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Policy Determinants and Medicaid Managed Care

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POLICY DETERMINANTS AND MEDICAID
MANAGED CARE

by

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Abstract

The U.S. Medicaid program is increasingly challenged by reductions in federal entitlement spending, a faltering private sector health insurance base, escalating health care expenditures and an aging and increasingly diverse population. Converging pressures on state Medicaid programs have challenged state policy makers to find new approaches to enhance program efficiency. One of these policy tools is the adoption of Medicaid managed care programs for individuals with chronic illness and disability, particularly important as these enrollees incur the highest health care costs. The increasing prevalence of chronic illness combined with the growth of households in poverty creates significant implications for Medicaid policy making. Consequently, Medicaid policies directly influence the health and well-being of millions of Americans. Although literature cites cost-containment as the genesis for the adoption and growth of managed care in state Medicaid programs (Hurley and Zuckerman 2003: 217), little research explores why the growth of Medicaid managed care varies among states.

This study uses panel regression analyses of the fifty states to examine redistributive and developmental policy attributes associated with Medicaid managed care and identifies policy determinants influencing the use of managed care in state Medicaid programs. Spatial patterns of state Medicaid managed care programs for enrollees with chronic illness and disability will be assessed using spatial autocorrelation. This will provide a descriptive picture of the relationship among states.

Outcomes reveal the enrollment rate of state Medicaid programs and the use of managed care for program enrollees with disability is significantly influenced by redistributive and demographic policy indicators. Examining spatial relationships among

states with respect to the percent of comprehensive state Medicaid managed care programs for people with disability yields only moderate correlation. This research looks beyond more overt policy characteristics such as state wealth, to uncover more nuanced factors influencing the public welfare sector and the health and well-being of Medicaid enrollees.

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Chapter 1

Introduction

By our policy decisions, we decide who we are as people

Thomas E. McCollough

The Moral Imagination and Public Life, (1991)

The U.S. Medicaid program is increasingly challenged by reductions in federal entitlement spending, a faltering private sector health insurance base, escalating health care expenditures and an aging and increasingly diverse population. Economic projections expect the growth of federal mandatory budget expenditures, particularly Medicare, Medicaid and Social Security, to absorb nearly sixty percent of the budget by 2030 (White House 2006). Considering both federal contributions and state funds, states spend more on health care than any other program, exceeding state funding for education (Boyd 2003: 59).

Converging pressures on state Medicaid programs have challenged state policy makers to find new approaches to enhance program efficiency. One of these policy tools is the enrollment of Medicaid managed care for individuals with chronic illness and disability, particularly important as these enrollees incur the highest health care costs. The terms “chronic illness” and “chronic conditions” are used interchangeably to describe the presence of illness or symptoms over an extended period of time (Institute for Health and Aging 1996: 9) while “disability” refers to limitations in activity of daily life (adapted from the World Health Organization, 2001). Medicaid policy making

directly influences the health and well-being of millions of Americans. Understanding the forces shaping policy making more fully informs state policy choices considered and solutions adopted.

Cost containment is often cited as the rationale driving the adoption of Medicaid managed care. However, as a cost containment effort, wouldn't all states seek to develop Medicaid managed care programs? Why do some states mandate Medicaid managed care for high cost enrollees and others do not? More broadly, why do some states use managed care more than others? While Wyoming and Alaska do not use Medicaid managed care at all, Tennessee has one hundred percent enrollment in the state Medicaid managed care program (Centers for Medicare and Medicaid Services 2006a: 4). Clearly, states vary in the use of Medicaid managed care. Current literature examining state social welfare policy presents inconclusive evidence regarding factors influencing state welfare policy outcomes, particularly those associated with Medicaid.

Why does state adoption of Medicaid managed care differ so much? Are the states using managed care to save money or to improve services for the medically needy? Structurally designed as a federal-state partnership, Medicaid creates a financial incentive for state participation, yet situates states as administrators of a sizable redistributive program. This begs the question, is state adoption of Medicaid managed care influenced by constituent need (redistributive characteristics) or economic efficiency (developmental characteristics)?

