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NEW SYSTEMS OF SOCIAL PROGRAMS?  
FIRST IMPRESSIONS FROM FIELD RESEARCH ON LOCAL IMPLEMENTATION OF  
HEALTH CARE, FOOD STAMPS, AND TANF

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The last fifteen years have seen a gradual re-orientation of American public human services policy away from a focus on the “poorest” poor to providing coverage of an increasingly large package of services to the much larger number of low-income working families. Beginning in the late 1980's there has been a steady expansion of eligibility for public health insurance programs, particularly for children under Medicaid and the Children’s Health Insurance Program (CHIP). Medicaid eligibility was once tied to the receipt of income support or “welfare,” but eligibility expansions in Medicaid and the passage of CHIP in 1997 expanded eligibility for public insurance to children in families with incomes well above the poverty level. Most states now cover children with family income up to twice the poverty level, and a few states have gone much higher. New Jersey, for example, covers children in families up to 350 percent of the poverty level, or over \$50,000 for a family of three. Some states are experimenting with publicly supported programs which support premiums for private health insurance or cover entire families rather than just children.

Perhaps the most dramatic shift in policy direction was the passage of welfare reform in 1996, which imposed restrictions on the receipt of cash assistance and allowed states great discretion in designing programs encouraging or coercing welfare recipients to get and keep jobs rather than remain on cash assistance. Cash assistance caseloads fell dramatically as a result of this legislation, but many former cash recipients are still eligible for support under the the “non-assistance” regulations, which allow lower income families to receive child care subsidies, transportation assistance, and other supports and services even if they no longer receive cash payments.

The result of these changes has been a shift in the clientele of several programs that were formerly closely tied to the cash assistance system. A recent study in sixteen states, for example, found that over 70 percent of low income adults and children enrolled in Medicaid in 2000 were *not* cash recipients, as

compared with less than half immediately before welfare reform.<sup>1</sup> The percentage of households in the Food Stamp caseload who are also receiving cash assistance declined from 42 percent in 1990 to 23 percent in 2001, and the percentage of households with earnings increased from 19 to 27 percent over the same period.<sup>2</sup> A recent study of state social service spending patterns before and after welfare reform in seventeen states indicates that states are spending much less on cash assistance and significantly more on services such as child care, job services, and other work supports, so that total social service spending has increased in many states.<sup>3</sup> It seems quite clear that the clientele and mission of human service programs has shifted from providing income support and services to the limited number of very poor to providing a wider range of services to the much larger group of low income working families.

It is less clear, however, that public human service organizations and administrative structures and processes have changed in ways that support this shift in mission and clientele. The pre-welfare reform system was organizationally integrated in the local welfare office and gave organizational and procedural primacy to the cash assistance (AFDC) program. Clients would come to be certified for cash assistance, which would often serve as a gateway to eligibility for Medicaid, Food Stamps, and sometimes other services and benefits, such as child care subsidies. This “one stop” location for many programs insured that virtually all cash assistance recipients enrolled in Medicaid and Food Stamps, but it was clearly not an arrangement designed to reach beyond the poorest families (i.e., those eligible for AFDC). Medicaid eligibility in most states did not extend much beyond the cash assistance population, and though eligibility for Food Stamps did cover many families (usually up to about 130 percent of the federal poverty level), using the FSP to support working families and augment their earnings was not an administrative priority before employment goals became central under welfare reform.

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<sup>1</sup>Courtney Burke and Craig Abbey “Medicaid Enrollment Trends, 1995-2000” (*Managing Medicaid Take-Up* series, Rockefeller Institute of Government, Albany, 2002).

<sup>2</sup>United States Department of Agriculture, Food and Nutrition Service, Office of Analysis, Nutrition, and Evaluation “Characteristics of Food Stamp Households: Fiscal Year 2001 (Advance Report)” (July 2002).

<sup>3</sup>Donald J Boyd, Patricia L. Billen, Paul J. Posner, Bill J. Keller, “Assessing State Social Service Spending on Welfare Reform” (Paper presented at the annual meeting of the American Political Science Association, 2002).

As Medicaid and CHIP programs covered a greater income range of people; as TANF conditioned cash assistance on work activities, child support enforcement, and time limits; and as Food Stamps was increasingly viewed as a way not only of rewarding work but also of providing a safety net for those who did not fare well under the new welfare rules; it would seem imperative that local offices re-engineer the relationships between these programs and establish new systems of human services. The behavioral requirements as well as the subsequent and typically enormous declines in cash assistance rolls in the late 1990s made TANF/AFDC a particularly poor gatekeeper for the expanding health care system and the increasingly critical role of the Food Stamp Program. But recent enrollment trends suggest that state and local agencies may not have fully adapted their local delivery systems and procedures to their new clientele. Both Food Stamps and Medicaid enrollments fell after the enactment of welfare reform, quite sharply in the case of Food Stamps. The number of FSP recipients fell from a high of 28 million in 1994 to less than 17 million in 2000 before increasing to just under 18 million in 2001.<sup>4</sup> Food stamp “take-up,” or the percentage of the eligible population that is actually enrolled, also declined over this period. Medicaid enrollments fell less dramatically after welfare reform and recovered sooner and more substantially, but some states still have fewer Medicaid enrollees in 2000 than in 1995. Medicaid “take-up” also appears to have declined in many states over this period, although much of this decline is the result of expansions in the number of eligibles than a decline in enrollment.<sup>5</sup>

More generally, these program changes and the flexibility provided by TANF as well as a number of new options under Medicaid and Food Stamps offered states and localities enormous opportunities for devolution, especially for crafting of new relationships among programs and creating new human service “systems.” But how have states and localities used these opportunities to change local systems? Have they begun to create more or less integrated systems of supports for a wide range of working families? Have they allowed the work requirements and other disincentives to use assistance under TANF to dampen access to other programs, especially Food Stamps and Medicaid? Or have they balanced or delinked the behavioral-change elements of TANF with the entitlement elements of Food Stamps and Medicaid in their local administrative systems? Or have they simply done very little at all to adjust these programs to one another, thereby continuing the traditional program fragmentation or

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<sup>4</sup>“Characteristics of Food Stamp Households: Fiscal Year 2001 (Advance Report)”, p. 5.

<sup>5</sup>Burke and Abbey, “Medicaid Enrollment Trends, 1995-2000.

“stovepiping” (or “siloining”) that has long characterized human service administration in the U.S.? In sum, how have states related major programs to one another—what linkages or delinkages have they created, and what ends are highlighted by these institutional developments?

