



# *Managing Medicaid Take-Up*

## *State-Local Relations and Their Effect on Policy Design and Implementation*

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### **Study Highlights**

*States vary considerably in terms of the distribution of power and responsibility between state and local government for managing state Medicaid Managed Care and Child Health Insurance Programs.*

- ❖ Four of the eighteen states in our comparative study of Medicaid and CHIP management practices — Colorado, New York, Ohio, and Wisconsin — are “state supervised and county administered.” By that we mean that states have devolved a considerable amount of flexibility to counties or other subnational units of government in the design and implementation of state Medicaid programs. In most cases, devolution is structural in the sense that it is established by state constitution or statute. The other fourteen states in our study are states where “second-order” devolution is *not* the norm. Whereas all these states are centralized, the degree of centralization varies across states. These are the states that have Medicaid programs that are state administered.

*At the local level, the amount of discretion local program managers exercise also varies considerably — from a high to mixed to low degree of local autonomy.*

- ❖ Five of the 28 counties in our study — Denver County in Colorado, Monroe and Albany Counties in New York, and Hamilton and Franklin Counties in Ohio — are in states that have delegated to local managers considerable discretion. Nine counties in seven states grant local offices very little discretion. Most programmatic decisions are made in the state capital. Arizona, Missouri, Oregon, Tennessee, Texas, Utah, and Washington State grant local managers little flexibility over program operations. These states are state controlled and state supervised, with little for counties to do except follow directions from the state. Thirteen regions or counties in eight states — Florida, Georgia, Kansas, Maryland, Michigan, New Jersey, Wisconsin, and West Virginia — fall in the middle. They are “mixed” systems.

*Within local administrative systems, the degree of cooperation between the county or regional agency that manages the Medicaid and CHIP programs and other agencies varies considerably, from loosely to tightly connected.*

- ❖ Four states — Florida, Oregon, Utah, and Tennessee — were classified as loosely connected. On average, these states did not have a history of interagency collaboration before welfare reform, did not have a local task force, and reported low levels of collaboration with other agencies, advocates, or community-based organizations. Three states — Wisconsin, Michigan, and New York — are classified as moderately connected, that is, in these states there is limited contact between the local Medicaid agency and others in the organizational set for the purpose of expanding enrollment. In the rest of the states, local Medicaid agencies are actively working with other stakeholders to increase enrollment and improve take-up rates. These are the tightly connected states, where the level of connectedness is high.

*Entrepreneurial leadership at the local level — either political or administrative — also varies from state to state.*

- ❖ Based on responses to the questions in the state report forms, we divided the sample into counties where *local political actors* have taken the lead and are supportive — the *leaders* — and political actors who are not — the *laggards*. We classified four states as leaders, twelve states as laggards, and in two states — Georgia and Maryland — we lacked sufficient evidence to classify them as either leaders or laggards. The counties where local *political* leadership shined were found in four states — Arizona, Colorado, Ohio, and Texas. Our field researchers observed leadership by local *administrators*, either at the regional level or on the front lines, who placed take-up rates high on their agenda and promoted the goals of improved enrollments and take-up rates in counties in three states — Arizona, Colorado, and Ohio. In all the other states in our sample, take-up rates were not a salient issue for local administrators and thus they did not push this agenda.

*Differences in state-local relations, local autonomy, degree of cooperation with other agencies, and leadership affect implementation efforts to improve state take-up rates.*

- ❖ Because our sample of eighteen states is purposeful rather than representative and because only one or two counties were examined in each of the states, establishing causation is problematic, at best. One conclusion we draw about the relationship between degree of centralization and take-up rates is that states that have state-administered Medicaid and CHIP programs have done a better job than states with state-supervised and county-administered programs, at least in terms of take-up rates. However, we consider this conclusion tentative and recommend more rigorous testing of this hypothesis.

## Introduction

In the summer and fall of 2001, researchers from a purposeful but unrepresentative sample of 18 states who are affiliated with the Nelson A. Rockefeller Institute of Government used a common report form to gather information about state-local relations in the management of the state's Medicaid and Child Health Insurance programs. These field researchers, who are social policy experts familiar with state and local political and administration contexts because they live and work in the state, interviewed key informants, examined agency records and documents, and made direct observations of state and local management practices in the field. Compared to scans and surveys, the main advantage to this centrally coordinated approach to data collection is that the data can yield rich comparable descriptions and in-depth explanations for variations across cases. One of the unique aspects of this study is that it is the first to examine in a systematic way how local programs — in one or two large counties in each of the 18 states — are designed and implemented, thus obviating the necessity of relying on what state officials *say* is happening in the counties. Our network of field researchers *can see first-hand for themselves*.

