Federalism, intergovernmental relations and implementation: a broad examination of the politics of Medicaid disenrollment

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FEDERALISM, INTERGOVERNMENTAL RELATIONS AND IMPLEMENTATION:

A Broad Examination of The Politics of Medicaid Disenrollment

BY

Kathleen M. Dalton

A Dissertation Submitted to the University at Albany, State University of New York In partial fulfillment of the requirements for a Doctor of Philosophy Degree

Rockefeller College of Public Affairs and Policy

2009
FEDERALISM, INTERGOVERNMENTAL RELATIONS
AND IMPLEMENTATION:

A Broad Examination of The Politics of
Medicaid Disenrollment

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Abstract

Variation in the Medicaid program has frequently been studied across states, and considered a product of political, fiscal and administrative factors. Few studies have considered variation in Medicaid as a product of federal bureaucratic behavior. This study examines federal variation, and uses federalism, intergovernmental relations and public policy lenses to compare two cases where classes of recipients were being disenrolled from Medicaid, in apparent conflict with federal regulations. In one case, when individuals moved from county-to-county and became disenrolled in Medicaid, the federal bureaucrats used most of the implementation tools at their disposal to try to bring states back into compliance by simply transferring cases. In another, when inmates were being disenrolled from Medicaid upon incarceration, and not being re-enrolled upon release, federal bureaucrats used few of the same tools to establish corrective action. This research focused on answering the question of why the variation in federal activity took place, and how the bargaining and negotiation that the federal principals did engage in impacted the implementation behavior of the state agents.

The findings indicate that federal variation across these cases was primarily related to three factors: 1) conflict and complexity of the regulations across audit, fiscal and programmatic lines; 2) lack of administrative resources to properly monitor and administer the program at the federal level; and 3) the political priorities of the ruling regimes. Perhaps the most interesting findings were that after more than a decade of negotiating with New York State, the federal principals were not able to get New York Medicaid officials to change their policy implementations. It was only when advocates and local bureaucrats became involved, and expanded the scope of conflict to the legislature and the courts, that the State Office of Health Insurance Programs initiated the changes necessary to ensure continuous enrollment.
Acknowledgements

Nobody gets to this stage of their education without having a number of people to thank. Given my age and the number of years I’ve been working on this Ph.D., whatever the normal number of people to thank is, I would likely have to double it. Never-the-less, this is my opportunity to acknowledge those who have supported me along this very long path, and I’ll do my best thank those who have given me so much.

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- To Dr. Frank J. Thompson, for teaching me, mentoring me, and believing in me.
- To Dr. Robert Nakamura, Dr. James Fossett, and Dr. Tom Church for saying “yes” when I asked them to sit on my committee.
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- To Barbara Clarke, my cousin, who donated hours of editorial assistance out of shear love and in memory of our family.
- To my friends (you KNOW who you are!), who make me laugh.

This work is dedicated to my children: Eric, who is my air; Kelly, who is my fire; and Ben, who is my earth. The three of you make my world worth being in. And to everyone else who taught me, helped me, supported me, or loved me, I can only say that I thank God every day for the people who have come into my life. ~~ Kathy Dalton
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CHAPTER 1:
Federal Oversight in the Medicaid Program and
The Politics of Disenrollment

This research examines intergovernmental relations (IGR) as practiced during policy implementation in the American system of federalism. Other publications have focused on IGR and its growing importance in understanding federalism, the administrative actions of executive departments at both national and subnational levels, and public policy development and implementation.\(^1\) As part of these reviews, Robert Agranoff noted that there are “three very large gaps in research: (1) actions by administrative officials who are now the predominant actors in the field; (2) trends and actions at subnational levels; and (3) IGR actions that are outside of legislative enactments or court decisions… Those transactions below the highly visible Washington radar screen are neither attractive nor highly accessible.”\(^2\) This dissertation attempts to address each of these three gaps in the literature.

According to Agranoff, IGR “is a field of study that is rooted in political science, but the dynamics of federal development and emphasis placed on fiscal policies and administrative action necessarily take IGR well outside of one discipline.”\(^3\) Wright notes that the distinctive features of IGR include “(1) the number and variety of governmental units; (2) the number and variety of public officials involved; (3) the intensity and

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\(^1\) See, for example, JPART Symposium on Intergovernmental Relations, *Journal of Public Administration Research and Theory: JPART* 14, no.4 (2004): 443-512.


\(^3\) Agranoff, “JPART Symposium Introduction,” 443.

regularity of contacts among the officials; (4) the importance of the officials’ actions and attitudes; and (5) the preoccupation with financial policy issues.**

IGR is inextricably linked to its policy content. As Thompson noted, “The forces of federalism, especially those rooted in Medicaid, leave a heavy imprint on health policy in the United States.”** Because of its size and complexity, Medicaid has been called the “colossus of intergovernmental programs in the United States.”** Thus, it seems fitting to focus on Medicaid policy, and the “intentions and actions (or inactions) of public officials, and the consequences of those actions”** in an attempt to further the field’s understanding of IGR and federalism. Thompson observed that “state political forces shaping policy formation and implementation [are]… increasingly important in determining who gets what in the health care arena.”**

If public policy is, by definition, a study of the distribution of public goods and services, then understanding who gets excluded from receiving benefits and why has the potential to provide as much enlightenment as an examination of those who receive benefits. As Radin observed, policies she cared about often “suffered from failure to think about interrelationships between programs and policies, policy implementation difficulties and negative consequences experienced by individuals who were expected to benefit from the policies.”** In response to these observations, this research focuses on two cases of Medicaid eligibility policy implementation in which federal program

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7 Wright, Understanding Intergovernmental Relations, p. 24.
8 Thompson, "Federalism and Health Care Policy," 67.
monitors (principals) were made aware that state Medicaid administrators (agents) were implementing Medicaid enrollment and disenrollment policies in ways that were having negative consequences for some individuals who were supposed to benefit from the program.

**Medicaid Eligibility, Enrollment and Disenrollment**

There are a number of categories under which individuals can currently become eligible for Medicaid. They include:

- Low income families with children (defined in Section 1931 of the Social Security Act);
- Infants born to eligible pregnant women;
- Children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal poverty level;
- Recipients of adoption assistance and foster care under title IV-E of the Social Security Act;
- Certain Medicare beneficiaries;
- Special protected groups who may keep Medicaid for a period of time; and
- Individuals who are Supplemental Security Income (SSI) recipients (or blind, aged and disabled individuals who meet criteria which are more restrictive that those of the SSI program and which were in place in the State’s approved Medicaid plan as of January 1, 1972).\(^{10}\)

There are also a number of optional categories of eligibles that states can support, both through discrete eligibility categories and under state Medicaid waivers. Table 1 illustrates both the mandatory and optional groups covered by Medicaid under the basic Medicaid program, without consideration of waivers.\(^{11}\)

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\(^{10}\) Center for Medicare & Medicaid services website, [www.cms.hhs.gov/medicaid/eligibility/criteria.asp](http://www.cms.hhs.gov/medicaid/eligibility/criteria.asp), April 8, 2003.

\(^{11}\) Table 1 is copied from Michael Doonan, “Reimagining Medicaid: The Evolving Federal Role in Medicaid, Background Issues and Challenges.” (presentation to the Council on Health Care Economics and
Policy negotiations frequently take place around issues related to expanding or contracting Medicaid, focused on who is eligible for Medicaid and who is not, and whether there is enough outreach to enroll those who are eligible. Conversely, once an individual or group has been made Medicaid eligible, much less scrutiny is placed upon disenrollment. Only recently have public policymakers begun to discuss issues related to disenrollment.

This study examines Medicaid disenrollment, specifically two classes of recipients who had been enrolled in Medicaid and became disenrolled, in apparent conflict with federal regulations. It describes the formal and informal communications between the federal oversight agency (Department of Health and Human Services or

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**Table 1. Primary Eligibility Groups**

<table>
<thead>
<tr>
<th>Mandatory</th>
<th>Optional</th>
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<tbody>
<tr>
<td>Eligible for the previous AFDC program</td>
<td>Infants/pregnant women at or below 185% FPL</td>
</tr>
<tr>
<td>Children at or below 133% FPL *</td>
<td>Children under 21 eligible for the old AFDC</td>
</tr>
<tr>
<td>Pregnant women at or below 133% FPL *</td>
<td>Institutionalized individuals</td>
</tr>
<tr>
<td>Elderly and Disabled SSI beneficiaries</td>
<td>Those eligible for institutionalization</td>
</tr>
<tr>
<td>Certain Disabled workers</td>
<td>but receiving home health care</td>
</tr>
<tr>
<td>Certain adopted and foster children</td>
<td>Aged, blind, disabled, non-SSI but</td>
</tr>
<tr>
<td>Medicaid Buy-In Groups</td>
<td>below the poverty level</td>
</tr>
<tr>
<td></td>
<td>Receiving state SSI supplement</td>
</tr>
<tr>
<td></td>
<td>Certain working disabled non-SSI</td>
</tr>
<tr>
<td></td>
<td>SCHIP eligible children</td>
</tr>
<tr>
<td></td>
<td>Medically needy</td>
</tr>
</tbody>
</table>

*Federal Poverty Level

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Policy negotiations frequently take place around issues related to expanding or contracting Medicaid, focused on who is eligible for Medicaid and who is not, and whether there is enough outreach to enroll those who are eligible. Conversely, once an individual or group has been made Medicaid eligible, much less scrutiny is placed upon disenrollment. Only recently have public policymakers begun to discuss issues related to disenrollment.

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Policy, Arlington, VA., September 20, 2002) It originally appeared on the Health Care Financing Administration’s (HCFA) website. HCFA has since become the Center for Medicaid and Medicare Services (CMS), and the original site no longer exists. Other parts of Doonan presentation are available at: [http://www.kaisernetwork.org/health_cast/uploaded_files/Michael_Doonan_Council_Presentation.pdf](http://www.kaisernetwork.org/health_cast/uploaded_files/Michael_Doonan_Council_Presentation.pdf).
DHHS) and the state (New York). In particular it examines the actions taken by key federal principals to maintain recipients’ access to Medicaid services.

**The Cases**

The two cases were selected, in part, because of the variation the federal agency demonstrated in pursuing these cases. In the first case, upon learning of the disenrollments, DHHS took extensive steps to validate that the state was disenrolling recipients, to inform the state of their interpretation of the regulations, and instruct the state to re-engineer implementation practices to come into compliance with federal preferences. In the second, they did not. Documenting and understanding the reasons for this variation are extremely important. Since one of the primary reasons that the Medicaid program was created at the federal level was to ensure equity of the distribution of this public service, it is imperative that we identify barriers to achieving this goal across populations. This research seeks to identify the factors that resulted in the variation in federal oversight activities. Key questions included the following:

- What variables explain the circumstances under which federal administrative principals actively seek to assure that state agents comply with their preferences?
- What tools do federal principals have at their disposal? Which do they employ, and why?
- What factors facilitate or impede the degree to which state (and ultimately local) administrative agents are responsive to or comply with federal directives?

The first case came to the attention of DHHS in the late 1990’s when agency staff learned that in some States where Medicaid eligibility was determined by counties, individuals who moved from one county to another were being disenrolled from Medicaid subsequent to the move, and forced to reapply for benefits in their new county of residence. The re-application could take as long as 90 days to approve, during which
time the otherwise eligible individuals would lose access to health insurance, and by extension, possibly to health care.

This disenrollment was deemed by appointees of the Clinton Administration to be a violation of the requirements for “statewideness” in the Medicaid program, and they quickly issued a national directive in the form of a State Medicaid Director letter that (1) identified the objectionable activities; (2) highlighted the applicable regulations and expectations; and (3) requested that all states review their current policies and implementation practices and report on their compliance with federal regulations to the appropriate Regional Administrator. Consequently, this is a case where federal oversight authorities (the principals) became aware of state program implementation practices that had a negative effect on otherwise eligible individuals and they took quick steps, using the policy tools at their disposal, to address the situation with state agents.

In the second case, also during the Clinton Administration, DHHS was made aware at the highest levels that inmates in jails and state correctional facilities who were formerly enrolled in the Medicaid program were being disenrolled, and that these disenrollments were not being reversed upon release. The results of these actions allegedly presented significant barriers to accessing care for individuals with mental health and other disorders. Despite years of activity and correspondence about the issue, DHHS has yet to issue definitive national guidelines on these practices, nor require states to review their policies and practices to ensure continuity of enrollment and care

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12 Timothy M. Westmoreland, (Director, Center for Medicaid Services and State Operations, U.S. Department of Health and Human Services), *State Medicaid Director Letter*. December 4, 2000. The *State Medicaid Director Letter* is the primary form of formal communication between DHHS and the states regarding Medicaid legal, regulatory and policy requirements.

13 Charles Rangel (Congressman, NY 15th Congressional District), letters to Donna Shalala, (Secretary, U.S. Department of Health and Human Services), and Tommy Thompson, (Director, Center for Medicaid Services and State Operations), U.S. Department of Health and Human Services, 2000 and October 1, 2001, respectively.
for these individuals. Hence, in the second case, federal principals became aware of program implementation policies that had reportedly negative effects on beneficiaries, yet they chose not to use all the policy tools at their disposal to pursue compliance.

Each case included many of the same policy actors, the same agencies, some of the same regulations regarding eligibility and disenrollment, and some of the same states (and therefore, Regional Administrators). Clearly, the disparate approaches in these two cases could not be attributed to different regime views on federalism nor the availability of different policy tools.

In light of these two cases, then, the primary research question was “what variables can explain the apparent variation in DHHS’s approaches to ensuring state compliance with federal Medicaid eligibility regulations; variation that resulted in disparate responses to Medicaid eligible individuals who relocated within a state versus those who became incarcerated?”

Seeking the answer to this question fulfills part of the research agenda outlined by Agranoff and McGuire. They questioned the extent and prevalence of program adjustments arrived at as a result of the bargaining and negotiating of public managers. The present research will show that there is much evidence of bargaining and negotiation between the federal government, the states, and localities, on the resolution of Medicaid eligibility issues.

Why Disenrollment Matters:  
The Role of Medicaid in State Health and Human Service Programs

In New York, as in other states, Medicaid is the largest insurer of children and people with disabilities. In 2006 Medicaid spending reached $315 billion, accounting for approximately 16 percent of all health care spending.15

Not only is Medicaid a full-benefit insurance program for many women and children; it is a stopgap program for other public programs, filling in holes and providing wrap-around benefits to a wide range of low-income and disabled individuals. In fact, it is the most heterogeneous insurance program in the country.16 For example, Medicaid has also become the single largest payer for mental health services.17

Given the multiple purposes and beneficiaries served by the Medicaid program, fiscal staff working in state health and human service agencies have tried to maximize federal financing for social services by including them as part of the federal/state Medicaid program. This has been especially true in New York, where every dollar spent on Medicaid is matched with a dollar from the federal government. In fact, in New York State the incentive to “Medicaid” services is even more attractive, because for every dollar of match money, counties pay fifty cents. This makes New York an extremely interesting site for IGR case studies on Medicaid, because federal, state and local policymakers are all stakeholders in the “game.”18

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Although efforts to cost-shift across levels of government are common, they are accomplished with various intended and unintended consequences along the way. In this case, the “Medicaiding” of services across service delivery systems has meant that if a low income or indigent person isn’t on Medicaid, services can be difficult to access. Over the years, as state money was used as a “match” to draw federal dollars under the Medicaid program, the percentage of money available for non-Medicaid health and human services has diminished.

Intra-state IGR in Medicaid

The trend toward “Medicaiding” services across client populations has also added to the complexity of IGR related to Medicaid policy development and implementation. In the effort to cost shift across programs and service delivery systems, states have abandoned historical patterns of dividing fiscal and program responsibility between federal and state governments for things like health care, mental health care, and criminal justice. Instead they have worked to blur the lines of responsibility in pursuit of federal financial support. In response, the federal DHHS has worked to thwart those efforts with various regulatory and policy initiatives.

Within states, “mission-driven” service agencies that are responsible for caring for individuals with disabilities, such as mental health and developmental disabilities departments, have established complicated relationships with state Medicaid agencies, and vice versa. Service agencies are happy that the Medicaid agency can help share the cost of service, but they are perplexed at the Medicaid agencies’ need to draw strict lines around the eligibility of recipients, the nature of services, and the providers of service. Medicaid agencies, on the other hand, are committed to ensuring service to eligible
recipients, but they are frustrated by the amount of money the service agencies are spending, the attempts the service agencies make to allow all of their clients to be Medicaid eligible whether federal and state guidelines permit it or not, and the propensity to manipulate claims for service so they appear eligible for federal financial participation (FFP).

As a consequence, intergovernmental bargaining in the Medicaid program has evolved from primarily vertical in nature to increasingly split between horizontal and vertical. Service agencies want Medicaid to pay for their programs, and want all of their clients to be eligible. Unfortunately, public managers in those agencies don’t understand (nor necessarily care about) the complex and arcane federal regulations that have been developed specifically to ensure that the federal government does NOT pay for services that have historically been state responsibilities – such as mental health and criminal justice.

Medicaid managers, on the other hand, recognize it is in the state’s interest to draw down federal match money as much as possible, while keeping the overall cost of the program under control. However, their jobs are to ensure that states do not receive disallowances, sanctions, and bad press because ineligible people are receiving services, providers are claiming for services that are not Medicaid eligible, or ineligible providers are billing for Medicaid. In order for a claim to be valid, the person, the service and the provider must all be eligible under the federal Medicaid regulations and the approved “State Plan.” These different agency missions and cultures put state Medicaid managers at cross-purposes with other public managers in the state who work for agencies with service missions.
As a result, accessing services for indigent, low income and disabled populations has the potential to erupt into a complex maze of intergovernmental bargaining. To understand the complexity requires examination of federal Medicaid law and historical divisions of responsibility in the federal system, operationalized by state laws, administrative procedures and culture.

**IGR and the Politics of Change**

Although this research began as a study of federal variation, the findings tell a compelling story about policy implementation, federal, state and local governmental capacity, and, especially, the importance of casting a wide net when examining the impact of IGR implementation actors. In particular, the findings of this research illuminate the multitude of players in the Medicaid issue network, their importance at each level of government at protecting individual rights to public benefits, and the resources at their disposal for bringing change to the implementing practices of the professional bureaucratic complex. These case studies illustrate that the extent and volume of intergovernmental bargaining and negotiation is far more complex than the literature has outlined to date, and has confirmed the position that “Public policy is not merely the result of independent policy-making institutions. Noninstitutional actors also play a significant role...”

Another fact that became apparent was that despite variation in federal oversight and compliance activities in these two cases, the disenrollment practices of New York State for these two populations did not change until 2008 – more than a decade after they became identified as problematic. Therefore, despite differences in the clarity of policies, 

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the vigor of enforcement and the social construction of the two target populations, federal activity yielded no differences in the reactions of state and local agents. In 2007 the state finally took initial steps to address both of these issues, but the changes were not the result of the efforts of federal principals. Rather, change in both cases was a product of intervention by outside actors who ultimately engaged the state courts and the legislature in their pursuit of equity.

The results show that despite what have been described as adequate policy tools on the part of the federal agencies to ensure state agencies comply with program regulations, this was not the case. The federal government was aware that the states, and in particular, New York, were out of compliance, but they believe they have limited tools at their disposal to bring states back into compliance. This is a result of both policies and politics.

This research has taken advantage of a broad approach to research to improve our knowledge and appreciation of Medicaid policy, and as a result, assists in gaining increased understanding of federalism, IGR and the U.S. administrative state. Chapter 2 presents a summary of the literature across each of these fields, along with the underlying base of information about public policy and implementation studies. In Chapter 3 the research methods are explained and defended. Chapters 4 and 5 provide detailed information regarding the case studies, and Chapter 6 summarizes the findings regarding which theories best anticipated the findings, and reports on lessons learned.
CHAPTER 2:
Different Disciplines, Different Frameworks

Why did the federal agency responsible for Medicaid oversight use all of the policy tools at their disposal to try to ensure that people who move from county-to-county still received their Medicaid benefits, while using few of the same tools to ensure that inmates who were enrolled in Medicaid prior to incarceration and moved from home to a correctional facility, and then back home, continued to be served? To adequately answer the questions posed by this study required multiple perspectives.

This is a study of federalism. According to Agranoff and McGuire “policy making and management can vary within federalism as federalism itself varies across time and policy realms.” Yet, these cases vary despite time and policy realms being held constant, supporting a need to widen the lens used to review these cases beyond existing theories of federalism. Therefore, this study is focused on administrative actors, examines activities at subnational and non-governmental levels, and, at least initially, studies actions outside of legislative enactments and court decisions. The fact that this study includes all three levels of government also makes this research somewhat unusual, and adds to the literature on federalism.

This is a study of policy implementation. From this perspective, it is a search for variables to explain under what circumstances federal principals actively seek to assure that state agents comply with their preferences. To this end, it is a study of policy implementation.

implementation fidelity – how close to what is supposed to happen did DHHS get, and what were the incentives and barriers in each case that prompted disparate actions? Krane recognized the opportunity cost presented by attempting an implementation study without understanding the literature on American federalism. He noted that “Decisions about the provision and delivery of public goods and services take place within the framework established by America’s most distinctive political invention – federalism.”

Krane argued that studying federalism without considering policy, or studying policies without studying the framework that federalism provides, creates significant gaps in knowledge about both areas. Weaving federalism and public policy together provides the opportunity to understand the institutional factors that are salient to policy design and implementation.

This is also a study of IGR. To examine the federal variation evidenced in these case studies required review of communications, bargaining and administrative capacity at the federal, state and local levels, across Medicaid, human services, correctional services and mental health agencies. The policy actors hailed from executive, legislative and court environments, as well as an active contingent of non-governmental stakeholders. As Agranoff noted, IGR is a study of the human element, and is comprised of the activities and attitudes of persons in official and unofficial positions. And while the review of the impact of bargaining between the federal government and the states has long been an object of political science review, the field is still seeking better

explanations and theoretical models through which to understand the variables that support or detract from the success of intergovernmental bargaining.\textsuperscript{23}

Completing research using different theoretical frameworks as a basis has a respected history. More than 35 years ago Graham Allison made the case that “what we see and judge to be important and accept as adequate depends not only on the evidence but also on the ‘conceptual lenses’ through which we look at the evidence.”\textsuperscript{24} He noted further that “Conceptual models not only fix the mesh of the nets that the analyst drags through the material in order to explain a particular action; they also direct him to cast his nets in select ponds, at certain depths, in order to catch the fish he is after.”\textsuperscript{25}

Is the variation evidenced in these cases a product of the rules, regulations and preferences of the federal regimes in power at the time of negotiation? Can we attribute the variation in implementation to different policy tools, theories of causality or the goals driving the causal chain of action? Or, is it the case that federal principals recognized the limits of how much states can be lured by money to pursue their goals, so they selectively bargained across policies, establishing intentional and unintentional priorities as they undertook and avoided action? The goal of this research is to evaluate these various explanations of federal administrative behavior, i.e. executive federalism, using the range of theoretical frameworks available to help explain the facts. The remainder of this chapter identifies the literature from the various disciplines as it relates to the case studies.

\textsuperscript{24} Graham T. Allison, \textit{Essence of Decision: Explaining the Cuban Missile Crisis} (Boston, MA: Little, 1971):2
\textsuperscript{25} Ibid., 4.
The Federalism Lens

Debating the appropriate division of power, authority and responsibility between the national government and the states is an activity as old as the United States itself. The Constitution provides an outline for the separation of powers, and the *Federalist Papers* expound upon the question of how power and authority should be divided between the federal government and the states.\(^{26}\) The American system is designed so there is not too much power in the hands of one person or institution. Therefore, federalism studies have been directed toward identifying and documenting how the balance of power shifts between institutions and individuals over time, and differs across political regimes and policy areas.

**Models of Federalism**

To date, even the most basic legal questions about the realm of federal powers are up for interpretation. According to the Constitution, the division of authority is organized by areas of responsibility. The national government is responsible for commerce, treaties with foreign nations, and defense, to name a few.\(^{27}\) Those powers not delegated to the national government nor reserved for the people fall to the states.\(^{28}\) Historically there have been differences of opinion about whether the reserve powers of the states are limited to health, safety, welfare and morals, or whether they are wider in scope. Nevertheless, the view that the Constitution divides responsibilities in a way that

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\(^{27}\) United States Constitution. Article I Section 8.

\(^{28}\) U.S Constitution, 10th Amendment (1791).
establishes mutually exclusive spheres of powers between separate governments is a concept known as dual federalism.

According to Beer and others, the notion of dual federalism is a thing of the past. In part, this position is an outgrowth of Supreme Court decisions that assert that the Constitution does not clearly settle the legal parameters of federalism. It is also a response to changes in government operations since the New Deal. Thus, studies of federalism became focused on federal-state relations as they were and are practiced by various regimes, and as they are expressed within policy implementation. Recent studies have documented the fact that the national and state governments share considerable realms of power in multiple policy areas -- now referred to as cooperative federalism.

Beer argues that the separation of powers also allows for a third thesis, beyond dual and cooperative federalism. This thesis postulates that “more important than any shifts of power or function between levels of government has been the emergence of new arenas of mutual influence among levels of government.” Beer notes:

Within the field of intergovernmental relations a new and powerful system of representation has arisen, as the federal government has made a vast new use of state and local governments and these governments in turn have asserted a new direct influence on the federal government. What is interesting about American federalism today is not its particular allocation of functions or powers between levels of government, but rather what it is adding to our national system of representation.

Beer argues that the real conflict regarding the separation of powers is not about territorial allocation of powers. Rather, it is about the democratic basis of power. If both the federal and state governments get their authority from the people, then both

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30 Ibid., 9.
31 Ibid.
governmental units have a responsibility to represent the people. It is the job of the federal government to protect people’s rights within the states, and vice versa.

**Shifting Power Relationships**

Setting aside the notion of federalism as a representational construct, examining and naming models of federalism based on the distribution of power between the federal government and the states is a long-standing political science pastime; one which has bordered on a parlor game over time. Deil Wright presents a representative laundry list in *Understanding Intergovernmental Relations*, with entries like marble cake federalism and picket fence federalism.\(^{32}\) Krane addressed this notion of political power struggles when he noted: “… American federalism is more than a maze of institutions; it is a matrix of reciprocal power relations.”\(^{33}\)

In discussing the debate about federalism, Radin noted that:

“a dialectic has emerged in which debate about federal issues within the U.S. takes two often contradictory forms: a general and sometimes symbolic approach (which is usually opposed to any increase in national governmental powers) and a specific policy approach (which focuses on specific problems and specific solutions which may or may not directly involve an increased role for the national government).”\(^{34}\)

The symbolic approach is typified by political rhetoric that identifies “regime-based” positions regarding the sharing of power and authority between governments. Whether the example is Ronald Reagan’s declaration that “the federal government has taken too much tax money from the people, too much authority from the states, and too

\(^{32}\) Wright, *Understanding Intergovernmental Relations*.


much liberty with the Constitution,” or Bill Clinton turning to the states to serve as “laboratories of democracy,” presidents and presidential candidates obviously believe there is value to outlining their vision of the proper relationship between the federal government and the states.  

However, it has yet to be firmly established whether policy actors and public administrators are influenced by this rhetoric, and if so, to what degree. In fact, Conlon points out that although Reagan was verbally committed to a small federal government, “Whenever Reagan had to choose between the goals of his federalism agenda and competing budgetary and philosophical objectives, he consistently fell short of his federalism aims.” Gais and Fossett see it similarly: “In sum, Reagan and the Congresses of the 1980’s did not oppose federal power as much as they opposed federal spending.” As for Clinton, it is well known that welfare administrators from the states found the Clinton bureaucracy much less enthusiastic about granting the federal waivers necessary for creation of the laboratories than the President may have first imagined.

Another hypothesis related to both the symbolic and policy approaches is that the balance of power is subject to regime changes, when power is devolved to the states and then re-centralized to the national government with pendulum-type regularity. Under this model, power is centralized during progressive periods, and devolved to the states during

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36 Ibid.

conservative eras.38 If this were the case, we would expect consistency between the Bush position and actions and the Clinton position and actions, and they should have been different from each other. As noted, this was not the case.

It has also been argued that power and authority ebb and flow within a single policy area and era, depending on the issue and whether there is an opportunity to claim credit, or shift fiscal burdens.39

**Regime-Based vs. Policy-Based Federalism**

The question of whether the expression of federalism is shaped by regimes or negotiated policy-by-policy is an important one. The belief that a regime’s approach to federal-state relations is relatively fixed leaves little room within which policy entrepreneurs can negotiate. It also infers that public administrators are somehow cued in to the regime’s approach, and willing and able to operationalize it within program administration. However, if power and authority ebb and flow within a single policy area and era depending on the issue and opportunities, then both policy entrepreneurs and public administrators can have a great deal more influence during policy negotiations and implementation, particularly if they have additional knowledge about the variables which have the potential to influence policy discussions. This is the argument posed by Michael Doonan, who examined several health care policy cases. In summarizing his findings, Doonan states:

No one particular conception of federal/state relations is very helpful in understanding or good at characterizing federal/state relations as policy is developed and implemented. Federalism as an ideology, a Constitutional

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39 Michael Doonan, “Federalism and Contemporary Health Policy” (Ph.D. Diss, Brandeis University, 2000).
principle, and as a mechanism for sorting federal/state responsibilities, needs to be understood more dynamically and within a broader political context. Knowledge of federal/state relations and the conditions and variables that influence this interaction is critical to understanding where and how policy is developed and programs are constructed.40

Doonan argues that while general theories of federal/state relations set the parameters, or “outline the stadium” where the game is played, they are “only partially helpful in identifying where and how intergovernmental decisions are made and where authority lies as policy is created and implemented.”41 He therefore recommends that additional research be conducted to establish transparency in intergovernmental relations to facilitate theory development regarding how federal/state relationships change across the policy process.

