Journal of Aging & Social Policy

ISSN: 0895-9420 (Print) 1545-0821 (Online) Journal homepage: www.tandfonline.com/journals/wasp20

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A Case Study in Compensatory Federalism

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To cite this article: Sanjay K.PandeyPhD (2002) Assessing State Efforts to Meet Baby Boomers' Long-Term Care Needs, Journal of Aging & Social Policy, 14:3-4, 161-179, DOI: 10.1300/J031v14n03_09

To link to this article: https://doi.org/10.1300/J031v14n03_09

Published online: 22 Sep 2008.

Assessing State Efforts to Meet Baby Boomers' Long-Term Care Needs: A Case Study in Compensatory Federalism

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SUMMARY. The role of the state government and the character of federal-state relations in social policy have evolved considerably. Frank Thompson uses the phrase *compensatory federalism* to describe increased activity by state governments to make up for a diminished federal role. For compensatory federalism to work, it is essential for states to take leadership roles in key policy areas. Few studies examine whether states have risen to the challenge of compensatory federalism in social policy. This paper examines an emerging issue of great significance in social policy–challenges involved in meeting future long-term care needs for the baby boomer generation. The paper provides an in-depth case study of attempts by Maryland to meet the challenges of financing long-term care needs for the baby boomer generation. The detailed description of the agenda-setting and problem-structuring process in Maryland is followed by an analysis that uses three different frameworks to assess the policy development processes. These models are rooted in a bureaucratic politics perspective, an agenda-setting perspective and an interest group politics perspective. The paper concludes with a discussion of the limitations and possibilities of state leadership in the social policy sphere.

[Haworth co-indexing entry note]: "Assessing State Efforts to Meet Baby Boomers' Long-Term Care Needs: A Case Study in Compensatory Federalism." Pandey, Sanjay K. Co-published simultaneously in *Journal of Aging & Social Policy* (The Haworth Press, Inc.) Vol. 14, No. 3/4, 2002, pp. 161-179; and: *Devolution and Aging Policy* (ed: Francis G. Caro, and Robert Morris) The Haworth Press, Inc., 2002, pp. 161-179. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: getinfo@haworthpressinc.com].

10.1300/J031v14n03_09

KEYWORDS. Devolution, federalism, Medicaid, state health policy, long-term care, baby boomers

INTRODUCTION

The last two decades of the twentieth century witnessed significant shifts in the relative roles of federal and state governments in the social policy arena. The federal government's dominant role in health and social policy was eroded by sustained federal budget deficits through much of this period. Worsening fiscal crises–combined with the maze of inter-governmental rules and regulations frustrating programmatic innovation at lower levels of government–prompted calls for reforms to put state governments in the driver seat. In the aftermath of the failure of the Clinton health reform efforts in 1994, the federal government ceded much control over health policy initiatives to state governments (Thompson, 2001). While there is some debate on whether these changes putting states at the helm are permanent, there is little disagreement regarding the enhanced role of the states (Alt & Marzotto, 1999; Leichter, 1996; Nathan, 1993; Rich & White, 1996).[1]

Assessments of state governments' capacity to assume a leadership role in addressing vexing social policy issues, however, evoke both optimism and skepticism (Bloksberg, 1989; Leichter, 1996; Morris, Caro, & Hansan, 1998). Leichter (1996), for instance, rates state governments highly for their willingness and accomplishments in addressing knotty health policy issues. Evidence of significant accomplishments by state-level policymakers is provided by other scholars as well (e.g., Oliver & Paul-Shaheen, 1997). Yet others take issue with the hopeful and purposeful images conjured up by Justice Brandeis's phrase describing states as "laboratories of democracy" and underscore the inevitability and indispensability of federal leadership in social policy (Sparer & Brown, 1996; Thompson, 2001).

This paper examines whether state governments can make up for the lack of federal leadership on a social policy issue. To borrow a phrase from Thompson (1998), the question may be framed as follows: What are the prospects for *compensatory federalism*? The compensatory federalism thesis suggests that when government institutions at one level fail to address an important policy issue, corresponding institutions at another level rise up to the challenge and provide the necessary leadership and guidance (Thompson, 1998). We assess compensatory federalism by examining how state-level policy processes are addressing

future long-term care needs of baby boomers.[2] Although the public-at-large pays little attention to long-term care, the oncoming "demographic tidal wave" of baby boomer retirees is likely to increase greatly the demand for long-term care services and transform this issue into an important public policy concern.

