaid/CHIP programs into two separate departments to complex systems with several departments and many sub-department units and bureaus involved in management and oversight of the programs. Some states integrate medical and welfare agencies within one department or organization, while others have placed those programs in different departments. Many states contract out various Medicaid administrative functions, such as outreach and eligibility determination, to private contractors.

Despite the differences in structures, many states have developed effective working relationships between offices responsible for TANF and for Medicaid and CHIP, but some problems remain.

- ❖ Welfare reform has been widely embraced in states, including the idea that Medicaid and other support services should be provided to help families in their transition from cash assistance to self-support. The most frequently discussed problem is that of clients falling through the cracks between Medicaid and CHIP, when they apply for Medicaid and are rejected but are not automatically considered for CHIP enrollment.

Different organizational approaches appear to have an impact on take-up levels and the accessibility of Medicaid and CHIP for low-income families, but states face difficult tradeoffs in taking different approaches.

- ❖ Proponents of separating Medicaid and welfare agencies argue that since there is a stigma associated with receiving cash assistance, more of those eligible for Medicaid will seek coverage if health and welfare programs are clearly separated. But administratively separating the two programs might come at a price, as welfare recipients and those moving off of assistance may find it more difficult to secure medical benefits than if these programs are located in the same office. Separating Medicaid and welfare offices is also less convenient for recipients and complicates their efforts to access the help they need.

Introduction

The Rockefeller Institute of Government at the State University of New York has created a network of researchers in 18 states who have been studying a variety of issues surrounding the relationship between welfare reform and Medicaid policy. One of the many important issues we have examined is the relationship between the state agencies responsible for Medicaid, the Children’s Health Insurance Program (CHIP), and for welfare or Temporary Assistance to Needy Families (TANF), the new name for cash assistance to poor families created as part of the 1996 federal welfare reform law.

The purpose of this management brief is to report on the findings of these studies and, in particular, to discuss what states have learned during the past several years about the management of these programs, and what innovations have worked or not worked as state officials have fashioned responses to the challenges posed by managing Medicaid and TANF programs. The experience of 18 states provides the basis for this study. These states do not represent a statistically representative sample of all states but, rather, represent a broad cross-section of approaches to welfare reform, Medicaid expansion, and related issues.

The findings of researchers in these 18 states suggest answers to a number of questions that have been raised concerning the implementation of Medicaid by states. One of the central questions is what has been the impact of different organizational approaches on take-up levels and the accessibility of Medicaid and CHIP for low-income families? Proponents of separating Medicaid and welfare agencies argue that since there is a stigma associated with receiving cash assistance, more of those eligible for Medicaid will seek coverage if health and welfare

programs are clearly separated. But administratively separating the two programs might come at a price, as welfare recipients and those moving off of assistance may find it more difficult to secure medical benefits than if these programs are located in the same office. Integrating Medicaid and welfare offices may produce some administrative efficiencies and be more convenient for recipients, but integrating programs that in the past have been separate may be disruptive for staff.

A second issue concerning the structuring of Medicaid services is that of privatizing some Medicaid administrative functions. Privatizing governmental services has been debated for decades, and Medicaid has always relied on private service providers, such as doctors, hospitals, and nursing homes, but hiring private companies to help states administer the Medicaid program has only recently become an issue in Medicaid. Unlike for welfare and other services, where privatization has prompted questions about using public funds for funding services by faith-based groups, here the issue is primarily one of improving the efficiency of service delivery. What are the strengths and weaknesses of contracting services to nonprofit and for-profit organizations?

A third issue is rooted in different ideas about how to promote accountability. One view is to divide different functions among different agencies, a kind of separation of powers and functions that encourages checking and balancing by this diversity of authority. The other view is to concentrate responsibilities in one agency so accountability is easily identifiable. If there are problems with a program, attention is directed to one specific organization, rather than trying to figure out whether the problem is one of policy design, implementation, monitoring, quality control, and who is re-

<i>States Participating in the Study</i>		
<i>Arizona</i>	<i>Colorado</i>	<i>Florida</i>
<i>Georgia</i>	<i>Kansas</i>	<i>Maryland</i>
<i>Michigan</i>	<i>Missouri</i>	<i>New Jersey</i>
<i>New York</i>	<i>Ohio</i>	<i>Oregon</i>
<i>Tennessee</i>	<i>Texas</i>	<i>Utah</i>
<i>Washington</i>	<i>West Virginia</i>	<i>Wisconsin</i>

sponsible for those different functions. How have states sought to promote accountability of Medicaid and related agencies?

A fourth question centers on the policy position state elected officials take toward enrollment and spending; some state officials seek to check the growth of Medicaid spending as part of their effort to contain state spending or balance state budgets, while in other states, the goal is to expand coverage so that more and more low-income children in particular are provided some kind of health insurance. If states are oriented toward expanding coverage, ensuring that all possible recipients receive help, and providing as much support to families transitioning from welfare to work as possible, what kind of organizational structure facilitates such efforts? In contrast, what organizational approaches do states take when their policy priority is to reduce spending on Medicaid or other social services?

The paper begins with a description of different approaches states have taken to structuring Medicaid and welfare programs. It then turns to a discussion of the implications of the different state administrative structures for the four questions outlined above — how does administrative structure affect Medicaid take-up rates, how does privatization affect Medicaid, how is accountability for implementing Medicaid to political officials pursued, and how do political pressures surrounding Medicaid policy interact with agency structure?