**Executive Federalism**

If ideologies regarding federalism are not a driving force for intergovernmental decision making, then what is? According to Beer, the “centers of influence on what government does have arisen within government itself.”42 Beer identifies two main types of public sector actors who have significantly expanded their influence within policy settings, and base their intergovernmental decision making on other factors. The first is what Beer refers to as the “intergovernmental lobby;” policy professionals who specialize in issues related to particular jurisdictions. These are primarily individuals who represent state and local governments during federal policy negotiations. The second is a group of policy professionals that Beer refers to as the “professional bureaucratic complex.”

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41 Ibid., 261
42 Beer, "Federalism, Nationalism and Democracy in America,” 17.
These are people with technical and scientific training that allows them to advance complicated policy positions based on their specialized knowledge. According to Beer:

> In the fields of health, housing, urban renewal, transportation, welfare, education, poverty, and energy, it has been, in very great measure, people in government service, or closely associated with it, acting on the basis of their specialized and technical knowledge, who first perceived the problem, conceived the program, initially urged it on president and Congress, went on to help lobby it through to enactment, and then saw to its administration.\(^{43}\)

In identifying the professional bureaucratic complex as primary decision makers in intergovernmental policy negotiations, Beer lays the groundwork for new theories of federalism which significantly incorporate the role of administrators in the executive branch of government.

Gais and Fossett, for example, have evolved this notion on the role of professional bureaucrats, as part of what they term “Executive Federalism.” Although the general term refers to leadership prerogatives undertaken by presidents and governors, it incorporates the roles played by bureaucrats in the executive branch. Gais and Fossett observe that as the federal and state governments began to cooperate on nearly all domestic issues, the policy agendas became “inextricably intertwined and overlapped.”\(^{44}\) They argue that the “convergence between state and national agendas has, along with other changes, transformed the federal executive’s role in the American federal system.”\(^{45}\)

From the Gais and Fossett perspective,

> In the last two decades… the executive branch has used a growing range of administrative tools to negotiate directly with states over specific policies or to alter the context of state policy making without specific congressional approval.

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\(^{41}\) Ibid.  
\(^{44}\) Gais and Fossett, “Federalism and the Executive,” 486.  
\(^{45}\) Ibid.
The federal executive branch and its interactions with the states have thus become a primary locus for producing major changes in domestic policies.\textsuperscript{46}

Gais and Fossett point to a wide array of administrative mechanisms available to federal bureaucrats that support their policy aims. These tools include waivers, rule making, direct grants to selected organizations, demonstration projects, direct contracting, appointments and so forth.\textsuperscript{47}

**What Makes Federalism Work?**

Thus far we have determined that federalism studies examine, analyze, document and theorize about the balance of power, shifts in power, and policy actors. Some federal implementation studies have taken a more practical and operational view and have sought to identify how intergovernmental programs work, and the variables that support or detract from the success of programs. Pressman and Wildavsky completed one of the first and best known studies of federal implementation with their analysis of the City of Oakland Economic Development program.

Their approach was to study the hidden operations of government. They state that “implementation may be viewed as a process of interaction between the setting of goals and actions geared to achieving them… Implementation is the ability to forge subsequent links in the causal chain so as to obtain the desired results.”\textsuperscript{48} They note that “the passage

\textsuperscript{46} Ibid., 486-487.
\textsuperscript{47} Ibid., 514.
of time wreaks havoc with efforts to maintain tidy distinctions. As circumstances change, goals alter and initial conditions are subject to slippage.\footnote{Ibid.}

`Essentially they found a complex maze of actors, decision-points and obstacles that they determined made implementation of federal policy intentions very difficult and frequently unsuccessful:

The evils that afflicted the EDA program in Oakland were of a prosaic and everyday character. Agreements had to be maintained after they were reached. Numerous approvals and clearances had to be obtained from a variety of participants. Failure to recognize that these perfectly ordinary circumstances present serious obstacles to implementation and inhibits learning. If one is always looking for unusual circumstances and dramatic events, he cannot appreciate how difficult it is to make the ordinary happen.\footnote{Ibid.}

Followers of Pressman and Wildavsky continued to study federal implementation, and continued to see “only endless complexity and chaos whenever the federal government chose to give assistance to state and local governments.”\footnote{Paul E. Peterson, Barry G. Rabe, and Kenneth K. Wong, \textit{When Federalism Works} (Washington: The Brookings Institution, 1986):6.} Others began to find “images of a compassionate government that protects consumers and gives succor to the needy.”\footnote{Ibid.}

Peterson, Rabe and Wong entered this mix of federal implementation literature and wanted to develop a theoretical and empirical basis for a more discriminating view of the federal system. They sought “a more coherent way of understanding how the federal system works, and when its use is most likely to be successful.”\footnote{Ibid.} Their new approach to the research yielded findings concerning the federal role that were different from previous studies. While they did find examples of bureaucratic ineptitude, they also

\footnote{Ibid.}
found examples of cooperation and mutual accommodation on the part of national, state and local officials.

In part, the Peterson, Rabe and Wong research was different because they studied programs across policy areas and across longer spans of time. In their findings, Peterson, et. al. argue that “Policies and programs that affect the entire society more or less equally are appropriately assigned to the central government...Policies and programs that affect only one subdivision of a society are appropriately assigned to local governments.”

They argue that by focusing on a program’s purpose, the classification scheme better clarifies how and why intergovernmental relations differ from one program to the next, and defines more useful guidelines for future revenue programs. They also argue that in redistributive programs, when administration is professionalized it is increasingly effective, whereas when it is politicized it is less effective.

The Policy Lens

Federal implementation research is but one approach to the study of public policy. According to Theodoulou and Cahn, there are three broad approaches typically used to study public policy: the policy cycle/process approach, the policy actor approach, and approaches based on policy type. Each of these three broad approaches has subcategories.

For the purposes of this study, the stage of the policy cycle is held constant at implementation. Previous studies have shown that the vast majority of variation in Medicaid programs across the country can be attributed to differences in policy choices,

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54 Ibid., 11.
bureaucratic discretion and advocacy activity taking place during the implementation phase.  

Consistent with the Peterson, Rabe and Wong model of when federalism is most effective, the two cases reviewed are redistributive policies. Holding the policy stage and type constant allowed for the more effective examination of other variables.

Implementation Studies

Examining policy implementation can help to gain new understanding and perspective about how various political systems work, thereby exposing what Wright refers to as the “hidden dimension” of government operations. However, there are a number of approaches to studying these hidden dimensions, and different models are promoted by a wide array of scholars. The sections below outline a few of the approaches most relevant to this work.

Models of Implementation

According to early work by Elmore, there were two models of implementation. Model 1 approached the analysis of implementation as systems management. The systems management model assumed that organizations can be readily programmed to respond to changes in policy. Model 2 understood implementation as a bureaucratic process. In the bureaucratic process model it is assumed that subunits will continue to do what they have been doing despite imposed policy changes, until some way is found to make them do otherwise. The major difference between the two models was that the first assumed that management controls were sufficient to control subordinates, while the

57 Wright, Understanding Intergovernmental Relations.”
second assumed discretion and operating routines were sufficiently well developed to
inhibit top management influence, and standard operating procedures make resistance to
control possible.\textsuperscript{58} Circumstances that reinforce the relevance of the bureaucratic process
model have been the development of factors such as organization size, complexity of
modern administration and the growth in distance between higher level bureaucrats and
street-level implementers.

Over time Elmore agreed with Allison that it is important to use different
theoretical models to view an implementation, looking at it as systems management,
bureaucratic process, organizational development and conflict and bargaining. He
supported an approach called backward-mapping, which starts with the outcome of a
policy implementation and delves backward to determine the factors that influenced the
outcome.

\textbf{Top-Down and Bottom-Up}

Sabatier noted that most early American implementation studies were of a single
case [such as the Oakland Public Works project] and came to very pessimistic
conclusions about the ability to effectively implement programs. The studies were
essentially system studies that sought to explain variation in implementation success
across programs and governmental units by reference to specific variables and conceptual
frameworks. They maintained a “top-down” perspective focused on if a statute’s
objectives were achieved over time and why.\textsuperscript{59}

Conversely, bottom-up theorists postulate questions about whether policy making can ever be completely controlled from top down without information on feasibility provided by the bottom-up. Bottom-uppers start with an analysis of the multitude of actors who interact at the operational level on a particular problem or issue. Taking this approach, these theorists argue that stages tend to disappear, and instead appropriate focus can be placed on the strategies pursued by the actors. Research of this type showed that local actors often deflect centrally-mandated programs towards their own agendas. The discretion available to street-level bureaucrats allows them to avoid fully serving as principled agents.

Sabatier and Mazmanian, however, argue that policy-makers are not forced to acquiesce to the preferences of street-level bureaucrats. They sought to identify legal and political mechanisms affecting the preferences and/or constraining the behavior of street-level bureaucrats, both in their initial decisions and in their behavior over time. Sabatier and Mazmanian argue that street-level bureaucrats can be kept within acceptable bounds over time if the proper conditions are met.

**Implementation Actors**

As mentioned, the bottom-up approach relied heavily on the examination of implementation actors at the street level. Other scholars argue that analyzing the behavior of all implementation actors is necessary. According to Bardach, the implementation process is twofold; first, assembling elements to produce an outcome, and second, the playing out of games whereby these elements are withheld or delivered. These games allow actors to control aspects of a process and affect the outcome.
Bardach argues that Pressman and Wildavsky’s focus on the passage of time and missed linkages in the causal chain between goal and outcome obscured the essential elements of the “implementation games” that were at play in the Oakland project. Essentially, setting the terms allowed the policy actors to control aspects of a process, and therefore affect the ultimate outcome of the implementation.

To understand the terms that each actor sets, Bardach recommends:

relying on the idea of stakes... [This approach] directs us to look at the players, what they regard as the stakes, their strategies and tactics, their resources for playing, the rules of play (which stipulate the conditions for winning), the rules of ‘fair play’ (which stipulate the boundaries beyond which lie fraud or illegitimacy), the nature of the communications (or lack of them) among the players, and the degree of uncertainty surrounding the possible outcomes.”

It is important to understand that different actors play different games, and that the games interact with each other.

**Implementation Outcomes**

While Bardach recommends that implementation studies focus on policy actors, Ingram and Mann recommend focusing on policy outcomes of an implementation effort. They state:

…how agencies adjust goals to match what has actually been accomplished; how public officials seize upon accomplishments other than substantive policy for which to claim credit; how agencies that are supposed to implement policy attempt to transfer responsibility. . . and how administrators learn from their failures and seek corrective action... constitutes an added dimension that political scientists can explore in attempting to understand political behavior… Political scientists …

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recognize that policy making is disjointed and not easily amenable to rational models.\textsuperscript{61}

In separate work Ingram and Schneider argue that the focus on outcome is critical, because “...while many different outcomes are tolerated in some policy arenas, for certain fundamental rights and privileges, such as equal access to public facilities, and minimum standards of living, much less flexibility can be given to local implementers to deviate from national standards.”\textsuperscript{62}

**Dynamic Models**

Dynamic models of implementation incorporate multiple views and perspectives, including the notion that implementation should not be viewed dichotomously, as simply a success or failure. Goggin’s model argues that three clusters of variables affect implementation: inducements and constraints from the top (federal level), inducements and constraints from the bottom (state and local levels), and state decisional outcomes and capacity.\textsuperscript{63} Within the model, Goggin notes that the interpretation of messages by implementation actors is key to understanding outcomes, since interpretation happens within context. Federal statutes, for example, can be interpreted in many ways. For this reason, Goggin notes that communications theory offers a means of synthesizing the top-down and bottom-up approaches that divide the implementation literature.

Delving into communications theory brings up the notion of implementation as intergovernmental bargaining. The field of intergovernmental relations, where


intergovernmental bargaining occurs, is yet another lens that offers models to assist in interpreting data.

**The IGR Lens**

The study of IGR is a key component in the study of federalism and implementation, and vice-versa. The literature review to this point highlights the interrelatedness of the three subjects, and how each can be used to develop approaches to understanding the behavior of federal principals, how they pursue their preferences with state agents, and what may induce or inhibit state agents to respond to their federal counterparts. In light of this, what are the components of IGR that make it unique within political science, and provide value to this study?

Many scholars consider the study of IGR to be focused on administrative officials who operate outside the legislative and/or court environments, and who have been demonstrated to hold considerable discretion in how a policy does and does not get implemented. Agranoff indicated that studying the transactions of those who conduct their business below the radar of legislative and court enactments is one of three large gaps in the IGR research.64

Wright staked out a position similar to Agranoff’s early in the study of IGR, when he noted that distinctive features of IGR include the number and variety of public officials and governmental units involved, and the importance of the officials’ actions and attitudes. Wright noted that the study of IGR provides an “alternative conceptual framework to capture and characterize the major changes occurring in political, policy and administrative relationships… something akin to a continuum of politics-in-

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64 Agranoff, “JPART Symposium Introduction.”
Wright argues that low-level, implementation-oriented politics characterize intergovernmental management (IGM), which is the operationalization of IGR. Similarly to Bardach, Wright believes that “politics is not absent from problem-solving and implementation efforts. IGM issues, and the strategies associated with their resolution, simply contain notably lower visibility, more limited scope, and lesser political quotient(s).”

Hugh Heclo expands on these ideas by recognizing “Issue Networks” within the Executive Establishment. According to Heclo, while looking for the few who are powerful we overlook a large number of bureaucratic players whose “webs of influence provoke and guide the exercise of power.” Examining the perceptions, motivations, positions, power and maneuvers of these players provides a network analysis that can help to understand policy outputs separate from examinations of individual actors or institutions.

**Subgovernments and Networks**

Many scholars have argued that government is fragmented and that the hierarchical relationships of government are growing less distinct as historical areas of responsibility for policy issues have evolved. As Liebschutz noted “The federal system is neither a tidy set of separate governments performing separate functions in isolation from each other, nor a hierarchical arrangement in which the federal government dominates the states and the states dominate the localities. Rather, the system is composed of thousands

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65 Wright, *Understanding Intergovernmental Relations*, 169.
66 Wright, *Understanding Intergovernmental Relations*, 173.
68 Ibid.
of separate governments, overlapping responsibilities, shared power and multiple access 
routes where opportunities for change arise repeatedly. There are increasing layers of 
organizational interdependence.\textsuperscript{69}

In the place of hierarchical relationships new structures have emerged. Whether 
they are called iron triangles and issue networks, the professional bureaucratic complex, 
or subgovernments, the belief that there are professional bureaucracies and standard 
intergovernmental actors who interact on a regular basis on specific policy agendas is 
widely held.

These interdependent organizations are sometimes described as subgovernments. 
Subgovernments are defined as small groups of governmental and nongovernmental 
actors that specialize in specific issue areas in response to the complexity of the national 
policy agenda. Because of their insularity and technical expertise they help sustain that 
complexity. A typical subgovernment is composed of members of the House and/or 
Senate, members of congressional staffs bureaucrats, and representatives of private 
groups and organizations interested in the policy area. The nongovernmental members of 
a subgovernment are most likely to be lobbyists for interest groups with high stakes in the 
policy agenda.\textsuperscript{70}

According to Ripley and Franklin, there are a number of ways that the operations 
of a subgovernment can be opened up. Perhaps most notably is if the subgovernment 
participants disagree on some fundamental point, the disagreement can become public


\textsuperscript{70} Randall B. Ripley and Grace Franklin, "The Nature of Policy and Policymaking in the U.S.," in 
*Congress, the Bureaucracy and Public Policy*, ed. Grace A. Franklin and Randall B. Ripley (Belmont, CA: 
and stimulate intrusion from subgovernment nonmembers. It is worth underscoring that participation in subgovernments offers the most pervasive and effective channel for interest-group effect on policy and program decisions.71

Some consider the structure of subgovernments to be too static to adequately describe the fluidity that accompanies policy making and implementation, and have turned to the concept of networks. Networks have been described as “social structures that permit interorganizational interactions of exchange.”72 In fact, scholars have argued that “The network is emerging as the signature form of organization in the information age...”73

Characteristics of these interorganizational networks have been generally construed to include the following:

- An array of public and private actors: Actors are usually members of separate organizations, but whole organizations are not usually involved.
- A variety of goals and objectives: These are sometimes compatible and sometimes not.
- Program-Oriented actors: responsible for the mobilization of resources to achieve implementation.
- Dominance of professional values: Authority relations often focus on professional status, and the values, ethics and beliefs of the professionals dominate their behavior.
- Subgroups of actors: Each subgroup performs specialized roles, and the coordination of roles varies within implementation structures.

71 Ibid., 10-13.
• Membership in several implementation structures: Each task has its own environment, and members generally belong to more than one.  

How these networks come together to create both major and minor policy shifts continues to be an object of study. As Thompson noted, “In the contemporary administrative state, implementing agents at the federal, state and local levels possess vast discretion to shape the processes, outputs and outcomes…” of programs. He warns that the “impact of a highly technical politics driven by professionals in and out of government should [not] be discounted.”

Bargaining and Negotiation

Riker has noted “Intergovernmental disputes are inherently necessary in federalism. If there are disputes, then federalism is alive and well. Clearly, if there are no disputes, then either the federal system has been fully unified or it has collapsed.”

Basically, intergovernmental disputes involve adjustments to the authority of other jurisdictions participating in the policy development and/or implementation. Generally they are resolved through bargaining among the parties involved.

The term refers to a process by which a joint decision is made by two or more parties. The parties first verbalize contradictory demands and then move toward agreement by a process of concession making or search for new alternatives. Second, the outcome of the process is an agreement between the parties settling

75 Thompson, “Federalism and Health Care Policy,” 41.
76 Ibid., 66.
what each one gives or receives in a transaction between them or what course of action or policy each pursues in respect to each other.\textsuperscript{78}

Anton found that during bargaining “officials are courteous to one another, they respect each other’s turf, they avoid confrontation, and they go to some lengths to avoid commands, even when the authority for such commands is clear.”\textsuperscript{79}

Bargaining is more difficult when the issues are perceived to threaten basic values. In these cases, agreement is less likely to come voluntarily and may occasionally be induced. Liebschutz found that the tools to induce concession included fiscal, court decisions and legislative mandates. Of the three, fiscal controls, exerted through direct spending or grants-in-aid were found most effective.

Ingram, on the other hand, directly questioned the use of federal grants-in-aid as an effective tool for implementing federal policy. She believes that states cannot be lured by money alone to be principled agents.

State agencies are not blind surrogates of federal agencies and are likely to have their own independent goals and objectives. Their success in implementing federal goals and/or their own goals will depend on their own organizational characteristics, leadership and the broader political environment within which they operate.”\textsuperscript{80}

Ingram argues that in order for the federal government to induce states to substantially change their behavior, the two jurisdictions must share common goals. Ingram concludes that federal money does not buy compliance; just an opportunity to bargain.

\textsuperscript{78} Liebschutz, Bargaining Under Federalism, 9.
\textsuperscript{80} Ingram, “Policy Implementation through Bargaining.”522.
Other Considerations

While the majority of this study was based on literature within federalism, policy implementation and IGR, there are a number of other considerations that were weaved into the research questions and methodology. They included the impact of social construction, the concerns of public administration, and the current state of health policy. Considerations related to each of these areas are briefly outlined below.

Social Construction

Examining the perceptions, motivations and activities of intergovernmental and bureaucratic actors bring us to yet another component of the study of public policy. When we ask the question of who gets what and why, according to Fossett and Thompson, there is clearly a “need to refine existing explanations of administrative responsiveness to the disadvantaged”\textsuperscript{81}

One of the existing explanations includes the concept of social construction. Schneider and Ingram present perhaps the most articulate and concise definition of social constructions as related to target populations.\textsuperscript{82} They state:

The social construction of a target population refers to (1) the recognition of the shared characteristics that distinguish a target population as socially meaningful, and (2) the attribution of specific, valence-oriented values, symbols and images to the characteristics. Social constructions are stereotypes about particular groups of people that have been created by politics, culture, socialization, … and the like. Positive constructions include images such as “deserving,” “intelligent,” “honest,”… Negative

\textsuperscript{81} James Fossett and Frank J. Thompson. "Administrative Responsiveness to the Disadvantaged: The Case of Children's Health Insurance," \textit{Journal of Public Administration Research and Theory} 16, no.3 (July 1, 2006): 371
constructions include images such as “undeserving,” “stupid,” “dishonest,” and “selfish.”

Schneider and Ingram argue that the social construction of the target populations is an important variable in the allocation of public goods and services, not only because of the perceived need of the recipient, but because of the acceptance of the benefit by those who have not been a target of the policy. They state:

…the electoral implication of a policy proposal depends partly on the power of the target population itself (construed as votes, wealth, and propensity of the group to mobilize for action) but also on the extent to which others will approve or disapprove of the policy’s being directed toward a particular target.

According to Schneider and Ingram, it is important to distinguish between four types of target populations, identified by whether they are construed positively or negatively, and whether they are advantaged or disadvantaged. For example, groups that are politically strong (advantaged) and positively construed include business leaders, veterans and the elderly. Groups that are positively construed but politically weak include mothers, children and the disabled. Those with negative constructions who are politically strong include the rich, large unions and minorities. Those with negative constructions who are weak include criminals, drug addicts and Communists.

While Schneider and Ingram’s argument is focused on elected officials, it is likely that similar concerns would befall public administrators and bureaucrats, particularly appointed officials whose jobs are at stake when the elected regime loses power. To date there have been few studies regarding the variation in the implementation of federal Medicaid policy by federal bureaucrats, especially in cases where the Medicaid laws and
regulations would seem to imply similar standards. The current study seeks to explore the role that the social construction of target populations plays in the implementation of Medicaid eligibility policy by federal and state officials.

**Public Administration**

The belief that policies can be implemented without political influence provided a basis for what was once thought of as the politics/administration dichotomy. Over time the notion of a dichotomy has eroded, and, as Wright noted, it has become more appropriate to think of a continuum of politics in administration. As Fossett and Thompson recognized, “administrative responsiveness involves decision-making by the implementing agency in response to enacted laws... The passage of laws that promise benefits to certain categories of the disadvantaged by no means guarantees that administrative agencies will spring into action…”

According to Allison, when the unit of analysis is placed on organizational output, it asks the question: From what organizational context and pressures did this decision emerge? He noted that organizations have “standard operating procedures” and existing organizational features that influence the approach to developing outputs. Placing a lens on public administration is also consistent with Bardach’s recommendations. In particular he recommends examining the engineering or re-engineering of implementation machinery. He wrote:

Whatever else it is, a policy-or program-implementation process is an assembly process. It is as if the original mandate, ... that set the policy or program in motion were a blueprint for a large machine ... This machine must sometimes be assembled from scratch. It can sometimes be created by

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85 Fossett, James Fossett and Thompson, “Administrative Responsiveness to the Disadvantaged,” 371.
86 Allison, Essence of Decision, 6.
overhauling and reconstituting an older, or preexisting, machine. Putting the machine together and making it run is, at one level, what we mean by the ‘implementation process.’

Clearly, how the machine is put together, what resources are brought to the project, and how pre-existing administrative machinery is re-engineered to accommodate new programmatic responsibilities are all within the purview of public administration. Further, the actions of bureaucrats can be deliberate attempts to assist in the implementation of political goals. Alternatively, bureaucratic action and inaction can also be natural by-products of administrative constraints and/or concerns.

**The Politics of Health Policy**

While Medicaid implementation can be influenced by federal, state and local policy makers and administrators, it takes place within the larger health policy arena. This is an arena where the roles of the various levels of government have significantly evolved. A century ago the national and state governments were mostly uninvolved with the issue, and local governments were primarily focused on public health. Over time that balance of power and responsibility has changed, as the federal government began to provide protection and services to selected groups (veterans, the elderly and disabled), and states became increasingly involved in regulation and financing.

While it is beyond the scope of this discussion to explore how health care has evolved as a policy area decade by decade, it is safe to say that in the last decade the federalism debate has been strongly focused on health care. Rich and White argue that “we are on the threshold of a new era of federalism in health care… decisions made in

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the next several years may set the course of federalism in health care and other major social policy areas well into the next century.”

This shift in attitudes regarding the proper realm for health policy can be traced to a number of developments. First and foremost is the rapidly rising cost of health care. This affects the national budget through Medicare and Medicaid, and state budgets through Medicaid and other, state-level programs. As costs have gone up, policymakers at both levels of government have sought to increase their authority to make program changes that will result in cost containment, and to restructure administrative frameworks to effectuate cost shifts to the other levels of government. This dynamic has caused Barrilleaux and Miller to comment that “State-federal relations under Medicaid are typically strained; each wishes to control the program to the greatest extent possible while minimizing its financial burden.”

However, the politics of health policy have gone beyond a question of the cost of health care and which level of government should pay for which program and/or service. It is important to consider that health policy has become a more salient political issue – and one with a greater potential to affect electoral politics -- since individuals have become more concerned about their own positions in the health care market. This expansion of the “scope of conflict” has become a factor on several levels. Business owners have been exposed to rapidly rising premiums for health insurance, individuals have been subjected to and concerned about the rising cost of insurance premiums and

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co-pays, and the number of uninsured persons in the country has become an increasing point of concern for the individuals who are, or who are at risk of becoming, uninsured.

Further, due to the large numbers of uninsured persons, and the fear that more people will lose insurance as it becomes more expensive, questions regarding health policy have become more of a priority for advocates and providers. As these issues have affected individuals on a national level, health care has risen in priority as a political issue at all levels of government.

The dynamic tension between cost and access as political issues has played out repeatedly at both the federal and state levels of government. States have expressed the strain of trying to respond to both areas of concern with somewhat contradictory actions. In general, since the 1990’s states have sought to expand eligibility for Medicaid through raising income eligibility standards and implementing waiver programs. At the same time, they have attempted to contain costs through the imposition of mandatory managed care programs, reduced benefit packages, and limits on access to prescription drugs. The federal government has expanded eligibility for Medicaid and created prescription drug programs at the same time that they debate block-granting Medicaid and reducing federal investments in the program.

The apparent desire to simultaneously expand and contract the Medicaid program, at both levels of government, reflects the changing politics of Medicaid. Is it a program ensuring health care access, or a welfare program for the needy? If a program for the needy, are the beneficiaries deserving needy or undeserving needy? And, depending on the answers to these questions, do policy makers perceive that voters support the program, or see it as an inappropriate expenditure of tax dollars? The answers to these
questions have equal applicability to politics at both federal and state levels, and, theoretically can affect the choices of policymakers and administrators regardless of their venue.

**Summary**

This section has summarized literature regarding the important contribution studies of federalism, public policy, IGR and public administration make in understanding who governs, and the significance of the Medicaid program as a key policy area for evaluating federal/state relationships. It reviews recent arguments that federalism as expressed in health policy does not seem to move pendulum-like between centralization and devolution, and instead varies the level of centralization of policy and administration based on opportunities for cost-shifting and credit claiming. It also reviews recent findings specific to the Medicaid program, which indicate that variation in Medicaid across states is often related to the administrative discretion of bureaucrats and the influence of advocacy groups. Finally, it places these findings within the larger context of health care reform, and the problem of ensuring broad access to health care services.

This review identifies several gaps in the existing literature. As Agranoff and McGuire have pointed out, there is a lack of research focused on IGR at subnational levels, particularly with regard to programs that are implemented through federal, state and local governments. This research seeks to address this gap, while paying particular attention to players within the subgovernments who are not executive branch actors at any level of government. In addition, this study seeks to address a large void in the research; the tendency of scholars to interpret data within specific research silos related to
federalism, public policy, IGR, and so forth. This research examines the data using all of these perspectives to provide a better understanding of which theories and perspectives provide the greatest insight.

Understanding the factors that influence federal policymakers and bureaucrats in the implementation of Medicaid eligibility policy should also help to shed light on two distinct problems: identifying the political and administrative variables that influence federalism, and understanding how these issues influence the Medicaid program and its potential for serving as a basis for broader health care reform.

The current study applied these different analytical frameworks to structure data collection and evaluate the data. Chapter 3 provides details related to this methodology.
Chapter 3: Methodology

This comparative case study was designed to address what Agranoff referred to as “three very large gaps in research.” In it, I document actions and inactions by administrative officials at both national and subnational levels, revealing policy implementation situations that, at least at the start, are outside of legislative enactments or court decisions. In particular, I review the ongoing monitoring, evaluation and corrective actions initiated by the Health Care Financing Agency (HCFA which eventually evolved into the Center for Medicare and Medicaid Services, or CMS) of DHHS in their role as the supervisory agency for the Medicaid program. The actions that HCFA took with the states are transactions that largely existed below the Washington radar screen. Reviewing them reveals information about federalism, IGR, and policy implementation in general, as well as health policy in particular.