This paper is a first attempt to draw on a wealth of field research in up to 30 local sites across the country on the local implementation of Medicaid, CHIP, TANF, and the Food Stamp Program. Our findings are somewhat mixed. We have found significant adjustments in the relationships among these programs. Entry or front-end processes for these programs have been both streamlined and delinked, so that the traditional gatekeeper role of TANF has been eliminated not only in law but in administrative fact, thereby giving families a much wider array of paths to choose from in entering the local human service system. We also found considerable (though not universal) delinkage among these programs at the “back-end”—that is, efforts to ensure continuity of coverage by both Medicaid and Food Stamps for welfare “leavers.” By contrast, we find less integration of programs, and greater fragmentation in processes and structures, in efforts to reach out to the large population of working, low-income families who are not eligible for cash assistance. In essence, states and localities have generally fixed many of the problems for the cash assistance population in the administrative relationships between cash assistance, on the one hand, and entitlements, on the other. But outside of the TANF cash population, programs, processes and institutions remain more separate, stovepiped and generally less accessible. In many areas, Medicaid and CHIP programs have undergone considerable changes since welfare reform to make them more accessible to working families and are frequently integrated, so that applicants can be reviewed for both programs at the same time. By contrast, the administrative processes and routines by which clients are approved for Food Stamps have changed relatively little in most areas. Thus, states and localities have generally not yet devised coordinated systems of services and benefits for the non-welfare working family.

### **Data**

We will draw on field research on the local implementation of Medicaid/CHIP, the Food Stamp Program, and the federal block grant, Temporary Assistance for Needy Families (TANF). Using a common report form or set of questions, the field research was conducted by public policy scholars, most of whom have considerable experience conducting research on public institutions in the states for which they were responsible.<sup>6</sup> The focus of the

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<sup>6</sup> A list of the many scholars involved in these studies is available on request. Send such requests to Rebecca Corso of the Rockefeller Institute at

research was on how local human service programs were implemented. What programs were used to carry out welfare reform or TANF? What institutions were used to put these programs into effect? What processes or practices were applied to clients? The Medicaid/CHIP and TANF studies were carried out in 26 and 30 sites respectively (see Table 1) during 2001 and early 2002. The health care reports were largely submitted by the end of spring, 2002. The TANF report forms were mostly submitted to the Rockefeller Institute by early September, 2002. The Food Stamp field study is still underway. About half of the 16 sites have submitted FSP report forms; the rest are expected within the month.

The field research approach used here is not simply a method of surveying states or localities but more a form of analysis. By asking questions of experienced field researchers with considerable understanding of their states and localities, we are conducting more of a coordinated set of case studies than a survey. The field research teams are expected to be able to place recent changes in administrative and policy systems in their proper contexts and help us understand what changes indicate real departures from the past, and what changes do not. Field research teams use a variety of methods to collect evidence needed to formulate their answers, but most rely on a combination of public documents (such as case manager manuals, budgets, forms, and data reports) and interviews with state and local managers. The consequence is that analyses reported to the Rockefeller Institute tend to depend on an eclectic range of sources, but the analyses provide a certain amount of reality-checking and context that surveys cannot provide.<sup>7</sup>

### **The Front-End**

The most widespread change in cross-program linkages at the local level, especially since the first years of TANF implementation, has been the establishment of simpler, more permeable, and more discriminating processes for determining eligibility for Food Stamps, Medicaid, and TANF assistance. When

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[cursor@rockinst.org](mailto:cursor@rockinst.org). The field research was supported by the Robert Wood Johnson Foundation, the W. K. Kellogg Foundation, and the Economic Research Service of the U.S. Department of Agriculture.

<sup>7</sup> A note on references: We quote from time to time in this paper directly from the field reports submitted by our research teams. Usually we indicate the state or locality. If anyone would like to obtain more information on the context of a quote or reference to our field reports, please feel free to contact us by e-mail, especially [gaist@rockinst.org](mailto:gaist@rockinst.org).

we examined TANF implementation in 1997-98, we found that, for poor families with children, access to Medicaid and Food Stamps tended to run through the cash assistance program, TANF or AFDC, and that access to these programs was restricted by “frontloading” new requirements, such as job search or compliance with child support enforcement efforts. Primacy was usually accorded to the cash assistance review. That is, eligibility reviews for Food Stamps and Medicaid often came *after* intake processes for TANF or AFDC (in states that still operated under waivers), in part because qualification for cash assistance in the pre-TANF years was closely linked to the family’s eligibility for health care assistance and Food Stamps.<sup>8</sup> Eligibility reviews for all three programs were typically conducted by the same front-line workers, and those determinations often, though not always, used the same management information system.

By 2002, local welfare offices in our sample have eliminated the gateway role of cash assistance. When clients enter a local welfare office now, in most local human service offices they are offered a variety of pathways to different combinations of benefits, depending on their needs and circumstances. That is not to say that eligibility processes for these programs have been institutionally separated. There may in fact be greater institutional consolidation of functions across programs. However, states and localities have not only simplified entry for each of the programs but have also taken steps to ensure that disqualification for one program does not improperly impact on eligibility for others. In essence, states and localities have delinked access to TANF, Food Stamps, and Medicaid by implementing common though more discriminating intake processes for families.

One of the most widespread ways in which access to different programs has been enhanced has been the establishment of common and usually streamlined applications for all three programs. In nearly all our local sites, eligibility reviews for TANF assistance, Food Stamps, and Medicaid are conducted in the same office, by the same eligibility specialist, at the same time, and using the same information system. In most sites, only one final application form is used. Colorado, for example, uses the “Single Purpose Application” for TANF, Food Stamps, and Medicaid. These application “forms” are often a series of screens that the eligibility specialist moves through in order to determine

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<sup>8</sup> Nathan, Richard P., and Thomas L. Gais, *Implementing the Personal Responsibility Act of 1996: A First Look* (Albany, NY: Rockefeller Institute Press, 1999); Gais, Thomas L.; Richard P. Nathan; Irene Lurie; and Thomas Kaplan, “Implementing the Personal Responsibility Act of 1996,” in *The New World of Welfare*, ed. Rebecca M. Blank and Ron Haskins (Washington, DC: Brookings Institution Press, 2001).

eligibility and benefit levels for these three programs. In a few cases, the application process has been streamlined by making eligibility for one program an immediate consequence of eligibility for another, but the programs triggering eligibility are no longer limited to cash assistance. In Washington State, for example, the state automatically issues Food Stamp benefits to clients who receive Supplement Security Income (SSI), without additional paperwork or interviews; and as we discuss below, some states, such as Texas, have used TANF “nonassistance” programs to establish categorical eligibility for Food Stamps.