I examine the relative influence of developmental and redistributive policy characteristics on state adoption of Medicaid managed care. As a public welfare policy, Medicaid redistributes resources to provide access to health care services to needy

individuals left out of the private market at substantial economic costs. Adoption of Medicaid managed care can enhance efficient use of available resources to sustain or extend the commitment to the redistributive program. A focus on developmental policy making might influence the adoption of Medicaid managed care as a cost-efficient mechanism to minimize economic burden constraining economic growth. Medicaid managed care provides the opportunity for states to function as “prudent buyers” in the health care market (Kettl 1993).

The Importance of Understanding State Medicaid Policy

Medicaid is an indispensable health care resource for low-income individuals with chronic illness and disability. Extensive evidence supports the bidirectional relationship between individuals of low-income and the prevalence of chronic illness and disability (Allen and Croke 2000), highlighting the importance of Medicaid as the only access to health insurance for more than forty-percent of the nation’s non-elderly poor (Kaiser Family Foundation 2007a: 5). While disability may lead to poverty, conditions of poverty may be a causal influence of chronic illness and disability due to lack of access to resources (Lustig and Strauser 2007: 195).

Escalating welfare spending (Lewin Group 2004a: 3) combined with increasing demand, influenced by increasing unemployment and reductions in employer-based health insurance coverage, pressure state Medicaid programs (Kaiser Family Foundation 2005a; Holahan and Garrett 2001). The increasing prevalence of chronic illness combined with the growth of households in poverty poses significant implications for Medicaid policy making. While seventy-five percent of Medicaid beneficiaries are children and non-disabled adults, seventy percent of Medicaid expenditures go toward

beneficiaries with disabilities and elderly beneficiaries(Kaiser Family Foundation 2007a: 14). At a cost of more than 283 billion dollars, encompassing 18 percent of total national spending, reconciling cost-containment efforts with the varied health care needs of all Medicaid enrollees is vital to both federal and state governments (National Association of State Budget Officers 2006a: 46).

Medicaid Managed Care

This study examines policy factors influencing state adoption of Medicaid managed care program as a means to better understand variance among the state programs. The policy determinant literature will provide a theoretical foundation to assess socio-economic, political system and policy diffusion characteristics associated with state Medicaid managed care programs. Panel regression analyses of the fifty states will be used to examine redistributive and developmental policy attributes associated with Medicaid managed care and identify policy determinants influencing the use of managed care in state Medicaid programs.

Managed care theoretically represents more efficient use of available health care resources. State Medicaid policy is under pressure to increase efficiency because of converging environmental pressures at both national and local levels, challenging state policy-makers to reconcile escalating costs with simultaneous demand for state Medicaid programs. In response to these environmental pressures, changes to Medicaid policy, including the adoption of managed care, influence the lives of fifty-nine million Americans (National Association of State Budget Officers 2006a: 46).

In this study, Medicaid managed care includes both commercial and non-commercial providers who offer a comprehensive array of health care services (Centers

for Medicare and Medicaid Services 2006a: 55). There are numerous varieties of prepayment arrangements used by state Medicaid programs, including managed care coverage for in-patient hospital services, managed care specifically for mental health services or managed care for services provided in non-acute care settings, just to name a few. Structured as prepayment mechanisms, these varied managed care arrangements complicate analysis of Medicaid managed care, warranting careful scrutiny of Medicaid managed care data to ensure consistency of terms and data compilation. In principle, managed care provides comprehensive health care services to enrollees through efficient service management and negotiated pricing with health care providers (Shi and Singh 2004: 326; Enthoven 1993: 29). Price competition assumes participation by an adequate number of provider plans to support negotiated pricing among competitors (Enthoven 1993: 29). I adhere to this definition by analyzing managed care plans identified as comprehensive programs.

Although literature cites cost-containment as the genesis for the adoption and growth of managed care in state Medicaid programs (Hurley and Zuckerman 2003: 217), little research explores why the growth of Medicaid managed care varies among states. Using cost as a “catch all” explanation for the adoption of managed care marginalizes the presence of other factors that may influence state variance; variance that plays out in the lives of Medicaid enrollees. Comprehensive managed care, a crucial component of state Medicaid programs, has been little studied in contemporary literature. In addition, to examining policy indicators, such as state wealth and ideology, this study includes investigation of factors associated with the need for public welfare programs, such as state disability rates and state rates of uninsured. I will use quantitative analysis to

discern influential factors contributing to the adoption of Medicaid managed care and the use of comprehensive managed care strategies among states.