In studying the performance of compensatory federalism, we use a case-study approach focusing on state-level policy development. While a case-study approach has its limitations, especially with respect to generalizability of findings, it is appropriate, given the purposes of this study. Studying state-level processes requires generating in-depth, extensive, and contextual knowledge about unique events; purposes that are best served by a case study research design (Yin, 1994). Thus, this paper assesses the potential of compensatory federalism by describing and examining the processes by which the state of Maryland pursued and developed its *Outreach Empowerment Campaign*, an effort directed at exploring and meeting future long-term care needs. To construct the case history, we draw upon extensive publicly disseminated documentation on the Outreach Empowerment Campaign.[3] No key informant interviews were necessary because the author has conducted policy analytic work focusing on state health policy issues in Maryland for several years. This firsthand experience with Maryland health policy issues provides the supplemental knowledge base necessary for creating the case history.

While detailed and accurate description is essential, it is even more important to provide plausible models to explain the unfolding of events in a case study. Not only are these models helpful in understanding the dynamics of compensatory federalism in this case, but they also may provide guidelines for understanding workings of similar processes in less familiar settings. We propose three models to explain the outcomes of the Maryland policy development processes; these models are rooted in a bureaucratic politics perspective, an agenda-setting perspective, and an interest group politics perspective. The remainder of the paper is organized in the following manner. First, we provide a description of the overall context of health care reforms in Maryland. Next, an in-depth description of the Maryland Outreach Empowerment Campaign is provided. This description is followed by a summary overall assessment of the Campaign. The progression of events in the Outreach Empowerment Campaign is explained using the three perspectives identified earlier. The paper concludes with some thoughts on the potential of compensatory federalism and state leadership.

MARYLAND HEALTH REFORMS IN THE 1990s: FISCAL CRISES ENGENDER PROGRAMMATIC INNOVATIONS

The pace and scope of health reforms in Maryland increased sharply in the wake of the failure of Clinton health reform efforts in 1994 (Oliver, 1998; Oliver & Oliver, 1998). Providing for future long-term care needs of baby boomers emerged as a subsidiary theme in the comprehensive reforms proposed by Maryland's Department of Health and Mental Hygiene. Policy development to meet baby boomers' long-term care needs required attention to several issues such as defining the nature of the looming fiscal crisis, obtaining public input, and raising public awareness. These activities were carried out under the rubric of a project titled "The Outreach Empowerment Campaign." This project received institutional leadership from the Department of Health and Mental Hygiene (DHMH). Much of the technical and operational assistance to DHMH was provided by the Center for Health Program Development and Management (CHPDM), based at the University of Maryland, Baltimore County.

Since the Campaign was a small part of a much larger reform effort, it is important to know the context and the relevant details of the larger reform effort. The rapid growth in Medicaid budgets during the 1990s became a matter of concern for most states, prompting the use of descriptors like "budget buster" (Boyd, 1998). Medicaid expenses continued to rise in Maryland, comprising an ever greater proportion of the state budget, reaching nearly two billion dollars in state fiscal year 1994 (Oliver, 1998). Few things are as powerful as a budget crisis in stimulating programmatic innovations. Maryland, much like other states, sought ways to contain growth in Medicaid expenses (Daniels, 1998; Oliver & Oliver, 1998).

Maryland was one of the first states to enroll most of its Medicaid beneficiaries in a primary care case management program named Maryland Access to Care (MAC) in 1991. By increasing payments for physician visits by nearly 50% and intensive outreach efforts, the MAC program sought to provide a medical home for Medicaid beneficiaries (Schoenman, Evans, & Schur, 1997). Maryland's continued efforts to look for ways to contain costs led to the genesis of the High Cost User Initiative (HCUI). This program targeted Medicaid patients with high levels of inpatient recidivism. It reduced readmissions by linking these patients to a case manager who facilitated access to health and social service providers (LoBianco, Mills, & Moore, 1996; Stuart & Weinreich, 1998).