Most of the local sites in our TANF and Medicaid samples also offer some form of preliminary screening process. Clients may be given a single yet preliminary application form that is used to route clients precisely to the benefits they want and for which they may be eligible. The forms are often short and simple, typically two to three pages long, and they usually do not require verification or documentation of statements. At a site in Michigan, for example, clients fill out a form before meeting with frontline workers that lets the workers know whether the clients are likely to be eligible for Medicaid, Food Stamps, TANF, or child care subsidies. Frontline workers in intake interviews are expected to discuss programs that might be appropriate even if the client did not initially apply for them. In Georgia, this initial review is done by a person known as a “screener,” a position that used to be clerical but has been enhanced through extra training and responsibilities to help clients complete a common application and go to the eligibility workers they need to see. In Wisconsin a “screener” greets clients entering the job center and is responsible for explaining the range of services and benefits for which they may be eligible and for making appointments with the appropriate people for formal eligibility reviews.

Most sites have also taken at least one or more steps to make the application process more user-friendly. Hours have been extended in many local offices. Processes were improved so that clients rarely had to stay all day waiting for an appointment—and often in vain. Applicants were more likely to be screened for previous or current program participation; and if they were already participants, data in the increasingly integrated information systems were called up and used. In a surprising number of localities, home visits were available for clients who had difficulties showing up at local offices. And eligibility processes in some states (e.g., Texas) relied more on electronic sources of data (such as credit reports) rather than verification by the clients themselves.

In some localities, where TANF was privatized, this streamlining and integration became more difficult by the fact that Food Stamps and Medicaid had to be, under federal rules, administered by public agencies. For example, in Arizona (Maricopa County) and Wisconsin (Milwaukee), privatization of TANF

assistance separated eligibility reviews for TANF, which was handled by private contractors, and Food Stamps and Medicaid, which were administered by county or state agencies. However, in these and other cases of TANF privatization represented in our field reports, states or localities have tried to minimize the chances that clients diverted from TANF will fail to apply for other benefits. In Arizona, for example, state eligibility workers responsible for the Food Stamp and health insurance programs are assigned to work at the privatized sites.

Some form of front-end changes to enhance client choice and reduce the difficulties in completing applications were nearly universal in our sample of counties and districts. In our sample, only one state, located in the South, took no steps to streamline its intake processes for families with children.

### **The Back-End**

Our field researchers also found that many localities have undergone recent and often significant changes in the back-end, that is, in policies and practices affecting welfare leavers, especially regarding their eligibility for Medicaid and Food Stamps. Many federal and state policymakers as well as advocates were concerned that the many families leaving cash assistance were being cut, inappropriately, from the Food Stamp and Medicaid programs. There were speculations that leavers were often required to reapply for the programs, a requirement that many leavers failed to satisfy. Also, many thought that welfare offices were not making clear to families that they are often—indeed, typically—eligible for Food Stamps, Medicaid, and child care after they got a job and left the welfare rolls. Since families often simply failed to come back for recertifications after they got jobs, they may not know that some benefits, especially the entitlements, were still available to them.

In response to some of these concerns, we have seen a variety of changes at the local level. Changes at the back-end have not been as widespread as the changes in front-end procedures, partly because the staff follow-ups they require are more labor-intensive than the changes made in the front-end. Yet most localities have put some effort in ensuring that welfare leavers continue to receive Medicaid and Food Stamp benefits.

#### *Medicaid*

The most common response has been to establish automatic mechanisms for retaining eligibility or enrollment, and this response has been especially widespread under Medicaid. The immediate management task confronting states after welfare reform was maintaining Medicaid coverage for welfare “leavers”–

clients who had been eligible for Medicaid by virtue of their receipt of cash assistance but went off cash payments as a result of state welfare reform efforts intended to increase participation in the work force. Traditional Medicaid eligibility systems were largely tied to the receipt of cash assistance, so that maintaining coverage required the “redetermination” of eligibility on other grounds. The welfare reform act extended so-called “Transitional Medical Assistance (TMA),” which allowed leavers to maintain Medicaid coverage for up to two years with no income eligibility requirements in the first six months. The act also authorized \$500 million for states to address Medicaid transition problems. These funds could be used for outreach to locate former recipients or for modifications to computerized eligibility and other systems.

Most states were slow to respond to these incentives. Medicaid agencies were not typically involved in the initial implementation for welfare reform, so maintaining Medicaid eligibility for leavers was not seen as a potential problem and systems and other process modifications to insure continued Medicaid coverage were not identified as a high priority. IT resources in many states were pre-occupied with addressing Y2K problems, and many states systems were based on old technology which were unusually difficult to modify. As a result, many states did not change automated eligibility systems until relatively recently, if at all.<sup>9</sup> Medicaid enrollment in many states also declined, in some states sharply, in the aftermath of welfare reform, as many welfare “leavers” who remained eligible for Medicaid were unable to secure continued coverage. Locating and redetermining eligibility for these leavers has continued to be a significant management issue for state and federal Medicaid agencies. The Center for Medicare and Medicaid Services (CMS) has issued a string of missives, most recently in 2000, directing states to locate and reinstate these individuals, and several states, including three examined here, have been the subject of filed or threatened lawsuits on this issue.

The states examined here fall into two rough groups around this issue. One group of states—Georgia, Florida, Missouri, Utah, New Jersey, Washington, and Oregon—took relatively early or aggressive action to minimize the number of welfare “leavers” who lost Medicaid coverage, mostly through manual “work arounds” to automated eligibility processes and extending automatic eligibility for TMA to all closing TANF cases without requiring additional action by clients.

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<sup>9</sup> See Mark Ragan, “Medicaid Take-Up and Information Systems: Delays in Modifying Information Systems Contributed to the Decline in Medicaid Enrollment” **Managing Medicaid Take-Up** (Rockefeller Institute of Government, forthcoming).

Georgia and Utah had procedures in place before welfare reform to increase Medicaid enrollment, extended automatic TMA coverage to welfare leavers, and did not experience significant declines in enrollment after the implementation of welfare reform. Missouri and Florida instituted supervisory review of all closed TANF cases to insure that Medicaid eligibility was continued. Washington was sued by advocate groups seeking to reinstate leavers. Medicaid enrollment in these states declined less, if at all, than in the other states in this study.

