Multi-Site Implementation:
Medicaid Section 1931(b) in California

Jacob Alex Klerman and Amy G. Cox, RAND

Address Correspondence to: Jacob Alex Klerman, RAND, 1700 Main St., Santa Monica, CA 90407, 1-310-393-0411, x6289, Jacob_Klerman@rand.org

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Abstract
This paper uses the implementation of the new Medicaid 1931(b) program in California and its 58 counties to consider multi-site implementation. Given California’s county-operated welfare system, the California Department of Health Services (CDHS) made policy that each of the state’s 58 counties was to implement. Combining unusually rich administrative data, official documents, and qualitative field work, we find that actual implementation occurred as much as several years later than was required by state-level policy, with considerable heterogeneity across the counties, and that the heterogeneity was to a great extent due to the details of computer systems. The paper concludes with a discussion of the implications of these results for implementation and the study of implementation.

KEYWORDS: Implementation, Field-Work, Medicaid.
Many government programs attempt to implement a common program, at multiple sites, with less than complete control by the highest level organization of the overall operation and specific implementation at the individual sites. It is widely suspected that individual sites do not follow the regulations promulgated at the higher level.

Conclusively confirming that suspicion is challenging. Such implementation of regulations by individual sites is conventionally studied through qualitative field work. The high cost of such qualitative field work usually results in an analysis plan involving one (or perhaps two) visit(s) to a small number of sites (e.g., half a dozen). As a result, a researcher is often left with the sense that there is considerable heterogeneity across the sites and that the timing of implementation has varied, but that interviewees have trouble even quantifying current outcomes. Interviewees clearly have more trouble—they often refuse—dating earlier changes and quantifying outcomes at earlier stages of implementation. This difficulty in measuring current outcomes and in understanding the timing of change makes it difficult to understand the magnitude of the heterogeneity, the timing of the heterogeneity, and the effect of implementation on outcomes.

One alternative is to use official computerized program records as the source of data, when they exist. However, different sites often have different computer systems and enter data into those systems according to different protocols. This heterogeneity in data systems and how they are used implies that establishing heterogeneity in implementation is usually prohibitively expensive and often impossible.

Using particularly rich data on implementation, this paper presents a case study of the implementation of the Medicaid Section 1931(b) program in California’s 58 counties. The 1931(b) program significantly expanded eligibility for Medi-Cal (Medicaid in California) for welfare leavers. The program to be implemented in each of the counties was identical, but each county was to devise its own implementation plan. However, implementation was complicated by late release of state regulations and the required major changes to county procedures.

To describe implementation, we rely primarily on analysis of the Medi-Cal Eligibility Data System (MEDS), a common statewide, individual-level, monthly
record of Medi-Cal enrollment by Medi-Cal sub-program. Different stages and options in implementation required using different sub-programs. Thus, using these statewide data we can track county implementation for each welfare leaver in each month. We augment this rich administrative data with analysis of particularly detailed documentary evidence and two rounds of conventional qualitative field work.

Our findings confirm the fears of implementation researchers. While the 1931(b) experience was probably extreme, the magnitude of the heterogeneity was huge. In many counties, the mandated transition procedures were essentially never implemented. Similarly, the timing of the implementation of the new procedure varied by several years. Finally, with the full administrative data and the written statements of county officials, it is clear that much of the heterogeneity was driven by variation in which computer system a county used, the details of the workflow procedures adopted to work with those computer systems, and the easiest way for those systems to handle the exceptions required by the mandated transitional procedures. Furthermore, little of this variability was apparent from the qualitative field work. Rapid turnover, weak institutional memory, poor communication between the state and counties and across counties, and institutional incentives to shade the truth made county-level interviewees unable (perhaps unwilling) to describe the timing of implementation of changes or how their own county’s implementation varied from that in other counties.

The balance of this paper proceeds as follows. The next section describes our data sources. We then provide the federal and state context for our case study (implementation of the Medicaid 1931(b) program). The fourth section contains the main results—implementation at the individual sites (for this case study, California’s 58 counties). The final section discusses the implications of the case study for implementation and for the study of implementation.

DATA SOURCES

Our analysis exploits three complementary and unusually rich data sources. First, we use primary source documents. These primary sources begin with CDHS’s All County Welfare Directors’ Letters (ACWDLs), the official communications between CDHS who sets statewide policy and the county welfare departments who administer Medi-Cal. They also include the counties’
responses to CDHS’s request that counties describe and certify their implementation of Section 1931(b) (see footnote 5 for a discussion of the stimulus for these county statements). Below we refer to these responses as the “Self Certification Statements.” We thus have an official (not necessarily unbiased) written description of implementation in each county. We also examined official correspondence from the U.S. Department of Health and Human Services (DHHS) and the Health Care Financing Administration/Center for Medicare and Medicaid Services (HCFA/CMS).

Second, we interviewed county and state staff. In 2001 and again in 2002, we spent approximately a day in each of five counties: Alameda (first round only), Butte, Fresno (first round only), Los Angeles (second round only), Orange (second round only), Sacramento, and San Diego. In each of these counties, we conducted semi-structured interviews with senior county Medi-Cal eligibility staff and focus groups with supervisors and caseworkers responsible for implementing Medi-Cal policy. In the first round, we also did shorter telephone interviews with two more counties: Kern and Santa Clara. We also conducted semi-structured interviews with several staff persons at CDHS. These interviews usually lasted approximately about an hour. Senior county staff were given a protocol of likely questions prior to our visit, although not all counties distributed the protocol to their staff.

Finally, we analyzed the statewide administrative files of individual Medi-Cal enrollment. California has a single statewide, computerized system—the Medi-Cal Eligibility Data System (MEDS)—that records monthly eligibility for Medi-Cal and the sub-program that confers eligibility. This information is used by providers to verify eligibility of individuals for Medi-Cal funded for health services and is thus considered to be of high quality.