The research approaches for this research were developed after a careful review of the literature, ensuring the ability to weave variables related to federalism, IGR and implementation into the design. For example, there was a decision to review the cases from both top-down and bottom-up, to identify variables related to inducements to act as well as constraints, to consider the possibility of the public administration/politics dichotomy, and to identify the implementation games and stakes for the various federal, state, local and non-governmental actors. As recommended by Wright, the research design includes an examination of the intensity and regularity of communications among the actors’ (both public and private sector), their attitudes and actions, and the impact of

their institutions of origin, including institutional culture, legal and regulatory requirements.

Given the similarity of this project with Peterson, Rabe and Wong’s research in “When Federalism Works,” I follow their path of documentary research and semi-structured interviews with federal, state and local officials and informed observers. The information provided by the interviews was supplemented with official reports, and other documents on the Medicaid program.

The following section provides an overview of the research and methodology. This section is followed by more detailed information regarding the design considerations, site selection, data collection activities, analyses, and criteria for evaluation. The chapter ends with a discussion of the research implications.

**OVERVIEW**

This study compares variation in federal responses to the implementation of Medicaid eligibility policy in New York State (NYS) across two cases:

1. disenrollment of Medicaid beneficiaries due to the relocation of recipients across counties in the same state, and
2. disenrollment of beneficiaries who become incarcerated.

The two cases in question were examined in terms of the interactions between the federal government, the state of New York, local government representatives, and non-governmental actors.

There are a number of reasons for this site selection, which are discussed further in the methodology section. However, for the purposes of this introduction, four points are salient: first, in order to examine federal variation, the state selected for the case
studies was held constant to reduce the influence of factors that vary by state; second, New York is one of the states that administer the Medicaid program through the counties, so the relocation issue was pertinent to state administrators; third, original documentation of the “inmate exclusion” problem for incarcerated individuals is available through letters from Congressman Rangel, who represents New York. In addition to the research considerations, the last reason for selecting New York was personal: I live in New York and had access to information and interview targets at a low cost, and as a former state bureaucrat I had personal relationships with many of the individuals who had to be interviewed which gave me exceptional access to individuals for elite interviews. In short, a New York case study provided a paper trail not available from other states and access to other types of data. This access allowed for a particularly intensive study of the variables affecting implementation of Medicaid policy.

It is important to note that because of the personal relationships that exist between myself and several of the interviewees, there are some research considerations to acknowledge. The first is that my own judgment may have been affected by those relationships. To minimize this possibility, I created an interview guide and made significant efforts to follow it and do the same amount of questioning across participants. The second is that people may have been reluctant to tell me things that might have reflected poorly on them, or things that I might have disapproved of. Although this may be true, there were a number of interviews completed with individuals I did not have relationships with, where much of any hidden information would likely have been revealed.
The primary research question for this study was “to what can we attribute the apparent variation in DHHS’s approaches to ensuring state compliance with federal Medicaid eligibility regulations regarding Medicaid disenrollment that resulted in disparate responses to Medicaid eligible individuals who relocated within a state versus those who became incarcerated?”

Because of the bargaining and negotiation evidenced on these issues between the federal government and the state, seeking the answer to this question fulfilled part of the research agenda outlined by Agranoff and McGuire, who questioned the extent and prevalence of program adjustments arrived at as a result of the bargaining and negotiating of public managers. However, the work is also a follow-up to Peterson et. al. who found cooperation and mutual accommodation between federal, state and local officials in redistributive programs, dubbing them “increasingly effective,” at least during the “third phase” of implementation. Examination of the variation in these cases helps to define what “effective” implementation is and is not, and factors that facilitate it or create challenges.

The scope of work completed for this study included:

1) Determining the controlling federal and state legal structures for Medicaid eligibility and enrollment as it related to the two case studies in question.

2) Documenting how the policies were administered in New York:

   a) Identifying the political and administrative factors at each level of government that played a part in the particular implementation decisions;

   b) Determining if the state was in and/or out of compliance with aspects of federal law and regulations.

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93 Peterson, Rabe and Wong, When Federalism Works, 7, 18.
3) Documenting the federal role:
   a) Identifying the steps DHHS took to monitor compliance;
   b) Discovering how the federal government became aware that states were out of compliance;
   c) Examining communications between DHHS and the state about their compliance;
   d) Determining what incentives and penalties, if any, were discussed to bring the state into compliance; and
   e) Assessing what assistance, if any, DHHS offered to bring the state into compliance.

4) Comparing and contrasting the implementation history of the two cases:
   a) Comparing the steps taken by the state and DHHS;
   b) Evaluating the individuals and groups that took positions on the issues,
   c) Identifying the political considerations affecting the implementations;
   d) Identifying the administrative considerations affecting the implementations;
   e) Evaluating the outcome of each situation, and the reasons for those outcomes.

This information and answers to related questions were answered through:

- A review of the statutory and regulatory structures governing the issues in these two cases, including an examination of key internal documents and communications;
- A review of DHHS external communications, including Medicaid Director letters, to determine the federal positions on each case and how those positions were conveyed to the field;
- A review of NYS DOH external communications, including Administrative Directives (ADMs), Local Commissioners’ Memorandums (LCMs), and General Information System (GIS) releases which imparted the State’s official positions about implementation to program administrators;
- Review of related documents, policy papers, court filings, and legislative proposals; and
- Thirty-six elite interviews completed by telephone and in face-to-face sessions with twenty-four responsible federal, state and local officials, advocates and others familiar with the actions and decisions made in these case studies.

The following sections outline specifics regarding the research methodology.
**Research Methodology**

There are several basic methods for conducting research in political science. Lijphart identifies the comparative method as one of the basic methods, along with experimental, statistical, and case study methods. 94 Combining the comparative method with the case study method has long been considered a mechanism for strengthening a methodological design.

Lijphart identified six types of case studies: “(1) atheoretical case studies: (2) interpretative case studies; (3) hypothesis generating case studies; (4) theory-confirming case studies; (5) theory-infirming case studies; and (6) deviant case studies.” 95 As noted in the literature review, the case studies in this project can be evaluated from a number of different lenses, and the theories that provide the bases for review differ. Therefore, this study is theory-confirming, theory-infirming and theory-generating. In general, however, the two cases were selected because of their variation from each other, and from established generalizations across the literature.

The selection of the comparative case study methodology to investigate the implementation of Medicaid policies across the federal, state and local levels is clearly in order in this instance. According to Agranoff and Radin, the comparative case study approach examines multiple situations within an overall framework in one policy area. 96 In this research I am examining two situations within the overall framework of federal statute and regulation in the area of Medicaid eligibility policy.

95 Ibid., 6.
The comparative case-study method is particularly important in this study. Scholars tend to agree that case studies in federalism and intergovernmental relations should incorporate examinations of public policy and public administration. The general principles include the following:

1. The study of federalism and intergovernmental relations is enhanced through case studies of how the relationships between governmental units and policy actors play out within specific policy areas;

2. Studies of federalism and IGR are incomplete without attention to the details of implementation and public administration; and

3. Case studies must consider political, fiscal and administrative issues simultaneously if they are to shed light on any aspect of government operations.

This study documents the two policy frameworks, implementation practices, federal oversight, state responses, remediation efforts, and especially implementation actors. In each chapter I consider the political, fiscal and administrative issues affecting decision-making.

**Design Considerations**

While it is impossible to control all variables across various contexts, these studies both included consistent inquiry into three key variables:

- Statutory and regulatory requirements- as specified in law, the code of federal rules and regulations, state rules and regulations, and interpretations of law and regulation as issued in federal and state policy communications such as Medicaid Director letters, state Administrative Directives (ADMs), Local Commissioners’ Memorandums (LCMs) and General Information Systems releases (GISs) and Informational letters.

- Administrative capacity- including resources such as staff and budget allocations, information infrastructures, and the existing implementation machinery; and

- Political influences- including cost-shifting considerations, the social construction of target populations, vertical IGR and advocacy pressures regarding service to high-need populations, and concerns about the political fall-out from media reports regarding Medicaid fraud and abuse cases.
While statutory and regulatory influences can and will account for some variation, ultimately those variables will be treated as the framework for the study. The major comparisons will be made between the political and administrative variables.

**Site Selection**

In selecting a site for the study of federal variation in the implementation and oversight of the Medicaid program, New York was a natural choice. First, New York has the largest Medicaid program in the country, so it is frequently the subject of Medicaid and federalism studies. As a result, there is a great deal of data about the New York Medicaid program available. Further, while it is undoubtedly true that a comprehensive review of the Medicaid program requires inquiry across the 50 states and territories which operate the program, it is also particularly valuable to examine how Medicaid is implemented in the largest states. Such studies provide specific insight about the challenges of providing Medicaid to the greatest percentage of recipients. In addition, since the initial letter identifying the issue of the disenrollment of inmates was generated by a Congressman from New York, there is a document trail between Congressman Rangel, DHHS central and regional offices, and New York Medicaid program administrators. Finally, since New York is a state-supervised, county administered program, it is subject to the requirements of continuous enrollment across county lines that were raised during welfare reform. This means that while the state operates the “single state agency” for Medicaid administration that is required by the federal government, the 58 counties and the City of New York (comprised of another 5 counties) are the agents of the state, responsible for putting into practice all of the federal and state
regulations and policies. From a research perspective this aspect is particularly important because several of the largest statues implement this model for Medicaid, including California and Ohio. And, as mentioned, studies incorporating data from all three levels of government represent a very large gap in the existing research.

As mentioned in the introduction, I also had unprecedented access to individuals identified for elite interviews. I was previously employed by the state, and have maintained long-term relationships with my former colleagues.

**Data Collection**

There were three different data collection efforts completed as a part of this study. They were as follows:

1. A statutory and regulatory review was conducted to substantiate the legal context within which the Medicaid program is operated, specifically as it related to:
   - eligibility for relocated welfare recipients and inmates,
   - requirements for disenrollment from the program,
   - requirements for “statewideness,”
   - federal financial participation for claims,
   - federal oversight of state programs,
   - mechanisms of federal control, and
   - state law and policy with regard to implementing eligibility determinations, enrollment and disenrollment policies.

2. A document review was conducted:
   - Communication between DHHS and the states with regard to implementing the Medicaid program between the years 1995 and 2007,
   - Communications between DHHS Central and Regional Offices and the State of New York,
   - Communications between the NYS Department of Social Services (DSS)/Department of Health (DOH)/Office of Temporary and Disability Assistance (OTDA) and local Commissioners of Social Services;
   - memoranda and other documents issued by other states, researchers, advocates, and national associations describing aspects of these issues;
memoranda in support and opposition of legal cases, and/or proposed legislation that took place regarding Medicaid benefits access;

(3) Semi-Structured elite interviews were conducted.

- Current and former staff members at DHHS/CMS
- Congressional staff
- Representatives from National Governor’s Association (NGA)
- Current and former staff members from NYS DOH
- Staff members from state legislative offices
- Members of local government and other affiliated agencies
- Researchers, advocates and lawyers who were involved in negotiating and bargaining with the federal government and NYS.

In total, I completed a total of 36 interviews with 24 individuals over the course of the study. Several individuals were interviewed more than once, either because the extent of their comments were such that it warranted more than one conversation, or because additional information came to light during other interviews that required clarification.

Individuals were selected for interviews for several reasons. First and foremost, individuals were targeted because they were listed on staff directories that identified key personnel by job title. In addition, certain participants were identified in documents and correspondence as having played a role in intergovernmental negotiations. Finally, each participant was asked to identify other potential participants who might be able to provide additional information. It is important to note that respondents were aware that their comments were not confidential, and that they might be quoted in this and other documents.

**Statutory Reviews**

A wide range of laws and regulations were examined to complete this study. Work began with analyzing Section 1905 (a)(28)(A) of the Social Security Act, United
States Code, 42 USC 1396(d)(a)(28)(A); 42 C.F.R. Section 435.1009, which specifically excludes FFP for medical care provided to inmates of a public institution, except when the inmate is a patient in a medical institution. It was supported by examination of other supporting sections of Title 42 related to The Public Health and Welfare, including those which provide definitions relating to institutional status, requirements for Medicaid terminations and recertifications, ex-parte reviews, and other operational requirements. In addition, understanding the entire scope of implementation required reviewing requirements related to Social Security benefits eligibility and administration, because of its relationship to Medicaid eligibility.

For the county-to-county-relocation case most of the statutory and regulatory requirements related to terminations, recertifications and ex-parte reviews applied to the relocators case as well. This was supported by requirements that the program be statewide.

The review of federal statute and regulation was supported by an examination of state law and regulation, primarily regarding the identification of districts of financial responsibility (DFR) under various circumstances related to a county-to-county move, and requirements related to the termination versus suspension of Medicaid for incarcerated individuals. (New York State Social Services Law Section 366 (1-a)).

For the most part, the statutory and regulatory review provided the background for understanding the cases as they were investigated. To the extent that specific laws and requirements are pertinent to understanding the case study, they are described in the case narratives.
Document Reviews

The document reviews began with a review of the 306 Medicaid Director Letters issued between 1994 and 2008 to identify those that were related to relocation and/or the inmate exclusion. This was followed up by contacting the New York State Department of Health’s Counsel’s office, and requesting that documents related to both cases be identified and shared with me. In addition, during each interview I would ask for any written documentation of the issues we discussed, which yielded copies of internal HCFA communications between the central and regional offices.

The federal reviews were followed by a review of state communications to local departments of social services. Policy Directives are issued by OTDA, DOH and the Office of Children and Family Services (OCFS) to keep local districts of social services (LDSS) and other interested parties informed about current program policy and procedures, and other significant information impacting health and human service programs. These formal communications come in the following forms:

1) **Administrative Directives (ADMs)** are designed to advise local social services districts of policy and procedures, which must be followed in the administration of programs.
2) **Local Commissioner Memoranda (LCMs)** transmit information directly to the local commissioners on very specific topics, such as notification of limited special funding available only to local districts, statewide audit results requiring corrective action, or instructions to follow new and existing program or administrative procedures.
3) **General Information System (GIS)** releases sent to Commissioners and other staff regarding upcoming issues, changes and ongoing policy debates.
4) Information Letters (INF) include articles of general interest to local district staff, i.e. pamphlets or brochures, new or revised lists of contacts, transmittals of recently enacted Federal or State legislation, and so forth.\(^{97}\)

Table 1, below illustrates the results of these reviews. The table documents the number of releases of each type of communication made each year, and the number that were related to county-to-county relocations and inmate terminations. As the table indicates, the numbers of communications on these issues were quite low.

<table>
<thead>
<tr>
<th>Year</th>
<th>State Administrative Directives (ADM)</th>
<th>Local Commissioners Memorandums (LCM)</th>
<th>General Information System (GIS)</th>
<th>Informational Letters (INF)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Apply</td>
<td>Total Apply</td>
<td>Total Apply</td>
<td>Total Apply</td>
</tr>
<tr>
<td>1996</td>
<td>17 0</td>
<td>111*** 0</td>
<td>44 0</td>
<td>2 0</td>
</tr>
<tr>
<td>1997</td>
<td>10 1R*</td>
<td>68*** 0</td>
<td>36 0</td>
<td>0 0</td>
</tr>
<tr>
<td>1998</td>
<td>7 0</td>
<td>0 0</td>
<td>41 0</td>
<td>2 0</td>
</tr>
<tr>
<td>1999</td>
<td>4 0</td>
<td>1 0</td>
<td>39 1R</td>
<td>1 0</td>
</tr>
<tr>
<td>2000</td>
<td>9 0</td>
<td>1 1I</td>
<td>31 1I</td>
<td>2 0</td>
</tr>
<tr>
<td>2001</td>
<td>6 0</td>
<td>4 1I</td>
<td>46 1I</td>
<td>0 0</td>
</tr>
<tr>
<td>2002</td>
<td>7 0</td>
<td>0 0</td>
<td>33 1R</td>
<td>2 0</td>
</tr>
<tr>
<td>2003</td>
<td>7 0</td>
<td>0 0</td>
<td>29 0</td>
<td>2 0</td>
</tr>
<tr>
<td>2004</td>
<td>8 0</td>
<td>0 0</td>
<td>34 0</td>
<td>0 0</td>
</tr>
<tr>
<td>2005</td>
<td>5 0</td>
<td>0 0</td>
<td>50 1I</td>
<td>3 0</td>
</tr>
<tr>
<td>2006</td>
<td>5 0</td>
<td>2 0</td>
<td>31 0</td>
<td>5 0</td>
</tr>
<tr>
<td>2007</td>
<td>0 0</td>
<td>0 0</td>
<td>28 0</td>
<td>3 0</td>
</tr>
<tr>
<td>2008</td>
<td>4 1I**</td>
<td>1 1R</td>
<td>23 0</td>
<td>2 0</td>
</tr>
</tbody>
</table>

*Documents related to Relocating from county-to-county
**Documents related to Inmates
***Combined number of LCMs released from DSS/OTDA/OCFS/OMM

\(^{97}\) Policy Directives, New York State, Office of Temporary and Disability Assistance (OTDA)
http://www.otda.state.ny.us/main/directives/2009/
Reviews of these documents were supplemented by examination of memorandums from advocacy groups, letters, research reports and documents evaluating programs and policies.

**Interviews:**

The interviews were completed to gain more information about the implementations, and the political and administrative contexts for the two cases. In particular, the interviews are used to document and describe the internal federal/state cultures and concerns at critical points during policy formation and implementation, and any external negotiations or pressures that took place between federal and state representatives. Interviews were also completed with local government representatives, advocates, attorneys involved in litigation on these issues, and representatives from various related professional associations. The list of the individuals who were interviewed appears as part of the bibliography. Several of the respondents were interviewed more than once. Therefore, the total number of interviews was 36.

Table 2 outlines the operational definitions (i.e., attitudes and behaviors) that will be construed to represent political and administrative activity:
Table 3:
Factors Affecting Implementation of Medicaid Eligibility Policy

<table>
<thead>
<tr>
<th>Political Factors</th>
<th>Administrative Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal</strong></td>
<td>1. Inconsistent interpretation of requirements by staff.</td>
</tr>
<tr>
<td>1. Not a priority population.</td>
<td>2. Not enough staff to monitor implementation.</td>
</tr>
<tr>
<td>2. Reluctant to increase Medicaid population.</td>
<td>3. Not enough resources to enforce changes.</td>
</tr>
<tr>
<td>3. Reluctant to increase Medicaid budget.</td>
<td>4. Approaching monitoring and enforcement slowly.</td>
</tr>
<tr>
<td>4. More important to control fraud than ensure service.</td>
<td>5. Can’t get the issue on the decision-makers’ agendas.</td>
</tr>
<tr>
<td>5. Don’t want to open door to cost shifting from states.</td>
<td>6. Bad communication with states.</td>
</tr>
<tr>
<td>6. Pressure by advocates.</td>
<td>7. Not enough tools available to ensure cooperation.</td>
</tr>
<tr>
<td>7. Policy preferences expressed by President, Secretary or other appointed officials.</td>
<td></td>
</tr>
<tr>
<td><strong>State</strong></td>
<td>1. Not aware that there’s a problem.</td>
</tr>
<tr>
<td>1. Not a priority population.</td>
<td>2. Problem changing existing implementation machinery.</td>
</tr>
<tr>
<td>2. Reluctant to increase Medicaid population.</td>
<td>3. Not enough resources to implement properly.</td>
</tr>
<tr>
<td>3. Reluctant to increase Medicaid budget.</td>
<td>4. Not enough staff to work on this.</td>
</tr>
<tr>
<td>4. More important to control fraud than ensure service.</td>
<td>5. Working on implementation slowly.</td>
</tr>
<tr>
<td>5. Interagency barriers to policy development.</td>
<td>6. Can’t get on decision-makers agenda.</td>
</tr>
<tr>
<td>6. Don’t want to interfere with local control of implementation at present time.</td>
<td>7. Federal administrators unclear or unhelpful.</td>
</tr>
<tr>
<td>7. Pressure by advocates.</td>
<td></td>
</tr>
<tr>
<td>8. Policy preferences of Governor, Commissioners or other appointed officials.</td>
<td></td>
</tr>
</tbody>
</table>

Information collected from each of the two cases were analyzed separately to determine the influences in each case.
Data Quality

Establishing the validity of the data collected through elite interviewing is very important. Such data may be biased by the questions and the actions of the interviewer, or interviewees may give evasive or untruthful answers. Efforts to minimize these errors included:

- creating interview guides that were sensitive to the notion that the content of the questions could make the respondent subject to political fallout,
- cross-checking verbal reports against each other to ensure that facts were verified that there was internal consistency to the narratives; and
- fact-checking information against written reports, statutes and regulations.

According to Agranoff and Radin, multiple data collection strategies, including using documents and focused interviews allow the researcher to “map” out the terrain of an organization and its key actors."98 Ultimately, this was accomplished within this study.

Analyses

The primary argument of this study is:

Existing theories of federalism do not explain policy implementation variation within oversight provided to a single state by the same federal agency during the same administrations. Federalism as practiced within health policy follows an instrumental model influenced by political considerations.

Criteria for Evaluation

According to Yin, the most important aspect of evaluating the data collected through case study research is to have a general analytic strategy within the original plan.

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“The ultimate goal is to treat the evidence fairly, to produce compelling analytic conclusions, and to rule out alternative interpretations.”99 Yin recommended two general criteria for evaluation, and suggested that relying on theoretical propositions is preferable to developing a case description.

As mentioned in the introduction and literature review chapters, the theoretical bases for these cases exist in literature related to federalism, IGR, policy implementation, public administration and health policy. The theoretical constructs specifically include the consideration of Regime-based federalism, Executive Federalism, the Elmore, Goggin and Sabatier models of implementation, the Bardach model of IGR, including the identification of the individual stakes of the actors within the case studies, and the stakes for them both personally and professionally. My work also includes a review of the subgovernments and/or networks involved in the case studies, and attempts to identify which theories best describe the patterns of facts as they exist in these cases.

The criteria for evaluating the data collected for this study will be based on identifying the administrative and political factors affecting implementation on the state and federal levels, including examining the attitudes and beliefs of individuals involved in each implementation regarding the relative weight each factor had on influencing the implementation decisions. As illustrated in Table 2, there was a construct for judging information.

Other criterion for evaluation was based on the “method of difference” and the “method of concomitant variations.” The method of difference consists of comparing when a phenomena occurs with similar instances when it does not. The method of

concomitant variations is more sophisticated, in that it goes beyond simple documentation of when something does and does not occur, to include observations regarding other operative variables and relates them to each other. The key questions in this study were related to identifying the variables affecting when HCFA took action against states disenrolling presumed eligible individuals versus when they did not. By definition, this allowed for following method of concomitant variation reviews. The findings expand our understanding of the relationship between politics and administration in a federal system, how conflicting approaches to federalism by the state and the federal government affect implementation, and the role that intergovernmental bargaining has on policy implementation.

**Conclusion**

This study is based on several levels of analysis. The first is institutional, including the statutory and regulatory frameworks for the policy, in both federal and state arenas. The second is individual, and incorporates individual perspectives on political and administrative contexts, social construction of the target populations and the locus of their conception, and the stakes each individual sees as being related to particular implementation approaches.

The logic linking the data to the propositions is based in the literature on Medicaid policy, implementation, IGR and federalism. Current context will be documented through statutory and regulatory reviews, document reviews, and elite interviews.

The criteria for interpreting the findings will be based within the theoretical propositions already enumerated. Therefore, the data will be judged as to whether it

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100 Lijphart. Lijphart, "Comparative Politics and the Comparative Method," 688.
supports or refutes the importance of political factors in the implementation of federal Medicaid policy, whether priority factors are institutional or individual, and whether the manner of implementation makes a difference to the target population.

**Research Implications**

There are a number of reasons this work is important, and they are different for each area of literature which has been reviewed. For IGR, as described, this study provides a whole new level of detail regarding intergovernmental bargaining, and the adequacy of existing policy tools for monitoring state and local agencies to ensure compliance with federal laws and regulations across redistributive programs. In addition, it expands and enhances our understanding of the role of policy networks, and the cross-policy influence that some networks are successfully pursuing.

In the area of federalism, this study builds on existing theory regarding when federalism works, as well as providing context and texture to understanding Beer’s “third position” of the emergence of new arenas of mutual influence among levels of government, with states and localities exerting direct influence on the federal government.\(^{101}\) In this “fourth” wave implementation study we find state bureaucrats who believe their understanding of federal regulations is more accurate that some of the federal bureaucrats involved in program implementation, and who are willing to challenge federal authority to compel change.

This study also provides clues to identifying the political and fiscal influences related to variation in federal policy implementation across decades of a program implementation. While interest groups are accustomed to lobbying legislators for their

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\(^{101}\) Beer, “Federalism, Nationalism and Democracy in America,” 9-21.
groups to be included in particular redistributive programs, they may not systematically monitor implementations to ensure equity in the proper distribution of goods and services. This study illustrates better than most that “the devil is in the details.”

Finally, given Sparer’s argument that Medicaid is likely to provide a backdrop for federal health care reform in the future, the factors that have influenced this implementation of Medicaid eligibility policy are significant to the discussion of this expansion.\(^\text{102}\)

The remaining chapters provide the details of these implications.

\(^{102}\) Sparer, *Medicaid and the Limits of State Health Reform.*
CHAPTER 4:
Case 1: County-to-County Re-locators

On December 4, 2000 Timothy Westmoreland, Director of the Center for Medicaid and State Operations (CMSO) of the Department of Health and Human Services, Health Care Financing Administration (HCFA) issued a State Medicaid Director letter noting that HCFA had identified cases where families were being subject to erroneous Medicaid terminations. Specifically, when families moved from one county to another county within their state of residence, some states were taking administrative actions frequently resulting in disenrollment. According to Mr. Westmoreland, Section 1902(a) (1) of the Social Security Act requires that a State Plan for Medicaid must be in effect for all political subdivisions of the state. Therefore, “in a county-administered Medicaid program, when a family moves within the State, the State and counties are responsible for transferring the case record from the old county of residence to the new county of residence so that Medicaid can continue without interruption. The State cannot require the family to reapply for Medicaid or comply with a Medicaid redetermination solely based upon a move to a new county.”

As a result of this finding, HCFA directed states to “review your official policies and procedures regarding Medicaid denials and terminations and redeterminations to ensure compliance with Federal requirements at 42 CFR435.916 and 435.930.”

Not only did HCFA require states to review their policies; they also asked states to review the practices of eligibility staff, particularly in those states where eligibility

104 Ibid., p. 2.
determinations were completed by staff in counties, such as New York. Specifically, HCFA asked states to review counties’ actions to verify that:

- No county in your state terminates Medicaid when families move out of that county to another county within the State;
- No county requires families who move within your State to reapply for Medicaid in their new county of residence;
- When families move, counties transfer case records in a timely manner and Medicaid is continued uninterrupted; and
- All written policies and procedures comply with Federal requirements for redetermining Medicaid eligibility.\(^{105}\)

If a state found itself out of compliance it was directed to contact the HCFA regional office to establish a corrective action plan for coming into compliance within the next 90 days.

For a student of federalism and its impact on health programs and policy, this case appears to exemplify the perfect federal bureaucracy in action. In it, the federal oversight agency (DHHS) discovers states may be implementing federal regulations in ways that are damaging to potential beneficiaries. While acknowledging that different states have different administrative apparatus, including states that rely on local county bureaucracies, the federal agency asked the states to review both policy and practice, and to institute a corrective action plan if it finds itself out of compliance. In the last act of federal oversight adequacy, the Central office reminds states that there are regional offices and officers available to provide assistance. Perfect.

But, is this common oversight practice for DHHS? How did the CMSO determine that these inappropriate terminations were being made, and how did such knowledge result in this letter being sent to the states? Most importantly, did this action by DHHS result in better compliance and fewer inappropriate terminations? Given the multiple

\(^{105}\) Ibid.
lenses available to examine cases, before deeming the oversight provided by DHHS on the Medicaid program a success, this implementation study requires additional analysis. The remaining chapter provides a history of the issues, describes the stakes and perceptions of the various players at the federal and state levels, and most importantly describes the state’s reaction to the federal oversight. It concludes with a summary of how the cases for the county-to-county relocaters got settled.

**Origins of a Federal Directive**

In 1996 the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was enacted by Congress and signed into law. PRWORA is a comprehensive welfare reform plan that changed the nation’s welfare reform system by eliminating the Aid to Families with Dependent Children (AFDC) program and the Job Opportunities and Basic Skills (JOBS) program, and replacing them with the new Temporary Assistance for Needy Families (TANF) program. As part of the TANF legislation, there was a critical change in Medicaid eligibility. No longer would there be an automatic link between eligibility for cash assistance and Medicaid.

De-linkage between cash assistance and Medicaid created new challenges for States. Historically low-income people first learned about Medicaid when they applied for AFDC. Under PRWORA, however, States are required to create systems to ensure that low-income families have access to Medicaid, regardless of their connection to the cash assistance system. Also, families that end their participation in the cash assistance program, either by choice or through sanction, may still be eligible to receive Medicaid.

For most states, these changes required substantive modifications in state and local welfare and Medicaid bureaucracies. Line staff in both Medicaid and cash
assistance units had to be retrained. Eligibility processes and supporting computer systems had to be reviewed. Requirements for notifications to beneficiaries had to be rewritten.¹⁰⁶

According to Cindy Mann, Director of Family and Children’s Health within the CMSO when the county relocater letter was sent, by 1999 there was evidence that states were not “fully or properly implementing the new rules for Medicaid.”¹⁰⁷ Specifically, Mann noted that many states were having trouble with de-linking, and how to treat Medicaid eligibles who were no longer receiving cash assistance.