State Administrative Structures for Medicaid and TANF

Among the 18 states in the Rockefeller Institute study, there are a variety of approaches to structuring Medicaid, CHIP, and TANF services, as shown in Table 1. States' implementation of Medicaid differ along a number of dimensions:

- ❖ Integrated Medicaid and welfare services or separate agencies
- ❖ Integrated Medicaid and CHIP or separate programs
- ❖ Contracting out of Medicaid-related administrative functions to private organizations or providing all services by government employees and agencies

- ❖ Streamlined agencies that combine most Medicaid-related functions or distributing functions in many different agencies.

There are a number of ways states can be grouped in terms of their Medicaid and welfare administrative structure. One major dimension by which these state structures differ is whether they place medical and welfare services in one agency or department or in separate ones. Most states separate these services into separate agencies; seven states, Kansas, New Jersey, Ohio, Oregon, Texas, Washington, and West Virginia provide these services under one umbrella organization. Historically, many states had placed Medicaid and welfare offices in the same agency, but as the number of clients grew and the number of programs expanded, especially medical care-related initiatives, these programs were reorganized into separate agencies.

A second difference among the states is their use of private, nonprofit and profit-making organizations and businesses to provide some of the administrative services. At least seven states have contracts with companies that provide a wide range of services; most of these contracts are for outreach efforts, processing of applications, and for Medicaid reimbursement and billing. In Kansas, contractors make eligibility determinations but decisions are monitored by state employees working on site. Texas has made the broadest use of contractors, and they largely administer the CHIP program. Table 2 describes these different approaches in more detail.

A third difference is the way in which states divide tasks and responsibilities. Some states have very simple, streamlined administrative structures, with a few agencies that combine the delivery of services with planning, oversight and monitoring, program evaluation, and other functions, while other states divide this tasks among several different agencies to create a kind of institutional checks and balance. Some of these differences are reflected in Table 1. Florida, Michigan, New Jersey, Tennessee, Texas, and Washington, for example, allocate responsibility for various Medicaid and CHIP functions. Most states manage Medicaid and CHIP from the same office, but six states have established separate agencies to administer the two programs: Florida, Michigan, New Jersey, New

Table 1. State Administration of TANF, Medicaid, and CHIP Programs

<i>State</i>	<i>TANF</i>	<i>Medicaid</i>	<i>CHIP</i>
Arizona	Dept.of Economic Security	Arizona Health Care Cost Containment System Administration	Same as Medicaid
Colorado	Dept.of Human Services	Dept.of Health Care Policy and Financing	Same as Medicaid
Florida	Dept.of Children and Families, Workforce Development Board	DCF, Agency for Health Care Administration	DCF, AHCA, Florida Healthy Kids Corp
Georgia	State Dept.of Human Resources/county Dept.of Family and Children Services	Dept.of Community Health	Same as Medicaid
Kansas	Dept.of Social and Rehabilitative Services, Division of Integrated Service Delivery	DSRS, Division of Health Care Policy	Same as Medicaid
Maryland	Dept.of Human Resources	Dept.of Health and Mental Hygiene	Same as Medicaid
Michigan	Family Independence Agency and Dept.of Career Development	Dept.of Community Health, Dept.of Management and Budget, and Insurance Comm.	MDCH, Managed Care Support Division
Missouri	Dept.of Social Services, Division of Family Services	Division of Medical Services	Same as Medicaid
New Jersey	Dept.of Human Services	DHS, Division of Medical Assistance and Human Services	DHS, Division of Family Development
New York	Dept.of Family Services, Office of Temporary and Disability Assistance	Dept.of Health, Office of Medicaid Management	DOH, CHPlus office
Ohio	Dept.of Job and Family Services	Division of Ohio Health Plans	Same as Medicaid
Oregon	Dept.of Human Services, Division of Adult and Family Services	Dept.of Human Services, Office of Medical Assistance Programs	Same as Medicaid
Tennessee	Dept.of Human Services	Dept.of Finance & Admin. TennCare Bureau	Same as Medicaid
Texas	Dept.of Human Services, Texas Works	DHS, Health and Human Services Commission	HHSC, separate office from Medicaid — mainly contracted to companies and nonprofits
Utah	Dept.of Workforce Services	Dept.of Health, Division of Health Care Financing	Same as Medicaid
Washington	Dept.of Social and Health Services, Economic Services Administration	DSHS, ESA and Medical Assistance Administration	Same as Medicaid
West Virginia	Dept.of Health and Human Services, Bureau for Children and Families	DHHS, Bureau for Medical Services	BMS, also DHHS Children’s Health Insurance Agency and Dept.of Administration’s Public Employee Insurance Agency
Wisconsin	Dept.of Workforce Development, Division of Workforce Solutions	Dept.of Health and Family Services, Division of Health Care Financing	Same as Medicaid

Table 2. States that Contract with Private or Nonprofit Companies for Service Delivery

<i>State</i>	<i>Contractor</i>	<i>Kinds of Functions Performed</i>
Arizona	Maximus	TANF eligibility-pilot project
Colorado	Several companies	Medicaid billing and information services, utilization review and quality assurance, and other functions
Florida	Benova	Provide information to recipients on various health care plans, enroll them in the plan of their choice
Georgia	Electronic Data Systems (EDS)	Medicaid billing and reimbursement functions
	Dental Health Administration and Consulting Services	Process CHIP applications
Kansas	Maximus	Intake and eligibility functions for Medicaid and CHIP
	Blue Cross/Blue Shield	Medicaid provider billing and reimbursement
Michigan	Maximus	Process CHIP applications
New Jersey	Maximus	Medicaid outreach, application assistance, eligibility determination, payments, and other services
Texas	TexCare Partnership — several businesses and nonprofits	Contracts for administrative services, market and media, community-based organization outreach, HMO health plans, exclusive provider organization health plans, CHIP quality monitoring and assurance, outreach efficacy study

York, Texas, and West Virginia. In most states, CHIP and Medicaid are very similar or identical in terms of the benefits they offer and the way they operate.