The remaining states made later and less aggressive attempts to deal with leaver enrollment problems and typically experienced larger declines in Medicaid enrollment after welfare reform. Some states—notably Wisconsin, Colorado and Ohio—did not make particular efforts to deal with caseload declines until advocates generated significant publicity about lowered caseloads or, in the case of Colorado and Ohio, initiated legal action. Other states, such as Kansas, took some steps to reinstate welfare “leavers” and redetermine Medicaid eligibility, but with variable success. While these states have made TMA coverage available to recent welfare leavers, getting coverage is more likely to require recipients to reapply rather than being automatically extended.

While almost all the states in this sample have made some changes in procedures to insure Medicaid coverage for eligible welfare leavers, these efforts have varied widely in scale and timing. States have typically been willing to institute changes to make Medicaid more accessible to current welfare leavers, but have been less willing to locate and reinstate prior leavers who have lost coverage. Modifications to computerized eligibility systems to reflect the decoupling has typically lagged welfare reform significantly—with the exception of West Virginia and Wisconsin, systems changes were not completed in most states until 1999 at the earliest, and several states, including such large states as Michigan, New York and Texas, continue to rely on eligibility determination processes that are largely manual.<sup>10</sup>

#### *Food Stamps and TANF*

States and localities also generally fixed practices that caused Food Stamp benefits to be lost inappropriately after families left welfare. Only one state in our sample still ends Food Stamp benefits as a standard practice after a TANF case is closed and requires the family to reapply. Most of the localities for which we have reports indicate some new procedures or exhortations to front-line workers and supervisors designed to ensure continuous eligibility for families leaving cash

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<sup>10</sup> Ragan, “Medicaid Take-Up and Information Systems,” Table 2.

assistance. In West Virginia, for example, the state agency's policies and procedures manual states that

If an active WV WORKS [the state TANF program] case, also certified for Food Stamps, is closed and there is enough information to continue the Food Stamp Certification, benefits are continued with no interruption. A new application must not be required.

Beyond fixing such basic procedural and IT problems that produced incorrect cut-offs in eligibility for Food Stamps, we do not, however, find many active efforts specifically designed to increase enrollments in Food Stamp Program among welfare leavers that are comparable to efforts made in support of Medicaid. Food Stamps—at least prior to the implementation of the recently enacted Farm Bill, which appears to offer states much greater flexibility than before—is generally viewed by local administrators as a more static, more rule-driven, less salient program, particularly by comparison to Medicaid and TANF.

Nonetheless, some states and localities have taken steps likely to increase participation in the Food Stamp Program, though these are usually parts of general efforts under TANF to serve welfare leavers through extended case management. States vary a lot in whether they offer this extended case management—both in policy and in fact—but there is no question that some states have been doing more of this in recent years. In Missouri, our field researchers report that

Rules are in effect to assure that those leaving TANF continue to receive those benefits for which they remain eligible, in particular, childcare subsidies and Food Stamps, as well as medical coverage. If a case manager discontinues TANF payments for a case, other benefits can only be discontinued after obtaining the signature of a supervisor.

In addition, when a TANF client moves off of assistance in Missouri, the file is retained by the case manager for 90 days in order to monitor whether the individual keeps his or her job or needs further assistance. Michigan also expanded its back-end efforts. The state recently began requiring an exit interview when TANF assistance cases are closed. The new policy calls on the agency to discuss what other programs—including Food Stamps and medical assistance—as well as other federal or community programs and resources are available to former welfare recipients. All clients leaving cash assistance are automatically reviewed and notified of other programs for which they are eligible.

In West Virginia, a survey in 1999 indicated an unexpectedly high proportion (48 percent) of welfare leavers were not receiving Food Stamps. The survey also reported a number of open-ended responses that indicated severe back-end problems, such as the former TANF recipient who said

‘After you get a job, they shouldn’t take your medicaid, food stamps, and checks, right away. [They should] let you keep them for a few months until you have some money saved up. As soon as you tell them you have a job they want to take everything.’ Yet another said, ‘Don’t take your food stamps immediately after you get a job because you have a job and still you’re not able to buy food.’<sup>11</sup>

Partly in response—though even more strongly motivated by a desire to increase take-up for Medicaid—the state attempted in 2000 to increase transitional case management for leavers by assigning TANF family support specialists to those families whose cases they were managing while the family was on welfare. This approach contrasts with the earlier pattern, in which families who leave cash assistance dealt with several different eligibility workers, each responsible for a different program. Oregon went, at least on paper, particularly far in providing case management by requiring case managers to follow clients after they got a job for at least one year.

However, in all of these states, this back-end case management has been threatened by recent strains on staff workloads, partly the result staff reductions due to state budget crises, and partly a consequence of a resurgence of cash assistance caseloads. In Oregon, for example, because the case managers have such high caseloads, often around 90 to 1, each case manager can only focus on a few clients. In the local sites where our report focused, those clients tended to be the more difficult cases still on assistance rather than the “success stories,” i.e., the clients who already got jobs.

But even these states—with their somewhat tenuous extended case management—tend to be exceptional. Most states provide little or no follow-up to people who leave TANF, and to the extent that any follow-up occurs, it tends to be focused on health benefits rather than Food Stamps. As our field researcher

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<sup>11</sup> The quotes come from Dilger, Robert, et al., “WV WORKS 2000: The Recipients’ Perspective,” paper presented to the West Virginia Department of Health and Human Services (December 14, 2000), quote in the Food Stamp Program field research report submitted to the Rockefeller Institute by Christopher Plein of West Virginia University, one of the co-authors of the Dilger report.

reports from his analysis of local sites, which tend to be typical of most sites in our sample, “There does not appear to be a systematic way in which case workers communicate with clients about continued eligibility for benefits once their TANF case closes.” This lack of follow-up seems partly a result of weak incentives. Ensuring continued use of Food Stamps is a goal whose salience depends in large part on the goals of other programs, especially TANF. States may put more emphasis on Food Stamp take-up rates among leavers when they, like Oregon, stress a “make work pay” model that views continued assistance after employment critical to the task of rewarding employment. Other states, such as West Virginia, have been concerned about TANF recyclers, families who leave cash assistance but come back fairly quickly. Ensuring that these families get help after they leave welfare is simply a means of minimizing this cycling.