**Problem Identification**

Mann described a number of mechanisms whereby HCFA learns that the states are having problems or participating in inadequate and/or inaccurate program procedures. Sometimes there is an event that comes up in a particular State, and HHS reads a newspaper report, or receives a call from a recipient or advocate. In those instances, a letter from the Central or Regional office is sent to the State to investigate the issue and gather data. Other times issues will be raised to the Central and/or Regional office by Technical Advisory Groups (TAGS), experts from state and local government offices and national associations with extensive knowledge of different aspects of the Medicaid program. According to Mann, there is no systematic oversight or audit of Medicaid State operations, and one of her biggest challenges was to try and run the Medicaid program with consistency and transparency. Her difficulty in managing the large bureaucracy was

¹⁰⁶ Betty Rice (Director of Medicaid Eligibility and Local District Relations, New York State, retired), face-to-face interview with Kathleen Dalton, (Castleton-on-Hudson, NY), October 11, 2007.
¹⁰⁷ Cindy Mann (Director of Family and Children's Health, Center for Medicaid and State Operations, Health Care Financing Administration), in telephone interview with the author, November 5, 2007.
to try and establish mechanisms whereby appropriate problems would “bubble up” to management’s attention.

In the specific case of eligibility questions, Mann tried to ensure that rules were made as clear as possible to State staff by encouraging central office staff to develop a consistent interpretation of the regulation, and put the directive in writing. Mann was particularly committed to addressing criticisms that questions would “bubble up into a black hole.” If the problem was under her jurisdiction and present in a number of states, Mann would recommend a State Medicaid Director letter. The letter would be reviewed by Mr. Westmoreland and, if controversial, might be reviewed at even higher levels by the Director of HCFA or the Secretary of HHS.

Mann acknowledged that a number of things could prioritize the distribution of particular State Medicaid Director letters: “lots of things bump into the agenda… who’s in charge and what’s a priority for them… if there is a special interest in Congress, or if a Governor calls the Secretary.” And, she notes that each high ranking appointee comes “with their own baggage.” She noted, for example, that she took her job at the CMSO already believing that de-linking was creating a problem. However, she also acknowledged that many things could present obstacles to sending Medicaid Director letters including lack of staff resources to write, edit and distribute the letters, sensitivities regarding controversial issues, and complexities within the law and regulations that created disagreements regarding the appropriate interpretation and related actions required by a particular issue.  

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*Learning about Inter-County Moves*

\[108\] Ibid.
Medicaid enrollment data subsequent to welfare reform did show a sharp drop-off. Along with the administrative issues implied by the drop, and the obvious predicament of otherwise eligible recipients not receiving services, the drop in Medicaid enrollments also created a political situation. According to Mr. Westmoreland, there was a particular sensitivity with the disenrollments because at the time President Clinton was taking “a lot of flack on welfare reform. The suggestion that mistakes were made [on Medicaid de-linking] was a problem.”

In response, the CMSO took a number of steps to address the apparent difficulties; steps that have been unanimously identified as unique. First, the central CMSO office directed the Regional offices to launch a national review initiative to examine Medicaid eligibility processes and practices across the country. A comprehensive on-site review of the 50 states’ program operations had never been undertaken by HCFA prior to that time. The review topics for the site visits incorporated seven areas:

1. Eligibility and enrollment process;
2. Maintaining coverage for families who leave public assistance programs,
3. Reaching families potentially eligible for Medicaid,
4. State Children’s Health Insurance Program (SCHIP),
5. Optional policies for Medicaid, outreach activities and eligibility expansions,
6. Ensuring administrative efficiency and Medicaid quality control, and
7. Computer systems.

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111 Consensus of interviewees, August-November 2007.
112 For additional information on this effort, see Thompson, Fossett and Gais, “Federalism and the Safety Net.”
During the same time period that the site reviews were taking place, a complaint was made to the Region II (New York) HCFA Associate Regional Administrator, Sue Kelly, that county-to-county relocaters were being inappropriately terminated. In particular, the charge was made that Suffolk County, New York Medicaid administrators were forcing people who were Medicaid eligible in another county to completely re-apply for Medicaid if they moved to Suffolk County.114

As was the practice of Central office, when such a problem was identified, staff would check with other states to determine if the problem was wide-spread. Because the complaint was lodged at approximately the same time as the on-site reviews, the county-to-county issue was immediately substantiated as being wide-spread enough to warrant CMSO intervention.

Taking Action

While the county-to-county relocation practices were identified as problematic during the reviews, on a national basis there were bigger problems with de-linking at hand. As a result of the findings from the national reviews, and with prodding from colleagues, Mr. Westmoreland distributed a State Medicaid Director letter that provided a broad overview of Medicaid Eligibility Requirements, and covered topics related to rectifying situations that were created by de-linking. The State Medicaid Director letter was dated April 7, 2000, and was seven pages long, supported by a number of addendums. The letter covered three related topics:

1. First, it outlines a series of actions that all States must take to identify individuals and families who have been terminated improperly and to reinstate them to Medicaid.
2. Second, it clarifies guidance on Federal requirements relating to the process for redetermining Medicaid eligibility.
3. Third, it reviews the obligations imposed by Federal law with regard to the operation of computerized eligibility systems.  

The letter was particularly unusual because up until this point, HCFA had never required States to identify beneficiaries who had been inappropriately terminated, nor insisted that they be reinstated.

The activities that were undertaken to address the de-linking problems were to establish the precedent for Clinton Administration’s existing HCFA appointees in the ensuing activity regarding county-to-county relocaters. The State Medicaid Director letter was issued on December 4, 2000, just prior to the end of the Clinton Administration. Although there were charges that a large number of letters were issued that month in an effort by Clinton appointees to establish policy during the Bush Administration, the consensus of opinion from the Clinton appointees was that those charges were untrue. As Mann described it: “Sometimes things languish because there’s no time to get it done, but when a deadline comes around you push it out. Some people thought we were trying to stick it to the Bush Administration… but it was just due.”

It’s important to note in these and other instances, the lack of resources in terms of staff was noted more than once. In fact, Mr. Westmoreland noted that towards the end of the Clinton administration he was faxing Medicaid Director letters to the states himself, because there was no one else to do it.

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The New York Experience

An on-site review in New York took place in June and July 1999. The review included unannounced visits to seven income maintenance/jobs centers in New York City, Nassau and Suffolk counties. HCFA staff also reviewed over 20 boxes of State policies and procedures, guidelines, regulations, training materials and schedules, and correspondence. Subsequent visits were made to offices in Suffolk County on May 19 and July 7, 2000 in response to allegations that inappropriate barriers were being imposed on Medicaid applicants in that jurisdiction.¹¹⁷

Origins of NYS DOH’s County-to-County Position

When the inquiry regarding New York’s county-to-county practices began, the State regulations stated:

When a recipient moves from one district to another and continues to be eligible, the “from” district continues to be responsible for providing Medicaid during the month of the move and may continue assistance for the month following the month of the move. Thereafter, the “where found” district is the DFR [District of Financial Responsibility].¹¹⁸

It is important to note that because New York counties pay 25% of all Medicaid costs, counties have required the state to be very specific about DFRs under a multitude of circumstances.

Betty Rice, the former Director of Consumer and Local District Relations [which included the Medicaid Eligibility unit] at the New York State Department of Health (NYS DOH) recalls the initial allegations regarding inappropriate treatment of those who move from county-to-county. “I remember this starting as an issue brought up by a local district. There was a residential treatment facility for kids on Long Island that was…[unhappy] about having to reapply for the kids.” Rice explained that the State and County made “good faith” efforts to alleviate the problems for the facility by arranging for special processing for children in the facility.

State and County staff believed that making exceptions for ensuring continued eligibility for the children was more appropriate than attempting to change the state’s policies. This was due in part to the belief on the part of staff within the Medicaid eligibility unit that moves generally included case changes that materially affected eligibility: new jobs, new spouses, changes in income and expenses. The eligibility unit believed it was necessary and appropriate to require new applications in order to ensure continued eligibility and avoid errors, error rate increases, and sanctions. This is an important point, because this opinion on the part of the eligibility staff ultimately shaped the State’s interactions with and responses to inquiries from DHHS and others.

Rice staunchly defended the policy of requiring a new application. In addition to the belief that there were likely to be material changes to cases where the recipient had moved, she also indicated “There were a lot of problems with cash assistance cases because eligibility levels changed from county-to-county.”

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119 Betty Rice (Director of Medicaid Eligibility and Local District Relations, New York State, retired), face-to-face interview with Kathleen Dalton, (Castleton-on-Hudson, NY), October 11, 2007.
120 Ibid.
121 Ibid.
The Context Created by Welfare Reform

Rice noted that the county relocaters issue became a problem during a time period that saw a number of issues rise to the surface. First, as a result of welfare reform implementation, in December 1998 seven New York City residents who had issues with actions taken by the City’s job centers and were consequently denied access to Medicaid benefits filed a class action lawsuit in Federal District Court. Known as the “Reynolds” case (Reynolds et al. v. Giuliani et al. SD 98 Civ 8877), the court conducted a three-day evidentiary hearing in January 1999, and the Associate Regional Administrator for Region II from the Division of Medicaid and State Operations at HCFA, Sue Kelly, had to testify regarding Federal Medicaid application and processing requirements. New York State and City officials also testified about actual procedures. On January 25, 1999 the court found that there were system-wide failures, and a preliminary injunction was granted. New York City was forced to re-engineer their approach to welfare reform as a result.\(^{122}\)

In addition, in April 1999, the New York Regional Office for Civil Rights (OCR) contacted the Region II Medicaid office in New York to inform them of complaints regarding delays for minorities, individuals with disabilities and persons with limited English proficiency when applying for cash assistance and Medicaid. In particular, the complaints alleged that applicants with limited English proficiency were not permitted to apply for Medicaid benefits until they returned to the offices with translators. HCFA and OCR investigated these complaints at the same time that the National Reviews were being conducted. Federal staff conducted unannounced visits to seven sites in New York.

City on June 3, 1999. Additional unannounced visits were made in Nassau and Suffolk Counties on June 7th and 8th respectively. As a result of these visits, Corrective Action Plans were required for application policies and procedures for limited English Proficiency cases.123

According to Rice, the Reynolds lawsuit raised the focus on eligibility issues, and “then there was a lot of noise nationally regarding immigration and limited English proficiency cases.”124 She expressed the impression that there was somewhat of a snowballing effect, where every time the HCFA Central Office found a problem somewhere, the problem would surface in New York. “The noise would spread from Tim Westmoreland in the Federal Central office to local advocates, who began dealing with [and complaining to] Sue Kelly in Region II. The two year period with Westmoreland was challenging. We were tootling along with stuff that we had been doing since the year of the flood, and thought was right and legal, and then everything got scrutinized.”125

Kelly from the HCFA Region II office describes similar remembrances. “Prior to Reynolds, there were tens of thousands of folks rumored to be tangled in eligibility issues… We can’t find a clear case of CMS [formerly HCFA] threatening sanctions, until welfare-to-work and welfare reform… the Reynolds case in New York. When Reynolds came along I was subpoenaed and the agency made a decision that it was in our interest to have me testify. The core of my testimony advocated for the job sites to take

123 Ibid.
124 Rice, interview, October 11, 2007.
125 Ibid.
immediate applications… This was the closest we came to taking a compliance action.”126

The fact that compliance actions have been limited is not surprising in light of the options available to DHHS. Section 1904 (42 USC 1396(c)) outlines that if, after reasonable notice and opportunity for a hearing the state is found to be out of compliance with their State Plan, or that there is substantial noncompliance with provisions of the Medicaid program, the secretary can withhold payments to the state until DHHS is satisfied that compliance is assured. DHHS staff have indicated that this is generally considered a “nuclear option,” and it is considered politically unacceptable as an option at all. Therefore, generally speaking, the only real option for DHHS is to bargain with the state over a period of time, in hopes that they will comply.

According to Kelly, the agency’s decision-making process regarding providing testimony is subject to a regulation referred to as the “Touhy” regulation. It requires the subpoenaing agent to justify why a federal employee is being called. The subpoena is supposed to be issued to the Counsel’s office for the federal employee, and the Counsel’s office is required to consult with the Department of Justice. If it is decided that it’s in the best interest of the agency to have the employee testify, a US Attorney must appear in court with the employee. She noted that for DHHS to approve her to testify in the Reynolds case, it was a big deal. Details of this process are important, because later when Kelly was asked to testify about county-to-county moves the process was not followed and Kelly was therefore unable to testify in the case.

126 Sue Kelly (Associate Regional Administrator for the Division of Medicaid and State Operations at Health Care Financing Administration, Department of Health and Human Services), face-to-face interview with the author, (New York City, NY) October 16, 2007.
In describing why she believed the welfare reform case was treated differently from other cases of denied eligibility, Kelly had several thoughts. “Reynolds was different… first because the magnitude was enormous.” She went on to explain that while other policies or inappropriate practices had impact on beneficiaries, the impact of welfare reform was national and affected a large number of applicants. In addition, Kelly felt that the states, and certainly New York State, were not responsive to HCFA’s concerns. New York was “dismissive on Reynolds. The first 2-3 letters went unanswered… And what was happening was serious. A pregnant woman was being sent for work before she could even apply for Medicaid. And, it wasn’t just New York City. The problems were statewide. The activities that were established for deferment of welfare cases were problematic.”

Kelly agreed that Mr. Westmoreland was assertive and aggressive on the eligibility issues. “Tim Westmoreland was director only over a year. He didn’t have extensive time, but it was when we had a big issue on welfare-to-work. So, he was driven to find out what was happening, and he was proactively calling offices, checking on training… Tim’s tenure can’t really be compared [with others]. It’s apples and oranges; his situation was extremely different. CMS had never looked at all 50 states and territories.”

**Federal-State Interaction**

New York was not formally contacted in writing by the Regional or Central offices of HCFA regarding the status of their compliance with county-to-county moves.

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127 Ibid.
128 Ibid.
until June 4, 2001. At that time, Sue Kelly sent a report to the State summarizing the findings of their review of New York eligibility operations. In the cover letter to Kathryn Kuhmerker, the New York State Medicaid Director, Kelly referenced previous communication: “As you are already aware, there are a number of items that we have identified …as issues of concern to HCFA. We will be following up with you with respect to the concerns that have been identified through the review process…”129

While none of the individuals interviewed for this research could recall the specific conversations and phone calls regarding the issues, Kuhmerker and Rice indicated that the state had numerous conversations with representatives from HCFA about the appropriateness of requiring new applications. According to Kuhmerker:

The Feds were saying it’s a statewide program, and so termination was inappropriate. In some respects that makes sense, but when moving your circumstances change, so there’s the potential for new ineligibility. And the counties didn’t make it easy. We originally had an ADM [Administrative Directive to the counties] that said documents didn’t have to be produced [for the new application], and some counties thought it was OK, but not all, particularly when the moves went between upstate and downstate. The problems were exacerbated by the fact that we have 2 different eligibility systems [one upstate computer system and one downstate computer system].130

Rice echoed Kuhmerker’s recollections:

We thought the application was the way to go rather than a recert. To us a move seemed like warning bells that there was a significant change in the case. The difference between a recertification and a reapplication is whether you have to resubmit documents. We had issued an ADM before that that said to look for information for the recert on WMS [the Welfare Management System]. That way folks didn’t have to resubmit paperwork so that it eased documentation. But then, in the Single State Audit and in local audits the auditors would site the local

129 Sue Kelly (Associate Regional Administrator, Division of Medicaid and State Operations, Regional Office II, Health Care Financing Administration, Department of Health and Human Services), letter to Kathryn Kuhmerker, (Deputy Commissioner of the Office of Medicaid Management, New York State Department of Health), June 4, 2001, 1.
130 Kathryn Kuhmerker (New York State Medicaid Director, retired), face-to- face interview with the author (Latham, NY) , October 7, 2007.
districts because copies of the documents weren’t on file. It got so bad in the counties that if the food stamp unit had a copy of documents but Medicaid didn’t have the same documents in THEIR files, the county got hit on the audit.  

Rice uncovered a critical issue that seemingly complicates much of the interaction between DHHS and the states. That is, an apparent disconnect between the program employees and the audit employees. Federal auditors have the responsibility to review claims that states submit to the federal government and investigate whether the claims are valid for payment. If the federal auditor determines that the claim is not valid the state receives a “disallowance” for the claim, and therefore the federal government does not share in the costs for that client and/or service. In this instance, absent any change in policy or procedure, if a Medicaid recipient could prove their eligibility in County A and then move to County B and receive Medicaid there without reapplying, the original paperwork would remain in County A. Therefore, the eligibility files in County B would be incomplete and left open to disallowances. State representatives believed that if the Federal agency didn’t want recipients to have to reapply, they should waive the requirements to have all the application documents in the county of residence at the time of an audit. The program staff at HCFA apparently did not believe the transfer of paperwork should be a problem.

After several discussions, on June 19, 2001 Kuhmerker wrote to Kelly “in response to Mr. Timothy Westmoreland’s letter of December 4, 2000 regarding state eligibility policies when families move from one county to another county within their state of residence.” Kuhmerker stated:

New York State conducted a very thorough review of our eligibility policies and automated systems as required in Mr. Westmoreland’s letter of April 7, 2000.

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131 Betty Rice, interview, October 11, 2007.
This review confirmed that our policies are consistent with federal rules and regulations, and the state’s systems support these policies.\textsuperscript{132}

Oddly enough, while she reported the State to be in compliance with federal rules and regulations, in the next paragraph Kuhmerker outlined the New York State policy again, which required counties only to cover the person for the month of the move, and allowing for coverage the month after the move before permitting termination. This was clearly in violation of the federal rules and regulations. She went on to say:

\begin{quote}
We agree with your statement that moves often connote a change in circumstances requiring families to report to the new county, but we recognize there are circumstances when families may not be able to contact the new county in a timely fashion. Therefore, to insure continuous coverage, we have proposed an amendment to State statute that will require counties to maintain Medicaid coverage for two months after the month of the move. Once this amendment is in place, we will issue implementing procedures to New York City’s Human Resource Administration and the Local Departments of Social Services.\textsuperscript{133}
\end{quote}

In writing this paragraph, Kuhmerker suggested that it was the Federal government who believed that moves were indicative of changes that should be reported immediately at the risk of losing coverage, and that the State was actually being lenient by providing for an additional month’s coverage prior to termination. However, she also offered to strengthen the state’s position by proposing legislation to require counties of origin to continue coverage for two additional months prior to termination.

At no time did she actually mention the fact that the state was still terminating recipients who moved from county-to-county, and would continue to do so even after the legislation was passed. Instead, the letter closed with assurances that cases that had been

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\textsuperscript{132} Kathryn Kuhmerker, (Deputy Commissioner of the Office of Medicaid Management, New York State Department of Health), letter to Sue Kelly, (Associate Regional Administrator of the Division of Medicaid and State Operations, Regional Office II, Department of U.S. Department of Health and Human Services), June 19, 2001.
\textsuperscript{133} Ibid.
\end{flushright}
terminated from Medicaid would be reviewed as part of a quality control review, and that reviewers would be instructed to pay particular attention to families that moved from county-to-county. She also assured Kelly that there was significant training throughout the state on the issue.

In describing the steps that the state took, Kuhmerker said “In this instance, we concurred with the Feds. Our process didn’t meet standards. But our process didn’t work well.”\textsuperscript{134}

Rice was a bit more dissident: “This came up because of the inappropriate terminations from de-linking, and the feds requiring a full caseload review. For anyone who was terminated, there was supposed to be a re-determination and reinstatement. We just said everything was fine because we were doing that for inappropriate de-linking terminations. There was no federal oversight… We believed the ‘may/shall’ change would give folks time to make a new application and things would be OK…”\textsuperscript{135}

\textbf{Round Two}

On January 30, 2002 – seven months after the state’s letter -- Charlene Brown from Central Office wrote back to Kuhmerker on behalf of Dennis Smith, the new Director of the CMSO within the now newly-named Center for Medicare and Medicaid Services (CMS). Brown noted that she was replying for Kelly, and then went on to say how CMS appreciated New York’s efforts to propose statutory changes to extend coverage. But then she addressed the continued issues relating to county-to-county moves:

\textsuperscript{134} Kathryn Kuhmerker, interview, October 7, 2007.
\textsuperscript{135} Betty Rice, interview, October 11, 2007.
…as stated in our December 4, 2000 State Medicaid Director letter, we must reiterate that a state cannot require persons to reapply for Medicaid or comply with a Medicaid redetermination solely based upon a move to a new county. Even when there is a basis for conducting a redetermination, the state must first perform an ex parte review to determine to the extent possible, based on information already available to the state, whether Medicaid eligibility continues. We urge you to ensure that counties in New York are not terminating Medicaid and requiring persons to reapply for coverage in their new county of residence, and are not requiring persons to participate in an eligibility redetermination (including a face-to-face interview) solely because of the move.  

Kuhmerker wrote back to Kelly on June 3, 2002. She announced that the amendment to extend coverage for the month after the move had been enacted, and that implementation procedures had been issued to New York City and the local social services districts. She expressed her hope that the two-month time frame would help facilitate transition to the new county of residence without an interruption in Medicaid coverage. She also notified the Regional staff that New York State had passed legislation simplifying the Medicaid application and redetermination process by allowing individuals to attest to their resources rather than having to provide documentation. In addition, no longer would face-to-face interviews be required of individuals recertifying for benefits, and a simplified recertification form was about to be developed for both Medicaid and the expansion program for adults in New York, Family Health Plus.

While Kuhmerker touted the simplified processes, she continued to express concern regarding eligibility subsequent to a move. She stated:

While procedures are already in place to assure that Medicaid continues when an individual moves from one county to another, there are legitimate reasons for contacting the individual as soon after the move as possible. A move to a new district means a change in address that must be verified. It can also mean a job change or a change in household composition. We expect to have a simplified

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136 Charlene Brown for Dennis Smith (Director of the Center for Medicaid and State Operations, Health Care Financing Administration), letter to Kathryn Kuhmerker, (Deputy Commissioner of the Office of Medicaid Management, New York State Department of Health), January 30, 2002.
notification form for county-to-county moves; one that inquires as to whether there has been any change in the individuals’ circumstances that could affect continued eligibility.\footnote{Kathryn Kuhmerker (Deputy Commissioner of the Office of Medicaid Management, New York State Department of Health), letter to Sue Kelly, (Associate Regional Administrator of the Division of Medicaid and State Operations, Regional Office II, Health Care Financing Administration, U.S. Department of Health and Human Services), June 3, 2002.}

Kuhmerker closed her letter by cautioning Kelly that the new processes would require significant transformation from the current process and that the changes would require reprogramming the information systems. She mentioned that there was still not a schedule for implementation, but that they were hoping for October 2002.\footnote{Ibid.}

Then the paper trail goes silent for more than a year.

**Round Three**

Kuhmerker indicated that during the time period when there were no formal communications regarding the county-to-county issues, she had some off-the-record conversations with Kelly, who incidentally was a former New York State Medicaid Director during the Cuomo Administration. According to Kuhmerker, Kelly understood that there were difficulties with trying to re-engineer the process for county-to-county moves, but there was really nothing Kelly could do to help. Kuhmerker noted, “Very few people understand the complexities of eligibility, so detailed conversations were difficult.”\footnote{Kathryn Kuhmerker, interview, October 7, 2007.}

Rice attributes the silence to the change in administrations that occurred in 2001. She said:

\footnote{Ibid.}
Once Westmoreland left, it seemed benign neglect was back in vogue. During the Clinton years, if you wanted to do good the Clinton folks would try to modify their interpretation of things so they could help you. Then all that stopped.\footnote{140}

Apparently, despite the lack of a paper trail, some conversations continued to take place over the course of the next year. On October 3, 2003, sixteen months after the last letter, the paper trail picked back up with a letter from Rice to Patricia Ryan, Health Insurance Specialist at the Division of Medicaid and Children’s Health in the Region II CMS office. In what Rice described as a tactical move to put the ball back in the Region II court, Rice made a formal request on the part of the State for technical assistance from CMS regarding how to implement the federal regulations for county-to-county moves in light of the State’s constraints. She also noted that other states expressed similar concerns as New York during the TAG conference calls on eligibility. In the four page letter, Rice outlined implementation issues in the text boxes that follow:

\footnote{140 Betty Rice, interview, October 11, 2007.}
Changes in Circumstances Attendant to the Move:

We cannot assume that the individual’s income, expenses, or living arrangements are the same after the move as before the move, in addition, other eligibility factors are subject to change when a move occurs, which require that the recipient’s current circumstances be reviewed. The move nature of a move in New York State signifies that a change in Medicaid eligibility may occur for Low Income Families, because there are 5 different standards of need, as a result of different shelter and heat allowances in New York State.

Presently, an individual is required to complete a Medicaid application and have a face-to-face interview so that ongoing eligibility can be determined. We have considered replacing these requirements with a simplified “Update Form”. The form would be used to capture any changes that could affect continued eligibility such as employment and household composition. Medicaid recipients would be permitted to mail in the “Update Form” and would not be required to attend a personal interview. With programming/format design, our automated Client Notice System would be used to generate the “Update Form”. Individuals would need to submit the form to the new district of residence by the first day of the month following the month of move in order to allow adequate time for an eligibility determination and the required data entry.

Managed Care Enrollment:

In New York State, enrollment in managed care is mandatory for most non-institutionalized Medicaid recipients in some local districts. Therefore, it is the only vehicle to access Medicaid services in these mandatory managed care enrollment counties. Individuals who move from one county to another may not have access to services through their chosen managed care plan. An enrollment/change in a new district must take place by the third week of a month in order for the individual to appear on the plan’s roster effective the following month. If the new district receives an “Update Form” by the first day of the month following the month of move, this gives the new district of residence’s eligibility worker three weeks to determine and establish eligibility and enter the enrollment on the Welfare Management System (WMS). Consideration needs to be given on how best to inform the recipient of the managed care options in their new district. We have considered initially converting these individuals to fee-for-service Medicaid, which allows access to all participating Medicaid providers but not managed care plans, until a new plan/enrollment can be accomplished. However, there are instances where an individual wants to remain with his managed care provider (moves across county lines). If the recipient is no longer able to participate in his or her managed care plan, we could also be interrupting an individual’s treatment or care.

Currently there are approximately 300,000 individuals in our Family Health Plus program. Pursuant to New York State Law and the terms and conditions of the 1115 waiver, providing Medicaid on a fee-for-service basis is not an option for these individuals, and thus is not a viable solution for this portion of the Medicaid population.
Prior Approval:

Certain services require prior approval, such as transportation and private duty nursing. Such prior approval becomes difficult when coverage remains with the former county (month of move and the following month) yet the individual physically resides in the new district. The same providers often do not contract with each local district. Additionally, the prior approval process adds to the tasks that need to be completed timely in order for an individual to receive uninterrupted services in his or her new district of residence.

Spenddown Cases:

Documentation of net spenddowns (excess income) is difficult at best under 42 CFR §431.831. Once a person moves out of the district that is responsible for the coverage (former district for month of move and following month) the challenges are increased.

Work Load Issues:

Our procedure to use a simplified “Update Form” for recipients who change county of residence, leaves the new district with a limited time period in which to authorize continued coverage. Due to extensive caseload size and continued growth in some local districts, it will be a challenge to process these forms in the time period required and not have a gap in coverage. While we work with local districts to improve case processing times, and some districts have hired new staff, the need to prioritize workloads remains. Should “Update Forms” be given a higher priority over new applications/interviews and recertifications? These are the real choices that many districts are facing.

Inquiry Limitations:

As you know, we intend to modernize WMS. Although efforts at both state and local district levels continue toward this endeavor, we must currently operate the Medicaid program under WMS as it currently exists.

When an individual moves between counties, the individual should only need to report changes that may affect eligibility. However, because districts do not have unlimited access to WMS and eligibility files outside their own district, it may be difficult to build a case in the new district based only on the factors that have changed (or what can be printed on the “Update Form”).

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According to Rice, after receipt of the letter, Region II backed off considerably.

They did check up with us periodically during the Westmoreland period, but then they didn’t come back. Essentially they kept their head down and did not ask questions, even though they said they were available for TA. They said we needed to do an ex parte review. We asked for support and technical assistance about how to get that done when the new county had none of the documents needed to do an ex parte review. Our letters were never responded to, and nobody responded by phone.

Documents indicate that Rice was largely correct. There is no record of a response to her letter until December 22, 2005, two years and two months later, when a letter was sent from Brian Wing, Deputy Commissioner of the Office of Medicaid Management, and the new Medicaid Director for New York State, to Sue Kelly. The letter references a call with Kelly and her staff on December 20, 2005. Wing also references the October 3, 2003 request for technical assistance, and adds several additional questions that the state would like Region II to provide assistance on. He suggests a meeting to discuss the issues raised.\textsuperscript{142} Kelly responded to this letter on January 18, 2006 telling Wing that she has shared the State’s questions with staff from the central office, and that Ryan would be working to arrange the requested meeting.