The course of Maryland health reform was profoundly influenced by two events in 1994, the first (as noted earlier) being the failure of Clinton reforms, and the second, the change in state health policy leadership.[4] The leadership change dramatically affected the scope and pace of reforms with the new administration's view of health reforms representing a paradigm shift, from incremental programmatic improvements to comprehensive system-wide reforms (Oliver, 1998). The DHMH proposal for comprehensive health care reform, conceived and developed under the new leadership, led to the passage of Senate Bill 750 after due deliberation and modification on the last day of 1996 legislative session (Oliver, 1998).

The Senate Bill 750 addressed reform of the Medicaid programs serving the non-elderly and the elderly quite differently. For the non-elderly Medicaid population (composed of families and children and disabled beneficiaries not in need of long-term care), the reform proposal presented a full-blown outline for phasing in all the beneficiaries into managed care as well as a complete redesign of the mental health system serving poor and uninsured state residents. In contrast to the extensive, detailed, and specific reform efforts directed at non-elderly Medicaid beneficiaries, Senate Bill 750 proposed a detailed study of managed long-term care initiatives. Specifically, it directed the DHMH Secretary to establish a Long-Term Managed Care Advisory Committee with a representative membership to "advise on development of a managed care proposal for the Medicaid long-term care population."

Although the authorizing legislation was focused on studying expansion of managed care to the Medicaid long-term care population, it also provided some latitude for exploring related issues by calling for the creation of a Long-Term Care Managed Care Technical Advisory Committee. The Outreach Empowerment Campaign, a project aimed at understanding the nature of the fiscal challenge posed by long-term care needs of aging baby boomers and providing public education, grew out of subsequent deliberations and recommendations of this technical advisory committee.

MARYLAND'S OUTREACH EMPOWERMENT CAMPAIGN: A CHRONOLOGY AND DESCRIPTION

While other aspects of the reform effort were linked to specific programmatic areas under the Department's ambit, meeting future long-term care financing needs emerged as a "stand-alone" issue. Thus, two key

goals of the Outreach Empowerment Campaign–defining the fiscal challenge posed by baby boomers' future long-term care needs and raising public awareness–did not have strong ties to specific programs or populations served by DHMH.[5] The beginning of the Outreach Empowerment Campaign (the "Campaign" hereafter) was fairly innocuous (see Table 1 for a chronology of key events). Senate Bill 750 directed the DHMH Secretary to study the feasibility of various managed care options for long-term care populations covered by Maryland Medicaid. The legislation authorized the creation of a 15-member Long-Term Managed Care Advisory Committee with broad representation and chartered it to study eligibility, benefits, financing, and implementation issues surrounding long-term managed care. There was no mention of the need for efforts to understand the nature and scope of potential fiscal challenges posed by baby boomers' future long-term care needs.

So, how did this process result in the creation of the Campaign that conducted an extensive study of baby boomers' future long-term care needs? Although the authorizing legislation did not explicitly address this issue, it provided for a consultative process involving public meetings across the state. With staff support from DHMH and CHPDM, the fifteen-member Long-Term Managed Care Advisory Committee made up of providers, consumer advocates, legislators, and agency representatives met almost weekly through the summer of 1996, hearing testimony from a variety of groups (Long-Term Managed Care Advisory Committee, 1996). By mid-fall of 1996 when the committee was beginning to wind up its efforts for a November 1 report to the DHMH Secretary, it had heard testimony from academic experts, provider groups, agency staff, consumer advocates as well as the general public. In a wide-ranging report on different long-term care populations and managed care options, two recommendations at the very end highlighted the need for a public education campaign on future long-term care needs. One of these recommended development of incentives to promote purchase of long-term care insurance; the other recommendation was, "Funding should be set aside for an ongoing state-sponsored educational campaign to the general population, their risks for needing long term-care, costs of long-term care. . . . The campaign must stress the financial reality of decreasing resources for Medicaid coverage of long term-care" (Long-Term Managed Care Advisory Committee, 1996, p. 52).

