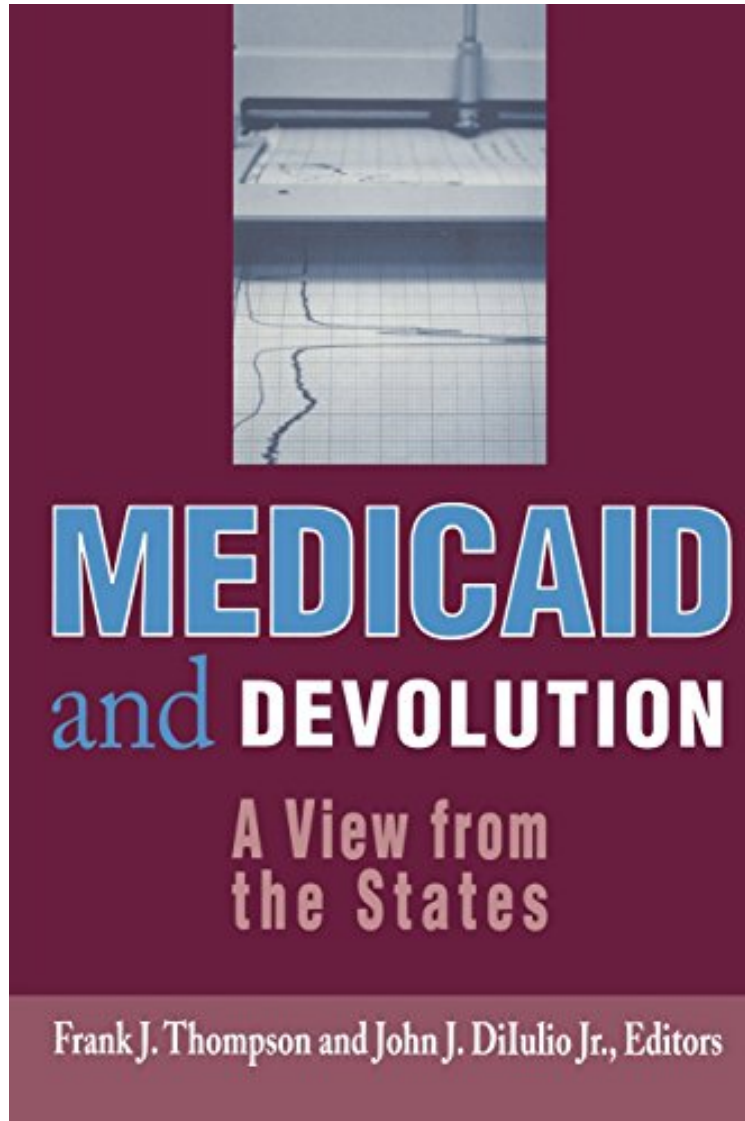


(Read now) Medicaid and Devolution: A View from the States

## Medicaid and Devolution: A View from the States

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**From Brand: Brookings Institution Press : Medicaid and Devolution: A View from the States** before purchasing it in order to gauge whether or not it would be worth my time, and all praised Medicaid and Devolution: A View from the States:

3 of 3 people found the following review helpful. Some decent thoughts on devolution and the history of Medicaid from the 1990s By JustinHoca Medicaid and Devolution: A View from the States I read this compilation of essays compiled by the Brookings Institution for greater insight into the history of Medicaid and where it was projected to go