What does not exist, however, are strong political incentives within the Food Stamp Program itself to expand enrollments or take-up rates. In most of our reports, Food Stamp remains focused on the Quality Control goals of minimizing eligibility errors, and relatively few political pressures are felt either at the state or the local level to augment that goal with concerns about take-up. Unlike Medicaid and CHIP, the Food Stamp Program tends not develop its own strong political base, so whatever expansionary efforts it benefits from will proceed from goals and initiatives under other, albeit related, programs, such as TANF.

### **Reaching Working Families**

We have seen that localities have responded to the challenges of smoothing and easing processes for families who enter and leave welfare offices, and of ensuring that eligibility decisions and changes in one program do not improperly spill over to other programs. But another and perhaps even greater challenge is to reach the large number of working families who have traditionally had little contact with such offices, namely, the working poor and nonpoor. This has been especially true for Medicaid and CHIP. And even though the Food Stamp Program has not actually expanded the range of income levels it serves, it has acquired greater flexibility in recent years so that states and localities can choose to adopt actions that expand participation.

#### *Food Stamps*

Aggressive outreach programs might make the Food Stamp Program more accessible to the large number of low-income working families who are not welfare leavers, that is, people who have had no recent contact with the public assistance system. However, Food Stamp outreach activities have been generally limited efforts and restricted to a small number of states. Federally funded

outreach programs have only been established by a minority of states—only 11 in federal fiscal year 2000—and these efforts are usually much less intensive than the outreach efforts for Medicaid or CHIP. Our state reports reinforce this picture. In one of our sites in Arizona, for example, our researchers report that “there is no system designed to serve, and thus attract, households not eligible for TANF assistance but eligible for Food Stamps,” even though the number of such families is quite high in a state like Arizona, which offers relatively small TANF cash grants. Among the states from which we have received local field research reports, no public outreach efforts for the Food Stamp Program were found in Arizona, West Virginia, Georgia, and Florida. Some outreach activities for the Food Stamp Program did exist in Washington State, Utah, and Wisconsin, but these programs tended to be focused on small, specific populations, such as Washington’s outreach efforts in Yakima County for elderly people and migrant farmworkers.

To the extent that anything has been done to make the Food Stamp Program more accessible to working families not on cash assistance, those have involved efforts to reduce the transaction costs for getting and keeping benefits. The most common changes affecting Food Stamps have tended to affect all major programs, such as extended hours for local offices, often including one or more evenings and the establishment of “Change Centers” or phone banks that permit families to call-in changes in their circumstances and thus avoid having to make face-to-face appointments. Less common were changes specific to the Food Stamp Program, such as increases in recertification periods for families with earnings. In most of the localities reporting thus far, recertification periods for Food Stamps remained three months. Part of reason for these short recertification periods were continued concerns about eligibility errors under the Food Stamp Quality Control program. This emphasis on minimizing eligibility errors may have limited states’ attention to and interest in problems of accessibility and convenience. In Michigan, for example, some local administrators reported that, around March 2002, priorities in Lansing and their own primary interest shifted away from the goals of WorkFirst/Project Zero—which emphasized employment of all nonexempt adult clients—to concentrate on the FSP error rate. The QC emphasis comes through in enhanced training activities for workers (e.g., Georgia), inclusion of FS error rates in county performance measures (Ohio), and the continuance of stricter recertification requirements for the FSP in comparison to TANF and Medicaid. Michigan, for example, not only requires more frequent recertifications for FS than for Medicaid and TANF, it also requires in-person rather than phone interviews for recertification.

Some states have begun to find ways to make Food Stamp benefits more accessible to the larger population of working families without creating severe

problems for Quality Control. One approach has been to piggy-back eligibility for Food Stamps onto the much broader and more flexible eligibility criteria for TANF “nonassistance,” which can include a great variety of services and benefits that support employment (such as child care or transportation) or otherwise do not provide basic sustenance for families. In Texas, for example, households with gross income less than 165 percent of the federal poverty level need only apply for TANF assistance and attend the required workforce orientation in order to qualify as recipients of “nonassistance” (by receiving case management) and thus become categorically eligible for Food Stamps. In Washington State, categorical eligibility for Food Stamps includes families that have received diversion payments as well as those that left welfare sometime during the previous 24 months because they had income over the gross earned income standard. In most of the states where our research has been conducted, however, these sorts of automatic connections have not yet been developed. The Food Stamp Program has become somewhat more accessible to working families not on cash assistance in recent years, but most of the changes are incremental and driven at least as much by other programs.

#### *CHIP and Medicaid*

By comparison with the limited efforts made under the Food Stamp and TANF programs to reach eligible working families, public health insurance programs typically made substantial efforts to reach and enroll working families. While these efforts varied widely in scope and scale, more states made significant attempts to improve coverage under Medicaid and CHIP for working families than to increase enrollment under Food Stamps.

The eligibility of working families for public health insurance programs has expanded considerably over the last fifteen years. Federally mandated eligibility expansions in the late 1980's and early 1990's “decoupled” Medicaid eligibility from welfare for pregnant women and children. Under these expansions, which were phased in over several years, states are now required to cover children from families with incomes under the federal poverty level and the costs of prenatal care, delivery and postpartum care for women under 133 percent of the poverty level. Many states went higher than these mandated minimums. The passage of CHIP in 1997 pushed eligibility for children significantly higher. Over two thirds of the states expanded eligibility to 200 percent of the poverty level or higher. A few states went even higher—New Jersey, for example, extended eligibility to children in families with incomes below 350 percent of the poverty level, or over \$50,000 for a family of three. Many of these families at these income levels had little or no prior contact with the welfare system, so states

were required to find them, encourage them to apply, and establish procedures outside the welfare office for enrolling them.

State initiatives to increase Medicaid and CHIP enrollment among working families can be grouped into three categories. The first is program “integration”, or combining application processes for the two programs. The second is outreach, or attempts to market these programs to eligible families and encourage them to apply. The third is application process changes to make the application process accessible outside welfare offices and simpler for families to complete.

#### Medicaid and CHIP Integration: Applying for both at once

The degree to which states succeed in integrating the application and renewal processes between CHIP and Medicaid possesses important implications for the effort to reduce the number of uninsured children in the United States. Out of some 9 million children under 19 who lack insurance, from half to 80 percent of them meet the income and asset criteria to be enrolled in either Medicaid or CHIP. The ample transaction costs families face in getting children signed up for these programs and keeping them on the rolls contribute significantly to this gap between policy promise and program performance. A well integrated, or seamless, relationship between Medicaid and CHIP can help reduce this gap. In particular seamless systems can help officials deal with two common challenges. First, some children in the same family may qualify for CHIP while others are eligible for Medicaid. This stems from the fact that in many states Medicaid eligibility criteria for younger children are more generous than they are for older ones. Thus, teenagers may meet CHIP eligibility criteria but not those for Medicaid. Second, as the economic circumstances of a family change over time, children may lose eligibility for one program but gain it for the other. Hence, some children on Medicaid will need to be moved to the CHIP program; others enrolled in CHIP will have to be shifted to Medicaid. A seamless relationship between the two programs can reduce the ever-present tendency for children to fall between the cracks of the referral process losing their health insurance.