What Causes Differences in State Medicaid Choices?

Fiscal constraint, increasing demand and political pressures are concurrently pressing upon state Medicaid programs. As a significant source of health insurance for low-income individuals, state Medicaid programs are gradually gaining greater authority from the federal government, highlighting the importance of state Medicaid policy making (Bovbjerg, Wiener, and Housman 2003: 30-31). Escalating health care costs challenge state budgets, and combined with the growing demand for Medicaid, as a safety net program force state policy-makers to weigh program demand against program costs. I include variables in this study to assess the influence of socio-economic, political and policy diffusion forces, each exerting pressure on state Medicaid programs.

Socio-economic Conditions and Medicaid

State Medicaid choices are significant because they affect the well-being of a growing number of impoverished Americans, many of whom are minorities. The U.S. Census Bureau projects that California, Texas and Florida will account for nearly one-half of the nation's population growth between 2000-2030, with states in the South and West encompassing eighty-eight percent of total national growth (United States Census Bureau 2005). Americans of Hispanic origin and races other than African-American and Caucasian will exhibit substantial growth in the United States, further contributing to cultural diversity and the need for increased cultural understanding (Day 2008). While the median income of Caucasian households increased from 2005-2006, income for all other races remained unchanged (DeNavas-Walt, Proctor, and Smith 2007).

U.S. Census Bureau figures indicate the growth of the “severely” poor (those with incomes at or below fifty percent of the federal poverty level or less than \$9,900 for a family of four) is escalating at a rate fifty-six percent greater than other segments of populations in poverty (McClatchy Newspapers 2007). Demographics, such as race, age, geography and income, influence state Medicaid programs. The aging Baby-Boomers, those born between 1946-1964, are fueling an increase in the median age of the American population, from 35.5 years of age in 2000 to projections of 39.1 years by 2035 (Day 2008). As the population ages, increased demand will be placed on the health care system, particularly the public welfare sector (Center for Disease Control and Prevention 2003). While Medicare provides health insurance for most adults age 65 and older, Medicaid is used by low-income elderly to pay Medicare premiums and costs not covered by Medicare (Kaiser Family Foundation 2004a: 1). Therefore, the aging population will exert significant pressure on state Medicaid programs.

Although the incidence of disability increases with age, the highest prevalence of individuals with disability are adults age eighteen to sixty-four, as they comprise the greatest percentage of the population. The U.S. Census Bureau projects 24.25% of the population will be under age eighteen in 2010 and 14.85% will be over 65; with 62.79% of the population projected to be working age adults (U.S. Census Bureau 2008). Data also indicate the percentage of working age adults with chronic illness is increasing (Hoffman and Schwartz 2008). The number of working aged adults reporting at least one major chronic health condition increased by 25% from 1997-2006 (W342). In addition, Medicaid payments for program enrollees with blindness and disability have nearly doubled from 1972 to 2004 (National Center for Health Statistics 2007). Disablement

and associated policy problems are not “old age” issues. Demographic changes in chronic illness and disability will pressure public programs, particularly as the private welfare sector, specifically employer sponsored health insurance plans, scale back.

Cost Pressures on State Medicaid Programs

A second reason that state Medicaid managed care programs have grown is that such approaches can control costs. The expansion of Medicaid managed care presents an opportunity to control costs without reducing the number of beneficiaries or eliminating necessary services. Consequently, managed care may potentially provide more efficient utilization of available health care resources deterring programmatic reductions.

States have been making Medicaid decisions in an unprecedented period of cost pressures. The federal government contributes funding to each state Medicaid program. In the past, federal Medicaid funding has allowed states to expand their Medicaid programs in good economic times and buffer Medicaid programs in more restrictive economic climates (Wachino, Schneider, and Rousseau 2004). The competitive, economic climate of the twenty-first century suggests current federal funding may be insufficient to buffer state Medicaid programs, evidenced by state retrenchment in Medicaid services and more stringent eligibility criteria (23). A decline in federal funds forces states to bear a greater share of Medicaid expenditures. States incurring higher Medicaid expenditures receive more federal funds, gaining revenue to be used in the general state coffer (Kaiser Family Foundation 2004a). Consequently, curbing state Medicaid expenditures means reduced federal funding, potentially constraining state budgets (Wachino, Schneider, and Rousseau 2004: 23).