Crucially for our purposes, each stage of implementation and each option for implementation required entering a specific “aid code”; i.e., the Medi-Cal sub-program conferring eligibility. Thus, the MEDS file that we analyze has monthly, individual-level, data on each the implementation status of each welfare leaver, in each county. This detail allows us to date implementation and demonstrate wide variation across the counties in that implementation.

From the MEDS, we constructed a file of the Medi-Cal enrollment status of each welfare leavers for 36 months or until they returned to welfare. To minimize the computational burden, we analyzed a stratified random 17 percent sample of the full file. The stratification is designed to yield
approximately equal sample sizes in each county. Results are weighted to represent the entire population of welfare leavers. From this file, we present tabulations of enrollment in Medi-Cal subprograms, stratified by county, calendar month, and months since leaving welfare.

**CONTEXT**

This case study considers the implementation of the Medicaid Section 1931(b) program for California welfare recipients who are leaving welfare (i.e., "welfare leavers"). Medicaid is a joint federal-state program. The federal government defines the basic program, provides states with a series of optional sub-programs, and provides matching funds. Within the options provided by federal legislation and regulation, each state implements its own Medicaid program and provides the balance of the funds according to a matching formula. Medi-Cal is administered by county welfare department (CWD) employees pursuant to statewide policies established by the California Department of Health Services (CDHS).

Prior to the Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA) (i.e., federal welfare reform), welfare recipients were categorically eligible for and enrolled in Medicaid. In addition, specific sub-groups of non-welfare recipients were also eligible: Pregnant women and poor children (through the "Percent Programs"), and adults with very high medical expenses (in California, through the Medically Needy (MN) and "Medically Indigent" (MI) programs). Other poor adults were usually ineligible. Some welfare leavers with earnings should have been eligible for Transitional Medicaid/Transitional Medi-Cal, but—for reasons that are unclear—enrollment in those programs was never large.

As a result of such narrow eligibility criteria, most individuals leaving welfare lost health insurance (in California, two-thirds or more; see Cox, Klerman, and Aguirre-Happoldt, 2001; Cox and Klerman, 2003). This high proportion of welfare leavers losing Medicaid eligibility was a concern both in California and nationally. Some research evidence suggested that the possibility of losing Medicaid/Medi-Cal, but not gaining private health insurance, “trapped” people on welfare (Moffitt and Wolfe, 1992; Yellowitz, 1995; Blank, 1998). To address this concern, PRWORA created a new Medicaid program, known as Section 1931(b). Section 1931(b) added to previous eligibility for Medicaid a new eligibility condition: Anyone who would have
been eligible for welfare on the eve of welfare reform could qualify for Medicaid under Section 1931(b) after welfare reform. Taking advantage of discretion in the PRWORA legislation, California chose to offer Section 1931(b) to anyone who was eligible for welfare under the new, post welfare reform, broader financial eligibility rules (i.e., those with higher earned income) as well as those eligible for welfare under the old rules.

The Section 1931(b) eligibility condition combined with California’s high welfare benefits and earned-income disregards implied that almost all welfare leavers (those making less than approximately $9 per hour at 40 hours per week, for a family of three) would have remained eligible under Section 1931(b) even after they left welfare. Furthermore, almost all of those not eligible for Section 1931(b) (i.e., those making more than about $9 per hour at 40 hours per week for a family of 3) would have been eligible for the Transitional Medi-Cal program (TMC).

However, actually continuing enrollment in Medi-Cal was more complicated. Before terminating a Medi-Cal case, the California Edwards v. Kizer decision required a county welfare department to verify that the leaver was not eligible for Medi-Cal under some other (non-welfare) Medi-Cal subprogram. The Edwards process had three steps. First, most welfare leavers (about 70 percent\(^1\)) were placed into a special short-term Medi-Cal status—Edwards v. Kizer/Aid Code 38. While the leavers were in the short short-term Edwards/38 status, the leavers remained covered by Medi-Cal. Second, to assess eligibility for some other Medi-Cal program, the welfare leaver was mailed an “Edwards Packet.” The Edwards Packet contained an MC 210E form that collected the information necessary to determine continued Medi-Cal eligibility. Third, returned Edwards packets were evaluated and individuals moved out of Edwards status. Of the leavers who returned the form, those deemed eligible were continued on some other Medi-Cal subprogram. Those deemed ineligible were terminated from Medi-Cal. Finally, those who did not return the form within

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\(^1\)Exceptions included death, written request, failure to cooperate with Medi-Cal requirements, not disabled and no link (e.g., all minor children left the household or reached majority), not eligible for Medi-Cal for any other reason, entered institution (e.g., prison or a nursing home), moved out of state, and loss of contact. It should be noted that there is considerable ambiguity about how to apply these categories.
about two months of welfare exit were terminated (for failure to return the form).

California’s implementation of 1931(b) was not a simple one-time change of policy. PRWORA required states to implement the new 1931(b) program when they implemented TANF (see Table 1 for a timeline). The California Department of Health Services (CDHS) interpreted the PRWORA legislation as requiring implementation of 1931(b) with the implementation of the major CalWORKs reforms in January 1998. However, through the end of 1997, CDHS provided no written guidance to the counties. Then, literally on the day before Section 1931(b) was to be implemented (i.e., December 31, 1997), CDHS sent e-mail #97175 instructing counties “to hold discontinued CalWORKs recipients in the Edwards aid code (Aid Code 38) or another zero share of cost (SOC) aid code until Section 1931(b) instructions were finalized.”

If implemented as written, this approach would have erred on the side of protecting leavers (the potential recipients of Section 1931(b)). No one whom Section 1931(b) would cover would have been left uncovered, and some people who should not have been covered would have been covered. This also meant that Medi-Cal costs would have been higher than they would have been with on-time implementation of 1931(b).