Drawing on data from these 18 state reports, an earlier brief in this Rockefeller Institute of Government's *Managing Medicaid Take-up* series reported that state Medicaid enrollment dropped after the adoption and implementation of the Personal Responsibility and Work Opportunity Reconciliation Act in 1996, bottomed out in 1998, and then grew at an increasing rate in 2000. Take-up, or the percentage of clients served compared to the potential universe of eligibles in the state, declined sharply between 1997 and 1998, then began to rise through 2000.<sup>1</sup> The authors divide the 18 states into four different categories: 1) states that had high take-up rates over the entire 1995-2000 period; 2) states that had low take-up rates before and immediately after welfare reform,

but invested sizable resources in outreach and enrollment simplification after CHIP was implemented; 3) states that experienced a decline in their relative take-up rates after welfare reform and CHIP adoption and implementation; and 4) states that had low take-up rates for the entire 1995-2000 period. They concluded that although several states expanded eligibility and increased enrollment “only two of the eighteen states in this study actually were successful at increasing enrollment while also improving their ‘take-up’ rates.”<sup>2</sup>

The purpose of this Brief is to report findings from this eighteen-state comparative study that shed light on state-local relations and their possible effects on Medicaid and CHIP enrollments of children and adults and Medicaid “take-up” rates. This report is organized around five questions:

- ❖ To what extent and how do the eighteen states in this study vary with respect to the distribution of power and responsibility between state and local government for managing state Medicaid Managed Care and Child Health Insurance Programs?
- ❖ At the local level, to what extent and how does the amount of discretion local program managers exercise vary?
- ❖ Within local administrative systems, to what extent and how does the degree of cooperation between the county or regional agency that manages the Medicaid and CHIP programs and other agencies vary?
- ❖ To what extent and how does entrepreneurial leadership at the local level — either political or administrative — vary?
- ❖ What lessons have we learned about the effect of state-local relations on the design and implementation of policies affecting Medicaid and CHIP enrollments and take-up rates?

This Management Brief is divided into three sections. In the first section the way states are organized with respect to the distribution of manage-

<sup>1</sup> Courtney E. Burke and Craig W. Abbey, “Medicaid Enrollment Trends: 1995-2000,” *Managing Medicaid Take-Up Management Brief*. Albany, NY: Nelson A. Rockefeller Institute of Government, August 2002.

<sup>2</sup> Ibid.

<b>States Participating in the Study</b>		
<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>

ment responsibilities between state and local government is described. In section two, management practices within local jurisdictions are examined, and concrete examples of how state-local relations does and does not work are highlighted. The final, concluding section of this Management Brief focuses on lessons learned about the effect of state-local relations on program design and implementation at the local level. The major organizing theme of this Brief’s concluding section is a summary of what we have learned from our field data about how structure does or does not help achieve whatever take-up goals a state has adopted. Three questions are addressed in the conclusion: What difference does it make if a state grants local administrators considerable flexibility? What difference does it make if local implementing agencies form coalitions with others in the locality? And how does the absence or presence of local entrepreneurial leadership affect the ability of local agencies to achieve their enrollment and take-up goals?

***Devolution and the Nature of State-Local Relations***

States vary considerably in terms of the distribution of power and responsibility between state and local government for managing state Medicaid Managed Care and State Child Health Insurance Programs. Whereas at the national level all states were given more responsibility and flexibility as a

result of the “devolution revolution,” at the level of state government some states have granted more decision-making authority to counties — what we label “second-order” devolution — whereas other states have maintained power over program design and implementation in the state capitol.

Based on the data collected by the Rockefeller network of field researchers, we divide the eighteen states in our study into those that are decentralized and those that are centralized.<sup>4</sup> Four of the eighteen states in our comparative study of Medicaid and CHIP management practices — Colorado, New York, Ohio, and Wisconsin — are state supervised and county administered. By that we mean that states have devolved a considerable amount of autonomy and flexibility to counties or other subnational units of government to design and implement the Medicaid program as they see fit, but within the constraints of federally or state-mandated requirements. These are the states in which there is much more likely to be variation in program design, management practices, and procedures *among* the counties. In these county-administered states, devolution is structural in the sense that it is established by state constitution or statute. The other fourteen states in our study are states where “second-order” devolution is *not* the norm. Whereas all these states are centralized in terms of administration, they vary in the degree to which they are centralized.

<sup>4</sup> For a related discussion of how these same eighteen states deliver Medicaid and TANF services in the context of devolution, see Gary Bryner, “The Relationship between Medicaid and Welfare Agencies,” *Managing Medicaid Take-Up Management Brief*. Albany, NY: Nelson A. Rockefeller Institute of Government, November 2002, p. 11.

## Local Managers and Discretion

At the local level,<sup>4</sup> the amount of discretion a local program manager exercises over things such as individual work assignments, the flow of work through central offices, changing office hours, or negotiating contracts with external organizations also varies considerably. One key indicator of the nature and extent of discretion at the local level is whether or not a local manager can institute procedural or other changes in agency operations without state approval. Using this and other indicators of the level of autonomy of local managers, we arranged the 18 states along a continuum from local autonomy to state control.