The 18 states in our sample vary considerably in the degree to which they have achieved a seamless relationship between Medicaid and CHIP eligibility process. The states fall into four general categories in this regard. The four states in the top category—Missouri, Ohio, Tennessee, and Wisconsin—have essentially avoided the pitfalls of referral by policy design. They rejected the stovepipe

model at the outset by using CHIP funds to pursue extensions of Medicaid coverage for children.

The remaining 14 states in the Rockefeller Institute sample established a separate CHIP program. Among them, three less populous ones—Kansas, Oregon, and West Virginia—have achieved relatively high integration in the referral of applications and renewals between Medicaid and CHIP. All three of these states feature two important structural features contributing to integration. First, they use joint application and renewal forms. Second, they essentially rely on the same workers to do eligibility determinations for both Medicaid and CHIP. In addition, the field reports reveal considerable commitment among officials in these states to sustaining referral processes between Medicaid and CHIP that foster higher take-up rates. In the case of Kansas and West Virginia, achievement of higher levels of integration is a relatively recent development. Officials in both states had grown dissatisfied with their past efforts to coordinate eligibility determination in the two programs.

A third cluster of five states—Maryland, Michigan, New Jersey, New York, and Washington—has achieved moderate integration in dealing with Medicaid and CHIP referral processes. All five states in this category opted to use joint application forms. All except Michigan have adopted joint renewal forms. In addition, each of these states has taken additional measures to build a bridge between CHIP and Medicaid enrollment processes. As discussed previously, for instance, Michigan has collocated Medicaid eligibility workers in the offices of the private contractor responsible for CHIP intake. For its part, Washington relies heavily on the electronic transmission of information from Medicaid to CHIP eligibility workers to smooth application and renewal. This transmission reduces the transaction costs for those seeking health insurance for their children.

A final group of six states—Arizona, Colorado, Florida, Georgia, Texas and Utah—ranks relatively low in the achievement of a seamless referral process. To be sure, all of these states evince some signs of working to overcome the barriers to collaboration endemic to the stovepipe model. For example, all of the states except Utah have adopted either a joint renewal or a joint application form for CHIP and Medicaid. Georgia employs a combined form for both initial intake and redetermination. But the field reports and related evidence generally suggest less effort or success by these states in establishing smooth referral processes between the two programs. Children appear to have more difficulty crossing the bridge between Medicaid and CHIP.

Three findings at least tentatively emerge from our analysis. First, most states did not opt for integration between Medicaid and CHIP eligibility determination as a matter of policy design. Second, states vary considerably in the degree to which they have attempted to surmount the referral obstacles created by the stovepipe model. Third, a slight majority of the 14 states with separate CHIP programs have arguably taken significant steps to smooth referral between that program and Medicaid.

#### Outreach and Marketing: Encouraging the Eligible to Apply

A second class of initiatives relates to outreach and marketing, or activities intended to locate eligible families and children and encourage them to apply for Medicaid or CHIP. Such program “advertising” has historically been unknown under Medicaid, as many states did not think it prudent to undertake activities which, if successful, would result in increased Medicaid spending. Funds were explicitly provided for outreach under CHIP, which marked the first occasion that many states had to develop such activities.

Because funds were available to support CHIP outreach, every state in our sample undertook some marketing activities around this program. Most states did not focus their outreach activities on one single approach, but invested in a wide variety of marketing devices ranging from media ads to distribution of applications and enrollment information through a variety of organizations and settings to grants to community groups to encourage application and provide help to families in completing them.

These activities can be divided into two groups. “Passive” activities provide information about coverage, applications, and other supporting material, but require the client to take the initiative to apply without providing any further assistance. TV commercials, such “branding” activities as distributing frisbees, shopping bags, and refrigerator magnets, providing 800 numbers for information and application, or making applications available in schools, medical facilities or community events may make clients aware of the existence of the program and provide information about who is eligible and how to apply. They provide no means, however, of answering any questions the client may have or providing help with understanding and completing the application or assembling any supporting documentation. These activities typically generate a large number of “contacts” at a reasonable cost per contact, but may be less successful in converting these contacts into successful applications. Conventional marketing wisdom holds that customers or clients need to be exposed to a certain number of messages—the so-called “minimum effective frequency”—before they are likely to

take action, and broad gauged advertising that is not especially well targeted on the eligible group may not be effective in raising the program in that group's consciousness or convincing eligible families that applying is a good idea. States may have used these devices in part because they had no prior contact with many eligible families and had little concrete information on their residential location, media usage or other channels by which they might be reached more efficiently.

More recently, many states have begun emphasizing "active" outreach efforts which allow for more direct contact with potential clients and provide more assistance in completing applications. These activities, which are usually done through contracts with local non-profit agencies or the hiring of specialized outreach workers, allow for more targeted efforts on areas which contain large numbers of potential eligibles and provide a more efficient means of reaching ethnic or racial groups which may have language difficulties or are otherwise more difficult to reach through mainstream media. They also allow potential clients to ask questions appropriate to their particular situation, and may include help in assembling the information required to apply, thereby reducing the "hassle" in the application process. While more expensive per contact than passive programs, these efforts appear more likely to convert contacts into enrollments. Among the states examined here, Missouri, New Jersey, Maryland, and Washington invested significant resources in these activities initially, and Arizona and West Virginia, which initiated their outreach activities more recently, focused particularly heavily in this area.

Most states have also supplemented this outreach activity around CHIP with outreach aimed at potential Medicaid clients, though at a significantly lower level. CHIP outreach in many states is credited with generating significant numbers of applicants who are in fact eligible for Medicaid, placing a particular premium on the effectiveness of the co-ordination activities noted earlier.

#### Process Simplification: Making Applying Easier

A third activity which many states used to make Medicaid and CHIP more accessible to working families involved simplifying the application process and providing for applications outside of the welfare office. Traditional Medicaid application processes had been widely believed to be onerous and complicated, frequently requiring multiple face-to-face meetings in welfare offices with eligibility workers, lengthy application forms, and the submission of a variety of supporting information to verify income and the value of cars and other assets. Most states required reapplication every six months or every time there was a material change in a family's economic circumstances.