Initially, the counties appear to have expected instructions two to four months after the effective date of the new Section 1931(b) provisions (i.e., by early spring of 1998). In fact, no additional written instructions appear to have been issued until nine months later, on September 30, 1998. On that date, over a year after the passage of the CalWORKs legislation, CDHS released

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2In California, this presumption would change in 2000 with SB 87’s mandate of an ex parte process. In most cases, SB 87 had the effect of reversing the presumption. After SB 87, welfare leavers were presumed to remain eligible for Medi-Cal under 1931(b) until their next annual redetermination. (On California SB 87 and its effects on Medi-Cal coverage, see Klerman and Cox, 2005.)

3See Klerman and Cox (2005) for a discussion of the reasons for the delay.

4Although the vast majority of Medi-Cal subprograms have no costs to the recipient, or “zero share of cost” programs, a few subprograms require recipients to contribute some out-of-pocket expenses, or “share of cost.”
an ACWDL with draft regulations for California’s 1931(b) program. That ACWDL noted that:

Because CalWORKs was effective January 1, 1998, the new Section 1931(b) provisions also went into effect on January 1, 1998. For this reason, retroactive eligibility for all AFDC-MN [Medically Needy], MI [Medically Indigent] children, federal poverty level cases with infants and children and Aid Code 38 (Edwards) or Aid Code 3C cases with or without a SOC [Share of Cost] must be evaluated back to January 1, 1998. This is important in the event eligibility for Transitional Medi-Cal needs to be established.

That ACWDL also provided guidance about how to process the cases “held” in the Edwards program in accordance with e-mail #97175 (from here onward, recipients held in a zero SOC code awaiting final eligibility determination are referred to as “held cases” or “holds”):

- “Redetermination packages for Aid Code 38 cases are to be sent immediately, but no later than December 1, 1998.
- Cases which do not return their redetermination packages are to be discontinued as provided under usual Edwards procedures; and,
- Case reviews of code 38 cases which return their redetermination packages are to be completed by April 30, 1999.”

Those draft regulations instructed counties to complete their retroactive review of all possibly affected cases within seven months of the first regulations (April 30, 1999). In this paper, we explore how this major policy change was implemented.

**IMPLEMENTATION AT INDIVIDUAL SITES**

Implementing CDHS’s instructions for 1931(b) required three steps. First, a county needed to put in place procedures to hold welfare leavers until new instructions were released. Second and third, once the regulations were released a county needed to simultaneously process the held cases (according to the new instructions) and to also process new welfare leavers (also according to the new instructions).

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5The ACWDL also instructed the counties to review all their ongoing MN, MI, and Percent Program (PP) cases for 1931(b) eligibility by December 31, 1999.
How the Counties Implemented the Initial Hold in Edwards/38

Formally, the instruction to hold cases was an extension of earlier practice. CDHS’s e-mail simply instructed counties to continue to “hold” cases after they left welfare but not to remove anyone until guidance was issued that clarified who would not be eligible under the revised program. In as much as counties followed CDHS’s instructions and held cases in Edwards/38, the fraction of leavers enrolled by Medi-Cal, and in particular enrolled in Edwards/38, should have risen quickly beginning in January 1998. Actual practice varied widely across the counties.

Some counties held leavers. Figure 1 plots Medi-Cal enrollment by subprogram in Orange County, with a focus on the “pseudo-first year” after leaving welfare. Because standard Edwards/38 enrollment covers the first few months after welfare and because we are interested only in longer, nonstandard, Edwards/38 enrollment, this pseudo-first year refers only to months 4 to 12 after welfare exit. This definition gives counties three months for “regular” processing of cases in Edwards/38. Therefore, there should be essentially no cases in Edwards/38 until April 1998; i.e., those leaving welfare in January would have been in their fourth month in April. Calendar time is shown on the horizontal axis, with the first quarter of each year labeled. The figure plots four categories of Medi-Cal coverage: Edwards/38, Section 1931(b)/3N, all other enrollment (where “other” is defined as neither Edwards/38 nor Section 1931(b)), and no Medi-Cal.

Having explained the structure of the figure, we turn to the substance. Both the qualitative and the quantitative data suggest that Orange County followed CDHS’s instructions relatively closely (at least as much as was feasible; see below). As discussed, prior to 1998, almost everyone was

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6Our choice of Orange County follows CDHS’s choice of Orange County as the first to be reviewed by CDHS’s Program Review Branch and the identification of three “best practices” during their review.

7We note two effects of this definition. First, since this definition excludes everyone within three months of leaving welfare, it will show no effect of a change affecting new welfare leavers until three months after the policy change. Second, we are plotting the average over the nine months, so changes to policies affecting leavers will not reach their full effect for 12 months after they are implemented for new leavers.
removed from Edwards/38 in under three months. Consistent with this interpretation, before 1998, Edwards/38 cases were at or below five 5 percent of the pseudo-first year population. Total Medi-Cal enrollment was stable at about 35 percent, mostly “Other Medi-Cal” (usually MN).

According to its Self-Certification Statement, Orange County began to hold nearly all leavers in January 1998. Consistent with that claim, beginning in April 1998, the fraction of cases in Edwards/38 begins to climb almost linearly. By December 1998, total Medi-Cal enrollment among people in their pseudo-first year out of welfare reached nearly 80 percent, about 45 percentage points above the 1997 levels.

Orange County represents one extreme. Figure 2 presents the equivalent figure for Kern County, demonstrating the other extreme. As in Orange County, in 1997 (i.e., before the instruction to hold leavers), pseudo-first year Medi-Cal enrollment was 35 to 40 percent, and Edwards/38 enrollment was well under 5 percent. However, in stark contrast to the pattern in Orange County, there is absolutely no evidence of an increase in Edwards/38 enrollment in 1998. Furthermore, even summing across all Medi-Cal subprograms available, there is no evidence of any increase in total enrollment in 1998, indicating that new leavers were not being held in some other Medi-Cal sub-program. These data are consistent with Kern County’s Self-Certification Statement:

All eligibility staff . . . began [Section 1931(b)] implementation on all new Medi-Cal applications and on recipients discontinued from CalWORKs on April 1, 1999. They also screened their ongoing cases back to January 1998 for 1931(b) at renewal and when a case went from no-share-of-cost to a share-of-cost. [italics added]

We infer from the quote that despite CDHS’s instructions, Kern County did not hold welfare leavers during the first 15 months of California’s new 1931(b) provisions. This was also what we heard in our phone interviews.