Five of the 28 counties in our study — Denver County in Colorado, Monroe and Albany Counties in New York, and Hamilton and Franklin Counties in Ohio — fall at this end of the spectrum, where states have delegated to local managers considerable discretion. Denver County is a county where the manager who oversees Medicaid eligibility determinations can decide that two or three county workers in the county human services agency should take one day of the week and work only on these. In Hamilton County, Ohio, according to Rockefeller field researchers Charles Adams and Miriam Wilson, “Local managers have total responsibility for work assignments, office hours, and contract negotiation.”<sup>5</sup> However, according to Adams and Wilson, when it comes to county-initiated changes in local procedures and operations, local managers have to present their suggested changes to state officials who usually rubber stamp them. The most pure case of local autonomy is Monroe County, New York, where, according to our state

associate, the county has “complete discretion” over how to design the local Medicaid program.<sup>6</sup>

Nine counties in seven states grant local offices very little discretion. Most programmatic decisions are made in the state capital. Arizona, Missouri, Oregon, Tennessee, Texas, Utah, and Washington State grant local managers little flexibility over program operations. These states fall at the other end of the continuum, and are state controlled and state supervised, with little for counties to do except follow directions from the state.

One of the most extreme examples of state control is Oregon’s Multnomah County. Our field researchers, Carol Freeman, Laura Leete, and Maegan Lindsay, report that,

Procedural changes are made at the state level and are communicated directly from the state office to local branches. While state offices are viewed by local workers as valuing innovation and new ideas, local workers also feel that changes are frequently implemented without giving careful thought to the implications at the local level. Thus, the state is frequently viewed by local staff as a barrier to effectively doing their job. In particular, local workers complain that the communication and retraining processes are sometimes chaotic and occur too quickly, before training or communication can take place at the local level.<sup>7</sup>

Other state field associates report similar experiences. In Texas, for example, the administration of both the Medicaid and CHIP programs are centralized. The state sets policy, often without consultation with local staff. Nevertheless, the state makes an effort to include all levels of staff in decision-making.

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<sup>4</sup> It should be noted that we are basing our assessment of local autonomy from reports from one or two counties in each of the 18 states, and these counties may not be representative.

<sup>5</sup> Charles Adams and Miriam Wilson, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

<sup>6</sup> Sarah Liebschutz, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

<sup>7</sup> Carol Freeman, Laura Leete, and Maegan Lindsay, “Oregon State Case Study of Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, September 21, 2001.

Fourteen regions or counties in eight states — Florida, Georgia, Kansas, Maryland, Michigan, New Jersey, Wisconsin, and West Virginia — fall in the middle. They are “mixed” systems. Florida represents a good example of a local system where managers exercise discretion over some policies and procedures but not others. Florida State University political scientist Bob Crew reports that field office managers have the freedom to determine individual work assignments and workflow. Yet as operational arms of state agencies, local organizations must conform to a structure that is identical across all local jurisdictions, with only the number of positions varying according to the number of clients served by the local agency. Minimum office hours are also set by the state and Medicaid contracts are negotiated in Tallahassee.<sup>8</sup>

Like Florida, in Kansas local managers exercise discretion over things like intake procedures but not office hours. But unlike Florida, local managers in Kansas negotiate many provider agreements. The same holds true in Michigan. The county office directors in Kent and Genesee Counties negotiate with hospitals and clinics but any procedural changes at local Medicaid offices need state approval. Thus, Michigan is categorized as a “mixed” autonomy state: Local discretion is exercised in some areas but not others.

West Virginia is another case of a mixed system. Both state Medicaid officials and the Community Service Manager in Mercer County, West Virginia, told Chris Plein, the Rockefeller field associate in that state, that local DHHR managers have substantial discretion in organizing the flow of work in their offices. In fact, Mercer County serves as a model for other local offices in the state. Plein reports that while local officials can arrange for appointments at special times for Medicaid clients who have trouble getting to the local office during regular working hours, they do

not have the same freedom that TANF program directors have; nor do they have the discretion to make major procedural or operational changes without state agency approval. In this regard, regional directors play an important role.<sup>9</sup>

Finally, in Fulton County, Georgia, local administrators also have discretion when it comes to some matters, but little or no flexibility when it comes to others. For example, the Division of Medical Assistance (DMA) of the Georgia Department of Community Health (DCH) is responsible for making policy for the Medicaid program. But the Department of Family and Children Services (DFCS) in the Department of Human Resources (DHR) is responsible for implementing it at the county level through the county DFCSs. Nevertheless, according to Amy Ellen-Duke and Michael Rich, the Rockefeller field researchers from that state, Georgia has a traditional county-based system for Medicaid, where “Local managers appear to be primarily oriented toward administering their own programs with attention paid to directives from their counterpart state agencies, though solutions are tailored to local problems.”<sup>10</sup> But when it comes to making procedural changes in Fulton County, a local program administrator explained that local frontline administrators are not consulted about such changes to the state Medicaid program, but simply given the goals and then asked to devise a local strategy for achieving them.

### ***Organizational Connectedness at the Local Level***

Within local administrative systems, the degree of cooperation between the county or regional agency that manages the Medicaid and CHIP programs and other agencies varies considerably, from tightly to loosely connected. By organizational connectedness we mean the degree to which other stakeholders share with local Medicaid agen-

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<sup>8</sup> Robert Crew, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

<sup>9</sup> Chris Plein, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

<sup>10</sup> 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.

cies a concern for the locating and enrolling of low- and middle-income clients of the Medicaid and CHIP programs. It also involves the extent to which organizations in the local organizational set collaborate to this end.