The alternative to increasing taxes to accommodate rising Medicaid rolls and associated costs is to cut program expenditures by decreasing numbers of beneficiaries and services provided and/or increasing financial contribution by Medicaid enrollees. Nearly seventy-five percent of states have experienced declines in federal Medicaid funding during 2006 and/or 2007 and all states have implemented some degree of cost containment strategy during the same time period (Kaiser Family Foundation 2006c). Environmental constraints, such as reductions in federal entitlement spending and the legal obligation for balanced state budgets necessitate more efficient use of Medicaid funds.

Political System Conditions and Medicaid

Political competition offers a third explanation for the growth of Medicaid managed care. Partisan control significantly influences state welfare policy (Hwang and Gray 1991: 294). A case study of Oregon policy making revealed redistributive policies often involved partisan and ideological conflict and exhibited less legislative success compared to growth policies (Wong 1989: 538, 543). Federal, state and local institutions permit a contentious platform through which public policy emerges. Politics serve as the dynamic process influencing the course and outcomes associated with the institutionalization of state Medicaid policy.

Political scientist Thomas Dye (1990) posits a theory of competitive federalism among state and local governments, as sub-national governments seek efficient provision of public goods while maximizing resident welfare. Competitive federalism assumes state and local governments possess the autonomy to exercise self-determination. Relative to welfare policy, literature suggests states compete against one another to

minimize welfare services in an effort to inhibit growth of the welfare rolls.

Simultaneously, states seek to develop the business sector in an effort to stimulate economic growth, pitting neighboring states in competition for private investment.

Competition among states means state and local decisions are political in nature, and states are not merely administrators of central government initiatives but autonomous decision-makers, as well (Dye, 1990: 4). Ideology of state officials, therefore, plays a substantial role in state welfare policy making.

The Diffusion of Medicaid Managed Care

A fourth influential factor, policy learning and diffusion, may be particularly relevant in the study of the Medicaid program. Policy diffusion is the spread of ideas (Carter and LaPlant 1997: 18; Walker 1969: 881). Policy diffusion examines the potential influence of the policy choices of jurisdictions near a state that may influence state policy making (Karch 2007: 40). Research demonstrates policy diffusion due to geographic proximity is enhanced by like attributes of neighboring states compared to distant states, characterized by similarities in economic, geographic and demographic conditions (Mooney and Lee 1995: 605).

As a federal/state partnership, the Medicaid program provides states the latitude to develop innovative policy solutions, allowing states to adopt and to tailor approaches used by other states. Federalism provides a degree of autonomy for the states to exercise power and control—to serve as policy innovators. Consequently, federalism possesses implication for the importance of spatial relationships. “Federalism makes geography highly relevant because federal systems allow substantial freedom for places to chart their

own course of policy action” (Gimpel and Schuknecht 2003: 2). In this regard, federalism provides a mechanism for policies to diffuse among states.

The Need to Examine Policy Determinants of Medicaid Managed Care

Research examining intrastate policy systems or socio-economic conditions may fail to appreciate exogenous factors contributing to state policy making efforts. As the federal government shifts greater authority for the Medicaid program to the states, the importance of tailoring state Medicaid programs to meet the varied needs of beneficiaries, particularly those with chronic illness and disability, holds greater significance. Assessing the presence or absence of interstate policy diffusion may expand consideration for policy determinants beyond socio-economic and political system characteristics.

As federal authority over the Medicaid program recedes, states are positioned to adapt to these national changes in unique ways. The manner in which states respond is not dictated by the federal government, but left open-ended, to the discretion of the states. It is not national directives fueling change at the state level, but a retrenchment by the federal government that is forcing states to pursue alternative state Medicaid policies.