Given the thrust of the DHMH-led effort to explore and develop managed care options for long-term care populations served by Medicaid, it would have been relatively easy for DHMH to set aside the call for public education. However, Secretary Wasserman put great emphasis

TABLE 1. Time Line and Milestones for the Outreach Empowerment Campaign

Time	Milestone	Key Outcome
April 1996	Passage of Senate Bill 750	Formation of Long-Term Managed Care Advisory Committee
November 1996	Advisory Committee completes report	Recommended development of programs to educate the public about long-term care
January 1997	Secretary's report to the Maryland General Assembly regarding Long-Term Managed Care Advisory Committee	Secretary recommends symposium to plan a "broad-based educational program"
Summer 1998	Symposium conducted at University of Maryland, Baltimore County	Identified goals for the educational program and recommended methods
1998-1999	Publicizing the program and obtaining support from various public and private institutions	Presentation to the State Interagency Committee on Aging Services, various area agencies on aging, etc.
2000		Continuance of presentations and search for further funding

on the public education campaign in a series of meetings conducted prior to reporting to Maryland General Assembly in 1997, going so far as to commission the planning and development of a public education campaign: "Today, individuals protect themselves and their families, to the best of their ability, against the costs of acute illness. They similarly need to plan to protect themselves against the costs of long-term care" (Wasserman, 1997). The first step in development of this broad public education campaign was the convening of a symposium to consider the effects of long-term care on families and communities, providing accurate information on long-term care, and publicizing the importance of long-term care insurance to opinion leaders.

The symposium was convened a year and a half later and was organized by CHPDM acting on behalf of DHMH. With adequate time for planning, CHPDM was able to organize a symposium with over 450 attendees (CHPDM, 1998a). After a morning plenary session, the symposium had a working session in the afternoon on four themes: health promotion, independent living, insurance-based options to pay for long-term costs, and non-insurance-based strategies to cover long-term care costs (CHPDM, 1998a). The symposium uncovered several limitations of insurance-based strategies, such as the public's lack of trust regarding long-term care insurance, lack of affordable insurance options, and unavailability of reliable information. Interestingly, the symposium also

brought to light several non-insurance-based strategies such as reverse mortgages and financial planning. Planning for a "spectrum of services" on aging and incorporating personal health planning as a means to obviate future long-term care needs also emerged as themes (CHPDM, 1998a).

The extensive and extended consultation period, thus, led to novel ideas for a public education campaign on future long-term care needs. Subsequent to the symposium, a business plan for implementing the Campaign was developed that outlined an underlying philosophy, goals, and outcomes and a time line for implementation (CHPDM, 1998b). The underlying philosophy for the Campaign had three key elements: using education to empower consumers, relying on public-private partnerships, and concentrating resources on defined populations (CHPDM, 1998b; Kaelin, 1999). By providing accurate and timely information to Maryland citizens on long-term care, the Campaign hoped to help Maryland adults exercise personal responsibility in planning to meet their long-term care needs.

Following development of consensus on key thematic issues for the Campaign, a number of presentations were made by the campaign to various state agencies including the State Interagency Committee on Aging Services. By presenting the plan to key stakeholders in the executive and legislative circles, the Campaign hoped to obtain a "firm commitment" to the goals and methods of the campaign (CHPDM, 1998b). Over the next year, Campaign philosophy, goals, and methods were presented to several key policymakers at both the statewide and local levels (CHPDM, 1998b).

OVERALL ASSESSMENT AND ANALYSIS OF LIMITATIONS OF THE MARYLAND CAMPAIGN: THREE POSSIBLE EXPLANATIONS

One of the more remarkable aspects of the Campaign was that the ideas motivating it emerged spontaneously through public consultation. With strong support from the highest level in Maryland health policy leadership, namely Secretary Wasserman, the Campaign's accomplishments on two fronts were significant. First, it was successful in "fleshing out" and vetting the complex set of issues surrounding baby boomers' future long-term care needs. The Campaign brought into sharp relief limitations of Medicaid reform and private insurance. It also highlighted alternate financial and health-based approaches for long-term

care planning. Second, the Campaign was successful in communicating this message statewide to a select audience. DHMH, the lead agency, assisted by CHPDM, was also able to disseminate this message to a wide body of governmental and non-governmental actors in the state. This is the point at which the Campaign seems to have hit a *cul de sac*.