We asked local administrators in 26 counties to tell us how involved the local Medicaid agency was with other state agencies, for example, local departments of education, associations of providers, advocacy groups, or other nongovernmental groups in an effort to expand Medicaid enrollment. We also asked them to tell us whether or not local task forces were created to improve enrollment numbers. Based on content analysis of the county reports in 18 states, we classified local agencies as tight, moderate, or loose in terms of their level of connectedness with other stakeholders in their county.

Five states — Florida, Georgia, Oregon, Utah, and Tennessee — were classified as loosely connected. Typically, these states did not have a history of interagency collaboration before welfare reform, did not have a local task force, and reported low levels of collaboration with other agencies, advocates, or community-based organizations.

Gary Bryner, the Rockefeller researcher in Utah, has told us that as the lead agency for expanding Medicaid take-up the Bureau of Eligibility Services provides information to and through other organizations, but “I wouldn’t describe them as working with other groups in the sense of designing outreach programs.”<sup>11</sup> The Bureau’s outreach program is limited to providing information to potential recipients through other organizations, such as schools. Georgia is another state where there is no history of collaboration among agencies. And there is no collaboration that focuses on increasing Medicaid and PeachCare take-up rates. Whereas there is no local task force that promotes collaboration among local agencies, there is a nonprofit group — Family Connection — that attempts to forge relationships with local health departments,

schools, and churches. County administrators from the Georgia Right from the Start (RSM) child health project and the PeachCare program work closely with the Robert Wood Johnson Covering Kids workers to find ways to make health care more accessible for low-income families.

Florida is another state where efforts to collaborate at the local level are far from robust. Our Florida field researcher, Bob Crew, reported that contact between Children and Families or ACHA and the Department of Education, associations of providers, and advocacy groups has been minimal and, with the exception of the KidsCare Coordinating Council, no formal task force with the goal of increasing enrollments has been formed. However, efforts to foster higher participation rates in the CHIP program are marked by contacts between the local agency and the public schools, other public and private organizations, and advocates of all kinds.<sup>12</sup> Crew has learned through his field research that

With rare exceptions, these agencies have not pursued collaborative efforts with other, non-Medicaid organizations such as the Department of Education or advocacy groups. To the extent to which there are exceptions, they have come in specific areas, and not as statewide initiatives. There has been no formal “collaborative” created for this purpose.<sup>13</sup>

In Oregon, at least in part due to the current budget crisis in the state, there are no state-led collaborative efforts to increase enrollment. However, like Florida, Oregon has created a statewide coalition, called Expanded Access Coalition, which is part of the Robert Wood Johnson Covering Kids grant. The lead state agency for this grant is the Oregon Health Division, a division within the Department of Human Services, and the main advocacy group involved is the Oregon Health Action Campaign. This coalition consists of advocacy groups, providers, and other nonprofit organizations.<sup>14</sup>

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<sup>11</sup> Gary Bryner, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

<sup>12</sup> Robert Crew, November 2001.

<sup>13</sup> Ibid.

<sup>14</sup> Freeman, Leete, and Lindsay, September 21, 2001.

Three states — Wisconsin, Michigan, and New York — are classified as moderately connected, that is, in these states there is limited contact between the local Medicaid agency and others in the organizational set for the purpose of expanding enrollment.

In Wisconsin, for example, the state has not had a particularly long history of collaboration with other local stakeholders to increase take-up rates. This is because there is already a built-in economic incentive for getting Medicaid-eligible clients to sign up for Medicaid. What is interesting in the case of Wisconsin counties is that since the mid-1990s the most significant change in connectedness relates to the way the local agency works with advocacy groups. Prior to welfare reform, cooperation between the local Medicaid agency and advocacy groups was directed at improving the quality of care delivered by Wisconsin's Medicaid HMOs. Yet the Medicaid agency had no focus on eligibility, leaving that to the agency that handled welfare. It is only recently that Medicaid managers have collaborated with local advocacy groups on eligibility and enrollment issues.<sup>15</sup>

Like Wisconsin, there is no tradition of collaboration among stakeholders in the state of Michigan, but collaboration seems to be on the rise. Because the Medicaid program was shifted from the state social services agency to the Michigan Department of Community Health shortly after the Personal Responsibility Act was passed, there is not a long history of collaboration between local Medicaid agencies and other local actors. Michigan State University political scientist Carol Weissert has told us that “There was some state coordination but it was discontinued when funding was over. The Covering Michigan Kids statewide panel still exists and the three primary state agencies — the Family Independence Agency, the Department of Community Health, and the

Department of Education — serve on that board along with advocacy groups and some providers.”<sup>16</sup> At the county level in Michigan, there is no evidence that local task forces or coalitions have formed to promote increased Medicaid enrollment.