This pair of figures raises two questions. First, how do California’s other 56 counties fall between these two extremes? And, second, what explains the stark divergence between these two counties?

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8 Enrollment was not 100 percent because some people moved out of state, aged out of the program (i.e., reached age 18), or died.
Figure 3 answers the first question and suggests a partial answer to the second question. It plots the change in enrollment in Edwards/38 and in other Medi-Cal programs among pseudo-first year leavers between December 1997 (immediately before the hold was to have started) and December 1998 (when Edwards/38 enrollment in Orange County peaked). The counties are ordered by their change in total coverage. The figure provides some additional information in the county label. For the larger counties, the label gives the county’s share of the total state welfare caseload as of January 2000. Counties with no percentage listed represent less than 1 percent of the state’s caseload. In addition, for each county, the label gives the computer system used by the county. During this period, almost all of California’s counties (53 of 58) used one of two computer systems: the Case Data System\(^9\) (CDS) (17 counties) and the Interim State Automated Welfare System\(^10\) (ISAWS) (36 counties).\(^11\) The remaining five counties used unique systems.

[INSERT FIGURE 3 HERE]

Figure 3 shows that ten counties show a pattern similar to Orange County, with increases in Edwards/38 rates among leavers in their pseudo-first year off of welfare in excess of 45 percentage points. Another four counties had increases in Edwards/38 rates in excess of 25 percent for the same group, and two more counties had increases in Edwards/38 rates between 5 and 15

\(^9\)The CDS system has its roots in a joint project of Santa Clara County and San Mateo County initiated in 1968. More (mostly larger) counties joined the consortium in the 1970s and 1980s. Because the system is thus more than 30 years old, it “require[es] more maintenance” ([http://www.eds.com/govt/gv_clients_ca_welfare.shtml](http://www.eds.com/govt/gv_clients_ca_welfare.shtml)). The follow-on system, CalWIN, is now well into development, with roll-out currently projected for 2004-2005.

\(^10\)The ISAWS system is a decade and a half younger than CDS. It has its origins in the NAPAS pilot system project begun in 1985 for Napa County and selected for broader implementation in 1989. Roll-out to 14 counties began in 1994. There were, however, serious technical concerns about the underlying Unisys MAPPER operating system; as a result, during the mid-1990s, the system was totally rewritten.

percentage points. In most of these counties, the change in Edwards/38 is larger than the total change in coverage, suggesting that some leavers who previously would have been transferred to another sub-program were instead held in Edwards/38.

The remaining 42 counties can be divided into two groups. In about half the counties (27 of 58), as in Kern County, there is no evidence of any hold (total increase in Medi-Cal enrollment of five percentage points or less). The remaining 15 counties appear to have had a moderate (more than five percentage points) increase in total Medi-Cal enrollment, though in some Medi-Cal sub-program(s) other than Edwards/38 (the “another zero share of cost aid code” phrase in the original CDHS instructions). In many of these counties, Edwards/38 coverage actually declined. For three very small counties (Mono, Alpine, and Modoc), these increases in total Medi-Cal enrollment are greater than 25 percentage points; for four other counties (San Benito, Amador, Imperial, Sierra), the increase is between 15 and 25 percentage points. For the remaining eight counties, the increase in total enrollment is between 6 and 15 percentage points. This is some hold, but much, much smaller than the increases of 25, 35, or even 45 percent in other counties.

These wide differences in the increases in Medi-Cal enrollment appear to result from differences in who was held. The counties with large fractions held appear to have continued their pre-1998 policy about who they put into Edwards/38, holding essentially everyone who was not known to be dead, to have left the state, or to have no eligible child. But unlike the pre-1998 policy, once held, no cases were removed.

In contrast, those counties that had moderate increases in enrollment (often not in Edwards/38) appear to have followed a different strategy. Eligibility for 1931(b) would require income below a statutory cutoff. It might therefore be reasonable to hold “all cases terminated due to excess income.” (The quote is from El Dorado County’s Self-Certification Statement.)

However, most families leave welfare passively; they simply fail to file their monthly status report (see Klerman and Cox, 2005). Thus, the CWD lacked information to determine who was truly “terminated due to excess income.”

Our second question asked: What explained the heterogeneity across the counties? The county’s computer system (noted in parentheses next to the county name in Figure 3) appears to be crucial. Inspection of Figure 3 shows that most of the high Edwards/38 enrollment counties are CDS counties, while
almost all the low Edwards/38 enrollment counties are ISAWS counties. A non-parametric run test decisively (p < 0.001) rejects the hypothesis that these differences occur by chance alone.

This relationship is consistent with the counties’ Self-Certification Statements and the nature of the computer systems. Both computer systems (CDS and ISAWS) automated the transfer of welfare leavers into Edwards/38. Thereafter, however, the two systems differed. CDS required the caseworker to check manually which leavers have not returned an MC 210E form and then to terminate Medi-Cal for those cases manually. The situation in ISAWS is quite different.

ISAWS is a more “modern” computer system in that it automates more regular processes; in the language of computer systems, it “incorporates more business rules.” Specifically, ISAWS maintains a list of people who should have returned an MC 210E form. If a caseworker does not indicate that an MC 210E form has been returned within two months, ISAWS automatically terminates Medi-Cal. As Humboldt County stated in its Self-Certification Statement:

In a[n] ISAWS county, Edwards Medi-Cal is automatically issued for the month after CalWORKs discontinuance in all circumstances except death, loss of residence, and no child in the home. The Medi-Cal redetermination process includes ISAWS issuing a SAWS 7 (status report) for the month of CalWORKs discontinuance. If the report is returned, benefits are redetermined based upon existing Medi-Cal programs as known to ISAWS. If not, the case is discontinued.