The public education component did not advance beyond this group of corporate entities to the wider target audience of baby boomer residents of the state. Relatedly, the Campaign was not able to enlist specific support from agencies other than those providing staff support (DHMH and CHPDM). In sum, the key contribution of the Campaign from a policymaking perspective had to do with insertion of some new ideas regarding baby boomers' future long-term care needs in the long-term care policy community in Maryland (Kingdon, 1984).

A more recent update from DHMH on the Campaign noted that, "A business plan for the campaign was developed, and funding is being sought. Meetings are being held with public and private leaders and stakeholders across the state to discuss the Campaign's implementation. CHPDM is developing an educational program for outreach, including a Web site, which should be ready by Fall of 2000" (DHMH, 2000). An examination of the CHPDM Web site, at different times from 2000 to 2002, indicated that the site cannot be described as an "educational Web site" to spread the Campaign's message. Additionally, a comparison of the Campaign time line (Table 1) with other aspects of comprehensive reforms showed that implementation was much farther along for other projects. For example, the Medicaid managed care program, HealthChoice, demonstration projects on long-term care, a case management program for vulnerable Medicaid beneficiaries have accomplished much and have been operational for several years (DHMH, 2000; Leeds, 2000; Pandey et al., 2000; Weiner et al., 1998).

Thus, it is reasonable to infer that despite initial successes, the Campaign seems to have fizzled with no tangible programmatic results. Yet the policy development processes entailed in the Campaign can provide valuable lessons and guidelines about conditions under which state leadership can be effective. We employ three different analytical perspectives: a bureaucratic politics perspective, an agenda-setting perspective, and an interest group politics perspective. After the analyses, we discuss the value of the lessons learned from the Campaign.

Context for Policy Development: Key State Agencies, Competing Policy Priorities, and Bureaucratic Politics

Maryland, like most states, has a number of agencies that have an effect on long-term care policies, programs, and services. Key agencies

that have impacts on long-term care in Maryland are the Department of Health and Mental Hygiene, Department of Aging, Department of Human Resources, Department of Budget and Management, Department of Housing and Community Development, and the Governor's Office on Individuals with Disabilities. These agencies perform a variety of functions related to long-term care including operation of home care programs, provision of social services, home financing and modification, information clearinghouse, and policy coordination on specific long-term care issues.

DHMH is a large state health agency with primary responsibility for policy development and program operations in three key areas, namely Medicaid, public health, and mental health. The Medicaid program operated by DHMH spent nearly $1.24 billion dollars on long-term care in 1999 (Leeds, 2000). Much of this spending was either to support existing long-term care programs or for development of new programs in three areas: enhancement of HCBS waivers, development of consumer-directed care models, and development of care systems that integrate long-term care and acute care (Leeds, 2000). With most of the operational effort taken up by these programs, there was little support within DHMH for a future-oriented educational campaign on long-term care targeted at the population-at-large. Further, the DHMH-led effort failed to obtain more than nominal cooperation from other state government agencies responsible for long-term care services.

The other lead agency in the Campaign, CHPDM, a university-based contractor, was not so constrained by its mission as the line agencies in the state government. Yet, there was little CHPDM could do autonomously.[6] CHPDM was created as a joint venture between DHMH and the University of Maryland, Baltimore County, in 1994. Since its inception as a direct provider of case management services, CHPDM has transformed into an organization that is able to provide support on a variety of policy research and program support activities (Oliver, 1998; Oliver & Oliver, 1998).

During the devolution heyday in the 1990s when the state legislature was unwilling to approve additional personnel for DHMH, the Department was able to build this capacity by contracting out to the University of Maryland, Baltimore County (Oliver, 1998). However, CHPDM does not have an autonomous legislatively-chartered mission. Its primary role is one of providing technical assistance to DHMH. Thus, though CHPDM was in a position to provide staff support to the Campaign, it could not proceed to rally support in executive and legislative circles like a typical mission-based agency.