Although New York State is also classified as moderately connected, the story in New York State is quite different from the story of organizational connectedness that comes out of Wisconsin and Michigan. One New York state administrator remarked that coordination among the various agencies is working “nearly as well as when all of these functions were under the DSS umbrella.” She contrasted the current collaborative environment to the “dysfunctional atmosphere” that characterized the early delinking of Medicaid and welfare services (e.g., Medicaid from TANF) and the reorganization of state agencies, and credited the improved level of cooperation to pressures from the counties and New York City.<sup>17</sup>

In the rest of the states, local Medicaid agencies are actively working with other stakeholders to increase enrollment and improve take-up rates. These are the tightly connected states, where the level of connectedness is high. Arizona is one of those states in our purposeful sample where the county agency has close contact with other local government and nonprofit organizations. Although there are no formal task forces promoting enrollment in the state, recent events have made collaboration even more important. Our Arizona researcher, John Hall, reports that

Collaboration in many facets of Medicaid expansion has occurred at various levels of the agencies, and is to some degree forced by events, the most prominent one being the recent and ongoing implementation of Arizona's Proposition 204. In order for this AZ initiative to be implemented — adding upwards of 186,000 additional clients, adults and children, to the AHCCCS state rolls — has required collaboration and cooperation of a significant magnitude. As the two

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<sup>15</sup> Thomas Kaplan, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

<sup>16</sup> Carol Weissert, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

<sup>17</sup> Liebschutz, November 2001.

agencies work to embrace these additional medically uninsured of the state, their roles are changing, work sites are merging and cooperation is unmistakable.<sup>18</sup>

Hall cites an example of collaboration among agencies that was pointed out to him by an AHCCCS manager: Due to apparent public confusion regarding appropriate sites to apply for AHCCCS, a clearinghouse was developed with representatives of AHCCCS, DES, KidsCare, and SSI on site to determine proper program eligibility.

Researchers from five states in this “tight” category — Colorado, Kansas, Maryland, Missouri, and Ohio — specifically mentioned the importance of the Robert Wood Johnson (RWJ)-sponsored Covering Kids Coalitions. Kansas, for example, has a statewide coalition made up of the HMO that provides services to two-thirds of Medicaid clients in the state, suppliers, contractors, and the Kansas Department of Health and Environment. The coalition was originally formed to prepare a grant application to the RWJ “Covering Kids” program, but now meets bi-monthly to devise and implement plans to increase enrollment in the state Medicaid and CHIP programs. At least three counties in Ohio are involved with local groups to improve take-up rates with the help of a Robert Wood Johnson grant. And in Missouri, Peter Mueser and Deanna Sharpe report that Missouri’s MC+ for Kids Statewide Coalition, which was formed in 1997 when the CHIP program was implemented in Missouri, is the formal task force charged with fostering higher participation rates in the MC+ program. A Robert Wood Johnson grant funds the coalition, which meets on a quarterly basis at alternating sites throughout the state.<sup>19</sup>

Four of these states — Ohio, Missouri, Texas, and West Virginia — noted the importance of local

task forces, coalitions, or partnerships. Ohio has created at least three partnerships: a task force called the Ohio Family and Children First (OFCF) initiative, which is a partnership of government agencies and community organizations committed to improving the overall well being of children and families; a Statewide School Based Outreach Workgroup to identify activities that enlist the support of schools to inform Ohio families about the availability of health care coverage through the Ohio Healthy Start and Healthy Families’ programs; and a Medicaid Joint Advisory Council. But the effectiveness of these exists to bring together providers, consumers and other interested partnerships varies from county to county. For example, in Ohio’s Franklin County, “the JACs are so poorly staffed by the CDJFS that they are falling apart. When this happens, there is no local body to hold the CDJFS accountable or to give the state feedback on the operation of the Medicaid program. The department has also been active with other advocacy groups and church groups.”<sup>20</sup>

Seven state agencies in Missouri have a long history of cooperation on matters of mutual interest. These state agencies work closely together as members of the Family and Community Trust commission, created by the Family and Community Trust Act of 2000. The goal of the coalition is to improve the well-being of Missouri families, children, individuals, and communities. The Trust is required to collaborate with public/private entities in order to build and strengthen comprehensive community-based support systems. It coordinates efforts with other statewide boards and commissions in order to advise the governor and legislature on statewide goals.

In West Virginia, the size and intimacy of the social services network necessitates interagency

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<sup>18</sup> John Stuart Hall with Mary Ann Steger, Melinda Hollinshead, and Mary Ann Miller, “Devolving Governance While Developing Capacity: The Unusual and Somewhat Surprising Story of Medicaid Expansion in Arizona,” 2001.