Implications of Administrative Structure for Medicaid, CHIP, and TANF Medicaid Take-up and Accessibility and Administrative Structure

Enrollment in Medicaid in the 18 states studied dropped considerably after passage of the welfare reform act of 1996, reached its lowest level in 1998, then began to increase through 2000. By the end of 2000, Medicaid enrollment overall was slightly higher than in 1995, but the growth rate

across the states varied considerably. Five states, Florida, Missouri, Maryland, Michigan, and Washington, saw increases of more than 10 percent between 1995 in 2000 in Medicaid enrollment, including CHIP enrollments that were part of Medicaid expansion. On the other hand, enrollment fell by more than ten percent in five states, Kansas, Ohio, Oregon, Texas, and West Virginia.¹

A number of factors are responsible for the differences in Medicaid enrollment in these states, including differences in state outreach efforts to potential applicants for Medicaid and CHIP and differences in the accessibility of Medicaid and CHIP services. Welfare reform’s emphasis on closing cases and moving recipients into the work force

1 Courtney E. Burke and Craig W. Abbey, “Managing Medicaid Take-Up, Medicaid Enrollment Trends: 1995-2000,” Federalism Research Group, The Nelson A. Rockefeller Institute of Government, August 2002, p. 4.

resulted in closing many Medicaid cases, even though most clients were still eligible for Medicaid, resulting in some decline in enrollment. As the transition to welfare reform became institutionalized, case workers were able to identify and enroll clients who were eligible for Medicaid, and some states streamlined and simplified the Medicaid application process, all leading to an increase in enrollment. In the six states that saw enrollment in Medicaid decline between 1995 and 2000, Texas, Ohio, and Wisconsin did not simplify their enrollment process until 2000, Oregon did not make any significant changes at all, and West Virginia and Kansas did less than other states to increase access to Medicaid.²

Integrating Medicaid and TANF may contribute to declining Medicaid enrollment, as declining welfare rolls and perceptions of more stringent welfare requirements discourage applicants from applying for health and other services. Five of the states that have chosen to implement Medicaid and Welfare through a unified administrative structure, Kansas, Ohio, Oregon, Texas, and West Virginia, saw Medicaid take-up fall between 1995 and 2000. However, the two other states with a unified Medicaid-TANF structure, Washington and New Jersey, saw Medicaid take-up increase, Washington, by 20 percent, and New Jersey, by 1 percent. The sample size is too small to make any definitive judgments here about the impacts of different administrative structures.

Integrating Welfare and Medicaid. Kansas is a good example of the approach taken by some states to bring most social services within one department. TANF, Medicaid, and CHIP are all administered by the Department of Social and Rehabilitative Services (SRS). The Department's Division of Integrated Service Delivery is responsible for TANF eligibility determinations. The Department's Division of Health Care Policy administers Medicaid and CHIP. Similarly, New Jersey's Department of Human Services houses six

agencies, including the Division of Family Development that administers TANF and Food Stamps, and the Division of Medical Assistance and Human Services (DMAHS) that administers Medicaid and CHIP.³ TANF is administered in Ohio by the Office of Local Operations of the Ohio Department of Job and Family Services (DJFS); Food Stamps is the responsibility of the Bureau of Family Stability; and Medicaid is administered by the Department's Division of Ohio Health Plans. Applicants fill out one form and the staff member assigns them to the programs for which they are eligible. Ohio adds a new dimension to the discussion of administrative options by delegating responsibility to counties for delivering TANF and medical services. Ohio counties vary considerably in terms of how they structure service delivery; some use teams, others take a case management approach, and some maintain separate structures for each program.⁴

There are clear advantages to the integrated approach. State officials can ensure that welfare recipients receive Medicaid and other support services that can help them become self-supporting. Integrated services are more convenient for recipients than having to go to different offices to secure different support services. But the integration also links welfare and Medicaid in ways that might discourage Medicaid up-take, as the stigma associated with welfare spills over to Medicaid. States might conclude that if their priority is to help welfare recipients become more self-sufficient, a unified structure of Medicaid, welfare, and other services makes sense. In contrast, if states decide that expanding health coverage to low-income residents is a more important social policy goal than welfare, a separate Medicaid agency may make more sense. Placing Medicaid in a state agency independent of welfare may reduce the political scrutiny to which the program is subjected and low levels of resources that often characterize welfare agencies.⁵

2 Ibid., p. 3.

3 Richard W. Roper, "Field Report Form: Medicaid Take-up and Welfare Reform," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.

4 Ibid.

5 Jocelyn M. Johnston, "Managing Medicaid and Managed Care: A Ten-State Comparison," The Nelson A. Rockefeller Institute of Government, 2002, p. 41.

Medicaid-CHIP Coordination. One area where structure seems to be significant is in the relationship between Medicaid and CHIP. Some states have integrated these two programs, and applicants are seamlessly assessed for both programs. Kansas, New Jersey, Oregon, and Washington, for example, have essentially merged Medicaid and CHIP into one program.