The Research Design

The objective of this study is to gain a better understanding of policy determinants influencing the use of comprehensive managed care mechanisms in state Medicaid programs. To do so, this study will examine socio-economic, political system and policy diffusion factors influencing state Medicaid policy making. Expansions and contractions in state Medicaid spending directly influences federal funding to the state (Kaiser Family Foundation 2004a). Predetermined federal medical assistance percentages (FMAP) are

used to compute federal funding contributions to each state. The federal medical assistance percentage or FMAP is a mathematical formula calculated by dividing the average, state per capita income by the average per capita income of all states to determine federal funding for state Medicaid programs. The FMAP is included in the statutory language of the Social Security Amendments of 1965. As noted during Senate testimony by the late Patrick Moynihan (D-NY), the FMAP was used by the federal government as a proxy for state wealth and need (Congressional Record-Senate 1999: S634). “The amount of FMAP a state gets is based upon the state's relative wealth, with lower per capita income states receiving higher FMAPs” (United States Department of Health and Human Services 2010). In this regard, FMAP rates and per capita income are negatively related (Wachino, Schneider, and Rousseau 2004: 3).

State wealth, then, can be an influential force in state Medicaid policy making because Medicaid redistributes funds to states with greater need. Wealthier states have greater resources to expend on social welfare; however, may do so using more cost effective approaches to care (Garrett, Davidoff, and Yemane 2003: 583). Additionally, more liberal state ideology scores would be associated with a greater propensity toward redistributive policies (Plotnick and Winters 1985; Hwang and Gray 1991), such as those associated with Medicaid. My study therefore examines these hypotheses:

- H₁: States with greater relative wealth, those with lower FMAP, will have a higher percentage of comprehensive state Medicaid managed care programs for individuals with disability

- H₂: More politically liberal states will have a higher percentage of comprehensive state Medicaid managed care programs for individuals with disability as a means to support and expand state redistributive efforts via Medicaid policy.

Medicaid managed care may be an economic tool to enhance cost-efficiency of redistributive policies and ease the financial burden on state economies to free up funds for growth-driven developmental policy. State fiscal resources must be maximized to support competing demands; the social welfare needs of constituents with strategies necessary to stimulate economic growth. As states compete to stimulate economic growth, they must allocate resources for redistributive policies with resources necessary to drive economic growth. My study therefore examines the following hypothesis:

- H₃: States with higher growth rates in personal income will have a higher percentage of comprehensive state Medicaid managed care programs for individuals with disability

I propose policy diffusion is an important consideration in the examination of policy determinants. In addition to socio-economic and political system variables, the influence of neighboring states also may influence Medicaid policy making. The diffusion of managed care in state Medicaid programs, particularly for vulnerable populations such as individuals with disability, may be influenced by the use of this alternative strategy by neighboring states. Descriptive statistics will be used to examine the following hypothesis:

- H₄: States with Medicaid managed care programs for enrollees with disability will demonstrate spatial associations.

Assessing spatial associations will help to identify the presence of clustering, contiguous states that similarly use Medicaid managed care for individuals with disability.

One factor that may inhibit the diffusion process is that managed care functions in a price-competitive market. Price competition assumes participation by an adequate number of provider to support negotiated pricing among competitors (Enthoven 1993: 29). As the federal government continues to relinquish control for Medicaid to the states, more rural states may be poorly positioned to adopt more efficient health care mechanisms, such as managed care.

Data: Selection and Measurement

This study seeks to better understand policy determinants influencing the use of managed care in state Medicaid programs. Socio-economic variables include the federal medical assistance percentage (FMAP), state Medicaid expenditures as a percent of total expenditures by state and growth in personal income as an indicator of state wealth. Political system characteristics will be measured using state ideology scores. Higher ideology scores indicate more liberal states. More liberal state ideology scores would be associated with a greater propensity toward redistributive policies (Plotnick and Winters 1985; Hwang and Gray 1991), such as those influencing state Medicaid programs.