<sup>19</sup> Peter Mueser, Lael Keiser, and Deanna Sharpe with assistance from Vicki Wilkins, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

<sup>20</sup> Charles Adams and Miriam Wilson, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

cooperation at the local level. Our West Virginia researcher, Chris Plein, reports that,

Adversarial relationships in West Virginia are tempered by the practicality that there is a relatively small universe of stakeholders and actors in the social service policy community. One can point to any number of times where relationships between advocates and the DHHR and relationships between the medical-health community and the DHHR have been tense. By the same measure, the main participants know each other, frequently interact, and find themselves in cooperative arrangements.<sup>21</sup>

### **Local Leadership and Its Effect on Enrollments and Take-up**

The implementation literature has long held that successful implementation is contingent on support from key players, either local elected politicians or local administrators. In fact, several studies have noted the importance of entrepreneurial leadership — in the form of a “fixer” or a “guardian angel,” for example.<sup>22</sup> So we asked our field researchers to find evidence of local politicians’ and administrators’ beliefs and attitudes about the importance of enrollments and “take-up” rates. Here we report the findings about the views and activities of local Medicaid and CHIP executives and political leaders in the 26 counties in our study. Since we are especially interested in their attitudes towards enrollment and take-up, we asked our state experts to gauge how aggressive these county leaders have been in trying to encourage other actors to pay closer attention to higher take-up. One indicator of initiative is whether the local politician or manager — or someone else — has taken the initiative for pushing higher enrollment targets and take-up rates. Another indicator is whether or not a local agency manager or county commissioner, for

example, considers take-up rates to be a salient issue for the county.

### **Local Political Actors**

Based on responses to the questions above, we divided the sample into counties where political actors have taken the lead and are supportive — the *leaders* — and political actors who are not — the *laggards*. We classified four states as leaders, thirteen states as laggards, and in one state — Maryland — we lacked sufficient evidence to classify it as either a leader or a laggard.

The counties where *political* leadership shined were found in four states — Arizona, Colorado, Ohio, and Texas. Denver County is an interesting case because local politicians are the most powerful players in this decentralized state and they, and not the state Medicaid director or the director of the local social services agency, determine priorities for the county. According to the Colorado report form, the take-up rate for the Medicaid program is a high priority for Mayor Wellington Webb and the City Council. However, the Welfare Reform Board of political appointees is much more interested in keeping TANF clients in the workforce. They are especially interested in providing funds for child care, transportation, and housing.

There are two Arizona counties in our study — Coconino County and Maricopa County — and political support for take-up rates varies from county to county. The Coconino County Board of Supervisors has been/is supportive of the outreach efforts of the Medical Assistance unit of the Coconino Department of Health Services because children enrolled in Medicaid/KidsCare will no longer be the county’s responsibility or liability when these children end up in the hospital without insurance. But in Maricopa County, because responsibility for eligibility determination was transferred from the county to the state on October 1,

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<sup>21</sup> Chris Plein, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

<sup>22</sup> Eugene Bardach, *The Implementation Game* (Berkeley, CA: University of California Press, 1977), and Malcolm L. Goggin, *Policy Design and the Politics of Implementation: The Case of Child Health Policy in the American States* (Knoxville, TN: University of Tennessee Press, 1987).

2001, the County has no further stake in Medicaid take-up outreach efforts.

We also have a reading on two county political leaders in the state of Ohio — Hamilton and Franklin and Hamilton counties. Our Ohio field researchers Adams and Wilson, note that in Hamilton County the commissioner interviewed expressed support of CDJFS efforts in general and of the efforts of the county to improve take-up rates specifically and they added:

The commissioners have a history of working closely with the Department and we are committed to their efforts to improve the health of the county's poorer citizens. If we are going to have welfare reform work here, we need to support people through other programs like food stamps and Medicaid services. My concern is that not everyone who is eligible is enrolled, but I believe that we are doing an exceptional job in getting the involvement of the entire community.<sup>23</sup>

In Texas, where you might expect local politicians to play a “hands off” role, a local Harris County judge has been very supportive and personally active in planning and organizing for CHIP in the Houston metro area. Moreover, he and his office have continued to be active in the Gulf Coast CHIP Coalition on outreach and Medicaid simplification issues. He has personally participated in TexCare Partnership information and enrollment events. Also, several of the local state representatives are supporting of the Medicaid program and outreach efforts.

With the exception of Maryland's Baltimore County, where we do not have enough data to determine local attitudes towards take-up rates by *political* leaders, we classified the rest of the states as “laggards.” Perhaps the most extreme examples of laggards are Monroe and Albany Counties in the state of New York. In these counties, the issue is money: Politicians in these upstate counties viewed promoting enrollment as fiscally burdensome. Sarah Liebschutz, the Rockefeller associate who collected data for us from these counties, reports that

The higher the position in the county government hierarchy, the more Medicaid take-up rates are publicly expressed as a problem. The elected Executives of Albany and Monroe Counties view Medicaid as the most onerous of the many “mandates” on counties by the New York State Government. In October 2001, as he released his proposed 2002 County budget proposal, Michael Breslin, the Albany County Executive, noted, not only “daunting economic and fiscal uncertainty” emanating from the September 11 terrorist attacks, but ever-increasing Medicaid expenditures mandated by the State. To avoid increasing taxes, Breslin proposed drawing upon budget surpluses accumulated since he took office in 1996. The Monroe County Executive, equally committed to stable tax rates, advocates that the State Government directly fund its mandates on local governments.<sup>24</sup>

Tennessee is one of several states where county executives complain that increasing Medicaid enrollment increases pressure on the state and local Medicaid budgets. Members of the voting public in Tennessee apparently believe too many people are already getting Medicaid benefits, and this attitude rubs off on local politicians. And in Florida, local political officials provide very little policy or operational direction to local welfare offices because, as state-level entities, they are for the most part insulated from local politics. The same conditions are found in Missouri's Jackson County, Oregon's Multnomah County, West Virginia's Mercer County, New Jersey's Essex County, and Georgia's Fulton County.