From the perspective of the Campaign, 1999 was a signal year that brought about a turnover of health policy leadership that had overseen health reforms since 1994 at DHMH. When the new health policy leadership took over at DHMH in 1999, several years of budget surpluses had rendered somewhat unnecessary the need to pursue policy development efforts such as the Campaign to meet future financing challenges. More pressing for this new administration was the need to address the operational problems being faced by the centerpiece of health reforms, the Medicaid managed care program (HealthChoice), serving nearly 400,000 beneficiaries in Maryland. There were high-profile errors in the risk-adjusted capitation system for HealthChoice; keeping the managed care organizations interested in continued participation posed a challenge, and there were few visible indicators of cost savings or quality improvements in the HealthChoice program (Garland, 1999; Salganik, 2001; Salganik, 2000; Sugg, 2000; Wheeler, 1999).

If there is one maxim in public policy with which few would quibble, it is that "the squeaky wheel gets the grease" (Bardach, 2000). Thus, it is not surprising that the new DHMH leadership, which probably had a somewhat different set of policy priorities, attended to the immediate operational needs thrust upon them by the HealthChoice program and not to furthering the Campaign aimed at stemming future long-term care expenses.

Agenda-Setting and Problem-Structuring Processes in the Outreach Empowerment Campaign

The failure of extensive and extended efforts by the Campaign to elicit broad and sustained public participation, one of its avowed goals, deserves some scrutiny. One of the most sophisticated models of agenda-setting processes has been advanced by Cobb and Elder (1972), and we will use this model for analyzing the progress of the Campaign. This model is helpful for obtaining an understanding of how an issue is defined and the processes by which it becomes salient to the public at large. According to Cobb and Elder (1972), issues are created through a dynamic process of interaction between a "triggering device" and an "initiator." A triggering device provides an opportunity for the initiator to spark public deliberation about an issue.

The failure of Clinton health reforms and extended budget shortfalls at the state and federal levels for several years, together with the ascendence of 104th Congress that favored devolution to the states in the social policy arena, served as the triggering devices. Policymakers at the

state level, especially those in charge of the Medicaid program (the largest payer for long-term expenses), viewed the prospect of huge potential expenses for baby boomers' long-term care needs with limited help from the federal government as a major risk. Therefore, DHMH (aided by CHPDM) served as the initiator for bringing the issue of financing future long-term care needs of baby boomers to public notice.

From the perspective of the initiators, the public education campaign may have been a pro-active effort to mobilize the public as well as other significant public and private actors to cooperate in exploring different ways of helping the initiators cope with this potential liability. Although the initiators failed to drive this issue forward, making it a salient issue for other actors, the involvement of a large number of groups helped bring out the complexity and multi-dimensional nature of the problem posed by the aging of baby boomers.

Cobb and Elder (1972) use the term "systemic agenda" to describe legitimate matters for public concern, issues that receive full public consideration. Cobb and Elder stipulate that an issue needs to satisfy three criteria to become part of the systemic agenda: widespread awareness of the issue, public concern regarding action, and falling within the legitimate jurisdiction of an agency. Furthermore, Cobb and Elder assert that "the quicker an issue can be converted into an emotional issue, the greater the likelihood that it will gain public visibility " (Cobb & Elder, 1972, p. 124).

Viewed through the models of issue expansion proposed by Cobb and Elder, the gradual (almost glacial) pace at which baby boomers' long-term care needs are likely to become manifest worked against it. Also, the issue lacked the three key characteristics Cobb and Elder identify as pre-requisite for expansion, namely widespread awareness, clamor for public action, and assurance regarding jurisdiction of the initiating agency. While health care was very much in the public consciousness and there was credible call for action, few considered the issue of long-term care as an issue in its own right. Even fewer readily made the connection between the aging of baby boomers and the need for long-term care and its implications for public budgets. When this is combined with other competing policy priorities, it is not surprising that this issue did not expand to become part of the systemic agenda.