The telephone conference call was held on April 13, 2006, and documented in a letter from Rice to Kelly in a letter dated April 18, 2006. The letter is supported by a six page proposal outlining various options for implementing procedures for continuing enrollment for Medicaid recipients who move from county-to-county. In it, Rice again outlines the barriers to performing ex parte reviews and couches her suggestions within a structure that highlights the specific requirements of the Code of Federal Regulations.

\textsuperscript{142} Brian Wing (Deputy Commissioner of the Office of Medicaid Management, New York State Department of Health), letter to Sue Kelly, (Associate Regional Administrator of the Division of Medicaid and State Operations, Regional Office II, U.S. Department of Health and Human Services), December 22, 2005.
Rice begins by focusing on 42 CRF 435.916, which requires States to have procedures in place to ensure that recipients make timely and accurate reports of changes. The options that Rice outlines for Kelly are based on requirements that the client report changes of address within 10 days of the move. Rice proposes that if the client makes the appropriate report in a timely manner, neither an application nor a face-to-face interview will be required to determine continued eligibility. The remaining portions of the letter cover how this procedure would work within a number of different scenarios within managed care and fee-for-service programs. She closes the letter with a request for expeditious review on the part of Region II and a request for another follow-up conference call.  

The last letter in this case study is dated July 6, 2006, and is from Brian Wing to Sue Kelly. In it, Mr. Wing references a phone conversation between Rice and Kelly on June 15, 2006. Without referencing the content of the phone call, Wing rescinds the April 18th request for review and approval of the State’s proposals, and informs Kelly that:

…we will rely on our longstanding interpretation of 42 CFR 435.916, which requires states to have procedures to ensure recipients make timely and accurate reports of changes in circumstances so that prompt redeterminations of eligibility can be made.

Essentially, the State closes the door to dealing with Region II on the alleged non-compliance, preferring to implement their own understanding of the federal rules and regulations, rather than that of CMS.

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143 Betty Rice, letter to Pat Ryan, October 3, 2003.  
144 Ibid.  
145 Brian Wing, letter to Sue Kelly, July 6, 2006.
Pressuring the State to Comply

On November 17, 2005 Peter Vollmer, an attorney from Long Island, filed a class action suit on behalf of Mary Luberto, a Medicaid recipient who moved from Nassau County to Suffolk County, New York, and was being required to reapply for Medicaid in Suffolk County. Vollmer had worked for a number of years in the Nassau-Suffolk Law Services agency, representing low-income individuals in public entitlement fair hearings and developing extensive expertise regarding federal and state entitlement laws, rules and regulations. In September 1993 he left that agency to start a law practice, noting that public law allows plaintiffs to collect legal fees if their cases are decided in their favor. Vollmer decided that these fees would be enough to sustain his independent practice. Luberto was a 54 year old woman who had a traumatic brain injury, was homebound, and was in need of continuous personal care. Prior to October 24, 2005 Luberto lived with a sister in Merrick, N.Y., but she was moving into the Islip, NY home of another sister. Vollmer wrote to both Nassau and Suffolk Counties in an effort to coordinate the transfer of Luberto’s case between the agencies. Despite this request, Luberto was informed by Nassau County that her Medicaid would be terminated effective December 1, 2005, and that if she wanted to continue on Medical Assistance she had to apply in Suffolk County.146

Given this filing, it is not surprising that the correspondence between the federal Region II office and the Office of Medicaid Management resumed the following month. In fact, Wing’s December 22nd letter to Kelly referenced the Luberto case. In addition,

the federal case files show letters from Vollmer to Kelly in May, 2006, requesting clarification of information. In one letter, dated May 30, 2006, Vollmer revealed that in response to a Freedom of Information Law (FOIL) request made to NYS DOH, he was able to determine that 24,386 New York State Medicaid recipients received notice of termination of their Medicaid coverage solely due to their inter-district relocation between January 1, 2003 and November 30, 2005.\textsuperscript{147}

According to Vollmer, soon after he filed the lawsuit the Judge in the case made it clear that a settlement was in order. During the course of negotiating with the State to bring the case to resolution, the Judge scheduled a trial to pressure the state into an agreement. Vollmer subpoenaed Kelly, who ultimately refused to testify.\textsuperscript{148} According to Kelly, she did not testify for Vollmer because he did not follow the conventions required by the Touhy amendment.\textsuperscript{149} Regardless of the reason, Vollmer was incensed:

It was bad enough that she [Kelly] sat on her hands for a few years… Now she’s not even going to help others to get change? There’s only a facade of order, both national and by the state. I find myself being the watchdog that Sue Kelly should have been.\textsuperscript{150}

Eventually the State and Vollmer were able to come to agreement regarding a settlement. As of November 13, 2007 there was a Stipulation and Order of Settlement “so ordered” by the court that had been agreed to by the State and Vollmer. In it, the state denied any wrongdoing or any liability to the plaintiff or the proposed plaintiff class,

\textsuperscript{148} Vollmer, telephone interview with the author, October 9, 2007.
\textsuperscript{149} Sue Kelly (Associate Regional Administrator of the Division of Medicaid and State Operations, Regional Office II, U.S. Department of Health and Human Services), face-to-face interview with the author, October 16, 2007.
\textsuperscript{150} Peter Vollmer, telephone interview with the author, March 20, 2009.
but recognized that the parties wanted to settle the action on terms and conditions that were fair to all parties. The state agreed to effectuate:

A systematic method for enabling Medicaid recipients who relocate from one local social services district to another to have their Medicaid eligibility continued and/or redetermined when they move…\(^{151}\)

In addition, the State agreed to take a number of steps to identify beneficiaries who were inappropriately terminated, and to reinstate them. The State agreed to a number of actions to change regulations, and train the counties in the new requirements. The State also agreed to monitor, to the extent possible, the implementation of the revised policies and procedures.\(^{152}\) Despite the settlement, Rice believes that the problems will continue.

There’s something quite disingenuous here. All CMS [and Vollmer] cared about was that Medicaid authorization continue. No one... cared about access to services. We always could have continued the Medicaid authorization, but many folks would have had a card that didn’t work for the services available in the new county. For example, in the Luberto case, in fact the whole home care process is different with every county, and they don’t contract with the same providers. Giving Luberto a card didn’t help her register with a new personal care agency.\(^{153}\)

The new policies established by the court order became effective December 28, 2007. The required legislation was passed and the LCM was issued in April 2008 describing the new procedures. In September through November 2008 DOH held regional meetings to train counties on the new procedures and answer questions from the local districts. In January 2009 staff from the systems unit began compiling a list of class

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\(^{152}\) Ibid.
\(^{153}\) Betty Rice, telephone interview April, 7, 2008.
members to provide retroactive relief. Final implementation of the new rules is scheduled for May 2009, and the timeline for implementation runs through 2010.\textsuperscript{154}

\textbf{Epilogue}

This case study reveals a situation whereby low-income individuals who had been eligible for Medicaid were inappropriately terminated from receiving benefits, primarily because the State and Counties involved did not have the necessary implementation machinery to maintain eligibility in the face of the change represented by a person moving from one county to another. However, in part the resistance was also due to the State’s belief that the federal policy was inadequate for protecting the integrity of eligibility determinations.

From the facts and commentary presented, it appears that the federal government would not have been cognizant of this situation, but for unusual situations including the concurrent problems presented by welfare reform, and the subsequent filing of a class action lawsuit.

Eventually, the federal oversight agency \textit{did} become aware of the inappropriate terminations, and used some of the tools at their disposal, namely identifying the problem and formally communicating a change request, to try and rectify the inappropriate terminations and ensure that eligible beneficiaries received services. This communication resulted in no positive change.

One tool that should have been at the Federal agency’s disposal was the capacity to provide technical assistance. The state requested technical assistance and little was

\textsuperscript{154} New York State Department of Health. “County-to-County Moves Implementation Plan.” Report prepared to fulfill requirements of Luberto v. Novello court stipulation of November 2008, revised January 20, 2009. Received via e-mail from Peter Vollmer, attorney for the plaintiff.
forthcoming. According to Federal staff, there are several reasons for this, including the fact that there is limited expertise at the federal level regarding the specifics of operationalizing eligibility rules. In addition, as a general rule, the federal agency has limited resources to provide technical assistance, including at the regional level.\textsuperscript{155}

The most compelling tool at the federal agency’s disposal is to level sanctions and disallowances. In fact, when states are out of compliance the federal agency can order a compliance review for all policies and procedures, and issue sanctions and penalties across program areas. However, these tools are considered too “political” and “controversial,” and have not been used to the best of the federal staff’s recollection.\textsuperscript{156}

On the State’s part, they were obviously dealing with several pressing obstacles to enacting change:

- The State did not have the administrative machinery available to support change;
- The State did not have the resources available to re-engineer the administrative machinery, particularly while they were instituting new policies and programs at the same time; and
- The State did not believe that the federal interpretation of the regulation was accurate nor a desirable change from their existing policy.

Given the facts, it would be reasonable to conclude that the state was particularly resistant to meeting the federal requirements, and used as many tactics as was at its disposal to thwart the federal directives. When asked about the Federal agency’s ability to require change in such a situation, Sue Kelly responded:

\textsuperscript{155} Marty Svolos (Deputy Director of Division of Benefits and Eligibility and Managed Care, Centers for Medicaid and Medicaid Services Central Office, U.S. Department of Health and Human Services), interview with the author, November 9, 2007.

\textsuperscript{156} Interviews with staff and former staff of the Centers for Medicaid and Medicaid Services, Health Care Financing Administration, U.S. Department of Health and Human Services, including Timothy Westmoreland, Cindy Mann, Marty Svolos, Bob Tomlinson, Dan Abel, Tom Shenk, Sue Kelly and Pat Ryan..
Medicaid is a political program, just as budgeting is a political act; so, there are political priorities that we see… We [in the regional office] try not to make it a political issue. We try to look at facts, rules and regulations, and apply them as well as our Baltimore folks would want us to… We try to make it more or less collegial. Sometimes that doesn’t work. If the state said ‘This is what we’re doing, and that’s the way it is,’ it would be different. Like in the Reynolds case where the state was stonewalling… and my correspondence wound up on the front page of the New York Times, and I’m thinking ‘the White House was probably reading this.’ But [in this case] they always said they would look into fixing it. But, we didn’t tell them what to do. We stop short of telling them how to run their program. We don’t see our job as telling the State step-by-step what to do, and the State wouldn’t want us to do that… But our role is to point the state in the right direction, and we will spend multiple years trying to get them in line… There’s a complexity in the federal/state partnership. We share financing. We have to approve their plan. We get complaints from beneficiaries and elected officials. BUT, it IS State administered. Our role with providers is different. If they are out of compliance we definitely have a policing role, but with states it’s different, and we make enormous efforts to bring States into compliance.157

Kathryn Kuhmerker sees the situation somewhat differently:

There’s a responsibility of a supervisory agency at some point to say “here’s what you need to do.” But they [CMS] didn’t do anything to enforce it. Sometimes it felt like they were making [me] miserable without giving me a disallowance or something that would get the attention of the powers that be, that would ultimately get me the resources I needed to do what they wanted.158

Ultimately the situation was brought to a head through a lawsuit, filed by a non-governmental actor seeking justice for this class of eligible individuals. Given the experience that the State had with DHHS, they realized they did not have a good case to take to court, and they settled with the plaintiffs. The settlement included a consent decree that addressed many of the needs of the entire class, including retroactively contacting individuals who had been disenrolled from benefits and seeking to re-enroll them. Local social services districts were formally notified of these agreements in a Local Commissioner’s Memorandum dated April 8, 2008. To

158 Kathryn Kuhmerker (Deputy Commissioner of the Office of Medicaid Management and Medicaid Director, Department of Health, New York State, retired), telephone interview with the author, October 7, 2007.
date a significant number of the changes agreed to have been implemented, and a timeline exists for completing the work in 2010.
CHAPTER 5

Case 2: Medicaid for Inmates

At the turn of the century Congressman Charles Rangel (D-NY) wrote to the Secretary of the DHHS expressing his concern over the practice of terminating Medicaid eligibility for inmates in the New York City jail system. He asked the Secretary to clarify the agency’s position regarding Medicaid eligibility for inmates. In April 2000 Secretary Shalala responded to the letter, and was unequivocal in her statement that, while Federal financial participation (FFP) is not available to pay for services rendered during a period of incarceration, Federal policy does not require states to suspend or terminate Medicaid eligibility for incarcerated individuals. She also stated that, if a State does opt to disenroll an inmate from Medicaid during a period of incarceration, “a State must ensure that the incarcerated individual is returned to the rolls immediately upon release…” 159

After the election of a new administration, the appointment of a new Secretary for DHHS, and no change in the administration of the Medicaid program in New York, Congressman Rangel wrote another letter to the Secretary, this time asking Secretary Thompson if DHHS continued to interpret section 1905 (a) of the Social Security Act in the same way as the previous administration. Secretary Thompson wrote back in October 2001 and assured the Congressman that the agency’s position had not changed. He further noted that there were plans to disseminate the policy on Medicaid eligibility for inmates, and the requirements related to implementing the policy, to all states.

159 Donna E. Shalala, (Secretary, U.S. Department of Health And Human Services), letter to Congressman Rangel, April 6, 2000.
Such a communication to state Medicaid Directors is exactly what had been called for by advocates, service providers and public administrators for several years.\textsuperscript{160}

According to a survey of state Medicaid Directors completed by the Council of State Governments (CSG) in the fall of 2000, over 90 percent of states reported that they terminated Medicaid enrollment for incarcerated individuals.\textsuperscript{161} Many (wrongly) cited compliance with federal regulations as their motivation. According to professionals in the field, the loss of Medicaid for jail inmates is a critical issue, potentially affecting nearly 1 million mentally ill inmates each year.\textsuperscript{162}

Despite these findings, and the statements of both Secretaries, as of the current time no official statement has been made by DHHS principals to the state agents concerning their preferences for the implementation of this policy.

This case is based on a very detailed story that includes multiple players over more than a decade. To describe it requires information about the population and the statutory and regulatory requirements concerning coverage, a knowledge of the initial players as well as those who carried the issues through the years, a discussion of federal knowledge, communications, and choices, the New York perspective, the interactions between the federal government and the state, and the interaction between the state and their stakeholders. This chapter tells this story in waves, covering time periods and the role of the actors during each time period. Then it moves forward, like the rounds of negotiations. The chapter ends with an epilogue about the current status of the policy.


\textsuperscript{161} Ibid.

\textsuperscript{162} Kathleen Dalton, “Medicaid Issues and Funding Options for Inmates with Mental Health Disorders” (presentation prepared for the Annual Meeting of the National Association of County Behavioral Health Directors. Milwaukee, WI. July 10-12, 2003).
The Inmate Exclusion Policy

In part, the focus on Medicaid access for people involved in the criminal justice system grew in conjunction with at least three related trends:

1. The growth of criminal justice populations: The United States prison population grew from approximately 330,000 in 1980 to approximately 1.5 million in 2004.

2. The growth in health care expenses for prisoners: Data from 2004 indicate that states expend more than $3.3 billion each year on medical care for incarcerated persons. And, while national statistics are not available for the costs of care to inmates in local correctional facilities, regional reports indicate that jail medical spending matches or exceeds the expenditure rate of state and federal prisons.

3. The increasing scope of health care needs for inmates: reports indicate that inmates suffer from health and mental health disorders at much higher rates than those of the general population. Prisoners are two-to-four times more likely to experience serious mental illness than others, and are more prone to HIV/AIDS, hepatitis C, diabetes, tuberculosis, sexually transmitted and other contagious diseases. 163

Despite their need for services, inmates residing in public institutions have generally been considered ineligible for the Medicaid program. According to Section 1905(a) (A) of the Social Security Act, states cannot receive FFP for services provided to individuals in jail.164 As a result, state and local agencies generally do not accept applications for Medicaid from inmates, even for individuals planning release. Not only are inmates not permitted to apply for Medicaid, but historically jurisdictions have terminated Medicaid eligibility for individuals who arrived at a correctional facility already enrolled in Medicaid. Reasons for these actions included avoiding inappropriate Medicaid claiming and the associated disallowances and penalties, and ensuring that Medicaid cards for incarcerates people are not being used fraudulently.

163 Social Security Act Section 1905(a) (28) (A). United States Code, 42 USC 1396 (d) (a) (28) (A); 42 C.F.R. Section 435.1009.
164 Ibid.
In addition to avoiding disallowances and fraud, States and localities were disenrolling inmates from Medicaid because there are financial incentives. Jurisdictions that report incarcerations of otherwise eligible inmates to federal authorities for the purposes of disenrollment from benefit programs receive cash incentives. The Social Security Administration (SSA) pays a bounty to local jails for notifying them that an SSI or SSDI recipient has been confined. These payments have created significant savings to SSA, since they can discontinue cash benefits to the inmates soon after their incarceration. However, they also result in disenrollment from Medicaid.

In New York State these disenrollment practices are complicated by the fact that New York has a state-supervised, locally administered Medicaid program. This means that while the state operates the “single state agency” for Medicaid administration that is required by the federal government, the 58 counties and the City of New York (comprised of another 5 counties) are the agents of the state, responsible for putting into practice all of the federal and state regulations and policies. Each county has a wide degree of latitude about how they operationalize their administrative responsibilities, which includes details regarding when and how they enroll and disenroll beneficiaries, and if and when they exchange information with criminal justice agencies. Ultimately, the bounties that are paid by SSA for reporting incarcerations are paid to the county coffers. This makes county social service bureaucrats beholden not only to their federal and state oversight agencies, but to their local budget directors as well.

Although local social services districts had barriers for inmates applying for Medicaid, release planners began to realize that a certain subset of inmates had been eligible for Medicaid prior to their incarceration, and absent any significant changes in
residence, family composition or income, should continue to be eligible upon release from jail or prison. Unfortunately, however, release planners soon learned that upon incarceration Medicaid agencies were terminating eligibility for inmates and requiring inmates to be released and reapply for benefits before allowing them to be re-enrolled.

**Inmates have a Champion**

Despite a general belief on the part of NYS Medicaid officials that inmates were ineligible for Medicaid, others disagreed. In particular, Brian Murtaugh was deeply knowledgeable about the needs of inmates with substance abuse problems and the related need for Medicaid eligibility because of his position as a former Assemblyman and Chair of the Committee on Alcoholism and Drug Abuse, and subsequent work as substance abuse treatment specialist for the court system. Thus, regardless of disagreements with the state Medicaid administrators, Mr. Murtaugh continued to look for ways to ensure the continuation of Medicaid for inmates who entered jail with their eligibility established. In doing so he reviewed the laws and federal record, and noted that while Section 1905 (a) (A) specifically excluded FFP for medical care provided to inmates of public institutions, FFP was available for inmates when they were patients in medical institutions.\(^\text{165}\) Upon investigation and analysis, he determined that 1905 (a) (A) only addresses issues of FFP, and that the section of law did not specify nor imply that Medicaid eligibility is precluded for inmates.

\(^{165}\) Brian Murtaugh (Former Assemblyman and retired Substance Abuse Treatment Specialist, New York State Unified Court System, Office of Court Administration), telephone interview with the author, November 9, 2007. Supported by State Agency Regional Bulletin No. 98-32 from the Associate Region Administration, Region 1, U.S. Health Care Financing Administration (HCFA) to All State Agencies, April 15, 1998.
Armed with this information, Mr. Murtaugh approached staff at the New York City (NYC) Department of Corrections (DOCS) and the NYC Human Resources Administration (HRA; the local agency responsible for Medicaid administration) and asked them to modify their practices and simply suspend, rather than terminate Medicaid eligibility. With such a policy, inmates would not have to re-apply for benefits and could access services immediately upon release. Despite his efforts, both the City and the State refused to change their practices, citing (inaccurately) Federal law as requiring termination of Medicaid for inmates.

Not to be easily deterred, Mr. Murtaugh brought his case to Congressman Charles Rangel’s office. In a series of discussions with John Sheiner, Special Assistant to Congressman Rangel in his role as Chairman of Ways and Means, it was decided that Congressman Rangel would send the letter to then-Secretary of the DHHS to receive a ruling regarding whether an inmate could be eligible for Medicaid, or whether Medicaid must be terminated upon incarceration. The letter was sent in early 2000.

As described, Dr. Shalala replied to the Congressman’s letter and was clear that FFP and eligibility were different things. While FFP is not available to pay for services rendered during a period of incarceration except in cases of inpatient hospital admission off the grounds of the penal institution, Federal policy does not require states to suspend or terminate Medicaid eligibility for incarcerated individuals. 166 In addition, Dr. Shalala noted that if an inmate was eligible for Medicaid prior to incarceration, then he or she was eligible subsequent to incarceration, and should be reinstated immediately upon release. This position was later reiterated and confirmed in 2002.

166 Donna E. Shalala, (Secretary, U.S. Department of Health And Human Services), letter to Congressman Rangel, April 6, 2000.
The National Policy History of the Inmate Exclusion

In the 1990’s, individuals in New York were not the only ones to focus their attention on Medicaid policy for people involved in the criminal justice system. Documents confirm that several states were confused about federal policy. DHHS central and regional offices were formally contacted by several states, including Minnesota and South Carolina, and asked to provide information about the availability of FFP for persons under control of the penal system, as well as specific policies regarding enrollment, termination and re-instatement of benefits. In fact, South Carolina’s questions almost exactly reiterated Mr. Murtaugh’s:

…if we really understood how the information concerning a client going to and getting out of jail gets communicated to Social Security and Medicaid by and between all of the different actors (County Jail, Federal Social Security Administration, State HHS or DSS), we could discuss these issues with the appropriate folks and identify ways to ensure accurate and timely communication and thereby, possibly, be able to prevent improper cut-offs of SSI and Medicaid, or at least unnecessary delays in re-starting benefits.

As mentioned in Chapter 4, federal policymakers have noted that the mechanisms for allowing problems like this to “bubble up” to a level where they can be appropriately addressed are inconsistent. However, in the process of reviewing the cases for this research, it became obvious that HCFA found it impossible to separate their involvement in these cases from the overall context of the national issues on the policy agenda at the time. In the county-to-county relocation case, the issue got wrapped up in problems

168 Mark W. Binkley (General Counsel, South Carolina Department of Mental Health), memorandum to Jim Caulder, Social Security Administration. November 18, 1999.
169 Ibid., 2.
170 Cindy Mann, telephone interview with the author, November 5, 2007.
related to implementing welfare reform. The inmate disenrollment issue became part of a larger national effort to help federal, state and local policymakers and criminal justice and mental health professionals improve the response to people with mental illnesses who come into contact with the criminal justice system.

Unfortunately for criminal justice professionals, the regulations in place for inmate disenrollment are far more complex than those involved in county-to-county moves. From most States’ perspectives, the inmate regulations placed eligibility issues at cross-purposes with claiming requirements for FFP. However, the federal regulations were also affected by DHHS’s efforts to bridge differences between adult and juvenile populations, and historic patterns of dividing programmatic and fiscal responsibility with emerging patterns of accepting responsibility for a portion of the cost of health and mental health services. The federal Social Security Administration having a different agenda than DHHS exacerbated these problems. In addition, there were intergovernmental tensions between human service agencies and criminal justice agencies. The sections below attempt to unravel the various influences.

**Original Federal Communications**

The first documented “bubble” from a state to DHHS on the inmate issue appears to be contact from Minnesota to their HCFA Regional Office sometime in 1992. The inquiry was specifically focused on the availability of FFP for inmates. According to the memorandums, the Region V Associate Regional Administrator reacted to the Minnesota inquiry by writing to the HCFA Central Office in October 1992. After more than two years the memo still had not been responded to. Thus the Regional Administrator sent another inquiry to HCFA Central Office on December 19, 1994.
According to Tim Westmoreland, “often times the Regional Offices would bring issues to our attention. There were calls once a week. Then we would talk about who should take action, the Central Office or Regional. Central Office action was stronger… [But] HCFA gave no central office guidance sometimes.”\^171 Apparently such was the case with the initial Minnesota inquiry.

A response to the memo was finally sent on January 19, 1995. It was from the Central Office Director of the Medicaid Bureau at HCFA and was addressed to the Region V DHHS Associate Regional Administrator, Division of Medicaid. In this memo the Director stated:

Section 1905 (a) of the Social Security Act provides that FFP is not available for services provided to individuals who are inmates of public institutions, except insofar as they are patients in a medical institution. To be considered inmates of public institutions, and therefore ineligible to have FFP claimed for services provided to them, individual circumstances undergo a two-part analysis.

First, the institution in which the individual is placed must meet the criteria established in the definition of a “public institution”. Longstanding HCFA rules have interpreted the term “public institution” to mean an institution, which is the responsibility of a governmental unit or over which, a governmental unit exercises administrative control. This control can exist when a facility is actually an organizational part of a governmental unit or when a governmental unit exercises administrative control (42 C.R.R. Sec. 435.1009).

Secondly, the person must be considered an “inmate”. An inmate of a public institution is an individual living in a public institution. The controlling factor is the physical residence in the institution.\^172

The memo continued by outlining specific case examples presented by Minnesota, along with responses from HCFA. It is “cc-ed” to all Associate Regional Administrators for

\^171 Timothy Westmoreland, telephone interview with the author, November 7, 2007.
\^172 Sally Richardson (Director, Medicaid Bureau, U.S. Department of Health and Human Services (DHHS), memorandum to Regional Administrator of Region V, Chicago, DHHS), January 19, 1995.
Medicaid. The memo is solely focused on the claiming issues and does not address Medicaid eligibility per se.

Despite this response, according to Tom Shenk, a Health Insurance Specialist, HCFA’s official policy wasn’t developed until 1997, when the eligibility issues were addressed along with the claiming requirements. This memo was sent to all of the regional offices, but was not shared with the States in the form of a Medicaid Director letter. The memorandum is dated December 12, 1997, and is from the Director of the Disabled and Elderly Health Programs Group from the CMSO. In it, the Director stated that central office staff had become aware of inconsistencies in Regional Office directives that had been given to the States. It also noted that there had been a growing influx of inquiries from the internet that prompted the CMSO to “expand and, in some cases, refine” their policy.

The memo itself is several pages long and outlines the statute, parameters, criteria for prohibition of FFP, privatization of prisons, and exceptions to prohibitions of FFP, and examples of policy applications. It is in this memo, in the first informational paragraph, that the Director highlights the specific differences between FFP claiming and eligibility. He stated:

Section 1905(a) (A) of the Social Security Act specifically excludes Federal Financial Participation (FFP) for medical care provided to inmates of a public institution, except when the inmate is a patient in a medical institution. The first distinction that should be made is that the statute refers only to FFP not being available. It does not specify, nor imply, that Medicaid eligibility is precluded for those individuals who are inmates of a public institution. Accordingly, inmates of

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174 Robert A. Streimer, (Director, Disabled and Elderly Health Programs Group, Centers for Medicaid and State Operations, U.S. Department of Health and Human Services), memorandum to All Associate Regional Administrators, Division for Medicaid and State Operations, DHHS, December 12, 1997.
a public institution may be eligible for Medicaid if the appropriate eligibility criteria are met.175

Responses by the Associate Regional Administrators to this memorandum illustrate yet again the variation across federal Regions documented by other studies.176 Most of the Regions did not formally respond. However, the Region 1 (Boston, MA) Associate Regional Administrator issued a State Agency Regional Bulletin (No.98-32) to all of the Medicaid agencies in Region I reiterating the Central Office memorandum virtually verbatim.177 Inquiries as to why only Region 1 took this action generally indicated that Regional Offices are given wide discretion over interactions with their regions. Daniel Abel, the attorney for HCFA/CMS explained his perspective:

There’s an issue in CMS regarding what the regional offices are for. What can they make decisions on, and what can’t they? Each Regional Director develops different theories. Some are advocates for their states. Some do more oversight. CMS hasn’t standardized it.178

Tim Westmoreland elaborated: “… the Regional Offices were sometimes inconsistent, which made everyone mad.”179 However, according to Mr. Westmoreland, the Regional Offices are generally relied upon to make determinations on implementation issues. Policy issues are typically deferred to Central Office; particularly eligibility questions. This is because eligibility issues are extremely complex and the number of “experts” available to unravel the answers is quite limited. There are not eligibility experts in each region. Therefore, the Central Office holds eligibility Technical Advisory

175 Ibid.
177 Associate Regional Administrator, Region 1, Health Care Finance Administration, U.S. Department of Health and Human Services, memorandum to All State Agencies, Region 1, Boston, MA. April 15, 1998.
179 Timothy Westmoreland, telephone interview with the author, November 7, 2007.
Group (e-TAG) telephone calls with states each month. Regional staff is not required to participate.

**Problem Identification**

Despite the release of the 1997 memorandum, states continued to have problems. Although it is beyond the scope of this inquiry to determine exactly why states began to raise questions, there is some evidence that advocates for both inmates and individuals with mental illness were making a concerted effort to gather information and “educate” state and federal policymakers, as well as staff in community-based service organizations, about the plight of mentally ill individuals who were coming into contact with the criminal justice system. The efforts included providing anecdotes to policymakers intended to make the “personal” political. In addition, several groups were publishing formal documents about the policies, their applications, and their impacts.