In large measure in response to the simplified eligibility procedures in CHIP, which required only data on family income and under which eligibility was typically extended for a year at a time, many states simplified the process of applying for Medicaid significantly. Almost all states—47 out of 50— eliminated the asset test for Medicaid and the requirement for face to face meetings, allowing clients to submit applications through the mail or over the phone. Most also revised Medicaid applications to make them shorter and easier to complete. A number of states also lessened verification requirements by relying on computerized checks of administrative data bases, particularly the reports of wages and salaries reported to the unemployment insurance system, rather than requiring applicants to submit pay stubs or other proof of income. Fewer extended the eligibility period for Medicaid to a year or allowed for so-called “presumptive eligibility,” or making a client eligible for Medicaid and allowing providers to bill for services while a final eligibility determination was made. Even fewer adopted a procedure supported by many advocates to link eligibility determination for Medicaid or CHIP to eligibility procedures for other programs, particularly Food Stamps, for which eligibility is determined more frequently.

States also varied in the extent to which they made Medicaid and CHIP applications available outside the welfare office. States have been required for some time to “out-station” Medicaid eligibility workers in particular hospitals and clinics that are heavily used by Medicaid clients and the uninsured, but compliance with this requirement has been uneven. Several states, particularly Missouri and New Jersey, expanded out-stationing, particularly in hospitals and other health care facilities, and others, as noted above, made significant efforts to expand the availability of assistance with applications outside the welfare office. Unlike TANF, however, Medicaid eligibility can only be determined by a public employee, so complete applications must still be submitted to the welfare agency for final determination.

### Conclusion

These findings suggest that states have made substantially greater efforts to make Medicaid and CHIP accessible to working families than to make Food Stamps more available to these same families. While the scale and scope of state efforts varies widely, almost all states have made perfunctory efforts to make application processes simpler and inform clients of the benefits for which they might be eligible, and some have invested significant resources and energy in locating and enrolling eligible families and children.

## **Patterns and Influences**

Our first impressions from examining recent changes in the implementation of Medicaid and CHIP, the Food Stamp Program, and Temporary Assistance for Needy Families suggest that the relationships among these programs have undergone major changes in recent years. From a system in which the cash assistance program AFDC provided a major gateway to other benefits, we have seen the development of more flexible, streamlined, and accessible human service systems in which cash assistance is just one of several entrances. We have also found greater discrimination at the back-end—at the the point where families leave one or more programs, especially cash assistance. Medicaid is furthest along in this regard, as it now appears to be substantially delinked from exits out of cash assistance, though there are also some efforts, usually less automatic and routine, to ensure that welfare leavers continue to receive Food Stamps. However, there are limits as to the extent to which new and expanded systems of human services have been established. While Medicaid and CHIP have adapted in many states and localities to the task of reaching the large population of working families who have no current or recent connection to public assistance offices, there have been much less extensive efforts to reach these working families with Food Stamp and TANF benefits. In essence, as we move from the poorest families to the larger populations of families with earnings, we see a more fragmented system of benefits—one that tends to be dominated by largely separate programs, much less integrated to meet the needs of their target population.

What accounts for these changes at the local level? Why have states or localities streamlined and delinked TANF, Medicaid, and Food Stamps at the front-end and, though to a lesser and more varied degree, taken steps to ensure better access to these programs at the back-end? As already mentioned, part of the story was the political pressure to address the rapid and somewhat unexpected declines in Food Stamp and Medicaid caseloads in the late 1990s. At least through 2000, federal pressures to make Medicaid and CHIP more accessible were strong, and, as we have argued elsewhere,<sup>12</sup> these pressures resonated with state-level political coalitions of health care providers, elected officials who saw decreased coverage as a problem and increased coverage as a political plus, and administrators who often saw expanded enrollments and higher take-up rates as

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<sup>12</sup> James Fossett and Thomas Gais, “A New Puzzle for Federalism: Different State Responses to Medicaid and Food Stamps,” Paper presented at the Annual Meetings of the American Political Science Association (August 2002).

good for their agencies and as good for their reputations among their professional peers.

But these changes may have been relatively popular for other reasons too. Some states—for example, Georgia and Michigan—saw these changes as elements of “customer service” programs within state and local human service agencies. Despite its vagueness, even the use of this phrase in the context of low-income families suggests a shift in how programs for low-income families are viewed. Many of our reports indicate that, at least at the local level, the notion of “dependence” has narrowed significantly since TANF was first implemented in the thinking and actions of agency administrators. While the receipt of cash assistance is still viewed as dependency in many states and, as such, its use is to be avoided, many services, medical assistance, and even Food Stamps are now treated more as work supports—and in some states, there has even been some softening in the way cash assistance is treated. In Wisconsin, for example, our field researchers report that local staff

say the state emphasis in W-2 [the state’s major TANF program] has been altered from its original ‘light touch’ policy, under which applicants were informed only of programs they specifically asked about, to an ‘informed choice’ approach, under which applicants are told about all the programs for which they may be eligible. . . . As part of ‘informed choice,’ applicants are also told of the time limits in W-2 and may be given the suggestion that they many not want to use up their clock if they do not absolutely need to. Staff emphasize drawing on as many family resources as possible to avoid the need for W-2. But if family or other resources are unavailable, W-2 is treated as a likely program option, and seemingly without much additional staff hesitancy.

Some of this emphasis on “informed choice” and “customer service” may, of course, grow out of bureaucratic incentives to help justify continued staff and other program resources after cash assistance rolls. In most of our localities, medical assistance and Food Stamp caseloads dwarf cash assistance caseloads, while other TANF services, except for child care subsidies, are often not counted or at least reported. Thus, estimates of agency workloads rely a great deal on the Medicaid and Food Stamp caseloads.

States have also received considerable encouragement—and some pressures—from a variety of external actors to enhance the accessibility of public programs to working families. Perhaps the most distinctive political feature around Medicaid in the late 1990's was an almost unprecedented effort by federal officials and other external actors to encourage states to expand health coverage

among low income populations, particularly children. Legislatively, the passage of the CHIP program in 1997 provided states with substantial funds, at a more favorable match rate than Medicaid, to further expand public insurance coverage beyond the traditional Medicaid population. CHIP also provided funding explicitly for outreach activities and other efforts to locate and enroll program eligibles, support which had previously been lacking under Medicaid.