Interest Group Politics: Middle Class Entitlement in the Medicaid Program

While viewing the failure of the long-term education campaign itself by examining it in light of agenda-setting models is valuable, consider-

ing the campaign as one part of a large reform package provides further insights. As noted in an earlier section, the emergence of the new federalism and long-standing fiscal uncertainty prompted DHMH in Maryland to scrutinize closely health care expenditures. The result of this close examination was a comprehensive reform package that was to be implemented in two phases, with many of the reforms pertaining to long-term care to be pursued in the later phase. In light of the fact that expenditures related to long-term care are larger and growing more quickly than other parts of the Medicaid budget, at first glance the phasing of the reform effort seems backward (Leeds, 2000; Oliver, 1998; Stuart & Weinreich, 1998). This "backward ordering" is not surprising if the reforms are viewed through the lens of interest group politics.

Several scholars, notably Grogan (1991; 1993), have argued that middle class entitlements in the Medicaid program enjoy strong and effective political support. Historically, policymakers have been more responsive to organized interest groups (Anton, 1989; Oliver & Dowell, 1994; Grogan, 1993). Provider groups as well as potential beneficiaries of long-term care services are better organized as compared with other Medicaid stakeholders. This strong political support is reflected in both the absolute amount and rate of growth in long-term care expenditure. The rate of growth in expenditures for elderly and disabled recipients has increased more quickly than that for other Medicaid groups (Burwell & Rymer, 1987; Grogan, 1993).

From an interest group politics perspective, the reform-package proposed in 1995 by the DHMH contained two types of provisions. The first kind, directed at politically powerless interest groups, were more definitive, more detailed, and were directed at making significant changes to the existing system (Pandey et al., 2000; Weiner et al., 1998). Contrasted with definitive proposals targeting politically powerless groups, reform proposals regarding long-term care programs and policies were less explicit and provided for greater public involvement. Moreover, in addition to slating long-term care reforms for later phases of the reform process, issues such as long-term care planning for baby boomers may have served as a dirigible to detract attention from other significant long-term care reform issues. By focusing on distal long-term care financing needs of baby boomers, more proximal issues, such as financing long-term care for the near-poor elderly, issues over which DHMH had clear jurisdiction, may not have received adequate attention.

DISCUSSION

The 1990s have been dubbed "the decade of devolution." National governments all over the globe rushed to transfer responsibility to state governments, often with uncertain results, leading one observer to characterize devolution as a "leap in the dark" (Lomas, 1999). *Compensatory federalism* offers a more optimistic perspective on devolution. According to Thompson (1998, 51), ". . . compensatory federalism asserts that policy retreat at one level of the federal system often spurs new activity at another level." Although skepticism regarding state capacity to address pressing social policy issues is quite common, there is a growing recognition that states are increasingly spearheading significant reform efforts (Alt & Marzotto, 1999; Leichter, 1996; Oliver & Paul-Shaheen, 1997). As Leichter (1996, p. 17) points out, state leadership in successful reform efforts is discernible in states as diverse as Hawaii, Maine, Oregon, and Texas, where "policymakers have shown extraordinary innovativeness and sensitivity in dealing with some of our most intractable health related problems."

What is it that makes some states more successful than others in addressing key social policy issues? The diversity across states, in governance mechanisms and political cultures, is a source of challenge in discovering universal patterns. However, in-depth case studies like the one presented in this article offer a valuable means for understanding the policymaking processes at the state level. The case study approach used in this paper is appropriate, despite limitations of generalizability and external validity. Indeed, cumulation of findings from studies like this (e.g., Hackey, 1998; Sparer, 1996) can provide insight into the limitations and possibilities of state leadership on social policy issues in different institutional environments.

This study demonstrates that more than mere administrative prowess is necessary for states to make significant policy accomplishments. States must provide their own "motive force" by fostering policy development processes that are autonomous in agenda setting and insightful in problem structuring. The current study offers lessons regarding issue identification and progression in state policymaking circles. For compensatory federalism to deliver the results, states must create institutional mechanisms for identifying and fostering the development of new ideas. Often, policymaking at the state level is reactive, responding to the latest changes at the federal level (Oliver, 1998; Sparer, 1996). Furthermore, policymaking at the state level tends to rely on a limited set of actors for new ideas (e.g., professional administrators, legislative

analysts). Bringing other stakeholders into policy development process, as in the public deliberation process on long-term care initiated by DHMH, can help inject new ideas. However, support from top political leadership is essential for these ideas to flourish, as is evident from this case study.