As an example of the former activities, the South Carolina memorandum to the Social Security Administration outlines the highlights of the advocates’ arguments, albeit in terms that advocates would not be likely to invoke:

An issue in many public mental health systems currently, including our own, is developing some non-traditional services for a generally very difficult population: persons with a mental illness who also engage in petty criminal behaviors… These persons generally also abuse substances and often have co-occurring substance abuse disorders…

[N] Either system is currently doing a good job addressing their behaviors. Once arrested, they get sober, but stay crazy and manipulative in jail, causing real management problems. When they serve their time and get out, they usually promptly re-offend. It makes sense to design and implement some programs, which may help some of these persons stay in treatment and change their behaviors…

These new and promising programs cost money. Many of the individuals who would meet the criteria for treatment in these programs would likely qualify for
SSI and Medicaid... Due to their unique lifestyle, these persons present a problem staying qualified for SSI and Medicaid: many of them spend part of every month, or part of every other month, in the pokey. \(^{180}\)

Betty Rice, former Director of Medicaid Eligibility and Local District Relations in New York tells a similar tale:

The story goes that people would be released at 2 a.m. [from Riker’s Island prison] with 2 subway tokens and a good luck wish. How we went from that to deciding everyone should be given access to Medicaid is beyond me. \(^{181}\)

The initial publications primarily took the form of “how to” documents developed by national research and trade associations to provide direction to community-based health and mental health workers about how to access benefits for citizens. According to these professionals, the loss of Medicaid for jail inmates was a critical issue, potentially affecting nearly 1 million mentally ill inmates each year. \(^{182}\)

Interestingly, some of the documents were developed by research organizations with funds from the Substance Abuse and Mental Health Services Administration (SAMHSA), another division of the DHHS. \(^{183}\) A comprehensive guide was published in March 2001 by the Bazelon Center for Mental Health Law. This document was specifically developed to assist seriously mentally ill individuals who had been incarcerated, and provided information on both the federal Medicaid and Social Security Disability programs. \(^{184}\)

\(^{180}\) Binkley, memorandum, November 18, 1999, 1-2.
\(^{181}\) Betty Rice, face-to-face interview with the author, October 5, 2007.
\(^{182}\) Kathleen. Dalton , “Medicaid Issues and Funding Options for Inmates with Mental Health Disorders.”
\(^{183}\) See, for example, The National GAINS Center for People with Co-Occurring Disorders in the Justice System, Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders, Summer, 1999/Revised Spring 2002.
\(^{184}\) The Bazelon Center for Mental Health Law, For People with Serious Mental Illness: Finding the Key to Successful Transition from Jail to Community. (Washington, D.C. March, 2001).
Other documents gathered from this time period indicate that there were several legal organizations focused on the access issues. In addition to the Bazelon Center, which published a number of documents, there are research memorandums from The Georgetown University Law Center Federal Legislation Clinic and the Youth Law Center. Both received wide distribution to interested parties nationally. Each of these memos document a range of activities where the Centers were not only assisting beneficiaries, program providers and other advocates, but also States that were struggling to understand what benefits were available to both adult and juvenile detainees.

**Acknowledging the Problems and Developing Solutions**

The fact that law centers and advocacy groups were being funded by SAMHSA to alert stakeholders came as no surprise to HCFA. Dan Abel revealed “There is data that almost every state is doing it wrong. If I remember correctly there was a lot of awareness that states were doing it wrong [during the Westmoreland years]. The problem was requiring re-enrollment, since technically folks can remain Medicaid eligible, but they’re not [eligible] for FFP. It’s coverage exclusion. There was recognition that from a practical state point-of-view it didn’t make sense to have folks on the roles and not eligible for services. So, there was a problem… [And] they needed a plan to immediately reinstate because legally there was no reason to take them off [of Medicaid].”

According to a survey of state Medicaid Directors completed by the Council of State Governments (CSG) in the fall of 2000, Abel was correct, and CSG documented reports that over 90 percent of states terminated Medicaid enrollment for incarcerated individuals. Many (wrongly) cited compliance with federal regulations as their

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185 Dan Dan Abel, interview, November 15, 2007.
motivation. The Council and other advocates used the results of the study to call for the release of a State Medicaid Directors letter.\textsuperscript{187}

The Council followed up their survey by empowering its “Justice Center” to engage in an effort called “The Consensus Project.” The Project was a national interagency, intergovernmental effort to collect data about how incarcerating people with mental illness was affecting the criminal justice system, community-based providers and individuals with mental health and/or substance abuse issues, and collate the data into useful policy proposals. Project members were also asked to identify best practices and model projects, and report on them to the other members. The project members included legislators, judges, criminal justice practitioners, service providers and bureaucrats, and they hailed from states and localities all across the country. The Consensus Project Report was released in June 2002.\textsuperscript{188}

\textit{DHHS: To Act or Not To Act... An Explanation of Variation}

Clearly, a wide range of stakeholders on all levels within and outside of government were involved in identifying problems related to incarcerating people with mental illness and substance use issues, measuring the scope of the problems, documenting the issues, and recommending solutions. One of the top recommendations was encouraging states to maintain Medicaid eligibility for people who become incarcerated in the belief that such eligibility would facilitate access to critical services upon release. According to Shenk, the HCFA Health Insurance Specialist, it became obvious to HCFA that people were being taken off the roles under the first Bush

\textsuperscript{187} Ibid.
Administration, and despite the intent, the 1997 memorandum did not clarify the issues for states.

Shenk reported that when it became apparent that the directives were being misapplied, the agency tried to get out a Medicaid Director letter to the states. Despite the fact that several versions were drafted, none was ever released. According to Shenk, there were other issues that were more important, and the inmates did not account for as much mis-spent money as other special population groups did.\textsuperscript{189}

Cindy Mann, Director of Family and Children’s Health, CMSO, recalled a two-year analyst effort to put the letter out (1998-2000). “There were multiple conversations with the e-TAG, and multiple letters drafted, but never sent.”\textsuperscript{190} Unlike Shenk, Ms. Mann described the main problem as lack of agreement about the definitions for juveniles: “What constitutes involuntary confinement?” Ms. Mann asked. She concluded, “There was no lack of intention or desire, just agreement. There was a complexity. It’s hard and there are lots of questions that [didn’t] necessarily get answered.”\textsuperscript{191}

Marty Svolos, Deputy Director of the Division of Benefits, Eligibility and Managed Care, seconded Ms. Mann’s recollection:

“We’ve been debating internally for years. Issues when an inmate goes to a hospital – are they inmates? Kids in juvenile facilities-- Also issues around some folks being kept on the roles by some states, and how to activate them before they’re released… We just don’t have a policy yet. We should have done this long ago.”\textsuperscript{192}

\textsuperscript{189} Thomas Shenk (Health Insurance Specialist, Centers for Medicaid and Medicaid Services, U.S. Department of Health and Human Services), telephone interview with the author, November 4, 2007.
\textsuperscript{190} Cindy Mann, telephone interview, November 5, 2007.
\textsuperscript{191} Ibid.
\textsuperscript{192} Telephone Marty Svolos (Deputy Director Division of Benefits, Eligibility and Managed Care, Center for Medicaid and State Operations, Health Care Financing Administration), telephone interview with the author, November 9, 2007.
Tim Westmoreland notes that CMS has made “wildly inconsistent decisions regarding inmates.” He ascribes difficulties to “deep disagreements, and reconciling all the precedents with different definitions.” Precedents, for example, related to the history of the division between federal and state financial responsibilities, and the obligation for states to pay for individuals residing in institutes for mental disease (IMDs) because of what’s referred to as the “IMD Exclusion.” For states, however, the issue becomes wrapped up in how many people who need health and mental health services get folded into state-only obligation categories. According to Svolos, CMS does not have financial models driving their decisions, since “the numbers frequently don’t pan out.”

Still, according to Tomlinson:

We go round and round and round. I don’t know the reasons why, but everyone has an ax to grind, and financial interests [to protect]. Will we provide FFP? What will states do to try to maximize it? Should something be all state money versus federal money? With an aging prison population and the possibility of privatization there’s a lot to worry about.

By the end of the Clinton Administration, it appears that while appointed policymakers had a desire to act, the ability was limited by policy disagreements.

**Different Administrations, Different Priorities**

After the Bush administration took control of DHHS and there still was not a release of a Medicaid Director letter regarding inmates, then-Secretary of HHS Tommy Thompson received another letter from Congressman Rangel. While Thompson reiterated the stand previously taken by HHS to the Congressman, sources say the Bush

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194 Bob Tomlinson (Health Insurance Specialist, Center for Medicaid and Medicare Services, U.S. Department of Health and Human Services), telephone interview with the author, November 14, 2007.
administration did not prioritize eligibility issues in the same way that the Clinton Administration did.\(^{195}\)

Matt Salo, a program specialist at the National Governors’ Association (NGA) and former associate at the National Association of State Medicaid Directors suggests that issues come in and out of focus on a national level for many reasons, including changes in administrations. “There isn’t consistency around simplicity of enrollment, minimizing eligibility criteria – asking fewer questions to get more people on [Medicaid]. Republicans say no one should be on whose not eligible, period. They focus on quality control, etc., instead of ‘express lane’ eligibility.”\(^{196}\) The perception is that Democratic Administrations crack down on errors where eligible people are mistakenly made ineligible. In Republican Administrations there is more concern about ineligible people being mistakenly claimed for FFP. Thus, releasing a Medicaid Director letter to improve inmate access to Medicaid after 2000 became less of a DHHS priority.

Marty Svolos agrees that over time the priorities of HCFA/CMS have evolved, consistent with different administrations, and that action on eligibility issues lost its urgency:

“[Medicaid law] sets forth a comprehensive redetermination requirement and gives folks an opportunity to provide information. You just can’t terminate someone; you have to check all the other categories first by looking at all the information you have. That became a political issue because the advocates were crying foul and the Clinton administration was sympathetic to these concerns... The Clinton Administration [also] focused on getting kids enrolled in Medicaid and CHP [Children’s Health Plan]... The particular target in the Bush Administration is to go after schemes where states are trying to get more money from us.”\(^{197}\)

\(^{195}\) Tommy G. Thompson (Secretary, U.S. Department of Health and Human Services), letter to Charles L. Rangel (Congressman New York 15th Congressional District), October 1, 2001.
\(^{196}\) Matt Salo (Program Associate, National Governor's Association), telephone interview with the author, November 9, 2007.
\(^{197}\) Marty Svolos, telephone interview, November 9, 2007.
In addition to the lack of Administration focus on eligibility issues, CMS staff report that there are simply not enough resources to take on all of the problems that they become aware of. According to Svolos, “These are complicated programs, and there are limited Regional resources. It’s difficult to comprehensively monitor what states do. If we had the manpower it would be great to do regular reviews, but as it is, we stick with the big money issues.”

Big money issues, and policy changes. According to Tomlinson,

There have been … delays caused by the change in policy within a short period of time, and the public has not been educated, and staff have not trained …States don’t have the staff and you [CMS] don’t have enough people… [Some policy changes require] asking states to do a complete mental reversal—like stopping a ship on a dime. It can’t be done. I feel sorry for state administrators, and nobody has a good answer. But we don’t have enough people, money or time to get [the job] done properly. Officials say there’s been no impact, but that’s not the case.

A Medicaid Director Letter is Released

One policy issue that became a priority for Secretary Thompson was homelessness. In fact, in 2004 Thompson served as the Chair of the United States Interagency Council on Homelessness where he worked on interagency, intergovernmental and intercommunity collaborations designed to end chronic homelessness. As part of that work, it was argued that one of the barriers to ending chronic homelessness was the policy to terminate Medicaid eligibility when a person entered an institution or IMD. Ironically, this policy for individuals who were homeless was the same policy that was affecting inmates – the only difference was that the “public institutions” were for incarceration. The focus on homeless individuals rather than

198 Ibid.
incarcerated individuals ultimately resulted in the release of a Medicaid Director letter. The letter states that “persons released from institutions are at risk of homelessness; thus, access to mainstream services upon release is important in establishing a continuum of care and ongoing support that may reduce the demand for costly and inappropriate services later.” While CMS did not require states to continue eligibility, the letter was “encouraging states to ‘suspend’ and not ‘terminate’ Medicaid benefits while a person is in a public institution or Institute for Mental Disease.”

Despite the fact that the title of the memo references homelessness, a significant portion of the memo specifically addresses inmate issues:

Once discharge from the facility is anticipated, the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility… Given the high incidence of substance abuse, mental illness, and physical illness among those who have been incarcerated…I encourage states to coordinate prison health services and other health care services…with Medicaid services. By working with parole officers and other professionals who deal with inmates and residents of IMDs… State Medicaid programs …can create an ongoing continuum of care for these individuals, regardless of the source of funding for such care.

Interestingly, the letter still did not address the definitions that the staff continued to disagree about, or differences between adults and juveniles. Since the letter was about the homeless, apparently staff felt more comfortable avoiding the tangential issues related to inmates. When questioned about the release of this letter, Tom Shenk noted that he didn’t draft the letter, but that inmates and homeless people have some of the same

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201 Ibid.
202 Ibid., p. 2.
disabilities, so the main issues dovetailed. Shenk further revealed that the letter was released during a transition period where there was a new “Acting Director” for the Disabled and Elderly Health Programs Group (DEHPG), and he “wanted to move it.”

When asked why, after being asked for so long to release a letter on inmates the letter was billed as a letter on homelessness, Shenk simply reiterated “the May 25th letter was in response to chronic homelessness.”

Despite the release of the letter, CMS has not monitored States’ responses and doesn’t plan to. Shenk indicated “there is too much monitoring needed, and we don’t have those people anymore.”

The New York Experience

The New York story intersected with the federal saga, but had a number of elements all its own. As Dan Abel notes: “New York tends to be unique… We try to stay away from New York because [everything] ends up political.” Consistent with Abel’s observations, a major factor in New York, at least in the beginning, was the role played by former Assemblyman Brian Murtaugh.

Having been an Assemblyman, Mr. Murtaugh had a systemic view of the jail/Medicaid issue from the perspective of the individual – one who might have been a voter, taxpayer, and/or constituent. The key for the individual’s well being was to ensure access to a wide range of services – inpatient, outpatient, and especially, psychotropic drugs. From Mr. Murtaugh’s perspective, involvement with the criminal justice system

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204 Ibid.
205 Ibid.
206 Dan Abel, telephone interview, November 14, 2007
should not be a barrier to accessing treatment, but in fact, could be seen as a mitigating factor in favor of the client being prioritized for services, because criminal justice/mental health clients are likely in more dire need of services, have mental health issues that have the potential to present a danger to themselves and the public, and have the potential to cost taxpayers even more money than would be spent on treatment alone.

Through his work with the mental health services industry, Mr. Murtaugh came to believe that without a guaranteed source of payment for health and mental health services, individuals would not be able to access treatment, and piecemeal payments through individual programs would not provide the support for the continuum of services required, particularly outpatient services. Therefore, Mr. Murtaugh was committed to helping individuals access Medicaid, and actually saw it as the most cost-effective mechanism for public protection. He stated:

If someone needed a 28-day treatment program it might be fine [to access other payment sources], but if they needed to be released to outpatient there was a problem, and the client wasn’t available to apply for Medicaid… [Having Medicaid] supports releasing patients instead of spending time in jail. Assign them to a treatment facility. It saves money and makes sense… Funding drives services. The government is compartmentalized and they worry about their own little part of the bureaucracy. But that’s crazy. There’s only one taxpayer.  

As part of Mr. Murtaugh’s crusade for services to inmates, on February 22, 2000 he sent a letter to Nancy Ann DeParle, Chief Administrator of the Health Care Financing Administration, with copies to Congressman Rangel, Director Westmoreland and Judy Berek, Director of the HCFA Region II office overseeing New York. In this first written plea for help, Mr Murtaugh argued:

I am writing to ask for your help to change what I believe is an illegal New York City policy which denies Medicaid benefits to poor families being dropped from

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207 John Brian Murtaugh, telephone interview, November 9, 2007.
NYC welfare roles … Unfortunately, when you are put on the Medicaid rolls via SSI or the Family Independence Administration, you are automatically dropped from the rolls if you lose those benefits, even if only temporarily. This practice results in some of our most vulnerable citizens…being dropped from the rolls…It is my contention that once you are on the Medicaid rolls for a legitimate reason, you can only be removed for reasons that relate to the Medicaid rules, and only the Medicaid rules (or state law). When dropped from the rolls, many simply do not reapply in a timely fashion, and many of the dual addicted population are not able to obtain their necessary psycho tropic [sic] Medications until they again enter the criminal justice system…I am requesting that you instruct your New York Regional Office to inform NYS and NYC that they are in violation of the HCFA Medicaid rules in this area and that the practice should be stopped immediately.208

Ms. DeParle did not respond to Mr. Murtaugh.

However, at approximately the same time Mr. Murtaugh sent his letter to HCFA, he also made a visit to Congressman Rangel’s office and informed staff member John Sheiner about the jail/Medicaid problems in New York. The result was the letter from Congressman Rangel to Dr. Shalala. According to HCFA staff, the Secretary was fastidious in responding to communications from elected officials, and particularly Governors and Congressmen. Therefore, Congressman Rangel got a response.

Despite what has already been described as a policy in formation, in April 2000 Dr. Shalala provided an unequivocal statement to Congressman Rangel that while FFP is not available to pay for services rendered during a period of incarceration, Federal policy does not require states to suspend or terminate Medicaid eligibility for incarcerated individuals. She also noted that if a State does opt to disenroll an inmate from Medicaid during a period of incarceration “a State must ensure that the incarcerated individual is returned to the rolls immediately upon release…”209

Although the letter to Congressman Rangel was clear in its direction, it was limited in its scope. According to Counsel Abel, however, even without a national Medicaid Director letter, the response to Rangel was still difficult to draft. “When a letter comes in from someone like Charlie Rangel, the agency has to weigh how they respond, because every other state could still be affected.”

Abel’s comment reflected the reality that HCFA was in a “Catch 22”. On the one hand they knew that some states were having difficulties with the inmate policies, and that states were clearly implementing the policies in ways that were inconsistent with HCFA’s public position, taken in 1997. On the other hand, HCFA was not internally comfortable with their own policy, they didn’t believe the issues would account for “big dollars”, and while advocates and beneficiaries were complaining, most states were not bringing the issue up. Most staff wanted to let the issue languish. Dr. Shalala’s insistence on answering her mail brought the issue to a head. However, by limiting their response to Congressman Rangel to re-stating the 1997 directive, they could possibly avoid the pitfalls inherent in issuing a national Medicaid Director letter--namely requiring all of the states to change their procedures.

The problems with this strategy were several. First, the Rangel letter still had the effect of identifying New York as having a compliance problem. This put Region II in the position of having to contact New York Medicaid to ask for a corrective action plan. According to Sue Kelly, “Part of the problem that Murtaugh addressed was that folks held at Rikers were being discontinued on Medicaid because DOCS [the New York City Department of Correctional Services] was notifying HRA and HRA was terminating them. Then HRA was having them reapply for Medicaid…. There were people needing

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210 Dan Abel, telephone interview, November 14, 2007.
continuous treatment, and the case closures were delaying treatment… [In New York] this was a problem.”

Of course, the other effect was on the national advocates, who had been waiting for a Medicaid Director letter to force compliance in their states. With the Rangel letter they had something almost as good. Fax machines in advocates’ offices all over the country ensured the Rangel letter went national.

**Origins of NYS Position**

According to Betty Rice the policies regarding inmate eligibility break down into two separate, relatively straightforward considerations: when to turn a case off, and when to turn it back on. When speaking about the issues of inmate eligibility, she places it squarely within the overall context of the role and mission of the New York division of Medicaid eligibility. Over her nearly 30 years with the eligibility division, she describes a culture where staff were driven by the belief that everyone who was entitled to services should have their case turned on. But if there were mistakes to be made, they should be in the direction of denial until the case could be proven:

At the end of the day, there’s an error rate, and it’s focused on who got on who shouldn’t anybody ever said there would be error forgiveness... I also had to worry about the other arms of the federal government that can come and audit us... None of us cared about media, or bad headlines [from errors for denials.] …It was always the error rate.212

In terms of case termination for inmates, the position New York State Medicaid took regarding inmates was one that evolved over her extensive tenure with the agency.

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211 Sue Kelly and Pat Ryan (Associate Regional Administrator and Medicaid Eligibility Specialist, respectively, Division of Medicaid and State Operations at Health Care Finance Administration), telephone interview with the author, October 23, 2007.

As far back as I can remember my first awareness of an inmate ‘policy’ is that eligibility stayed open on the file. I can’t remember when it happened, but we either detected or feared that fraud was occurring... so we came up with the ‘Prisoner Match’ [electronically matching the files from the Department of Corrections (DOCS) to the Welfare Management System (WMS) which contained all of the Medicaid eligibility files]. It was especially important for cash assistance cases, because we didn’t want checks going out to people every month who weren’t there and weren’t eligible. But we realized the Medicaid card could also be used, so we turned it all off. By the late ‘80’s or early 90’s I know that we [the State Medicaid agency] were definitely matching state prisons, and some counties did it with local jails. Erie, for example, I think did it once a week. We might have even been matching with Jersey.²¹³

Rice also explained the basis for not performing ex-parte reviews prior to terminating eligibility for inmates:

The feds said before we terminated they wanted us to do an ex-parte review, but our argument was what do we do it with? If they were a cash assistance case they were no longer eligible under that category, and we couldn’t use documents in the county of incarceration to determine if they were eligible for another category because the new county didn’t have any documents. If they were an SSI case, New York and most states contract to have SSA do the Medicaid eligibility determination so that there is only one determination of eligibility for both programs. If you lose [SSI] eligibility, the state gets a transmission with a reason code. Certain codes close a Medicaid case automatically, like death and incarceration. SSI doesn’t do a good job with reason codes, so how do we do that [an ex-parte review] when we don’t get the info [on termination]? Also, SSI had most of the paperwork for the ex-parte review. What we did get was not particularly reliable, and the [data in the] computer systems weren’t reliable either.²¹⁴

Rice continues to believe New York had the right policy. The decision to terminate was built on the foundation of avoiding fraud and inappropriate claims for FFP for individuals who were incarcerated during the period of the claim. Each of those situations represented inappropriate expenditures for the state. As to refusing immediate reinstatement, Rice had a number of points supporting the state’s position:

Part of us not wanting to turn Medicaid right on is the relocation issue… we don’t know what county they will return to when they are released… And just because

²¹³ Ibid.
²¹⁴ Ibid.
they were eligible before doesn’t mean they will be after. What if the household size is different? Who will they have legal responsibility for? What are the resources of the household? Managed care also complicated things…

Rice argues that the evolution of the federal position on inmates was actually a reinterpretation of their policy, and that it would have been different prior to the Clinton Administration. “Administrations prior to Clinton had eligibility folks who could go toe to toe with us, and nobody ever said anything.” But, like her federal counterparts, she notes that the Clinton Administration took a much broader view of the Medicaid program than what had been taken previously.

Medicaid became … a more expansive program under Clinton. Prior to that we were just a payer. Now they’re considered a full health insurance program. Medicaid is so complex. It’s a fragile house of cards that can fall at any time. We all wonder what’s going to break it, and how it will play in the Media when it does. …Unless we were forced to implement this, we had to make choices about how stuff would line up in the queue. How would it look to put prisoners ahead of pregnant women and children?

The newly articulated position did help New York in one way. Prior to the release of the federal interpretations on inmates, New York was not claiming FFP for any services provided to inmates, whether chronic or acute. Subsequent to the 1995 memorandum put out to Region V, New York gradually became aware that they might be able to receive FFP for acute care provided to inmates in hospitals. According to Richard Billera, a former fiscal professional in New York, the Division of Audit and Quality Control decided to test the Central Office interpretation and submit claims for inmates who received acute care in hospitals:

The condition was that the inmate had to be eligible prior to incarceration, because prisons had no right to make a person eligible. When I found this out I

215 Ibid.
216 Ibid., 4/7/08.
217 Ibid.
began asking jail and prison officials to send claims directly to us when someone received care outside the facility. We had reviewers who would see if the person was eligible. It didn’t go through MMIS, [the Medicaid Management Information System], we did it by hand. It still happens today.218

While Billera was uncertain exactly when the state began claiming FFP for prisoners, a General Information System (GIS) update from Betty Rice to Local Social Services District Commissioners, Medicaid Directors and Finance Directors dated February 14, 2001 informed the county staff of a proposed revenue project entitled “Revenue Reimbursement Project: Retroactive FFP Claiming of Certain Inpatient Medical Claims for Inmates of Correctional Facilities.”219 The GIS explained that if the proposed project included in the Governor’s budget was passed, the law would allow districts to submit claims for services provided to an inmate from a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility. In an interesting twist, the memorandum informs districts that although the counties might receive a federal share for costs claimed for an inmate in the county jail, there would be no state share forthcoming.220

The GIS was followed up with a Local Commissioners Memorandum (01 OMM LCM-4) explaining statutory changes that removed state law restrictions on claiming FFP for inmates (Chapter 20 of the laws of 2001), and advised local districts on the methods for retroactive claiming.221 Since then there have been two additional GIS releases; one on June 22, 2001 which again explained the difference between eligibility and claiming,
and one on February 15, 2005 to update local Departments of Social Services about the status of the Revenue Reimbursement Project.\footnote{Policy Directives, New York State, Office of Temporary and Disability Assistance (OTDA) http://www.otda.state.ny.us/main/directives/2009/; GIS 6/22/01 and 2/15/05 respectively.} According to Billera, the project has gone quite well, “I think that for year end June 30, 2007 we got $3,842,000 from county jails and another $9,800,000 from the state.”\footnote{Richard Billera, telephone interview. October 13, 2007}

Despite the fact that New York has been claiming FFP for inmates for more than five years at this point, the fragmentation between the CMS Central and Regional offices was again illustrated in conversations completed as a part of this study. When Sue Kelly was asked about the ongoing FFP payments for inmates who receive acute care, Kelly was unaware that they were being made. In a phone call subsequent to the interview, Kelly and Ryan indicated that they had provided misinformation, and that CMS does pay when counties submit claims for patients who have an inpatient stay. Kelly indicated that “this is a narrow exception for claiming” and that “this is one of the policy issues pending.”\footnote{Sue Kelly and Pat Ryan, telephone interview, October 23, 2007} Representatives from states in other regions have stated that they have tried to claim FFP for acute care provided to inmates, and their Regional office representatives have rebuffed them.

**Federal-State Interaction**

Kathy Kuhmerker and Betty Rice both acknowledge that Murtaugh’s strategy of getting the jail/Medicaid issues on the New York agenda through the letter from Congressman Rangel to Secretary Shalala was successful. The State began to respond to the letter almost immediately. The response to Rangel was dated April 6, 2000. E-mail records from Thomas Shenk to Pat Ryan dated June 21, 2000 indicate that the state got in
contact with Region II to clarify the response shortly thereafter. In particular, the state requested clarification of two terms: “longer periods of incarceration” and “returned to the rolls immediately upon release”.225 These definitions were incorporated into a letter from Sue Kelly to Kathy Kuhmerker dated September 14, 2000.

The letter specifically informs the state that they are permitted to temporarily suspend eligible individuals from payment status during periods of incarceration in order to ensure that FFP is not claimed. The term “longer period of incarceration” is defined for the state as “specifically a period of time that exceeds the State’s customary period of time before a [sic] eligibility redetermination would be conducted.”226 The letter indicted that redeterminations do not need to be completed as long as an individual is incarcerated, but the state must do a redetermination once discharge appears imminent. Perhaps the most problematic aspect of the letter was the directive that unless the State had determined that someone was no longer eligible for Medicaid, it must ensure that incarcerated individuals are returned to the Medicaid rolls immediately upon release from jail or prison, allowing individuals to access services on the day of release.

Kathy Kuhmerker remembers her response to receiving the letter as follows:

I didn’t understand their interest in this, given all the other things they were starting to yell at us for… I think they were following the times by saying everyone should be eligible until there was a re-determination. Part of them taking the position was just politics. We were all concerned about welfare to work, and people losing cash assistance and not Medicaid… making sure we had appropriate follow-up…and they kept beating on us…they did a whole review proactively and were supervising us more than they had been before. It was unlike them to be in our face, but there was a lot of political pressure and advocate pressure. More so in New York than in other places… Their stand on prisoners was not inconsistent with this activity, but we were stunned.

I believe WE believed the feds were wrong. But, I don’t believe we ever had a legal discussion with the feds on this... There had never been a suspended status... they just didn’t have a leg to stand on. I thought, let them force us to do it. Then THEY would have to explain why we should lay aside the work we were doing with moms and kids so that we could focus our resources on inmates...We’re not supposed to say this, but, why would I spend scarce resources on a prisoner when I had little kids not insured? Since we had this disagreement, NY responded in writing that we didn’t have a “suspend” status, and we asked for advice about how to do that. We never got an answer to that, and as I recall, we asked several times.  

Rice concurred with the concerns regarding lack of resources and prioritizing inmates:

We were being inundated with new programs and requirements. Choices had to be made. Were we going to recertify women and children, or inmates? This wasn’t even good government... [We believed] they had to look across the board at their discharge planning, and not just focus on Medicaid... Besides, why would we make it easier for one population [inmates] to get Medicaid than another? I had a problem with the disparity... I made recommendations to Kathy and the second floor [the Governor’s office] that we fight this. They agreed.

The “fight” included asking DHHS for guidance, and involving other states. According to Rice: “we wrote to Donna and said ‘We don’t have a clue how to do this.’ We also raised it on the e-TAG to see if we were the only ones who were told to change. The other states weren’t told to do it. The states thought it was inappropriate.”