### *Local Administrative Leaders*

In addition to tapping the attitudes of political leaders towards increasing Medicaid and CHIP enrollments and increasing local take-up rates, we examined the attitudes of regional and local department and program managers. Again, we divided the sample into leaders and laggards, based on the data that were provided in the 18 state reports. With one exception, the results of our analysis are similar to the results that were reported in

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<sup>23</sup> Adams and Wilson, November 2001.

<sup>24</sup> Liebschutz, November 2001.

the previous section. Local administrators — either at the regional level or on the front lines — placed take-up rates high on their agenda or promoted the goals of improved enrollments and take-up rates in counties in three states — Arizona, Colorado, and Ohio. In all the other states in our sample, take-up rates were not a salient issue for local administrators and thus they did not push this agenda.

The “leaders” were uniform in their approach to take-up rates. In Coconino County, Arizona, the Medical Assistance unit manager considers the expansion of Medicaid enrollment a high priority, and her unit has conducted outreach to expand enrollments for many years. The Medicaid Awareness grant awarded to the unit, however, was the first time that outreach activities were funded by AHCCCS. In the past, outreach work was funded locally through the Coconino Department of Health Services.<sup>25</sup> In Denver County, a local administrator wants to devote more resources to training so more eligible clients can be identified and enrolled, not only in Medicaid but also the TANF and Food Stamps programs. She offered this opinion about priorities for the county,

I am interested in doing more about training our personnel so they can serve clients better. So I included in next year’s budget a new position of a full-time trainer. There is tremendous variation in supervision and I would like to improve quality. I am also interested in doing more outreach, doing more senior fairs, more benefits nights, more health fairs. I want to allow more community-based organizations to sign people up for Medicaid, Food Stamps, CHP+, and TANF. I want to be sure that anyone in Denver County who needs services will get services. I am also interested in getting the computer system in place so we can cross lines. To do the things for clients that I want we have asked for 24 new positions in the new budget.<sup>26</sup>

In “laggard” counties in states like Georgia, Missouri, Kansas, and West Virginia, local admin-

istrators are typically not enthusiastic about promoting take-up rates, most often because it may come at the expense of other, more important priorities, or, as is the case in New Jersey, Wisconsin, and Florida, because local managers do not have the authority to determine what gets on the local agenda. In Fulton County, Georgia, local officials did not even seem to be aware of signals sent from the state that increasing enrollment was a priority. One county-level administrator told the Rockefeller field researchers that if there were a Medicaid only unit in Fulton County, she would place her weakest workers in that unit.

In Oregon, our field researcher has told us there are no branch-level initiatives to reduce errors. As one manager told our field associates in Oregon, “I don’t think that case workers think about money sources for clients [when placing them in programs]. Anyone who walks through the door for medical is getting services but where the money comes from is a problem.”<sup>27</sup> The overall attitude of managers is that their clients are receiving appropriate medical coverage. And in Texas, DHS regional and local management are apparently opposed to enrollment simplification if it would mean elimination of existing jobs. There is also a sense that issues endemic to state bureaucracies (large size, communication hurdles, underfunding, understaffing, etc.) have hindered the attention of DHS managers to Medicaid “take up” issues.

The department managers in the New York counties in our study, we are told, shy away from promoting enrollment for different reasons. They find themselves in the difficult position of “being simultaneously responsible for holding down costs at the local level and for complying not only with the letter, but with the spirit of these State initiatives.”<sup>28</sup> Interestingly, this attitude in Monroe and Albany Counties in New York was in stark contrast to the attitude on the part of local managers in Franklin County, Ohio. There, the impression that

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<sup>25</sup> Hall, November 2001.

<sup>26</sup> Malcolm L. Goggin, “Field Report Form: Medicaid Take-up and Welfare Reform,” report prepared for the Nelson A. Rockefeller Institute of Government, November 2001.

<sup>27</sup> Freeman, Leete, and Lindsay, September 21, 2001.

<sup>28</sup> Liebschutz, November 2001.

Miriam Wilson came away with is that “for the county, why not push enrollments, given that the costs of benefits first are fully covered by the state and feds. The squeeze locally comes with administering the programs, but these costs seem to have been largely shifted backward on to caseworkers who are asked to handle caseloads in the mid to upper 300s (compared to target loads of 125-150).” Local managers in Shelby County, Tennessee, share the same sentiments.

## Conclusion

Our field data from 18 states and 28 localities within those states show that enrollment patterns and take-up rates in both the Medicaid and CHIP programs vary considerably across the states and localities in this study. Of course, this variation could be due to a number of factors, some of which have been examined in other Management Briefs in this series. For example, Gary Bryner found that variations in outcomes might be systematically related to differences in the ways in which states go about organizing TANF, Medicaid, and CHIP and related programs at the state level of government.<sup>29</sup> Bryner concludes that whether a state separates or integrates the welfare and Medicaid programs may affect take-up levels and the accessibility of Medicaid and CHIP services for low-income families. Chris Plein, on the other hand, examined the relationship between the administration of the CHIP and Medicaid programs at the state level and demonstrated that collaboration between the two agencies at the state level has positive effects on state enrollment and take-up rates.<sup>30</sup> In his report, Plein stresses the importance of informal links between the two agencies that run these programs.