The Kansas CHIP program, called Health-Wave, now serves all Medicaid children and CHIP enrollees, and the goal of the state is to move toward an integrated insurance model for health care for low-income families with no distinction between CHIP and Medicaid. Area offices in 11 regions throughout the state implement TANF, Food Stamps, and Medicaid programs; CHIP is centralized, with one office in Topeka processing all applications.⁶ The state has an active outreach program for medical programs to encourage all families that are eligible to receive services.

New Jersey's Department of Human Services houses six agencies, including the Division of Family Development that administers TANF and Food Stamps, and the Division of Medical Assistance and Human Services (DMAHS) that administers Medicaid and CHIP. Medicaid and CHIP are completely integrated; there is a seamless process of application where applications from any office are processed by the New Jersey Family Care program.⁷

The Washington Department of Social and Health Services has been the umbrella organization for welfare and medical programs for more than 30 years. Medicaid and CHIP are administered by the ESA through its 65 local offices of the Community Services Division located throughout the state. The Department's Medical Assistance Administration (MAA) develops health policy and oversees the Medicaid and CHIP program. The Medicaid and CHIP program are closely integrated and the two programs offer similar benefits.⁸

This integration of CHIP and Medicaid is a significant administrative development because of evidence in some states that applicants not eligible for one program may not be picked up by the other, and, as a result, some potential recipients of assistance are not being served. In Kansas, for example, there are currently no conflicts between the TANF and Medicaid sections of the Department, but the historical separation of Medicaid and CHIP eligibility processing has resulted in some applicants falling "through the cracks" and a private contractor has been hired to resolve that problem. In Texas, some state officials and advocacy groups believe that many potential Medicaid recipients have fallen through the cracks as a result of the complicated application process and do not have health coverage. West Virginia officials have reported some problems in coordinating the Medicaid and CHIP application processes, particularly in cases where an individual is not eligible for Medicaid but qualifies for CHIP.

In other states, CHIP and Medicaid are viewed rather differently, and CHIP is typically seen as more politically popular, while Medicaid seems to be associated with some of the stigma characteristic of welfare. Colorado's CHIP program, for example, has enjoyed a much more aggressive outreach effort than does Medicaid. In Georgia, a new agency was created to administer CHIP or Peach Care, rather than giving it to the Medicaid program, because officials believed that the existing department would not give the new program sufficient attention, and that giving it to a new agency would be a better way to promote its services to a broader audience. Michigan illustrates how differences in structure may be a result of happenstance. The division of responsibility was not by design, but the result of the state health department being so overwhelmed with implementation of Medicaid that when the MICHild (CHIP) program was created, it was given to another agency that had the capacity to take on a new program.

6 Ibid.

7 Richard W. Roper, "Field Report Form: Medicaid Take-up and Welfare Reform," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.

8 Ibid.

Oregon provides a particularly interesting case of health policy, and is in the middle of an organizational transition. TANF, Medicaid, CHIP, and Food Stamps have been administered by divisions of the Oregon Department of Human Services (DHS). The Office of Medical Assistance Programs administers the Medicaid portion of the Oregon Health Plan (a state initiative to ensure that all Oregonians with incomes at the Federal poverty level or lower are covered by Medicaid and guarantee a set of health care benefits) and the CHIP program. CHIP is not part of Medicaid, but, rather, part of the Oregon Health Plan (OHP). State officials emphasize that the OHP is clearly distinct from welfare.

Oregon has an integrated application process, including a single form and the same staff members, for CHIP and OHP Medicaid. The Office determines policy, provides billing and reimbursement services, contracts with Managed Health Care Plans to provide services, and monitors and evaluates the delivery of services. The Oregon Health Plan Policy and Research Office, the Oregon Health Council, and the Oregon Health Services Commission monitor the Oregon Health Plan and provide policy and budget recommendations. Relations between Adult and Family Services (AFS) and the Office of Medical Assistance Programs (OMAP) have been described as good, although they have much different styles; AFS is more collaborative and open in communication, while OMAP is more traditional.

In 2001, DHS began undergoing a reorganization that is expected to be completed in June 2003. Under the old structure, each of the five divisions in the Department of Human Services had its own field office; under the new organization, each local office will become a DHS office rather than an office of one of the divisions, and will house a full range of services. The Department will then include a Field Operations division; a division of Administrative Services to provide accounting, in-

formation services, and other functions department wide; a Continuous System Improvement office for training, research, planning, evaluation, and other functions; and Policy and Program Groups to develop and coordinate policy in three areas: (1) health, (2) seniors and people with disabilities, and (3) adults, families, and children.⁹

States that give priority to expanding health care benefits to low-income residents may find that integrating Medicaid and CHIP is an important step in achieving that goal. CHIP appears to be associated in at least some areas with efforts to expand health insurance coverage to more children, and to offer coverage to them that is similar to that available to other children through private insurance, rather than viewing CHIP as a welfare-like program. States that are pursuing that goal may also find that separating welfare and Medicaid/CHIP might contribute to that goal even though it makes it more difficult for welfare recipients to secure health benefits.

Separating TANF and Medical Administrative Services. Arizona, Florida, Georgia, Michigan, Missouri, Tennessee, Utah, West Virginia have all created separate agencies to administer medical and welfare programs.