The formal letter from the State was sent on January 24, 2001 from Kathy Kuhmerker to Sue Kelly. It specifically references a November 30, 2000 E-TAG conference call, and reiterates Betty Rice’s participation on the call concerning:

- Requirements for an eligibility redetermination when discharge is imminent;
- Requirement to restore eligibility immediately upon release unless the individual has been found to be ineligible;

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227 Kathryn Kuhmerker, face-to-face interview, October 7, 2007.
228 Betty Rice, face-to-face interview, October 5, 2007.
229 Ibid.
• Suggestion to suspend eligibility during incarceration and/or use simplified redetermination procedures, including an ex parte review after a period of incarceration;
• Assertion that Medicaid cannot be terminated until redetermination is done, even though federal financial participation is not available for incarcerated individuals.  

The letter highlights that New York was the only State to receive the instructions from the CMSO, and indicated that the other states expressed the same concerns about the instructions that New York had. Kuhmerker closed the letter by asking for input on the practical applications of the requirements.

During the time period that the New York Medicaid office was developing their response to DHHS, they had already begun to be contacted by New York advocates regarding the Rangel/Shalala letter. For example, the Commissioners of the Health and Mental Health Departments received a letter from Joseph Glazer, President and CEO of the Mental Health Association of New York stating that it was “great news to hear that the federal government is bringing change to the current situation” and asking for information about the time frame for implementing the new processes for inmates.

Kuhmerker responded to the letter on November 22, 2000, and informed Glazer that the state was “exploring our administrative options to redetermine Medicaid eligibility when discharge appears imminent.”  

She also informs him of a program implemented September 5, 2000 by the Office of Mental Health in New York called the Medication Grant Program (MGP), which provides medication and other services necessary to

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231 Joseph A. Glazer, Esq. (Executive Director, Mental Health Association of New York State), letter to Antonia C. Novello (Commissioner, New York State Department of Health, Albany, NY), November 2, 2000.
232 Kathryn Kuhmerker, (Deputy Commissioner of Medicaid Management and Medicaid Director, retired) NYS Department of Health to Joseph A. Glazer, (Executive Director, Mental Health Association of New York State). November 22, 2000.

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prescribe and administer medication to treat people with mental illness, including those being released from correctional facilities.\textsuperscript{233}

Consistent with the division of responsibilities described by Tim Westmoreland, Sue Kelly did not immediately respond to Kathy Kuhmerker’s letter. Instead, she sought guidance from the Central Office. In a memorandum dated February 22, 2001 to Cindy Mann (Director of Family and Children’s Health Plans Branch) and Thomas Hamilton (Director Disabled and Elderly Health Plans Branch) Kelly reported the situation:

“As you may recall, in April 2000 the New York Regional Office received some inquiries regarding Medicaid eligibility for detainees and inmates in the New York City jail system. It was brought to our attention that New York State was terminating Medicaid eligible individuals entering the New York City jail System.

After careful review of former Secretary Shalala’s April 6, 2000 letter to Congressman Rangel… on September 14, 2000 we went a letter to New York State outlining Federal policy … [and that] Federal policy permits states to use administrative measures that include temporarily suspending eligible individuals from payment status during the period of incarceration...

We have recently received a letter from NYS that discusses the November 30, 2000 conference call of the Eligibility Technical Assistance Advisory Group (E-TAG) … New York has expressed concern that no other states have received similar policy statements from HCFA. The state has inquired as to whether HCFA has provided this guidance to all States and Regional Offices. Additionally, the state would appreciate HCFA’s thoughts on the practical application of these requirements.\textsuperscript{234}

Kelly’s letter was not responded to, and thus, Kuhmerker’s letter was not responded to. Betty Rice won Round One.

\textsuperscript{233} Ibid.
\textsuperscript{234} Sue Kelly, memorandum to Cindy Mann and Thomas Hamilton (Director, Disabled and Elderly Health Plans Branch, Washington, D.C.), February 22, 2001.
Round Two

By mid-2001 there had been no changes in New York regarding the status of inmates on Medicaid. Congressman Rangel sent another letter to DHHS, this time to the new Secretary. In his letter, Rangel reported the interpretation of the statute and regulations that he received from Shalala, and asks Thompson if the interpretations is being made the same way in the new administration. On October 1, 2001- Tommy Thompson responded to Congressman Rangel. He referenced a September 14, 2000 letter that stated States may not terminate until a redetermination has been conducted, including an ex parte review. Further, he agreed that states must ensure that once-eligible individuals are returned to eligibility rolls immediately upon release from incarceration. He closed by noting that there were plans to disseminate the policy to all states.\(^\text{235}\)

Joseph Glazer of the Mental Health Association wasted no time in writing back to Commissioner Novello. In a November 2, 2001 letter he notes that he wrote the year before and was informed that the state was exploring their administrative options. He opined that a year had gone by and no progress had been made, and he let Commissioner Novello know that he was aware that Secretary Thompson had been in touch with Congressman Rangel to confirm the DHHS interpretation of the regulations. He asks again for the status of the directive’s implementation.\(^\text{236}\)

Unfortunately for Glazer, the Health Department was not swayed by his contacts. According to Rice “The Thompson letter came out, but it didn’t get us to waiver on our opinion. I think maybe we wrote another letter. But really, nobody wanted to do it. First, we had no staff to do it, and second, if we had to recertify [inmates] the staff didn’t

\(^{235}\) Tommy G. Thompson, letter to Rangel, October 1, 2001.

\(^{236}\) Glazer, letter to Novello, November 2, 2000.
want to go to prison for the face-to-face. When NY went to mail recertification it might have been different.”

Rice indicated there were other factors that had begun to support the Department of Health’s position. The State had implemented Kendra’s law, which according to Rice “covered a wide range of services, instead of making Medicaid the singular push button of successful prisoner re-entry, which is silly. Just giving Medicaid for jail releasees doesn’t cut it. Getting meds is just not as important as housing and food.”

Rice explained the law and its impacts, citing statistics that she believes support her position.

The drug and services parts of Kendra started to be funded through presumptive eligibility, but we ultimately changed it to a state cost for meds and counseling, and to help file Medicaid applications, along with applications for other benefits, and a case manager to access services, SSI or SSDI. Once we had a good program we didn’t need to fix the Medicaid issue… and it’s a good thing. Under Kendra’s law people were required to file Medicaid applications, but only about 40% of them were ultimately found eligible. The other 60% were not, so giving presumptive eligibility would have been wrong. Our fear of the error rate was correct.

According to both Rice and Kuhmerker, Region II did not continue to contact them about the inmate issues, and the Central Office didn’t pursue it either.

**HCFA Drops the Ball**

According to Marty Svolos, the general approach with States has been not to be hard-nosed. HCFA/CMS is dealing with a complicated program that has limited resources. At times they’re dealing with issues where a great deal of money is at stake.

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237 Betty Rice, face-to-face interview, October 5, 2007.
238 Ibid.
239 Ibid.
240 Svolos, interview, November 9, 2007.
Some smaller things fall through the cracks. Tomlinson agrees, “We’re short of staff. It’s hard for us to go in and prove when states are out of compliance… actual actions against states don’t happen. There’s lots of jawing…” Shenk describes the situation as well, “not to belittle the problems. It’s just the way things are. It’s sad… We don’t have the manpower- dollar wise, it’s hard to do the program. If you have 10 kids and one has a snotty nose, you care, but you have 4 more who need their diapers changed… Whattaya gonna do? These are big issues…. you have to choose things.”

Each staff person describes a situation where formal sanctions are very rarely pursued. According to Svolos “There are certainly politics at play. If the government in the White House is the same party as the Governor, then forget it.”

Counsel Abel concurs.

There is no standard procedure to ensure compliance. There is a process in the 1904 Social Security Act, but it’s almost never invoked. We usually just send a letter that says there’s a problem. Withholding money is not in reality a way we politically or practically wants to go. The force of persuasion-- there are many different forms. There are lots of issues and we used to maintain a formal compliance list, and when a state came in to ask for anything the list would be pulled out. At some point keeping the list became cumbersome, and it stopped being kept formally…the whole process really depends on voluntary compliance by states. While our enforcement options are limited, a lot of states can’t easily blow CMS off because they’re subject to lawsuits by beneficiaries. States don’t want to be in a position where they ask CMS to help them and have CMS say ‘No- we told you already that you were out of compliance.’

And that’s exactly what happened in New York.

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244 Abel, interview, November 15, 2007.
The Context: Advocates and Intergovernmental Partners

Betty Rice noted that interest in inmate issues “picked up with the Charlie Rangel letter,” but she believes that awareness of the issues in New York “really spiked on Riker’s Island with the Brad H lawsuit.”

The Brad H lawsuit was a class action suit brought in New York State Supreme Court against New York City in August 1999 by the Urban Justice Center, Debovoise and Plimpton, and New York Lawyers for Public Interest. The plaintiffs were a class of 25,000 people with mental illness who were released annually from New York City jails. According to the suit, New York City released inmates with mental illness at the Queens Plaza between 2 and 6 a.m. with $1.50 and a $3.00 Metrocard. The suit argued that this practice violated inmates’ rights under New York State Mental Hygiene Law, Section 29.15 (g) that requires:

A written discharge plan that provides, among other things, for how the released patient will receive on-going mental health services, where he or she will live, what services will be available in that setting, and how the patient will get the public benefits s/he is entitled to.

According to the suit, case law had expanded the requirements to include that housing be obtained prior to release. There was also an obligation to follow up with the patient to ensure that the plan is sufficient and that the patient has been able to implement the plan. The lawsuit was filed against the Mayor, the New York City Departments of Corrections, Health and Mental Health, the Health and Hospitals Corporation, the Human Resources Administration, Prison Health Services, and the Directors of each. The suit

245 Rice, interview, October 5, 2007.
246 New York Mental Hygiene Law Section 29.15 (g)
specifically argued that inmates receiving mental health services in jail were entitled to receive the discharge planning described under the law.\textsuperscript{247}

Settlement of the suit essentially created a right to discharge planning from Riker’s Island. The City was given 60 days to implement it.

Given the suit’s focus on accessing public benefits, both the state DOH and the State Office of Temporary and Disability Assistance (OTDA) were brought in. According to Brian Wing, the Medicaid Director who replaced Kathy Kuhmerker,

\begin{quote}
“The Inmate issue stretched both agencies… I never understood why we couldn’t expedite enrollment during release. It’s somewhat of a mystery. Both corrections and parole knew who was coming out and when. But the info from DOCS didn’t always have the right information. Sometimes they had aliases, or typographical errors that made cases impossible to process. There is a bigger philosophical question, to get people who were likely eligible into services. The problem is the person on the street who doesn’t get that kind of service.”\textsuperscript{248}
\end{quote}

Kuhmerker and Wing indicated that they received a great deal of pressure to cooperate from Chauncey Parker, the former Governor’s Secretary for Criminal Justice Services, and Robert Doar, the former Commissioner of OTDA. These policymakers became involved in jail/Medicaid issues through an initiative with the National Governor’s Association (NGA). NGA was sponsoring policy workgroups and inviting state-based teams to come to Washington to work on building a state interagency initiative that addressed jail/Medicaid issues. Kathy Kuhmerker and Betty Rice were sent with some of the staff from the criminal justice agencies.


\textsuperscript{248} Interview with Brian Wing, (Deputy Commissioner of Medicaid Management and Medicaid Director, retired), November 9, 2007.
According to Kuhmerker, there was an initial effort before going to Washington to get the New York team on the same page.

“We met with the Criminal Justice guys before we went to the national meetings. We felt that program agencies were not familiar with the difficulties of implementation, so we didn’t want to sandbag each other in public. There were all sorts of issues trying to work with DOCS [on facilitating enrollment], like the client having aliases and no social security numbers. DOCS was flabbergasted at the barriers, and even when we had an internal policy and pressure to do it, it was still difficult. Robert Doar [of OTDA] got involved in release planning, and thought of Medicaid as an important social support. He took up the gauntlet...[but he] was missing how complicated it was. [At DOH] we were distressed internally that he was making it look easy when it wasn’t, and it was making us look bad. We set up a bunch of workgroups to do this for Medicaid eligibility, and it became obvious that it wasn’t easy. It persisted for what seemed like years and years and years. It was going on as at the same time as the Payment Error Rate Measurement (PERM) issues, where Medicaid was being criticized for not having appropriate eligibility documentation. It was inconsistent to bend rules for prisoners and not for a 2 year old who needed health care.  

Betty Rice had similar recollections.

While we were dealing with the Brad H lawsuit and the City, we also had NGA wanting to meet on release planning, and Parole and Corrections working on it. Periodically they would put together work groups on successful reentry. It seemed to us the attitude was ‘just give them a Medicaid card and everything will be wonderful.’ What I learned from all of that is that the ‘sisters’ [the Health and Human Service agencies] came to the table and the ‘brothers’ [the Corrections Agencies] wanted the sisters to do everything. And the brothers would fight with each other. DOCS would take prisoners’ cards and licenses away and then Parole wouldn’t be able to get the documents. The brothers definitely didn’t get along. Then the sisters said they would go to prison and get the documents. The brothers definitely didn’t get along. Then the sisters said they would go to prison and get applications, but the brothers wouldn’t get the birth certificates and ID cards. When they did we would get documents with aliases. We did a lot of show and tell, and it all looked good in the limelight, but it never came to anything. There were demos and pockets where places worked it out, but nobody would agree across the board. At NGA they never quite understood the [Medicaid] state plans. They wanted the brothers to have state plan input. They didn’t understand that we needed a process, not a legal review. They just thought we were being secretive. Some states did change their processes as a result of the NGA efforts, but NY was not one of them.  

250 Rice, interview, October 5, 2007.
Bringing a Solution Home

Marty Horn has been a criminal justice professional for decades. He has worked in New York State Corrections and Parole, Pennsylvania corrections and New York City Probation and Corrections. He currently serves as the Commissioner of both New York City Corrections and Probation. Horn has been working on issues related to providing mental health and substance abuse services to criminal justice populations during most of his tenure, and has a strong appreciation for the role that Medicaid can play in facilitating access to services. Over the course of his career, he has been an active member of the American Correctional Association, where he has spoken forcefully on issues related to release planning.\textsuperscript{251}

In 2005 Horn was approached by Joe Hines, the long-time District Attorney for Brooklyn, and asked to Chair the Corrections Sub-Committee of the Criminal Justice Section of the American Bar Association. Horn’s first meeting was held in New Orleans in November 2005. At that time the Committee recruited Cecelia Klingerland to write a report for the Committee that documented the issues related to the importance of Medicaid eligibility as a component of inmate release planning.

The basic argument presented by Klingerland is that “institutionalized persons are the only Americans constitutionally guaranteed access to medical care,” which although not statutorily created, was established by the Supreme Court in Estelle v. Gamble (429 U.S. 97, 103 (1976)).\textsuperscript{252} The report, therefore, outlines the financial and bureaucratic obstacles that serve as barriers to providing health care to incarcerated and formerly

\textsuperscript{251} Martin Horn. (Commissioner Departments of Corrections and Probation, New York City, NY) face-to-face interview with the author, October 16, 2007.

\textsuperscript{252} Cecelia Klingerland, draft report to the Corrections Committee of the American Bar Association from the ABA Criminal Justice Section, (unpublished manuscript, 2006).
incarcerated people. The original draft report actually argued for inmates to be eligible for Medicaid both during and after incarceration.

In May 2006 the Committee met and adopted the report and a policy statement recommending that, among other things, states suspend Medicaid upon incarceration, and ensure that formerly eligible inmates are released with their Medicaid cards operational. The Criminal Justice section passed the policy statement, and made a recommendation to the House of Delegates of the Bar Association to pass the Resolution. Ultimately the delegates refined the resolution, and limited it to maintaining Medicaid post-incarceration. It was ratified in January 2007, and adopted.

Concurrent with his activities on the national level, Horn pursued solving the New York jail/Medicaid termination issues legislatively. In his role as Commissioner of Corrections, Horn proposed legislation to the NYC Mayor’s office for submission as part of the City’s annual State legislative package.

According to Danielle Lidner, former Legislative Liaison for the Mayor’s Office, it took about 3 years to get the bill passed. In the first year the NYC Department of Health and Mental Health carried it, but the bill was introduced late, and there was no Senate Sponsor. In the second year, DOCs took it over. The Chairman of the Senate Health Committee became the Senate sponsor, but it was not a priority.

Jane Preston, Senior Legislative Aide to the Health Committee explained the sticking points: “Once you commit a crime and go to prison you lose a benefit. There was an agreement that that was a fair outcome.”

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253 Danielle Lidner (Former Legislative Associate for City of New York), telephone interview with the author, October 29, 2007.
254 Jane Preston (Former Legislative Director for the New York State Senate Health Committee), face-to-face interview with the author, October 30, 2007.
Department sent representatives in to speak with her about protecting county claiming for FFP. As a result of those discussions, the bill was amended.

By the next year the advocates had the chance to “educate” the Senator and his staff. According to Preston,

They pointed out the cyclical nature of terminating Medicaid for jail inmates, and it made sense from an efficiency point of view to ease the administration and do it differently. The other thing that came out was just trying to understand what happens when someone is released from jail when they have mental health issues or diabetes. Then they don’t have access to the medications they require. If they don’t have that it does affect recidivism.\(^{255}\)

In 2007 there was a new Democratic Administration in Albany, and new appointees in the Medicaid unit. Betty Rice retired and the position she formerly held was reconstituted, dividing her responsibilities over several other staff. This change allowed Lidner to work through both the Executive and the Legislative branches. In her work with the Executive branch, Marty Horn significantly supported her. Horn had been assigned to newly elected Governor Spitzer’s Transition Committee, working on the criminal justice sub-committee. Horn worked with the Chair, Denise O’Donnell to get the Medicaid Suspension proposal included in the proposals from the transition committee. Largely due to Horn’s influence, the proposal became the #1 recommendation from the committee. Although Horn and his staff had met with members of the Executive branch previously, once the Spitzer Transition Committee embraced the proposal, the new Medicaid Director Deborah Bachrach supported the proposal.

Horn thought the changes would eventually come through the Executive branch action, but Lidner didn’t give up on getting a bill passed: “We had more time, and we

\(^{255}\) Ibid.
really rallied the troops. We got the Correctional Association, the New York State Association of Counties, and lots of other advocates involved. I think the strong lobby support by the advocacy groups was one of the factors that made it work.\footnote{Lidner, interview, October 29, 2007.}

Preston agreed that the strong lobbying support made all the difference. There were memorandums of support for the legislation from the City of New York, the New York State Association of Counties, the New York State Conference of Local Mental Hygiene Directors, the Correctional Association of New York, and the Coalition for Women Prisoners, along with the report from the Criminal Justice Section of the American Bar Association. In the end, according to Preston, the bill was passed in 2007 “without a hitch. For us it had nothing to do with Spitzer Administration support. It had everything to do with the cities and counties supporting it.”\footnote{Jane Preston, interview. October 30, 2007.}

But, of course, the State was still involved. Sue Kelly recalled:

This year we got a call from Judy Arnold [NYS DOH staff]. She reached out regarding the state legislation to make sure the elements of the legislation would meet CMS’s concerns. Subsequently we had a meeting with Deb Bacharach, who was totally delighted at the changes that were being made.\footnote{Kelly, interview, October 23, 2007.}

Perhaps another example of the new Democrats willing to err on the side of expanded eligibility.

**Epilogue**

Legislation to suspend rather than terminate Medicaid eligibility was passed as Chapter 255 of the Laws of 2007, with an implementation date of April 1, 2008.\footnote{Chapter 355 of the Laws of 2007.} In an ironic twist, the newly retired Betty Rice was asked to work as a consultant to DOH and
write the Administrative Directive to be sent to the counties to explain the implementation plans. The Directive was issued April 21, 2008. Over the past 11 months the state has suspended the enrollment of 5,220 inmates, and reinstated approximately 700 back to eligible status.²⁶⁰  

Counsel Abel from HHS perhaps summarized the lessons learned on variation from this experience as well as anyone:

It’s not my job to rate personnel, but not being a monolith, jobs can't be changed. We’re people with different orientations and there is a lot of inconsistency in what goes on. It’s not a vast conspiracy where we all march in lock step… Personalities and management styles really may make a difference…People have a big effect on how things come out and where resources are put…we don’t operate the programs. So, we stay silent on some things and let the states work it out with beneficiaries… To the CMSO, our clients are the states—the entities they give grants to and they’re serving. Beneficiaries are a third party. So, we try to get states what they wanted. Cindy and Tim brought a beneficiary perspective to the position that was refreshing.²⁶¹

²⁶⁰ Kim Cirullo (Regional representative, New York State Department of Health Regional Office), telephone interview with the author, March 20, 2009.  
²⁶¹ Abel, interview, November 15, 2007.
Chapter 6:

The Devil is in the Details

Practitioners who are also scholars think in operational terms: why does something work or not work the way it is? What are the various approaches to explaining it so we can determine how it can be changed? And, more globally, what are the similarities between this case and others, so we can start getting more things right the first time? These questions provided the origins of this study, because as has already been quoted:

…while many different outcomes are tolerated in some policy arenas, for certain fundamental rights and privileges, such as equal access to public facilities, and minimum standards of living, much less flexibility can be given to local implementers to deviate from national standards.”^{262}

Access to health insurance is one of those policy areas where much less flexibility can be tolerated, because access to health care has been proven to be related to access to health insurance, and Medicaid is the primary option for low-income people to access health insurance. People who are denied or disenrolled from Medicaid have few other options.

As Thompson noted nearly a decade ago, “State political forces shaping policy formation and implementation...[are] increasingly important in determining who gets what in the health care arena.”^{263} It is the job of state (and local) bureaucrats who implement Medicaid to ensure that everyone who is eligible is enrolled. It is the job of federal bureaucrats to oversee the state bureaucrats, and ensure that they are applying the

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^{262} Schneider and Ingram, "Social Construction of Target Populations," 7.
^{263} Thompson, "Federalism and Health Care Policy," 66-67.
rules appropriately, consistently and fairly. This makes the study of federalism within Medicaid, and identifying the variables that affect federal, state, and local bureaucratic actors particularly important. Within these constructs, this chapter outlines the lessons learned. The first section reviews specific information about the components of federal variation, and the factors that affected it. The second section looks at the state activities and the variables that affected their responses to CMS, as well as their positions on the two policies. Section 3 highlights some of the theories reviewed in Chapter 2 regarding federalism, implementation and IGR, and identifies theories that were affirmed, and several that were infirmed. The chapter closes with a summary of the most compelling findings, their implications and suggestions for additional research.

**Explaining Federal Variation**

The information gleaned from these case studies answered several sets of questions with regard to federal variation: first, what creates variation in general; and second, what created variation in these cases.

Generally, in order for federal principals to act consistently across cases several factors must be in place:

1. The rules must be clear.
2. The rules must be consistently communicated across cases.
3. The rules must be monitored.
4. The federal principals must be apprised that the rules are being broken in both cases; and
5. The federal principals must have the same tools available to try to bring the state agents into compliance.

Table 4 shows the findings for these variables across both cases, and indicates the role that interest group actors and bureaucrats from outside the Medicaid policy network played to try to ensure individual access to benefits.
Table 4: Comparing the Cases- Federal

<table>
<thead>
<tr>
<th>Federal Activities</th>
<th>CO-to-CO</th>
<th>Inmates</th>
<th>Role of Extended Network Actors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish Clear Rules</td>
<td>Yes</td>
<td>No</td>
<td>Pushed for clarity</td>
</tr>
<tr>
<td>Communicate Clear Rules</td>
<td>Yes</td>
<td>No</td>
<td>Requested policy statements</td>
</tr>
<tr>
<td>Monitor Implementation</td>
<td>No</td>
<td>No</td>
<td>Monitored states</td>
</tr>
<tr>
<td>Informed re: non-compliance</td>
<td>Yes</td>
<td>Yes</td>
<td>Informed CMS of non-compliance</td>
</tr>
<tr>
<td>Same Tools</td>
<td>Yes</td>
<td>Yes</td>
<td>Requested use of tools to enforce right to access.</td>
</tr>
</tbody>
</table>

As the table illustrates, there were several points of variation across the cases. This variation is examined in further detail below.

**Clarity of Content**

At the statutory level, legislative enactments may or may not be clear, but scholars have documented that elected policymakers frequently leave the details of many statutes to rulemaking among bureaucrats. This allows the elected officials to create agreement among the largest segment of legislators while allowing legislators to preserve their ability to justify their votes to their constituents and other stakeholders. The general belief is that federal bureaucrats are well positioned to understand the existing program structures, and therefore have the ability to create the rules and regulations required for statutory implementation.

While this may be true for many programs, these case studies illustrate that the implementation imperatives and the clarity of regulations can be definitively cloudy within the Medicaid program at the implementation level. They certainly were not clear
in the case of inmates. When a Medicaid-enrolled person gets picked up for drunk driving, is he/she an inmate? Are inmates eligible for Medicaid? If he/she leaves jail because of a heart attack and gets admitted to the hospital, what is the Medicaid status at that point? Inpatient or inmate? Eligible or ineligible? How are these rules the same or different for children and juveniles who are involuntarily confined?

The lack of agreement between federal principals about the answers to these questions was one of the basic causes of the federal variation displayed in response to these cases. And while part of the explanation for the variation, therefore, was the lack of clarity, what may be of greater concern is the inability of federal technocrats to create clarity after years of debate. Are there populations other than inmates where the experts cannot make a definitive determination about their status, such that otherwise eligible persons are falling through the cracks? It leads one to question whether the Medicaid program has become too complex to serve as a major component of future health care reform.

**Consistency of Message**

The steps that CMS took to clarify the policies in these two cases differed to the extreme. In the case of disenrolling individuals in county-to-county moves, a Medicaid Director letter was released almost immediately upon finding the problem. The letter not only communicated the details of the policy, but also instructed states to review their policies and procedures, and to create corrective action plans when their procedures were out of compliance. To the present day CMS has not released a Medicaid Director letter clearly articulating all the information necessary to ensure ex-inmates have access to Medicaid. This is the case despite the fact that there appeared to be few advocates
pressuring federal actors to address the county-to-county issues; whereas, there was an entire orchestrated effort on the part of advocates and state and local bureaucrats to press federal action on inmate access to Medicaid.

In part, the lack of action on the part of CMS was related to the lack of a clear policy to communicate. However, it was also reported that federal bureaucrats were responding to political priorities related to the President’s agenda when addressing the county-to-county issues, and the issues related to inmates were not tied to the same priorities. As it turned out, what appeared to be the model response actually turned out to be the anomaly. In most cases non-compliance either goes unrecognized and/or unaddressed with calls of national reviews and corrective action plans.

Oversight and Feedback Loops

Our third requirement for evaluating variability across cases is determining if the monitoring and oversight mechanisms that are in place provide consistent feedback when states are not carrying out the preferences of federal principals. As Mann and others have pointed out, there are no institutional mechanisms in place to consistently identify when regulations are not being followed, and no consistent standards for prioritizing corrective actions across regions, nor within the Central Office of CMS, when violations come to light.

Mann noted that she was very concerned about having appropriate issues brought to the attention of CMS, because there were not systematic methods in place for such monitoring. And while the cases examined for these two studies did “bubble up” appropriately, there is no way to determine if these are the only two cases of
inappropriate disenrollment, or if there are others that have not been brought to light. Variation is likely the norm rather than the exception in such circumstances. Again, without the activities of actors from outside of the standard Medicaid network, the inmate case would not have come to the attention of CMS principals.

While this lack of systematic monitoring and oversight is certainly problematic within the current Medicaid program, it is of particular concern if Medicaid expansion becomes part of national health reform. One of the major criticisms of creating national health reform is the fear that it will result in “big government.” There will be significant pressures to contain the administrative costs of such a program, and systematic monitoring and oversight are not likely to become an added feature of Medicaid during future negotiations.

**The Tools of Federalism**

Federal bureaucrats have fragmented implementation literature regarding questions on the use of implementation tools. Some studies have looked at the tools and their applications, and found them efficacious for the purposes intended. For example, Church and Nakamura were impressed by the tools put in the hands of the EPA for Superfund Clean-up, which included an array of “carrots” and “sticks” that were shown to be effective, despite the tendency of Regional Administrators to use them differentially.\(^{264}\) Gais and Fossett have also identified a wide array of tools available to federal administrators, and have argued that waivers, rulemaking, grants and other administrative tools have positioned federal bureaucrats to negotiate directly with states.

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\(^{264}\) Church and Nakamura, *Cleaning up the Mess.*
to create major changes in domestic policy.\textsuperscript{265} And many years ago Liebschutz noted that when the federal government and the states are in conflict, federal actors have the power of the purse, court decisions and legislative mandates in their arsenal; of the three she identified direct spending as most effective.\textsuperscript{266}

Yet, within the Medicaid program, federal administrators believe they have limited tools at their disposal to force states to come into compliance with federal regulations. What are the differences between the studies cited above and the case studies outlined here?

To begin with, unlike the Superfund study, these studies were limited to negotiations between the federal government and a state. As was noted, when CMS deals with providers in Medicare they have far more stratified and effective tools because Medicare is paid entirely with federal money. However, it is important to note that there is a sense that since states foot a portion of the bill for Medicaid, it is more difficult to demand concessions from them.