This Management Brief has taken a different, but complementary, approach. The organizing theme of this report is the nature and extent of relations between states and localities, paying particular attention to organizational structure, interconnectedness among agencies in the local organizational set, and local, entrepreneurial leadership. The public policy and administration literature suggests that organizational arrangements at the local level affect the ability of local organizations to achieve their goals.<sup>31</sup> Here we focus on lessons learned about the effect of state-local relations on local implementation of policies affecting Medicaid and CHIP enrollments and take-up rates.<sup>32</sup> We summarize what we have learned from our field data about how structure does or does not help achieve whatever take-up goals a state has adopted.

Granting localities flexibility and autonomy, both in terms of developing goals such as increased enrollments and improved take-up rates, as well as designing programs to meet them, has been a part of federalism since the 1980s. Devolution, so goes the argument, increases efficiency; and “local control” leads to responsiveness to local needs and the ability to tailor programs to local conditions. But devolution can also mean that local implementers can go their own way, thus defying state priorities. What difference does it make if a state grants local administrators considerable flexibility?

*There is no clear pattern, especially among those fourteen states that have state-administered Medicaid or CHIP programs.* In four of these states with state-administered programs take-up rates were high during the entire 1995-2000 period, in two states, take-up rates were low at the be-

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<sup>29</sup> Bryner, November 2002.

<sup>30</sup> Christopher Plein, “Building Administrative Capacity for CHIP and Medicaid: Image, Outreach, and Organization,” *Managing Medicaid Take-Up Management Brief*. Albany, NY: Nelson A. Rockefeller Institute of Government, December 2002.

<sup>31</sup> See, for example, Goggin, *Policy Design*, 1987; and Malcolm L. Goggin, Ann O’M. Bowman, James Lester, and Laurence O’Toole, *Implementation Theory and Practice: Toward a Third Generation* (Glenview, IL: Scott, Foresman/Little, Brown, 1990).

<sup>32</sup> Ideally, we would like to be able to establish a causal relationship between the way organizations are structured at the local level and enrollment and take-up rates, but, unfortunately, we do not have any *local-level* enrollment or take-up data.

ginning but improved as a result of state effort to improve enrollments; in four states take-up rates were declining; and in another four states take-up rates were low during the entire six-year period. The most important finding is that three of the four county-administered states<sup>33</sup> — Ohio, Wisconsin, and Colorado — either had continuous low take-up rates or had continuous low take-up rates during the 1995-2000 period. The conclusion that one could draw from the field data is that states with state-administered programs have done a better job than states with state-supervised but county-administered programs, at least in terms of take-up rates. However, these findings must be considered tentative until further research can be undertaken.

Organizational connectedness, or the degree to which local social services agencies and other organizations share a concern with locating and enrolling nondisabled adults and children who are eligible for the Medicaid or CHIP programs, also varies and may have a bearing on the choice of goals and the means to achieve them at the local level of government. What difference does it make if local implementing agencies form coalitions with others in the locality?

*Whether states have a history of collaboration at the local level or not, the one enduring collaboration that seems to make a difference is the Robert Wood Johnson-sponsored Covering Kids*

**Coalitions.** These efforts at capacity building at the local level have often resulted in task forces that work towards increasing Medicaid and CHIP enrollments by making these programs more accessible to low-income children and families.

Finally, leadership and management may well matter in any explanation for variation in participation rates in the Medicaid program across states and localities. How does the absence or presence of local entrepreneurial leadership affect the ability of local agencies to achieve their enrollment and take-up goals?

*Whether local political and administrative leaders (for example, county commissioners, city mayors, and local agency chiefs) do or do not embrace the goals of increasing enrollments in the Medicaid and CHIP programs seems to explain cross-county variation, but budgetary pressures often trump local entrepreneurial leadership.* What we have learned, however, is that a lack of leadership makes implementation success at the local level less likely. Counties that lacked a policy entrepreneur were much less likely to give high priority to the goal of increasing enrollments or take-up rates locally. But because the CHIP program is often state-centered, this is less true for CHIP programs than it is for Medicaid programs. In several states, enrollment success at the local level was often short-lived because of state or local budget woes.

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<sup>33</sup> Take-up rates for the state of New York were not available.

## ***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 1997 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***

Malcolm L. Goggin, a visiting professor in the department of political science at Michigan State University and a senior fellow at the Nelson A. Rockefeller Institute of Government, wrote this report. Michael Cooper, the Rockefeller Institute's Director of Publications, did the layout, with assistance from Michele Charbonneau.

## ***For More Information***

For more information about the Rockefeller Institute of Government, call (518) 443-5522 or visit the Institute's web site at [www.rockinst.org](http://www.rockinst.org)

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