Some states integrate eligibility determination for Medicaid/CHIP and TANF, but have established separate agencies to actually administer the programs. In Arizona, the Department of Economic Security, the state welfare agency, is responsible for determining eligibility for TANF and Medicaid and other medical programs and for overseeing casework and eligibility determinations.¹⁰ The Missouri Division of Family Services is responsible for eligibility determinations for TANF and for medical programs. Policy making, oversight, billing and reimbursement, and other functions associated with health programs are performed by units within the

9 Carol Freeman, Laura Leete, and Maegan Lindsay, "Oregon State Case Study of Medicaid Take-Up and Welfare Reform for The Rockefeller Institute of Government State Capacity Study," September 21, 2001.

10 See John Stuart Hall, et al., "Devolving Governance While Developing Capacity: The Unusual and Somewhat Surprising Story of Medicaid Expansion in Arizona, 2001," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.

Division of Medical Services.¹¹ Wisconsin's Department of Workforce Services administers TANF (called W-2 in Wisconsin) in its Division of Workforce Solutions. The Department of Health and Family Services administers Food Stamps, Medicaid, and CHIP in its Division of Health Care Financing. Benefits and service delivery for CHIP recipients and Medicaid families with minor children are identical and both receive services through the same HMOs. The Division of Workforce Solutions' Bureau of Division-wide Services manages the computer system that manages enrollment for W-2, Food Stamps, Medicaid, CHIP, and child care benefits, and DHFS pays the Bureau for those services.¹²

Other states have separate programs but locate them within the same buildings to facilitate client access. The Colorado Department of Human Services administers the TANF and Food Stamps programs, and the Colorado Department of Health Care Policy and Financing administers Medicaid and CHIP. Both the Medicaid and TANF administrative offices are located in the same building, but operate quite independently of each other.¹³ Utah's Department of Workforce Services (DWS) is the agency responsible for administering TANF in Utah. Applicants for TANF, Medicaid, and Food Stamps can apply for these programs at DWS offices. Health care programs available to low-income families in Utah such as Medicaid, the Utah Medical Assistance Program (for those not eligible for Medicaid), the Qualified Medicare Beneficiary program (provides help in meeting some of the costs Medicare recipients must pay and recipients over 65 who qualify for free Medicaid), and the Children's Health Insurance Program (CHIP) are administered by the Utah Department of Health. The Health Department contracts

with the Workforce Services Department to manage all Medicaid cases where other services, such as TANF assistance or Food Stamps, are provided. Employment counselors help clients apply to Medicaid and other programs. Welfare and Medicaid have always been seen as quite separate programs in Utah. In 1996, the Department of Health started a campaign to expand Medicaid enrollment by more aggressively going to low income communities and registering those eligible for Medicaid. The outreach effort was not related to welfare reform, just a coincidence in timing. DWS officials emphasize to TANF recipients the availability of Medicaid and CHIP once cash assistance ends.¹⁴

In New York, TANF and Food Stamps are administered by the Office of Temporary and Disability Assistance in the Department of Family Services, and Medicaid and CHIP are administered by different divisions within the Department of Health. CHPlus A (Medicaid) is part of the Office of Medicaid Management; CHPlus B (non-Medicaid eligible) is located in the CHPlus office, part of the Division of Planning, Policy and Resource Development. There are some differences in orientation between the two health programs, based on their history. CHPlus A evolved as an anti-poverty program, and was for many years located in the former Department of Social Services, while CHPlus B has traditionally been viewed as a health insurance program. Despite these differences, the two programs are closely coordinated. TANF, Medicaid, and Food Stamps are administered by county departments of social services, and CHIP may be located in either county health or social services departments.¹⁵

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- 11 Peter Mueser, Lael Keiser, Deanna L. Sharpe, with the assistance of Vick Wilkins, "Field Report Form: Medicaid Take-up and Welfare Reform," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.
 - 12 Tom Kaplan, "Field Report Form: Medicaid Take-up and Welfare Reform," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.
 - 13 Malcolm L. Goggin, "Field Report Form: Medicaid Take-up and Welfare Reform," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.
 - 14 Gary Bryner, "Field Report Form: Medicaid Take-up and Welfare Reform," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.
 - 15 Sarah F. Liebschutz, "Field Report Form: Medicaid Take-up and Welfare Reform," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.

These examples illustrate how states separate welfare and medical programs administratively in order to delineate between them, and to reinforce the idea that receiving medical assistance is more acceptable than getting cash assistance. States that want to communicate such a signal may find it helpful to separate medical and welfare agencies. However, there is no clear pattern here in terms of the consequences of this administrative approach for Medicaid take-up, since these states have seen dramatic increases in enrollment as well as modest expansion.

Administrative separation may also facilitate efforts to control healthcare costs. Tennessee is an example of a state that has made administrative changes to Medicaid as part of an effort to control costs. The Department of Human Services (DHS) is responsible for TANF, Food Stamps, and Medicaid eligibility. The Department of Finance and Administration (DFA) houses the TennCare Bureau. The Office of Information Resources, part of the DFA, is jointly responsible with the DHS for development and operation of the Medicaid eligibility system. TennCare is broader than Medicaid, and includes coverage for uninsured and uninsurable individuals, and TennCare officials are responsible for enrolling those who do not qualify for Medicaid but are eligible for the other TennCare programs. TennCare clients receive service through Managed Care Organizations and Behavioral Health Organizations. TennCare includes responsibility for Medicaid policy making, oversight, billing and reimbursement, and other functions. CHIP is part of TennCare and is more closely linked to the uninsured/uninsurable program than Medicaid. But CHIP eligibility is determined in the Department of Health. Concern about the rising cost of Medicaid has resulted in organizational changes that have moved medical programs away from the Department of Health and toward the Department of Finance and Administration.¹⁶