in the late 1990s. I have a role in forecasting Medicaid expenditures for my job in state government. "Medicaid is truly the the colossus of intergovernmental programs in the United States. It accounts for 40 percent of all federal grant monies to the states...Between 1988 and 1995 Medicaid spending grew from about \$54 billion to \$157 billion, roughly \$90 billion of which were federal dollars...elderly and disabled persons, who represent less than one-third of all program beneficiaries (consume) about two-thirds of all program dollars...(A)bout one-half of all program beneficiaries are low-income children..." (p. 3-4). The \$157 billion represented roughly 15 percent of all U.S. health expenditures (p. 17). The original Medicaid legislation passed in 1965 was ten pages long, compared to its 500 pages as of 1998. State programs are governed by more than 300 pages of instructions by the federal government, along with other directives and guidelines (p. 41). "Devolution" means divulging more power to the states from the federal government. As some powers have been divulged and more freedoms given to the states, states have found ways to shift more of the cost onto the federal government. States want both freedom to set their own prices and policies and a free lunch of shifting the burden onto the federal government. The book is partly a reaction to the Republican-led efforts to turn Medicaid into a Medigra system of block grants to states, an idea that is still pushed by Rep. Paul Ryan and others. Some of the essays deal with the pros and cons of such proposals as well as some theoretical outcomes. Most authors seem to believe that if states have a lump sum that they decide how it is spent, then states will likely eliminate services and keep it as trim as possible, particularly in poorer states in the South where Medicaid programs tend to be less generous than in the more prosperous Northern states. One essay describes a theoretical "race to the bottom," where states have an incentive to provide fewer incentives than their neighbors so that the poor of the population will migrate to the other state to receive the benefits. Anecdotal evidence from Minnesota (which offered relatively large Medicaid benefits) is cited. (It will be interesting to see studies about ACA related migration in the 2014-2020 period, no?) In the 1990s, states really started moving toward managed care programs as a cost-reduction mechanism, particularly after the recession of the early 90's when revenue shortfalls were common. The 1997 Budget Act gave states the ability to experiment with managed care on a wider basis (without a waiver from the feds). At time of publication (1998), the economy had been growing steadily and Medicaid enrollment growth was slowing while state budgets were recovering from early-90's recession shortfalls, so some authors foresaw less interest in managed care and Medicaid reform in general. State-power advocates often argue that expanded home and community-based services managed by the states will decrease Medicaid costs relative to costly nursing home and facility treatments. The authors cite studies however that these services tend to increase Medicaid costs instead (Chapter 6). That issue has since been revisited with the ACA and Medicaid expansion, with opinion apparently leaning towards in-home care being cheaper. Consider data from a recent study, this for Kentucky: Compare the average annual costs of caring for a frail or elderly Kentuckian, according to state data: \$67,525 in a private-pay nursing home. \$47,187 in a Medicaid-paid nursing home. \$15,000 for community- and home-based services. Read more here: <http://www.kentucky.com/2014/06/29/3314842/kentucky-must-do-better-by-elders.html#storylink=cpy> Kentucky is facing criticism for not devoting more resources to the cheaper community and home-based treatments. But the authors argue that this pre-supposes the Medicaid patients' families being capable of providing competent care and decision-making, as well as the recipient having a home capable of supporting treatment (p. 217). With an aging population, this problem is huge. The Disproportionate Share to Hospitals (DSH) is scrutinized. The federal government sends states additional funds to help defray the costs of treating Medicaid patients at hospitals that see a disproportionate share of those patients as a percentage of their overall patient load. Through DSH payments (and other means) states learned to game the system to get more federal dollars and share costs among providers: "In 1987 Congress established minimum criteria for the state allocation of these funds that went into effect on July 1, 1988...a hospital became eligible (for DSH) if (1) its Medicaid utilization rate was more than one standard deviation above the average rate for all hospitals that participated in a state's Medicaid program, and (2) its rate of utilization by low income persons was at least 25 percent. States soon began to take advantage of DSH. From 1989 through 1992, DSH payments for acute and mental health hospitals grew from slightly more than \$500 million to more than \$17 billion. States possessed enormous discretion to determine which hospitals got DSH funds"(p. 34). 50 different states mean 50 dramatically different systems for providing Medicaid and eligibility standards. For example, States vary widely in the rate at which they reimburse doctors for Medicaid compared to Medicare. "The ratio of Medicaid to Medicare fees ranged from a low of .38 in New York to a high of 1.79 in Alaska" (p. 35). The authors lean toward putting more faith in the federal government to attract the talent and expertise needed to make good Medicaid policy relative to states, where legislators and regulators may be "amateurs." While conservatives argue for a "states as laboratories" approach, these authors argue for a federal government being neutral arbitrator, maintaining the quality standards that state programs have to meet in order to benefit society as a whole. The real answer is "it depends." If the movement toward more decentralization and managed care by the states is shown to decrease costs without decreasing quality or the number of vulnerable covered, then great. If not, then more centralization of at least certain aspects seems to be the given answer. One area the authors agree could be done better is the gathering of information, the modernization of which the federal government provided matching/offsetting funds for the states, only to see outcomes vary widely between states. This problem obviously came to light when the federal government had to design a national health care

exchange system that relied on accessing states' Medicaid data-- some states still had pre-1990s archaic systems. There are a lot of helpful statistics on the growth rate of Medicaid expenditures, the overall history of the program, reform efforts in the 1980s, as well as some studies that look at the generosity of Medicaid laws relative to the wealth and political leanings of states. I give this book 3 stars out of 5. Not a necessary read unless you are a Medicaid wonk. The references are plentiful and well-cited.

How much responsibility for providing health care to the poor should be devolved from the federal government to the states? Any answer to this critical policy question requires a careful assessment of the Medicaid program. Drawing on the insights of leading scholars and top state health care officials, this volume analyzes the policy and management implications of various options for Medicaid devolution. Proponents of devolution typically express confidence that states can meet the challenges it will pose for them. But, as this book shows, the degree to which states have the capacity and commitment to use enhanced discretion to sustain or improve health care for the poor remains an open question. Their failure to attend to issues of politics, implementation, and management could lead to disappointment. Chapters focus on such topics as Medicaid financing, benefits and beneficiaries, long-term care, managed care, safety net providers, and the appropriate division of labor between the federal government and the states. The contributors are Donald Boyd, Center for the Study of the States; Lawrence D. Brown, Columbia University; James R. Fossett, Rockefeller College; Richard P. Nathan, Nelson A. Rockefeller Institute of Government, State University of New York, Albany; Michael Sparer, Columbia University; James Tallon, United Hospital Fund; and Joshua M. Weiner, the Urban Institute.

About the Author John J. DiIulio, Jr., Frederic Fox Leadership Professor of politics, religion, and civil society at University of Pennsylvania and a nonresident senior fellow at Brookings, was a former assistant to the President and has served as a consultant for the National Institute of Justice and the National Institute of Corrections. He has authored and coauthored numerous books, including *What's God Got to Do with the American Experiment?* (Brookings, 2000), *Body Count: Moral Poverty... and How to Win America's War Against Crime and Drugs* (Simon Schuster, 1996), *Inside the Reinvention Machine: Appraising Governmental Reform* (Brookings, 1995), *Making Health Reform Work: The View from the States* (Brookings, 1994), and *No Escape: The Future of American Corrections* (Basic Books, 1991). Frank J. Thompson is dean of the Graduate School of Public Affairs at the State University of New York, Albany.