Furthermore, overriding this feature is difficult. We again quote Humboldt County’s Self-Certification Statement:

A SAWS county can continue Edwards beyond the second month by adding eligibility with a direct MEDS on line entry. The case remains active on MEDS but is outside of the SAWS sphere and has to be controlled manually. The SAWS conversion plan had called for the elimination of county data processing systems and allocations for

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12Only six of the 18 counties holding more than 10 percent of their cases are not CDS counties: Three of them are using “other” computer systems (Riverside County—MBS, Los Angeles County—LEADER, Ventura County—WICAR); only three of them are ISAWS counties: Plumas County, Calaveras County, and Sutter County.

Conversely, all but eight of the 40 counties holding less than 10 percent are ISAWS counties: Three of them are using “other” computer systems (Stanislaus County—C-IV, San Bernardino—Legacy, Merced County—MAGIC); only five of them are CDS counties: Santa Cruz County, San Mateo County, Solano County, San Luis Obispo County, and Santa Barbara County.
support staff were redirected for SAWS case maintenance. The county no longer maintained sufficient support staff to do large quantities of manual changes. It was fully Humboldt County’s expectation that 1931 B would be implemented into the SAWS automated system within a reasonable period.

Thus, counties mostly did what was the default in their computer system. For CDS counties, the default was simply to instruct caseworkers not to process returned MC 210E forms. For ISAWS counties, the default was simply to allow ISAWS to terminate the Medi-Cal of those who did not return the forms. Any other strategy would have required either considerably more staff resources or major changes in computer systems. Given the high priority demands for staff and computing system revisions induced by ongoing welfare reform, neither increased staff nor computer modifications were readily available.

Note, however, that the county’s computer system was not completely determinative. While most CDS counties had large (25 percent or more) increases in total enrollment, six (of 17; San Luis Obispo, Santa Barbara, Santa Cruz, Yolo, Solano, San Mateo) did not. Conversely, while most ISAWS counties had increases of well under 15 percent of their leavers, seven (of 36) had increases in total enrollment above that level, almost always in some sub-program other than Edwards/38 (Sierra, Imperial, Amador, San Benito, Modoc, Alpine, Mono; note however that several of these are among the smallest counties, such that much of the variation is pure noise).

How the Counties Processed the Held Cases

For the counties with substantial numbers of held cases, the release of CDHS’s first Section 1931(b) guidance on September 30, 1998, began the second part of the 1931(b) implementation process. County staff needed to send held cases new redetermination packets and MC 210E/MC 210 RV forms, returned packets needed to be reviewed, and ineligible cases and unreturned packets needed to be terminated. However, rather than doing this on a flow basis, counties now had a block of almost a year’s worth of redeterminations, and CDHS’s instruction required they be completed in seven months, by April 30, 1999.

While seven months may have seemed like a long time to CDHS, consideration of the timeline for such a major policy change implied that this goal was nearly unachievable. Before they could begin to process the backlog,
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county senior staff needed to be trained in the new Section 1931(b) program. CDHS’s training for senior county staff occurred in November and December 1998, consuming two to three of the seven available months. After receiving the training, senior county staff needed to develop county-specific procedures and training materials and then train county line workers. At best, this consumed another month. Thus, counties in general had about three months to handle (what was now) 15 months of welfare leavers.

Furthermore, counties processing the backlog had to concurrently process new cohorts of welfare leavers, at a time when rates of welfare exit were swelled by a strong economy and welfare reform. For both the backlog and the new cohorts of leavers, processing was substantially more time-consuming than it had been before welfare reform. The new regulations added additional procedures to the process of establishing eligibility for continuing Medi-Cal, and, more importantly, the computer systems were not equipped to incorporate these new procedures. This meant that more of the eligibility determination (e.g., budget calculations) now had to be done by hand and then entered into the computer. Moreover, this processing had to be done by an eligibility staff that had often been denuded by promotions of eligibility workers to the newly created and better-paying welfare-to-work positions and by exits of eligibility workers to available and better-paying positions in the booming private sector.

Again, Orange County represents a best case in terms of timelines (as shown in Figure 1 above). In Orange County, packets were mailed out shortly after CDHS issued its instructions. This was before CDHS training for senior staff and certainly before training of county line staff. Individuals who did not return the packet were promptly terminated (thus, the sharp—25 percentage point—drop shown in the figure for Edwards/38 in January 1999). Late packets and reapplications were reinstated into Edwards/38 (thus, the small—about 3 percentage point—increase in February 1999 shown in the figure). Returned packets were reviewed steadily, so that the county reported no backlog as of December 1999. Note that while this appears to be about as fast as was possible, it was still eight months past CDHS’s April 1999 deadline. During the interim, the county fell a little behind in processing its more recent welfare leavers, as shown in the figure. (Edwards/38 levels remained above 10 percent until February 2000.) Finally, note that after processing the held cases, total Medi-Cal enrollment was about 15 percentage points higher than it
had been pre-1998. More people qualified for Medi-Cal under the new broader Section 1931(b) eligibility rules. However, this increase is much less than the short-term 40 percent increase in enrollment during the hold period.

Such prompt processing of the held cases was unusual. Beyond Orange County, only four other counties with sizable holds—Placer County, Sonoma County, Santa Clara County, and Tulare County—had less than 20 percent of their pseudo-first year leavers in Edwards/38 by December 1999. To have brought down the Edwards hold that fast, a county needed to have mailed out MC 210E forms shortly after CDHS issued guidance, promptly acquired and trained sufficient staff to process the returned MC 210Es, and not made extraordinary attempts to contact those who did not return their MC 210Es.