Inter-Agency Harmony. The Rockefeller Institute Field Studies all examined the nature of relationships between Medicaid, CHIP, and welfare agencies. One hypothesis is that separate institu-

tions might be competitive, distrustful of each other, reflective of different organizational history and culture, or otherwise characterized by conflict that would inhibit delivery of services to clients. The studies reported little conflict or tension between the Medicaid and other health and welfare agencies. Relationships are regularly characterized as cordial and positive in virtually every state in the study, regardless of whether the agencies are housed within the same department or are located in different ones. In Arizona, for example, where the medical and welfare agencies are housed in separate agencies, the independence of the agencies is credited with minimizing friction. Their information systems share data on a daily basis, there are weekly meetings between staff, and Medicaid employees are located in TANF offices to review cases where Medicaid benefits have been terminated to ensure decisions were correct and to ensure that families receive Transitional Medical Assistance if they are eligible. TANF officials notify Medicaid staff of families that are not eligible for Medicaid because of their income level, and Medicaid staff write letters to those families that qualify for KidsCare coverage and encourage their participation in the program. Missouri governors have emphasized cooperation between the Medicaid and TANF agencies. The administrative offices for the two agencies are located in the same building in Jefferson City. The current directors of each agency have both worked for several years in the other agency, and this cross training of directors has helped increase understanding and communication.

This comity may be a result of the maturation of programs, since administrative reorganizations associated with welfare reform are now several years old. It is possible that differences have largely been worked out and agency officials have learned how to successfully manage interagency relations. Given the difference in some states between welfare and medical programs and the stigma attached to the former, one might expect some conflict between the two agencies. More important than that may be the fact that Medicaid/CHIP and welfare have separate budgets, and budget pressures may be a much

16 John Gnsuschke, "Field Report Form: Medicaid Take-up and Welfare Reform," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.

greater source of tension than interagency efforts to coordinate service delivery. As long as medical and welfare programs are funded from separate federal accounts and the programs are not seen as competing for the same dollars, agency officials may find they have much in common as they try to serve similar clients. However, state funds for medical and welfare programs may come from the same source, and as state budgets have become much tighter and budget politics more conflictual, tensions between health care and welfare agencies could surface. It is not clear, but certainly possible, that such conflicts could be managed more effectively in states where medical and welfare services are combined in one agency, under one head.

Devolution to Local Government. Twelve of the 18 states in the study organize the delivery of Medicaid and TANF services through local field offices of state agencies, and do not delegate responsibility for these programs to local governments. Six states delegate at least some responsibility to county governments. While many states have made significant changes in the structure of Medicaid, TANF, and other related programs at the state level, some local governments have not engaged in the same kind of restructuring of programs, and the interaction of state and local agencies can be quite complex. Counties also differ within a state, and the Rockefeller study only examined two counties in each state, making it difficult to know exactly how welfare reform has affected the delivery of Medicaid and CHIP services.

In New York, for example, at the state level, TANF is located in the Department of Family Services and Medicaid and CHIP are found in different divisions of the Department of Health. Within the Department of Health, CHIP is further divided into two programs, CHPlus A, with an antipoverty focus

and CHPlus B, with a health insurance emphasis. At the county level, TANF, Medicaid, and CHIP are also administered by different departments (in New York City, by the Human Resources Administration). In Monroe County, Medicaid is located in county departments of social services while CHIP is in county health departments; in Albany county they are both located in social services department. In both counties, TANF and Medicaid are administered by separate units, including separate eligibility determinations. The different structures pose challenges for the flow of directives from various state agencies to the mix of county units, and require workers in different areas to know how their programs intersect with others.¹⁷

Ohio has a strong tradition of county governance and counties differ in the way they structure the delivery of services: some counties use a case management structure, others employ teams, and still others deliver services in separate administrative units. Collaboration and coordination across these programs has been difficult.¹⁸ Colorado is another state that delegates service delivery to counties. The CHP+ program is managed by the state “and is not well integrated at all at the county level.”¹⁹

In other states that delegate service delivery functions for Medicaid and TANF to states such as Wisconsin and Georgia, the relationship between county welfare offices and the state agency is quite hierarchical and applications are processed through the state data system which is quite prescriptive.²⁰ But Georgia counties retain specialization by program area.²¹ Jackson County, Missouri, reorganized its caseworkers in 1997 so that they deal with TANF and medical services, and coordination among caseworkers is reportedly close.²²

17 Liebschutz, 2001, pp. 5-8.

18 Miriam Wilson, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for The Nelson A. Rockefeller Institute of Government, November 2001, pp. 9-11.

19 Goggin, 2001, 25.

20 Kaplan, 2001, 12-13.

21 Amy Ellen-Duke and Michael Rich, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for The Nelson A. Rockefeller Institute of Government, November 2001, p. 14.

22 Mueser et al., 13-14.

Privatization

Privatization of Medicaid administrative services is a recent development in the states studied. The typical function of contractors is to provide outreach and payment services, but some states have contractors do more. Arizona has launched two privatization pilot project for TANF, operated by Maximus, Inc, in the Phoenix area and in Mohave County in Northern Arizona. Maximus case workers make TANF eligibility decisions, while DES employees located in the same building decide Food Stamps and Medicaid eligibility. The state sought a waiver to allow Maximus employees to take over Medicaid and Food Stamp eligibility decisions, but the Federal government denied the request. Florida contracts with a private business to provide information to recipients on various health care plans, enroll them in the plan of their choice, provide the names of physicians that can provide services, and other services. Georgia contracts with a private corporation, Electronic Data Systems, to manage billing and reimbursement functions, and with Affiliated Computer Services to process medical claims for Medicaid, Peach Care for Kids (the state's CHIP program), the State Health Benefit Plan, and the University System health plan in October 2002. Georgia is apparently the first state to consolidate claims processing for Medicaid recipients and for state employees.