In addition to enhanced funding, federal actors, beginning with President Clinton and HHS Secretary Donna Shalala, invested an unusually large amount of energy in encouraging states to expand enrollment. Improving access to health care was a high priority issue for the Clinton Administration and the President personally, and both the President and Secretary repeatedly and publicly promoted enrollment in Medicaid and CHIP by publicizing on-going enrollment problems and state success stories, encouraging continuing media attention to take-up.<sup>13</sup> The president also required eight federal departments to develop plans for helping to enroll children in these programs, which produced over 150 proposed action steps.<sup>14</sup> Both the White House and the Health Care Financing Administration (HCFA) encouraged state interest groups such as the National Governors Association and the American Public Human Service Association to address the enrollment issue and solicited media support for public service ads. Several health-related foundations also initiated research and service programs intended to publicize, analyze and address the enrollment problem. The largest such initiative was sponsored by the Robert Wood Johnson Foundation, which allocated approximately \$50 million to fund community coalitions in all fifty states to develop outreach initiatives and encourage states to to simplify and improve eligibility processes and computer systems.

These public initiatives were further reinforced by a steady stream of missives from HCFA to state Medicaid and CHIP officials. These communications variously instructed states to review closed welfare cases for continued Medicaid eligibility, provided advice and examples of how to maximize coverage, and promised lenient treatment in the quality control process for mistakes. In early 1999, for example, HCFA and the Administration for Children and Families issued an extensive “Guide to Expanding Coverage in the

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<sup>13</sup> Frank Thompson and Thomas Gais “Federalism and the Safety Net: Delinkage and Participation Rates” *Publius* 30(Winter/Spring 2000): 199-142.

<sup>14</sup> U.S. Department of Health and Human Services. Report to the President: InterAgency Task Force on Childrens Health Insurance Outreach. Washington, DC, 1998.

Post-Welfare Reform World,”<sup>15</sup> which had the avowed intent of instructing states how to expand coverage to the maximum limits of the law. More recently, HCFA issued a “Dear Medicaid Director” letter requiring states to identify and reinstate individuals and families who had been improperly terminated from Medicaid as part of their separation from TANF.<sup>16</sup>

Finally, HCFA officials have occasionally relied on admonition and the threat of sanctions to encourage states to pursue expanded enrollment. When, for example, New York City officials pursued an aggressive TANF diversion strategy that also discouraged enrollment in Medicaid and Food Stamps, HCFA administrators complained loudly and publicly to New York State officials in Albany that they were not doing enough to monitor practices in New York City. In May 1999, HCFA officials in the New York regional office announced that they would require New York State officials to document their efforts to comply with federal enrollment requirements. In August, President Clinton announced that he was instructing HCFA to “conduct comprehensive on-site reviews of Medicaid enrollment and eligibility processes in all states to determine levels of compliance with federal laws and offer recommendations for improvement.”<sup>17</sup>

This combination of attention, exhortation, encouragement, and financial support from both federal and private sources is unlikely to have been decisive either in compelling action by unwilling states or in increasing enrollments, but it has unquestionably given considerable support and resources to politicians, state agencies and advocacy groups who wish to boost enrollment in Medicaid and CHIP. The availability of both federal and foundation funding to support outreach and administrative improvements lessens the need to seek funds from state sources, and the favorable publicity given to well-performing states allows elected officials in these states to claim credit for these achievements. Children are a popular political constituency even in conservative states, and the availability of financial support and favorable publicity may have limited potential opposition to these efforts.

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<sup>15</sup> U.S. Department of Health and Human Services. Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World. (Washington, DC, 1999).

<sup>16</sup> U.S. Health Care Financing Administration, Letter to State Medicaid Directors, April 7, 2000. <http://www.hcfa.gov/medicaid/smd40700.htm>

<sup>17</sup> Robert Pear “Clinton to Chide States for Failing to Cover Children” New York Times (August 8, 1999)1:27 and Raymond Hernandez “Inquiry Grows as Rolls Fall for Medicaid” New York Times (June 8, 1999):B1.

But all these efforts and pressures to expand health care coverage also suggest what is lacking with respect to the development of broader human service systems for low-income working families. States and localities have clearly modified their local human service systems where they have had to face strong political pressures or concrete and measurable problems. Dramatic declines in Medicaid and Food Stamp caseloads—sometimes accompanied by litigation over problems of access to entitlement benefits—sharpened political pressures and pushed states and localities to make substantial changes in how they meshed entitlements and welfare reforms. TANF’s emphasis on caseload reduction and work participation also led some states and localities to pay greater attention to back-end processes in order to enhance work incentives or simply to reduce the number of families who quickly cycle back onto the cash assistance rolls. But as of yet, there are few instances of locally measured and watched “problems” that cut across program areas and that involve the large number of low-income families who are not on cash assistance or who have not recently been on such assistance. If there is to be major re-engineering of local human service systems to serve a wider variety of working families, it would seem that critical requirements would include recurrent measures of the scope and nature of the problems affecting this large population of families, and strong political and administrative incentives to monitor and remedy such problems.

**Table 1.**

**Federalism Research Group, State Capacity Study  
State and Local Areas**

<b>State</b>	<b>Local Area</b>	<b>Medicaid</b>	<b>TANF</b>	<b>Food Stamps</b>
Arizona	Maricopa County	X	X	
	Coconino County	X	X	X
Colorado	Denver County	X	X	
Florida	Dade Region	X	X	
	Palm Beach Region	X	X	
	Duval Region	X	X	
	Jefferson Region	X	X	X
	Holmes Region	X	X	
Georgia	Fulton County	X	X	X
Kansas	Wyandotte County	X	X	X
Maryland	Baltimore	X	X	
Michigan	Genessee County	X	X	X
	Kent County	X	X	
Mississippi	Hinds		X	
	Coahoma		X	X
Missouri	Jackson County	X	X	X
New Jersey	Essex County	X	X	X
New York	Albany County	X	X	
	Monroe County	X	X	X
Ohio	Franklin County	X	X	X
	Hamilton County	X	X	
Oregon	Multnomah County	X	X	
	Jackson County			X
Tennessee	Shelby County	X	X	
Texas	Harris County	X	X	X
Utah	Salt Lake County	X	X	X
Washington	King County	X	X	
	Yakima County	X	X	X
West Virginia	Mercer County	X	X	X
Wisconsin	Dane County	X	X	
	Milwaukee County	X	X	X
<b>19</b>	<b>31</b>	<b>28</b>	<b>30</b>	<b>16</b>