The pattern in San Diego County (see Figure 4) was more typical. As in Orange County, Edwards/38 enrollment and total enrollment rose sharply through 1998. However, intensive work did not begin on processing the held cases until mid-1999. Thus, many families remained in Edwards/38 into their second year off of welfare (as shown in Figure 5). In addition, new leavers were also placed into Edwards/38, maintaining the fraction of pseudo-first year leavers in Edwards/38 steady at about 60 percent.

Starting in late 1999 and continuing through early 2000, the number of San Diego’s pseudo-first year leavers in Edwards/38 drops sharply. Some of these cases were transferred to the new Section 1931(b) program, and many were terminated. Nevertheless, a sizeable backlog remained (15 percent) well into 2001, and some backlog (about 10 percent) remains through the end of our data (2002). Finally, as in Orange County, total enrollment of welfare leavers is about 20 percentage points higher after the hold was processed than it had been pre-1998.

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13Nominally, Los Angeles County and Contra Costa County also meet this definition. However, their Self-Certification Statements (and examination of their rates in our tabulations) suggest that they did not actually process the returned MC 210Es. Instead, they simply shifted their held cases into 1931(b).
Multi-Site Implementation

San Diego County’s Self-Certification Statement helps to explain the longer time to process the held cases:

- “Extensive outreach was performed on these persons in cooperation with managed care plans in San Diego County.
- The agency had a shortage of experienced Medi-Cal staff to process these cases.
- Delay in complete 1931(b) implementation instructions from the Department of Health Services delayed implementation of backlog processing.”

Similar lists of issues were mentioned by many counties in their Self-Certification Statements and in our qualitative field work. Several counties noted a need to hire new staff or to authorize considerable overtime. Several counties waited until mid-1999, when the regulations were more stable or until the counties were able to hire new staff to train their staff to handle Section 1931(b) until mid-1999 (e.g., Riverside County and Sacramento County trained their staff in July and June 1999, respectively). Many counties—Contra Costa County, Fresno County, Los Angeles County—mention very low return rates for MC 210E forms, leading to extraordinary efforts to contact non-responding families: multiple mailings, phone calls, home visits, and referrals to contractors for additional attempts to contact. These efforts were consistent with earlier instructions from the federal HCFA.

What Was the Timing of Implementation of 1931(b)?

Despite the statewide regulations, Section 1931(b) was implemented in the counties at different times, as discussed above. Figure 6 summarizes the timing of implementation of the new Section 1931(b) program. Along the vertical axis, we plot the percentage of the caseloads in Edwards Hold in December 1998. The plotting symbols indicate the computer system used by the county. CDS counties have higher hold rates; ISAWS counties have lower hold rates.

\[\text{In addition, some of the counties had special considerations. For example, in Alameda County, processing the held cases was delayed in part by labor relations considerations during the hiring of new staff to process the backlog. Eligibility workers there were unionized and able to limit the size of their caseloads, whereas other counties dealt with staff shortages by increasing the number of cases per worker.}\]
Along the horizontal axis, we define implementation conservatively as the month in which at least 20 percent of pseudo-first year leavers are in Section 1931(b). As expected, while the figures suggest considerable heterogeneity, long implementation delays seem to have been the norm. A few (ten) counties reach the threshold in 1999, most (twenty-nine) counties reach the threshold in 2000, many (seventeen) do not reach the threshold until 2001, and two do not reach the threshold until 2002. This timing is much later than CDHS’s regulations which called for implementation of the new provision for the backlog (for those being held) by April 1999 and earlier for new welfare leavers. As a result of the long implementation delays, many leavers who should have been covered by the new Section 1931(b) provisions were not covered.

While computer systems did make a difference on whether cases were held, the effect of computer systems on implementation is more complicated. Most of the CDS counties implemented in mid-2000. Some of the ISAWS counties implemented in late-1999. However, many of the ISAWS counties delayed implementation until about July 2001. As Kings County explained in its Self-Certification Statement (June 14, 2001):

"Originally the SAWS counties decided to stick together with the statement “If it was not in SAWS we are not going to do it.”"

The quotation refers to the fact that the new Section 1931(b) procedures had not been integrated into the ISAWS computer system, so that any implementation of 1931(b) would need to be done manually. CDHS notified the ISAWS counties that waiting for the procedures to become automated was not an acceptable position, but even the approaches developed to implement Section 1931(b) with ISAWS were resource-intensive. We again quote Kings County’s Self-Certification Statement:

"The Excel spreadsheet that we are using is faster than manual budgets, but we still have to override SAWS and do a new spreadsheet each time a change occurs. The manual overrides have to be Supervisor authorized as well."

Note that the Excel spreadsheet referenced here was created by entrepreneurial caseworkers looking for a way to automate some of the regulations, not by CDHS.
or anyone associated with updating the computer system. As Humboldt County's comments (quoted above) indicated, the ISAWS counties had cut staffing levels on the assumption that ISAWS would truly automate processes and thus lower required staffing levels. CDHS’s instructions pushed these counties back into considerable manual processing. Additional staff were needed and hiring them took considerable time where doing so was even possible (e.g., Kings County required seven additional positions—see its Self-Certification Statement; some counties were operating under hiring freezes).

**DISCUSSION**

We organize our discussion of the implications of this case study into three parts. We begin with a brief discussion of the effect of this slow and uneven implementation on Medi-Cal enrollment. We then consider the implications of this analysis for implementation in a multi-site, loosely coupled, bureaucracy. Finally, we discuss the implication of this analysis for studying implementation in general.

**Effects on Enrollment**

From a narrow programmatic level, this is a case study of slow program implementation. A program that should have been implemented in January 1998 was not, in fact, implemented until mid-1999 in the earliest of the counties and late-2002 in the latest of the counties.