The impetus for privatization is presumably to reduce costs through competitive bidding for services. The Rockefeller studies did not examine the impacts of privatization so little can be concluded from these studies. Again, patterns are inconclusive. Six of the eight states that have contracted with private firms saw an increase in Medicaid enrollment, but enrollment fell in two other contracting states, Kansas and Texas. It may be that states with major increases in caseloads turn to contracting to help constrain costs. But contracting need not result in pressure to reduce enrollment. To the contrary, depending on how contracts are written, contractors may be encouraged to enroll more recipients. Privatization may be a tool to reduce administrative costs, but its impact on take-up rates depends on the conditions included in the contracts.

Privatization of some administrative services is also part of a broader approach to structuring Medicaid and CHIP in ways that make them appear more and more like private health insurance programs. As indicated above, some states are moving toward making CHIP look much like private health insurance as a way to reach more eligible children and pursue their goal of expanding health insurance for the uninsured. As CHIP becomes viewed as more like private health insurance, states can reduce the stigma that public health insurance has shared in the past with welfare. Medicaid can similarly be structured more and more like private insurance to expand health insurance coverage in a state and reduce any stigma that might discourage some from applying for benefits. On the other hand, disengaging Medicaid/CHIP and TANF does not come without some costs. It may make it more difficult to ensure that TANF recipients receive health insurance during and after their eligibility for cash assistance, and may fail in some cases to help provide the kind of support essential for many TANF recipients to become more self-sufficient.

Accountability

States vary considerable in terms of the administrative complexity of medical programs. The states employing integrated medical and welfare programs tend to be relatively simple. In contrast, a few states have developed quite complex administrative structures. And the contracting out of services discussed above adds to administrative complexity.

Florida, for example, has devised a complicated structure of four state agencies and two public/private hybrid organizations to administer TANF, Medicaid, CHIP, and Food Stamps. Eligibility for TANF is the responsibility of the Florida Department of Children and Families. TANF services are provided by 24 regional Workforce Boards that employ privately owned (nonprofit and/or private) companies to deliver workforce services such as job training and placement. Administration of the Medicaid and CHIP programs is shared by three organizations. (1) Eligibility for Medicaid and KidCare Medicaid is determined by the Department of Children and Families. (2) The

state Agency for Health Care Administration (AHCA) and its Office of Health Policy makes policy and provides data analysis; AHCA's Division of Medicaid, Bureau of Medicaid Program Development oversees the Medicaid program and administers the primary care case management program, called MediPass, and the MediKids part of the KidCare Program for children under five; and AHCA's Division of Medicaid, Bureau of Contract Management oversees eligibility, processes Medicaid claims, and audits the payment system. AHCA's Division of Managed Care and Health Quality monitors HMOs and other health care provider facilities and services through 11 multi-county field offices throughout the state.

The state Department of Insurance, Treasurer, and Fire Marshall certifies HMOs to do business in the state and monitors financial and contractual arrangements. There are four separate programs for health insurance for low-income children that are all part of KidCare. KidCare Medicaid is for children from birth to 18 who are eligible for Medicaid. MediKids is for children under five who are not eligible for Medicaid, and Healthy Kids is for ages 5-18. Children's Medical Services Network is for children from birth to 18 who have special needs or long-term health conditions. A private/public partnership called Florida Healthy Kids Corp. coordinates these programs through its Coordinating Council, made up of representatives from the state agencies, local governments, health insurance companies, health care providers, and organizations representing low-income families.²³

Michigan is another state with a complex administrative structure for medical programs. Two agencies administer TANF: the Family Independence Agency (FIA), responsible for eligibility determinations; and the Michigan Department of Career Development, which handles job training and employment opportunities. Four agencies are involved in administering Medicaid. The FIA is responsible for receiving Medicaid applications and

determining eligibility; the Department of Management and Budget monitors the program and submits required reports to the Federal government; the Insurance Commissioner is responsible for the licensing and oversight of managed care organizations; and the Michigan Department of Community Health (MDCH) sets policy and administers the program. Two different offices within the MDCH are involved in programs for children. The Comprehensive Health Plan Division manages the Healthy Kids (Medicaid) program (as well as the Medicaid managed programs); the Managed Care Support Division is responsible for MICHild, the state's CHIP program. Healthy Kids provides free health coverage; MICHild is a low-cost health coverage program; both cover children from birth to age 18. Eligibility decisions for Healthy Kids is made by the FIA and by the Managed Care Support Division of the MDCH for MICHild. The MICHild program, in turn, uses a private company, Maximus, to review applications; Maximus employees refer applicants that might be eligible for Medicaid to the FIA.²⁴

Assessing the differences between the administrative styles of states can be rooted, in part, in different ideas about how to promote accountability. One view is to divide different functions among different agencies, a kind of separation of powers and functions that encourages checking and balancing by this diversity of authority. The other view is to concentrate responsibilities in one agency so accountability is easily identifiable. If there are problems with a program, attention is directed to one specific organization, rather than trying to figure out whether the problem is one of policy design, implementation, monitoring, quality control, and who is responsible for those different functions.