In addition, there’s the sense that there is a lack of progressive sanctions available to meet the needs of the Medicaid program. Central Office and Regional bureaucrats legally have the ability to send letters and levy financial sanctions. Yet they consider letters too lenient and financial sanctions too aggressive. Therefore one tool has no use, and the other is ineffective.

In theory, there is also the ability to provide technical assistance (TA). However, except in the least complex cases, this tool is only theoretical. Both federal and state respondents indicated that there are two major impediments to CMS providing TA. The

\textsuperscript{265} Gais and Fossett, "Federalism and the Executive."
\textsuperscript{266} Liebschutz, Bargaining Under Federalism, 195.
first is that certain areas are far too complex for most employees to provide technical assistance. Medicaid eligibility policy is among those subjects. The federal rules are arcane and convoluted, and there are few who know them well enough to understand them, let alone apply them across states that themselves have different laws, rules and regulations.

The second issue is a lack of resources. There are simply not enough federal employees to provide the kind of detailed and specific technical assistance most states require to make the business process and re-engineering changes necessary to come into compliance on the wide array of issues evidenced. In this sense, states don’t have the capacity and the federal principals don’t have the resources to supply them. This is clearly one cost of the “hollow state.”

In response to the question regarding variation in the use of tools across cases, there is limited variation because there are limited options. In both cases the state was contacted. The variation existed in the number of contacts and their urgency.

The lesson learned with these case studies is consistent with the findings of Ingram long ago; that federal principals cannot force states to be principled agents within the Medicaid program. Federal money doesn’t buy compliance, just the opportunity to negotiate. And, from the states’ perspective, they are aware of the lack of tools in the federal arsenal. Implementation games -- such as NY requesting federal assistance—are deliberate strategies to stall calls for change. This is a problem from the standpoint that currently there are individuals and/or populations that are supposed to be represented by the federal government to the state (ala Beer) to ensure their distribution of public goods and services. But again, in light of the possibility of relying on Medicaid

267 Ingram, "Policy Implementation through Bargaining."
as a basis for national health care, the lack of progressive and effective tools to ensure compliance, particularly with regard to some of the complex and arcane regulatory requirements, is a major problem.

**Variables Affecting CMS**

In light of the finding that the CMS responses to these two cases varied in a number of ways, what can be said about the causes of the variation? A few of the key findings indicate that CMS was influenced by:

- Uncertainty related to clarity of regulations
- Concerns related to cost-shifting
- Competing Agendas
- Administrative resources and priorities
- Political influences

The issues related to clarity of regulations have already been reviewed in general, but not necessarily in relation to the next two factors: cost-shifting and competing agendas. Given that criminal justice programs have historically been the fiscal responsibility of state and local jurisdictions, CMS was keenly aware that they did not want to interpret issues related to inmates as opening a door for FFP for inmate health services. Whatever the content of communications to the states regarding the inmate exclusion might be, they could not be misinterpreted as having the federal government take any responsibility for the cost of health care for inmates. This is an important point, frequently lost in the weeds. But there are criminal justice advocates who assert that the Supreme Court created a right to inmate health care with the Estelle v. Gamble decision, and that the federal government should therefore assume financial responsibility for providing it. CMS was sensitive to that agenda.
In a related issue, CMS was, and continues to be, inconsistent on issues related to paying claims for inmates who receive services in acute care facilities instead of correctional facilities. This exception to the inmate exclusion appears to be clear in the statute. However, at the current time only New York State is being permitted to submit these claims and receive FFP from CMS. Other states have been informed by their regional offices that this exception does not exist. Putting out a statement on the eligibility issues would require CMS to establish consistency of claims payment, and that is not something that CMS wants on their agenda. In this case, there are conflicting and competing agendas between the desire to extend coverage and the desire to contain costs.

The third concern is one that affects all implementations: the availability of resources to properly assemble the implementation machinery. CMS respondents unanimously acknowledged the lack of capacity to complete all of the work it would take to establish consistency and continuity between cases and states. And, lacking the resources to do everything forced them to establish priorities.

In terms of establishing priorities, it is worth noting that the federal respondents never identified a relationship between the two cases, nor specifically reflected on the possibility of establishing consistency across implementations. Therefore, there was not an expressed comparison between the two cases and a decision about where to place priorities. One explanation for the lack of comparisons is that different bureaucratic units deal with county-to-county moves and children versus inmates and other special populations. Thus, some federal technocrats were never aware that there were separate cases following different trajectories.
At the higher levels, however, certain bureaucrats were able to weigh in on both sets of cases. For example, Sue Kelly in the Regional Office was aware of both cases, as was Cindy Mann in Central Office. But while the technocrats were responding to separate sets of regulations, the appointees were responding to different political imperatives.

For Kelly, the inmates represented a relatively small political problem with Congressman Rangel. Whereas, the problems with county-to-county moves got linked to the larger issues of welfare reform, issues of the uninsured, and the priorities of the president. There was obviously no political comparability between cases. Addressing county-to-county moves was the political priority, so in terms of setting priorities for scarce resources, Kelly was bound to be more engaged in the county-to-county move issues.

Mann, too, was responding to political priorities that were made clear to her by the political regime of which she was a member. Although she was aware of the inmate issue, the county-to-county moves were considered part of the welfare-reform de-linking issues, and therefore considered a component of the national reviews. The Clinton Administration had definitively prioritized the policy prerogatives of fixing welfare reform implementations and addressing the problems of the uninsured versus philosophical concerns about the proper role of the federal government. Again, given scarce resources, requiring dispensation of inmate issues was not the priority of the regime.

One interesting finding with regard to these cues, however, is the general knowledge and understanding by federal AND state bureaucrats about what the priorities of elites were. Professionals in the field acknowledged receiving the cue from the Clinton
administration that the priorities were about enrollment, and from the Bush administration that the priorities were about closing loopholes and reducing cost shifting. These were not philosophical positions regarding the size of government, but operational priorities about how to prioritize the application and expenditure of administrative resources.

**Summary**

The review of CMS and the federal activity related to cases of disenrollment for people who moved from county-to-county versus those who were incarcerated documented a number of disparities in the responses to both cases, and the factors contributing to the variation that was found. From a research standpoint, the original questions that inspired this research are answered. Federal variation was a product of political factors including the President’s agenda, concerns regarding cost shifting, and attempts to maintain historical divisions of responsibility and authority. It was also affected by administrative issues related to competing agency agendas related to claiming versus program priorities, and the lack of administrative capacity to attend to both issues equally. Disparity did not appear to stem from the social construction of target populations or regime-based philosophical positions related to expanding or contracting the size of the federal government.

These are interesting findings in their own right, but in addition to answering the original research questions, these case studies yielded extensive related information worthy of comment. For example, despite the variation in the CMS approach to the cases, and the vigor with which CMS pursued state compliance, the cases ultimately turned out the same. In both cases change was not accomplished through the efforts of
CMS. The state did not react differently to the different approaches by CMS, and instead chose to withhold compliance in both cases. Lacking any other intervention, it is likely that neither target population would be receiving benefits to this day.

This finding leads to obvious questions: what was the state’s response? Why? And what finally happened to establish access to services for the target populations?

**The State Response**

Table 5, below, outlines how CMS approached each case nationally, and how the state responded to being singled out for enforcement action on inmates.

### Table 5: Comparing the Cases-
Federal Variables and State Outcomes

<table>
<thead>
<tr>
<th>Federal Activity</th>
<th>Co-to-Co</th>
<th>Inmates</th>
<th>State Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contacted All States</td>
<td>Yes</td>
<td>No</td>
<td>Reported compliance, asked for National response to inmate exclusion</td>
</tr>
<tr>
<td>Asked for Corrective Action</td>
<td>Yes</td>
<td>No</td>
<td>Reported compliance, Brought other states into inmate issue to expand scope of conflict</td>
</tr>
<tr>
<td>Initiated follow-up</td>
<td>Yes</td>
<td>No*</td>
<td>Asked for technical assistance</td>
</tr>
<tr>
<td>State Change in response</td>
<td>No</td>
<td>No</td>
<td>No change; disagreed with policies</td>
</tr>
</tbody>
</table>

New York used many factors to support their decision to withhold compliance with CMS preferences. First, since CMS was not consistent across cases, New York State used the inconsistency as a basis for non-compliance. They brought up the issues on national calls, and had other states complain about the possibility of having to change their policies as well. In the county-to-county cases, New York asserted compliance, based on
their reading of the questions from CMS and the law, and assumed (because of past history) that CMS would not vigorously pursue a compliance action or sanction. When CMS continued to follow-through on calls for compliance from NY, they requested technical assistance, rightly assuming that CMS would not have the appropriate resources to bring that assistance to bear. These activities underscore New York’s intent to avoid or stall making changes to their implementation strategies for both of these policies, but shed little light on the reasons why.

**Factors Affecting State Action**

The factors that affected State action are many, some related to responding to federal principals, but most not. Table 6 provides several of the highlights:

### Table 6: Comparing the Cases - State

<table>
<thead>
<tr>
<th>State Activities</th>
<th>CO-to-CO</th>
<th>Inmates</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed with CMS policy</td>
<td>No</td>
<td>No</td>
<td>Threat to error rate</td>
</tr>
<tr>
<td>Believed policies conflicted</td>
<td>Yes</td>
<td>Yes</td>
<td>With claiming/audit</td>
</tr>
<tr>
<td>Possessed Infrastructure to change</td>
<td>No</td>
<td>No</td>
<td>WMS/SSA data</td>
</tr>
<tr>
<td>Resources available</td>
<td>No</td>
<td>No</td>
<td>Not enough staff</td>
</tr>
<tr>
<td>Political Issues</td>
<td>No*</td>
<td>No*</td>
<td>Not until transition</td>
</tr>
<tr>
<td>Tools: Asked for TA</td>
<td>Yes</td>
<td>Yes</td>
<td>Stall</td>
</tr>
<tr>
<td>Tools: Involved other States</td>
<td>Yes</td>
<td>Yes</td>
<td>Through e-TAG</td>
</tr>
<tr>
<td>State Change</td>
<td>Yes</td>
<td>Yes</td>
<td>Change result of extended IGR, not CMS activity</td>
</tr>
</tbody>
</table>

Major findings from the interviews with state Medicaid bureaucrats were related to their efforts to understanding the federal rules, their belief that they understood how...
the rules from various parts of the program (i.e., eligibility versus audit) affected program operations better than their federal counterparts, and their commitment to a culture that adhered to strict construction of the rules that were applied to audits, error rate reviews and disallowances. New York Medicaid eligibility professionals are steadfast in assuring that costly eligibility errors will not be made on their watch.

It is important to understand this motivation, because it differs from the notion that street-level bureaucrats don’t like to make changes, or drag their feet at implementing policy. While that may be true, it was not what was recognized in these cases. As Betty Rice pointed out, she might be willing to implement a policy if it was warranted, but if she did she wanted to make sure that changes were not made that would affect an enrolled person’s ability to stay in their managed care program or access services from a home care provider in another county. Policy changes implemented by her unit had to be operationalized across a broad set of concerns, and not simply turning on a card. Understanding this, and all of the components that were required, empowered her to go to her state principals and recommend that they go head-to-head with CMS. And, as Kathy Kuhmerker noted, she was willing to apply the limited resources available to her to implement that which she was told was a priority, but she was never convinced that either of these issues were priorities.

**Bringing Change to the State**

Although there was variation in the federal response to these cases, ultimately the cases ended the same way. Both target populations were ultimately saved from disenrollment by changes in eligibility policy implementation, despite the long-standing
objection of the Medicaid agency. How were changes brought about? Through the political means established in the Constitution, and as applied by citizens. These included:

- Expanding the scope of conflict through democratic participation: Advocates, interest groups, and average citizens identified the problems affecting the just distribution of public services and became active at all levels of government.
- Checks and balances: Both the court system and the legislative branch were brought into the conflicts to bring the implementation tools at their disposal, namely mandates.
- Regime changes at the Executive level: the installation of a new political regime in the Governor’s office in New York provided support to expanding the approaches to eligibility and applying the resources necessary to get the jobs completed.

In these cases the non-governmental actors and bureaucratic networks that were not usual members of the Medicaid subgovernment became involved in the issues and served as key players to enforcing compliance. Thus, change was enacted by expanding the scope of conflict.

**Examining Theories and Models**

Answering the research questions regarding the identification of factors that facilitate action presented the opportunity to review a number of existing theories. Much of the literature review in Chapter 2 outlined different theories regarding federalism, and implementation actors: what inspires federal principals to ensure that state agents comply with their preferences? What factors impel state agents to faithfully implement federal preferences? Are implementations the outcome of management imperatives or subordinates’ impediments? Who participates in IGR networks and what are their roles? This section examines the findings of these case studies vis-à-vis these questions.
One of the most interesting findings from this study is that State bureaucrats in the Medicaid program do not view themselves as agents of federal principals. In fact, State respondents were bothered by the notion that the federal interpretations of the statutes were “right” and that it was their job to “comply.” Respondents were happy to argue that theirs was the appropriate methodology for implementing the federal laws and regulations, and that CMS was not as knowledgeable about how to operationalize the laws and regulations as the states. Perhaps this is because these State bureaucrats participate in “Executive Federalism” at their own level.

If understanding state bureaucrats within the Medicaid program as agents of federal principals does not apply, then it is reasonable to inquire if there is a better model that can explain state bureaucratic activities? The results of this study would suggest that whether one embraces Beer’s notion of a professional bureaucratic complex, Heclo’s definition of issue networks, or the model of subgovernments, there does exist a cadre of bureaucratic professionals spread across federal, state and local governments, not-for-profit advocacy groups and legal organizations, and other stakeholders, who share a mission to provide services – particularly health care-- to the needy. In fact, it is not uncommon for these professionals to occasionally change places, when a state bureaucrat becomes a federal bureaucrat, an advocate becomes a government employee, or vice versa. For example, as noted in these case studies, Regional Administrator for CMS Sue Kelly was once the New York State Medicaid Director.

These professionals tend to share similar educational backgrounds and professional experiences that provide a basis for understanding many of the complex and arcane components of the health care system in general, and the Medicaid program in
particular. And although each of these actors share a commitment to provide services, many believe they have the best understanding of where the line is drawn in statute and regulation, and should be drawn in statute and regulation, to provide balanced public policy between the haves and the have-nots, the taxpayers and the recipients, the deserving and undeserving poor. Although unelected, many of these professionals have the power to implement or thwart legislatively created initiatives. During each interview, however, there was not a person who spoke who did not indicate that they were entirely in favor of ensuring that those who were eligible for services should receive them. The devil was in the details of operationalizing the rules. In this, state and local bureaucrats hold the majority of the cards.

There is truth to the argument espoused by several scholars that much control lies in the hands of the implementing bureaucrats, whether at the street level or in middle management. These actors generate a great deal of credibility when they argue that federal rules don’t allow for certain changes, or that existing implementation machinery can not be re-tooled to meet the challenges being advocated. As Peterson et. al. observed, “Many administrators have discovered that the most effective response to elected superiors is not that it shouldn’t be done, but that it can’t be done.”

Unlike what Peterson observed however, these actors do not have a guild-like loyalty to a single set of goals and objectives. It seems that each actor has an understanding of the opportunities and limits of their position. How they apply themselves and their preferences to the issues at hand stem from their personal understanding of the stakes involved, and their own personal orientation, both to the

268 Peterson, Rabe and Wong, “When Federalism works.”
program and services, and to their work in general. Some are natural activists, advocating for their own perspectives, or those of their supervisors. Others aren’t.

Factors that facilitate program changes can be identified, however. As Kathy Kuhmerker noted, if the federal bureaucrats had said “It SHALL be done”, or convinced her superiors that the changes they requested must be implemented, Ms. Kuhmerker would have ensured that the tasks were prioritized, even at the cost of withdrawing resources from other areas that had been considered priorities. More recently, when the state Medicaid Director insisted that computer reprogramming be undertaken to accommodate the changes necessary to support eligibility through county-to-county moves, responsible technocrats were able to marshal the resources to comply. Thus it appears that one factor is that a direct superior requires that a change be made. This eliminates the appearance of discretion for the lower-level bureaucrat, and changes the stakes from expressing personal preferences or enjoying the comfort of the status quo to needing to protect their job.

Invoking the order required the political will to articulate a priority and the willingness to release resources to make the changes possible. When those two factors were in place, the changes were made. The differences in these case studies were a result of where the impetus to make the changes originated, whether it was court-imposed, legislatively mandated and/or negotiated through intergovernmental channels. This is where the room exists for policy entrepreneurs to maneuver. If they can identify a policy’s champions, the obstacles within the bureaucracy, and then bring the appropriate pressure and resources to the table, there is the ability to change almost any policy and implementation.
Other Theory Affirming Considerations

Table 7 provides a broad outline to some of the other theories that were affirmed.

**Table 7: Theory Affirming**

<table>
<thead>
<tr>
<th>Author</th>
<th>Area</th>
<th>Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Krane</td>
<td>Federalism</td>
<td>Mix of reciprocal power relationships</td>
</tr>
<tr>
<td>Beer</td>
<td>Federalism</td>
<td>Representational, PBC</td>
</tr>
<tr>
<td>Doonan</td>
<td>Federalism</td>
<td>Opportunistic</td>
</tr>
<tr>
<td>Gais &amp; Fossett</td>
<td>Federalism</td>
<td>Executive Federalism</td>
</tr>
<tr>
<td>Sabatier &amp; Mazmanian</td>
<td>Multivariate Model</td>
<td>Top-down and bottom-up</td>
</tr>
<tr>
<td>Bardach</td>
<td>Implementation/IGR</td>
<td>Implementation Actors, machinery, games, stakes</td>
</tr>
<tr>
<td>Goggin</td>
<td>Implementation</td>
<td>Inducements/constraints bottom and top, state</td>
</tr>
<tr>
<td></td>
<td></td>
<td>capacity, interpretation by actors</td>
</tr>
<tr>
<td>Fossett and Thompson</td>
<td>Implementation</td>
<td>Passage of law doesn’t guarantee action</td>
</tr>
<tr>
<td>Thompson</td>
<td>Health Policy</td>
<td>State political forces increasingly imp.</td>
</tr>
<tr>
<td>Ingram et. al.</td>
<td>Implementation</td>
<td>Outcomes, money can’t buy compliance, for certain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>rights less flexibility</td>
</tr>
<tr>
<td>Agranoff</td>
<td>IGR</td>
<td>Study of administrative officials, at subnational</td>
</tr>
<tr>
<td></td>
<td></td>
<td>levels, horizontal and vertical</td>
</tr>
<tr>
<td>Beer, Ripley and Franklin</td>
<td>IGR</td>
<td>PBC, Subgovernments</td>
</tr>
</tbody>
</table>

These findings are reflected upon in the sections below.

**Federalism**

As Krane argued, federalism does, in fact, appear to be a maze of reciprocal power relationships. Sometimes the power can be generated politically, from the top-down. Other times it will be dominated by the preferences of street-level and mid-level bureaucrats, generated from the bottom-up. In either case, it is likely that any given
policy implementation will evolve and change over time. Doonan’s argument that there is no particular conception of federal/state relations that can reliably serve as a mechanism for sorting federal/state responsibilities captures the essence of these dynamic and political relationships. Still that doesn’t mean that all attempts at theories at this point are futile.

First, it’s important to recognize that Radin’s conceptualization of the differences between symbolic approaches to federal or State dominance versus operational approaches to specific policy outputs probably has some resonance. To this end, identifying actual federal and state policy priorities can be separated from symbolism by tracking where the resources are put. The old adage of “follow the money” remains good advice.

As Gais and Fossett recognize, the Executive Branch does have a great deal of leeway to put resources into priority areas without negotiating with legislative colleagues. This approach to policy making can be successful, but only to the extent that federal bureaucrats reach out to State bureaucrats sympathetic to their cause. Otherwise, federal agencies lack the capacity to supersede the states. In addition, as Thompson argued, federal principals must be cognizant of state capacity and commitment as they select jurisdictions to invest in to achieve their policy preferences. Finally, this research supports the notion that Executive Federalism is at play at the state and local levels as well, so bureaucrats at each level need to be leery when they enter other jurisdictions and try to dictate policy.

It seems reasonable to summarize that those scholars who caution theorists to measure variables on a sliding scale have the right idea. Government is not pure

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269 Doonan, “Reimagining Medicaid,” 259.
administration or pure politics, but each effort can be located somewhere on that scale, given the right measures and accurate data. Likewise, policies – particularly in Medicaid – are not successful or unsuccessful, but can be both at any given time and in any given jurisdiction, depending on the criteria for measurement. To this end, Thompson’s call for more transparent federalism is appreciated. Performance-based accountability would allow for more detailed policy learning, which, in turn, could facilitate more policies being more successful in more jurisdictions at the same time. Prior to developing this type of transparency, attempts at large-scale health care reform will be risky, particularly if the expansion of Medicaid is a key component of its operationalization.

**Implementation**

As Chapter 2 illustrated, there are many approaches to the study of Implementation, and “schools” of thought. Approaches include examining policy types, systems and processes, and policy actors, to name but a few. These studies did lend some data to support certain assertions, and chip away at others.

With regard to systems and processes, Elmore argued that there were two models of implementation: the systems management model, which assumed that organizations can be readily programmed to respond to changes in policy; and the bureaucratic process model, which assumed that subunits will continue to do what they have been doing despite imposed policy changes, until some way is found to make them do otherwise. The major difference between the two models was that the first assumed that management controls were sufficient to control subordinates, while the second assumed discretion and operating routines were sufficiently well developed to inhibit top management influence.
Alternatively, the Goggin model included three clusters of variables that affect implementation: inducements and constraints from the top (federal level), inducements and constraints from the bottom (state and local levels), and state decisional outcomes and capacity. Goggin believed that the interpretation of messages by implementation actors was key to understanding outcomes, since interpretation happens within context. Consistent with Goggin, Sabatier and Mazmanian believed that policymakers were not forced to acquiesce to the preferences of street-level bureaucrats.

This research implies that the Elmore model was a good start, but did not go far enough; that Sabatier and Mazmanian were correct in their belief that policymakers have options; and that the Goggin model provided a better explanation. Sabatier and Mazmanian counseled implementation scholars to identify the legal and political mechanisms affecting the preferences and/or constraining the behavior of street-level bureaucrats, and believed that street-level bureaucrats can be kept within acceptable bounds over time if the proper conditions are met. Goggin went a step further to ensure that the inducements and the constraints from the top were also evaluated, along with an assessment of capacity. The case study found that issues related to capacity, in the form of the existing implementation machinery, was a critical factor in assessing what could and should be done. It affected federal, state and local actions with regard to establishing compliance with federal policies. Arguments regarding the resources that would be required to re-engineer implementation machinery to bring the state and local governments into federal compliance were taken seriously, and essentially ruled the day.

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until a policymaker was willing to use her authority and political capital to direct the resources at her disposal to change the machinery.

Another model that is clearly supported is the implementation actor approach supported by Heclo and Bardach, particularly Bardach’s notion of “Implementation Games.” Bardach argues that relying on the idea of examining the players’ stakes, assessing their strategies and tactics, evaluating their resources for playing, and understanding the rules of play (including notions of fair-play), can provide the best information for understanding the possible outcomes of an implementation approach. These case studies directly support this argument.

**Theory Infirming Considerations**

Table 9 highlights just a few of the hypotheses that were not supported by the findings from this study.

### Table 9: Theory Infirming

<table>
<thead>
<tr>
<th>Author</th>
<th>Area</th>
<th>Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nathan</td>
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These case studies seem to support the various scholars who have argued that theories of federalism that incorporate separate spheres of responsibilities, or even

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cooperative spheres, are no longer viable. In addition, approaches to federalism do not seem to be regime-based, fluctuating between centralization and regionalization with pendulum-like regularity. Instead, bureaucrats seem extremely conscious of fiscal federalism, and the potential that it creates for opportunistic federalism.

With regard to policy types being an important predictor of when federalism “works” as an implementation strategy, Peterson et. al. argued that the redistributive/distributive distinction is an important component of determining when a federal policy will be successful, and when a policy may be more appropriately lodged at the local level. They argue that by focusing on purpose, the classification scheme better clarifies how and why intergovernmental relations differ from one program to the next, and provide a more useful guideline for future revenue programs. However, these two case studies both represented redistributive policy, and the policy type was not useful in predicting the policy outcome. More important factors were related to the preferences of policy actors, historical patterns of dividing costs, and opportunities to cost shift.

There is some evidence that the social construction of the target populations were a consideration in this study. Schneider and Ingram have identified the tendency for elected officials to make fine distinctions by subdividing seemingly homogenous groups into deserving and undeserving. Medicaid-eligibles are one such population that policymakers can, and do, divide. This study compared decisions related to the distribution of public services to positively construed/politically weak groups (mothers with children) with one which is negatively construed/politically weak (inmates). The findings indicate that while none of the implementation actors were interested in eliminating benefits for inmates, they were sensitive to the notion that in a time of scarce
resources, providing resources to solve the issues related to inmates would necessarily delay dealing with issues related to women and children. The bureaucrats were not interested in making that decision unless and until someone with more political capital and authority on the issue directed them to. There was also a sense that prioritizing reinstatement of benefits on the day an inmate was released was somehow actually placing the inmates first in line for benefits, instead of having them “wait in line” as other applicants were forced to do. Again, these were not driving forces, but they were political conditions that were acknowledged and played a part in the overall progression of the cases.

Still however, it is important to recognize that at the end of the day there was NOT variation in the outcomes for both target populations. At the federal level, despite variation in approaches to securing benefits both populations were not successful in having states take the steps necessary to implement changes that would provide Medicaid enrollment. At the state level, both populations ultimately received benefits despite state reservations about the propriety.

**Inspiring Action**

With regard to identifying variables that explain the circumstances under which federal administrative principals seek to assure state agents comply with their preferences, these cases illustrate the importance of intervention by political and non-governmental stakeholders. Since there is no comprehensive or systematic oversight or monitoring of the Medicaid program, federal principals are propelled by their political sponsors, impelled by advocates or other stakeholders, and/or compelled by the courts to take action. This case study and the related research uncovered no instances where CMS
took independent steps to review state and/or local implementations and respond to findings of noncompliance by state agents. This doesn’t mean it never happens, just that it appears to happen inconsistently.

On the state level, in order to obtain action stakeholders had to invoke several prongs of our democratic structure to obtain positive results for citizens. In fact, they were able to expand the scope of conflict, bring in other branches of government to institute checks and balances, and capitalize on regime changes to ultimately gain public services for target populations. The fact that these avenues exist within our democratic structure is as the founders intended. The fact that it took more than a decade to obtain a victory may be longer than most citizens are willing or able to wait, particularly when the service being withheld is health care. Perhaps the recognition that success comes when the scope of conflict is expanded and includes other branches of government, may help stakeholders plan their strategies in ways that will be more effective, and more timely.

Given the critical role that stakeholders have played in this study, beneficiaries, advocates and PBC in general must vigilantly monitor administrative activities. In addition, when breaches of regulations are reported, Federal oversight agencies need more transparency, carrots and sticks to perform oversight and corrective action functions. Clearly, simple pressure from federal oversight agencies is not necessarily sufficient for ensuring States’ implement their preferences.

**Summary and Next Steps**

In closing out this chapter, and the results of the study, it seems we are left with several areas to ponder. The first is related to existing theories of federalism, implementation and IGR, and recommending a future research agenda. Given that the
findings of many studies, including this one, demonstrate the importance of incorporating each lens into a research design, political scientists may wish to consider how to more formally and systematically weave the components of the three areas together into one comprehensive research agenda. For example, it may be important to recommend that implementation studies include examination of inducements and constraints from the top (federal level), inducements and constraints from the bottom (state and local levels), state decisional outcomes and capacity, and the role of extended networks including other branches of government. The review of these variables must necessarily include the view of individual stakes and opportunities for implementation games that are part of inducements and constraints. Developing systematic research tools to this end could be a good place to start.

Along with developing the research tools, scholars should consider two specific research areas. The first would expand on the question of whether States perceive their role as agents of the federal government or as representatives of their state’s citizens to the federal government. This question has significant implications for the role played by states in cooperative programs. Secondly, scholars may wish to review IGR, and the role that bureaucrats external to the primary network play with regard to affecting the agenda in other policy streams. These bureaucrats will include, for example, criminal justice bureaucrats in Medicaid arenas, and local bureaucrats advocating at state and federal levels.

Other issues are related to the existing Medicaid program. If there is not to be a systematic and consistent monitoring and oversight component of the program, then other steps should be taken to ensure that classes of citizens who are being inappropriately
denied benefits have a centralized mechanism for lodging complaints. Those complaints should be tracked by an organization—either internal or external to CMS—that has the authority, resources and political capital to raise the issues to the appropriate state and national levels when patterns of inequality are revealed. In addition, performance measures and accountability tools, which can create a more transparent federalism, should be incorporated into Medicaid so that the policy learning that is so salient from this program can be better captured and harnessed.

From a health care reform perspective, succinctly stated, this study matters because access to health care matters, and understanding the strengths and weaknesses of the existing systems of national healthcare can help us to design a better system of national health care for the future. In these cases, the outcome of the bureaucratic actions examined mattered a great deal to the people who are supposed to benefit from this set of public policies. The lesson learned may be that Medicaid expansion is not a good choice for future health care reform, because the institutional thickening that has evolved over the last 30 years has created a system that, state-by-state, is too complex to try to re-tool for future generations and needs.


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