A panel study using data for 2000, 2003 and 2006 of the fifty states will use regression analysis to examine redistributive and developmental policy indicators influencing adoption of Medicaid managed care. The dependent variable captures the percentage of state Medicaid managed care programs providing comprehensive care for individuals with disability. Nearly half of all U.S. adults, age twenty-five to sixty-four with a severe disability are covered by Medicaid; or for some disabling conditions,

Medicare¹ (Steinmetz, 2006:8-9), highlighting the importance of state policy making in the public welfare sector. The independent variables used in the above analysis are defined and measured as follows:

- Federal Medical Assistance Percentage (FMAP) for Medicaid, by state. The FMAP formula is calculated upon average per capita income by state relative to the national average. Data for 2000 and 2003 are from the Department of Health and Human Services. Data for 2006 is from the Kaiser Family Foundation, statehealthfacts.org, 2007.
- Medicaid expenditures as a percent of total expenditures by state, FY 2000, 2003 and 2006. (National Association of State Budget Officers, 2001, 2004, 2007)
- Citizen ideology, by state. Data obtained from the University of Kentucky, 2006, which computes state ideology scores by averaging the ideological position of Congressional members by district (Berry, Ringquist, Fording & Hanson, 1998).
- Growth in personal income by state, computed as the change in personal income from 1999-2000, 2002-2003, and 2005-2006 (Bureau of Economic Analysis 2009)
- Percentage of people without health insurance coverage by state. Uninsured rates are measured by the U.S. Census Bureau using survey questions which seek information about insurance coverage by public and private sources at any time during the previous year. The state uninsured rate provides an indication of the insurance gap in each state, the number of individuals left out of both the private and public health insurance markets and the need for health insurance coverage within each state. Data for 2000 is the two-year average for 1999-2000 (Mills 2001). Data for 2003 is the two-year average for 2002-2003 (DeNavas-Walt, Proctor and Mills 2004). Data for 2006 is the three-year average of 2004-2006 (DeNavas-Walt, Proctor, and Smith, 2007).
- Disability status of non-institutionalized population, age 18 and older, by state, 2001, 2003, 2007 (Behavioral Risk Factor Surveillance System 2009). Also known as the BRFSS, this survey assess state disability rates through telephone survey. State data selected for this study is in response to the following BRFSS question: “Are you limited in any activities because of physical, mental, or emotional problems?” State responses are weighted to account for selection bias, including post-stratification adjustments to address bias due to non-response and households without telephones (BRFSS FAQs).

¹ Individuals with certain medical conditions, such as End Stage Renal Disease qualify for Medicare benefits after a 24 month waiting period.

The statistical model to examine the percentage of state Medicaid managed care programs for adults with disability, as the dependent variable, is specified as follows:

$$\begin{aligned} \text{Dependent variable} = & B_1 + B_2\text{FMAP}_{it(\text{Redistributive})} + B_3\text{Medicaid Expenditures}_{it(\text{Redistributive})} \\ & + B_4\text{Ideology}_{it(\text{Redistributive})} + B_5\text{Income Growth}_{it(\text{Developmental})} + B_6\text{Percent} \\ & \text{uninsured}_{it(\text{Demographic})} + B_6\text{State disability}_{it(\text{Demographic})} + \textit{error} \end{aligned}$$

In this model i represents the state, t represents the year; u represents error (Gujarati, 2003: 647-648).

The adoption of managed care assumes adequate medical providers supporting price competition, a characteristic of supply-side economics. States with higher rates of state population living in urban areas will attract more health care providers facilitating price competition. Rates of state urbanization provide an indication of a price competitive market, a contextual characteristic necessary for effective use of managed care strategies. State urbanization rates were considered for the analytical model, but omitted due to significant correlation with the FMAP variable².

² A correlation matrix of the regressors in this study revealed a moderate statistically significant negative association (alpha=.05) between the State Federal Medical Assistance Percentage (FMAP) and the percentage of state urbanization ($r = -0.62$). In other words, states with lower FMAP contributions from the federal government are those exhibiting higher percentages of urbanization. The FMAP is defined within the statutory language of the 1965 Medicaid legislation. It provides a mathematical formula to determine federal contributions to state Medicaid programs based upon personal income. The FMAP exhibits a policy decision used to level the playing field among states. The percent urbanization variable is computed by the U.S. Census Bureau based upon the percentage of state residents living in urban areas. Since this study seeks to understand policy indicators of the Medicaid program and appreciating the degree of association between FMAP and urbanization as an indicator of collinearity, the urbanization variable was omitted from the model. However, the importance of the FMAP and urbanization association must be kept in mind relative to statistical outcomes.