It is difficult to compare the advantages and disadvantages of the two approaches. Both have roots in the American political tradition. The separation of functions approach clearly harkens to the

23 Robert Crew, "Field Report Form: Medicaid Take-up and Welfare Reform," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.

24 Carol Weissert, "Field Report Form: Medicaid Take-up and Welfare Reform," report prepared for The Nelson A. Rockefeller Institute of Government, November 2001.

constitutional structure of checks and balances. The idea of administrative unity has been widely championed in the literature on administrative science. One way to sort them out is to choose between two forms of accountability: the separation of functions approach seeks to produce accountability through oversight of procedures, constant monitoring, and other efforts, while the administrative unity approach focuses more attention on overall performance and on ultimate responsibility of administration to political officials.

The Importance of Policy Priorities and Political Choices

More important than structural differences, however, are policy differences. In some states, state leaders have been concerned about the rising costs of Medicaid, while in others, expanding coverage is a high priority. That political decision, rather than whether the TANF and Medicaid offices are in the same or different department, seems to shape significantly the administration of these programs. In Kansas, for example, the increasing costs of Medicaid has been a “dominant concern.” Wisconsin officials have been ambivalent about Medicaid enrollment trends. Staff members are oriented toward enrolling as many people in Medicaid as qualify, while political leaders have been concerned with rising costs of Medicaid. Medicaid staff members do not engage in “outreach” activities but in “educational” efforts. In Washington, the relationship between the Medicaid and TANF agencies has been described as harmonious and collaborative. Getting people off welfare has been a state priority, but maintaining Medicaid enrollment has not even been a first-tier priority of state officials.

In contrast, in states like Arizona, officials in both TANF and Medicaid agencies have agreed on the goal of increasing Medicaid enrollment, but enrollment only grew by a modest 3 percent. Maryland officials have as a priority maintaining Medicaid enrollment high, particularly for women and children. The figures cited above about differences across states in terms of the growth of Medicaid enrollment, where numbers have increased significantly in most states studied, do not

suggest clear impacts of policy priorities. States that have not emphasized expanding enrollment have seen increases as well as those that have embraced that goal.

There are clear differences between states in terms of their commitment to expanding or curtailing Medicaid take-up rates. But these policy positions may be transitory, a function of the political ideology or priorities of the governor or legislature that might change from one election to the next, or changes in the state’s budget and fiscal health. Institutional changes are likely to be more long lasting and at least partially resistant to changes in political sentiments. New governors and legislatures may promise to reorganize state bureaucracies in order to promote values of efficiency, accountability, reduced spending, or increased service to clients, but it is difficult to make such changes very often. And at least as important as state policy priorities are the economic conditions in a state that shape the demand for social services as families’ incomes and employment rise and fall.

State administrative structures are likely to be more stable than political priorities or budget conditions. Many states have made rather dramatic changes in administrative structure as part of their reforming of welfare, and, once made, these changes are likely to last for many years. However, some of those changes may only take place at the state level, and not occur at the local level where services are actually delivered. For most states in the study, because they rely on service delivery by local units of state agencies, changes in reorganization of state agencies likely reach those who deliver services. For the states discussed above in the section on devolution to local government, the reorganization that was prompted by welfare reform in the mid-to-late 1990s did not necessarily occur at the county level, complicating considerably efforts to change the delivery of TANF and Medicaid services.

Outcomes and Results of Administrative Decisions

In sum, there is great variety across the states in organizing TANF, Medicaid, CHIP, and related programs. The administrative structures range

The Nelson A. Rockefeller Institute of Government

The Nelson A. Rockefeller Institute of Government, the public policy research arm of the State University of New York, was established in 1982 to bring the resources of the 64-campus SUNY system to bear on public policy issues. The Institute is active nationally in research and special projects on the role of state governments in American federalism and the management and finances of both state and local governments in major areas of domestic public affairs.

The American Federalism Group

The Institute's American Federalism Group was established in 1996 in response to the growing importance of state governments in the American federal system and the devolution of social programs. Despite the ever-growing role of the states, there is a dearth of high-quality, practical, independent research about state and local programs.

The mission of the American Federalism group is to help fill this gap. The Group conducts research on trends affecting states and serves as a national resource on issues such as welfare reform, and Medicaid Managed Care for public officials, the media, public affairs experts, researchers, and others. The Group is directed by Tom Gais, who has spent the last decade analyzing state and local issues with federalism. Jim Fossett oversees research in the area of public health programs.

This Report

Gary Bryner, professor of public policy at Brigham Young University, wrote this report. Institute field researchers from the states in the study obtained enrollment data and qualitative information. Michael Cooper, the Rockefeller Institute's Director of Publications, did the layout, with assistance from Michelle Charbonneau.

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from relatively simple separation of TANF and Medicaid/CHIP programs into two separate departments to complex systems with several departments and many subdepartment units and bureaus involved in management and oversight of the programs. Most of the states seem to have fostered cordial relationships between offices responsible for TANF and for Medicaid and CHIP. There is little evidence of difficulties in coordination, although the most frequently discussed problem is that of clients falling through the cracks between Medicaid and CHIP. More difficult may be the challenge of devolution to counties that retain discretion over

these programs, since some counties have not restructured their staffs in line with state-level changes. In the short run, policy position state elected officials take toward enrollment and spending appear to have been significant factors in accounting for changes in enrollment; some state officials seek to check the growth of Medicaid spending, while in other states, the goal is to expand coverage so that more and more children in particular are provided some kind of health insurance. Given the high cost of Medicaid programs, these policy goals are quite sensitive to changes in states' economic conditions.

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