In the short term, some families that should have been enrolled in Medi-Cal (while they were being “held”) were not enrolled and many that were enrolled were unaware of the coverage available during this hold. Our analysis of MEDS data provides no direct evidence on the effects of a decision not to hold welfare leavers; however, two effects seem likely. First, it is well established that health care is price-sensitive (e.g., Manning et al., 1987). Thus, it seems likely that compared to what would have happened if the family had been enrolled in Medi-Cal, less health care was received among those dropped from Medi-Cal, leading to poorer health status. Second, even in the absence of Medi-Cal, some welfare recipients had to get some health care and that health care had to be funded somehow: sometimes by the family out-of-pocket, sometimes by medical professionals as uncompensated or charity care, and sometimes by county government through expenditures on public clinics and public hospitals.
In the longer term, as Cox, Klerman, & Aguirre-Happoldt (2001) and Cox and Klerman (2003) discuss in detail, the effects may have been minimal. Medi-Cal enrollment among welfare leavers rose nearly continuously from January 1998, apparently first because of the hold and then because of the broader eligibility rules under Section 1931(b) and further coverage expansions under California SB 87 (Cox, Klerman, & Aguirre-Happoldt, 2001, and Cox and Klerman, 2003).

**Implications for Implementing Changes Under Devolution**

For the broader questions of implementation in a multi-site bureaucracy, the results of this case study are troubling. First, we have the standard result that legislation and regulations are only the first steps toward implementing a new policy. To induce change fully for the population of interest, the statutes and regulations need to be implemented in procedures for line workers (Lipsky, 1983; Mazmanian and Sabatier, 1983; and Meyers et al., 1998). That process takes time—evidently a lot more time than the authors of legislation or the authors of regulations would like to believe.

Furthermore, while computers have almost certainly improved caseworker efficiency, they make things much worse during the implementation phase of program changes. Between writing regulations and training staff, computerization introduces another step—modifying the computer system. For non-trivial changes (e.g., new programs) that step takes (many) months.

The time required to update computer systems makes careful consideration of the regulation writing process crucial. Writing regulations requires accuracy on all program details and covering all possible cases. However, updating the computer system enough to handle the common cases requires knowing only the basic structure of the program. The sooner preliminary guidance with the basic structure of the program can be released, the sooner the computer programmers can begin their task of designing, writing, and testing the required modifications.

Furthermore, the strong divergence in outcomes by computer system revealed by this analysis emphasizes just how important the seemingly minor details of computer systems have become for the ultimate eligibility decisions. If staffing levels have been reduced to capture the efficiency gains from computerization, there will often not be enough staff for “work arounds” and manual processing until the computer systems are being updated.
Computerization lowers the level of skill required to do eligibility tasks, and, as a result, some skills (e.g., computing manual budgets, carefully following eligibility flow charts) will atrophy. As a first approximation, it may be useful to argue that a new program is not truly implemented until it is fully integrated into the computer system.

These are basic insights for implementation in any environment with senior staff writing regulations and designing new procedures and line staff implementing the new procedures. As we noted at the beginning of this paper, Section 1931(b) implementation in California occurred at two levels. First, the state developed regulations. Then, each of the California’s 58 counties developed procedures based on its existing local processes, staffing patterns, and computer systems.

Our discussions with senior state officials and with the people they worked with at the county level suggested that the two-level structure left state bureaucrats writing regulations with less than complete understanding of what would be involved in trying to implement them on the line (e.g., the value of preliminary guidance, reasonable time lines, effective oversight strategies). There were actions that might have been taken if CHDS staff had better understood the actual implementation challenge, but were in practice not taken.

- For welfare leavers, CHDS could have drafted an addition to the MC 210E packet notifying welfare leavers of the imminent major expansion of eligibility for Medi-Cal and strongly encouraging them to return the MC 210E form, even if they believe that they would be ineligible under the current regulations. As far as we can tell, CDHS drafted no such materials; neither did any individual county.
- For CWDs, CDHS could have followed CDSS’s pattern and provided some written preliminary guidance, presumably based on CDSS’s preliminary guidance. That preliminary guidance might have covered the most common cases. It would have been enough for CWDs to begin developing procedures and training staff. Then as modifications to regulations were released, CDHS could have developed and distributed consolidated regulations.
• For computer consortia, CDHS could have strongly encouraged early work on implementing the required computer changes. Again, some preliminary written guidance would have been enough to allow work to begin and to make operational more quickly a computer system for the most common cases.

If CDHS staff had been more closely connected to line staff, perhaps by being in the same organization, CDHS staff might have had a better sense of the implications of their actions for implementation and, therefore, might have taken some of these actions.

The two-level structure also had negative implications at the county level. Given that each county already had its own procedures and staffing plans, each county had to develop its own implementation plan. The larger counties had the capacity to do so; for the smaller counties, this was a major challenge. Similarly, the use of multiple computer systems increased the complexity of integrating policy development with implementation.

More important, the loose relation between the two levels became a major impediment to implementation. First, there appears to be little mechanism for county feedback to the state. Counties reported that questions about the regulations went unanswered or were incorrectly answered because there was not sufficient staff at the state level to provide technical guidance. Second, CDHS could and did issue instructions requiring implementation by a given deadline. However, CDHS does not appear to have had an effective mechanism for monitoring compliance with its instructions. CDHS manages the MEDS system we have analyzed here, but there is no evidence that they attempted to use that data system to track compliance with their instructions. As important, it is not clear what penalties CDHS had available, even if they had tracked compliance. It appears that, in statute, CWDs are required to follow CDHS instructions; in practice, no one we talked to mentioned any consequences for failure to do so.