Despite the extended period of attention to future long-term care needs of baby boomers (see Table 1 for time lines), no new policies and programs were enacted. The three models discussing the dynamics of issue progression provide insight into the reasons behind stalling of the policy development efforts. First, as the agenda-setting perspective makes clear, the inherent dimensions of a policy issue have a significant impact on the progression of policy development efforts. Second, the interest group politics perspective suggests that the most important lesson for state-level policymaking leadership is the value of the ability to work successfully with interest groups. Policymakers's ability to articulate clearly the stakes for different interest groups has the potential to motivate self-interested action consistent with broader policy goals. To some extent, the Campaign's inability to proceed beyond a certain point may be due to the fact that DHMH was not able to provide well articulated rationale and motivation for other governmental and non-governmental actors.

Finally, the analysis from a bureaucratic politics perspective points to difficulties state agencies may face in policy development in contested or unclaimed policy domains. In addition to other activities necessary for policy development, the focal agency needs to build a consensus around its preferred perspective and in the process gain the necessary legitimacy to pursue further action. Clearly, pursuing the objective of meeting future long-term care expenses for the population at large necessitated the involvement of a large number of external stakeholders. An alternate approach could have focused on devising strategies to meet future long-term care expenses for the poor and the near-poor. While not meeting the overarching goal in one fell swoop, this strategy could be productive in two ways. First, by restricting its focus to groups for which DHMH already had responsibility for design and operation of programs, the task of creating new programs and policies would have been considerably easier. Second, these accomplishments could become the first steps in a sequence of steps through which these programs could be expanded to the larger population.

How can the analysis in this paper be used in a productive manner by state policymakers? The three models may serve as analytical tools to assess the limitations to and possibilities of policymaking leadership at

the state level. Assessments like these, rather than ideological preferences or prevailing attitudes on federalism, can be used to drive state-level policy development efforts in policy domains devoid of federal leadership.

NOTES

1. The character of new federalism that grew out of the 1980s and 1990s, with its emphasis on state leadership, stands in sharp contrast to federal-state relations in an earlier era of some ferment. Sundquist and Davis (1969, p. 4) describe the dominant federal role in federal-state relations during the 1960s in the following words: "The program remains a federal program; as a matter of administrative convenience, the federal government executes the program through state or local governments rather than through its own field offices, but the motive force is federal, with states and communities assisting, rather than the other way around."

2. The fiscal challenge posed by the aging population is one that neither the public nor existing public programs are prepared to deal with (Morris, Caro, & Hansan, 1998). Medicare provides for extremely limited long-term care coverage. The prospect of federal initiatives to meet this emerging need is dim. Medicare reform efforts over the last several years have failed to make modest strides in the direction of providing incremental reforms such as pharmaceutical coverage; therefore, expecting radical redesign of the program to build in coverage for long-term care is not realistic. Similarly, the extant burden of providing support for a public long-term care system by the Medicaid program is so heavy, that it is not reasonable to expect the Medicaid program to expand long-term care coverage.

3. As of March 2002, most of this material was available on the Web site http://www.umbc.edu/chpdm/ltc.htm.

4. In 1994, Martin Wasserman took the oath of office as Secretary of the Department of Health and Mental Hygiene. Dr. Wasserman served till 1999 and was succeeded in this position by Dr. Georges Benjamin.

5. To be precise, the Campaign does not use the specific term "baby boomer"; instead, the target population is defined as "adults over the age of 40."

6. Organizations like CHPDM are going to be increasingly important in state policy development efforts. Despite the lack of line responsibilities, such organizations play a pivotal role, defining and elaborating on policy alternatives.

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The author gratefully acknowledges insightful comments on an earlier version of the paper by David Frankford, Robert Morris, Sheela Tiwary, and an anonymous reviewer that have greatly strengthened the paper. The article also benefitted from interactions and exchanges with former colleagues in the Maryland health policy community.

This work was supported in part by partial summer support from the Center for State Health Policy at Rutgers University in the summer of 2001. Naturally, the support from the above named parties does not necessarily imply an endorsement of the opinions and interpretations in the article.

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