For these purposes, the Food Stamp Quality Control system provides both a useful model and grounds for modesty. The Food Stamp Program is a joint federal-state program. The federal government provides nearly all of the funds; the states determine eligibility. This arrangement gives states an incentive to err on the side of granting benefits. To counteract this incentive, the federal government does a regular audit of Food Stamp eligibility decisions, with the threat of (potentially large) penalties for
"high" error rates. This threat clearly induces reaction on the part of local welfare agencies; high error rates cause retraining, informational campaigns, and intensified local audits to identify problematic individuals and procedures. Nevertheless, actually imposing the penalties has proved very difficult (see Klerman and Cox, 2005). Similarly for Medi-Cal, if the state truly wants the counties to implement the program as designed, more resources probably need to be devoted to state oversight of county implementation and the state needs to have mechanisms through which to induce compliance (e.g., financial penalties). The budget problems of the early-2000s (well after the period covered by this report) have led to some moves in this direction.

**Implications for Studying Implementation**

Beyond the substance, this case study has some broader methodological implications. This analysis demonstrates the benefit of combining results from multiple data collection methods. Qualitative fieldwork yields rich information about causes of outcomes, and without it, our interpretation of the quantitative results would have been thin, if not simply wrong. The story that emerges from the tabulations alone is incomplete.

In this analysis, we also found that key informants’ and line workers’ comments during qualitative fieldwork varied radically from the information contained in the official administrative data (i.e., the MEDS). It appears that staff’s understanding of current practice was (at best) incomplete; their ability to characterize and date changes over time was strikingly weak; and they had an incentive to hide or shade the truth when it diverges from the guidance received from above.

Administrative data can be an important complement to such qualitative fieldwork, yielding a richer picture of implementation. For studying the implementation of Section 1931(b), the administrative data were particularly useful, since the data provide consistent (across time and county) data on every welfare leaver and his/her Medi-Cal take-up. Furthermore, the detailed coding of Medi-Cal sub-programs allows us to track first the hold and then the moving of cases into Section 1931(b). For some counties, the qualitative data (in particular, the county Self Certification Statements to CDHS) and the quantitative tabulations suggest two very different histories of implementation. This divergence serves as a warning about relying on
individuals’ reports in the absence of corroborating (or contradicting) administrative data.
### Table 1
Chronology of State Welfare and Medi-Cal Reforms Related to the Medicaid/Medi-Cal Section 1931(b) Program, by Calendar Quarter

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996Q3</td>
<td>8/22/1996</td>
<td>Federal welfare reform legislation (PRWORA) signed, which included the new Medicaid section 1931(b) program.</td>
</tr>
<tr>
<td>1996Q4</td>
<td>11/26/1996</td>
<td>Federal government approves California’s TANF Plan</td>
</tr>
<tr>
<td>1997Q3</td>
<td>8/11/1997</td>
<td>California welfare reform legislation (CalWORKs) signed; allowed recipients to keep more of their earnings, expanded welfare-to-work (WTW) programs, created Medi-Cal 1931(b) program.</td>
</tr>
<tr>
<td>1997Q4</td>
<td>12/31/1997</td>
<td>CDHS E-mail #97175 instructs counties to hold all potential 1931(b) cases, including welfare leavers, pending further instructions.</td>
</tr>
<tr>
<td>1998Q1</td>
<td>1/1/1998</td>
<td>CalWORKs program begins.</td>
</tr>
<tr>
<td>1998Q4</td>
<td>11-12/1998</td>
<td>CDHS training for counties on 1931(b) regulations.</td>
</tr>
<tr>
<td></td>
<td>12/1/1998</td>
<td>CDHS ACWDL 98-43’s deadline for counties to mail Medi-Cal redetermination packets to all “held” cases.</td>
</tr>
<tr>
<td>1999Q2</td>
<td>4/16/1999</td>
<td>CDHS ACWDL 99-18 advises counties that “deadlines specified in ACWDL 98-43 would not be modified.”</td>
</tr>
<tr>
<td></td>
<td>4/30/1999</td>
<td>CDHS ACWDL 98-43’s deadline for review of all returned redetermination packets for “held” cases.</td>
</tr>
<tr>
<td>1999Q4</td>
<td>12/31/1999</td>
<td>CDHS ACWDL 98-43’s deadline for review of non-held 1931(b) related cases.</td>
</tr>
<tr>
<td>2000Q2</td>
<td>4/7/2000</td>
<td>US DHHS HCFA All State Medicaid Directors letter “required States to review their policies and standards surrounding implementation of 1931(b)”.</td>
</tr>
<tr>
<td>2000Q3</td>
<td>9/30/2000</td>
<td>SB 87 (Escutia), streamlining enrollment in Medi-Cal for welfare leavers, enacted.</td>
</tr>
<tr>
<td>2001Q2</td>
<td>4/23/2001</td>
<td>CDHS ACWDL 01-29 instructs counties to self-certify 1931(b) implementation.</td>
</tr>
<tr>
<td></td>
<td>5/1/2001</td>
<td>County self-certifications of 1931(b) implementation due to CDHS.</td>
</tr>
<tr>
<td>2001Q3</td>
<td>7/1/2001</td>
<td>SB 87 provisions (e.g., ex parte, revised NOAs) to be implemented.</td>
</tr>
</tbody>
</table>
Figure 1—Welfare Leavers’ Medi-Cal Enrollment by Subprogram in Orange County, Pseudo-First Year (Months 4-12)

Figure 2—Welfare Leavers’ Medi-Cal Enrollment by Subprogram in Kern County, Pseudo-First Year (Months 4-12)
Figure 3—Change in pseudo-first year After Leaving Welfare (Months 4-12)
Edwards/38 and Total Medi-Cal Enrollment, by County, December 1997 to December 1998
Figure 4—Welfare Leavers’ Medi-Cal Enrollment by Subprogram in San Diego County, Pseudo-First Year (Months 4-12)

Figure 5—Welfare Leavers’ Medi-Cal Enrollment by Subprogram in San Diego County, Second Year (Months 13-24)
Figure 6—Timing of 1931(b) Implementation, by Size of Edwards/38 and Computer System

NOTE: “Implementation” is defined as more than 20 percent of pseudo-first year leavers in 1931(b).
BIBLIOGRAPHY