Secondly, spatial patterns of state Medicaid managed care programs for enrollees with chronic illness and disability will be assessed using spatial autocorrelation. This will provide a descriptive picture of the relationship among states. Data sources for the panel regression variables and the state spatial data are publicly accessible.

The use of regression analyses used in this study is intended to better understand redistributive and developmental policy decisions that can influence the adoption of Medicaid managed care for people with disabilities and examine factors influencing state variance in the use of Medicaid managed care, conditions virtually overlooked in the literature. The use of managed care for vulnerable populations is steadily growing across the country. Improved understanding of Medicaid policy making possesses implications for policy approaches and policy solutions under consideration.

Conclusion

As health care costs and the demand for public programs continue to increase, Medicaid issues, particularly those associated with chronic illness and disability, become more urgent. The U.S. will be forced to confront an increasingly fragile health care system and the public necessity for reform. Policy solutions will require new conceptual perspectives and innovative health care strategies, including consideration for the role of managed care in state Medicaid programs.

A better understanding of Medicaid, as a component of the health care safety net, is needed to discover how conditions at the state level not only influence, but potentially facilitate or deter alternative strategies for Medicaid enrollees, particularly those with chronic conditions and disability. The need for creativity and program improvement in an effort to meet the needs of all Medicaid enrollees is undeniable. The ability of the

federal government to adapt to needed changes in the health care safety net is hindered by the fragmented political system in the United States. Devolving authority for Medicaid to the states provides an opportunity for state flexibility and creative policy solutions.

Chapter 2

Medicaid and the Role of Institutions

An adversarial political culture is not unique to the United States, but it is in the United States that the political institutions—the separation of powers, judicial review, and federalism—allow it full expression and reinforce its central features

James Q. Wilson,
Bureaucracy, (1989)

Health care coverage in the United States is provided in a patchwork fashion via public and private welfare sectors (Davis 2001). Public programs include Medicare and Medicaid, while private insurance is primarily provided through employment. While most individuals aged sixty-five and older receive health coverage through Medicare, nearly seventy-percent of the non-elderly are covered through private, employer-based insurance plans. However, the role of employers as the mainstay of health insurance benefits is diminishing. Data indicates the percentage of employers offering health insurance coverage has declined nine percent between 2000 and 2005 (Kaiser Family Foundation and Health Research and Educational Trust 2005). As a federal/state program, how has state Medicaid policy making gained greater significance in United States' health care?

Escalating health care costs are challenging the integrity of the private welfare sector and contributing to increasing demand on the public welfare sector, primarily Medicaid. As a component of the health care safety net, Medicaid plays a vital role in supporting the health care needs of the impoverished. Over the past decade, the federal government has gradually transferred authority for Medicaid to the states. Increasing autonomy of state programs means state policy making holds growing importance in the lives of program enrollees.

Relinquishing control over Medicaid at the federal level contributes to greater variation among state programs. The devolution of Medicaid administration to the states is particularly relevant for program enrollees with chronic illness and disability who use greater health care services. The ability of the federal government to adapt to needed changes to address chronic conditions is hindered by the fragmented political system in the United States. What do these changes in programmatic governance mean for individuals with chronic illness and disability and what is the political relevance for state Medicaid policy-makers?

Federalism determines the arena (national versus state) in which policy debate takes place. Politics provide the mechanism by which policy issues reach the policy agenda and policy solutions emerge. Medicaid encompasses both national and state arenas compounding the policy-making complexities of this public welfare program. The contentious policy-making process culminates in the selection of policy solutions leading to policy outcomes. In terms of the Medicaid program, these outcomes—the true impact of policy on the lives of those affected—influence the health and well-being of millions of program enrollees.

The Institutional Influence on U.S. Health Policy

Institutions provide the framework through which policy solutions are assessed (Hall and Taylor 1996: 936-957). “Institutions participate actively in politics: they shape interests and motives, configure social and economic relationships, promote as well as inhibit political change” (Orren and Skowronek 2004: 78). Political scientist Marie Gottschalk describes two types of institutions. The first type is the formal institution. With an organizational structure built upon rules and procedures, formal institutions shape the type of policies that reach the legislative agenda leading to policy making (2000: 5). The second type of institution, informal institutions, focus on “patterns of behavior” (Gottschalk 2000: 6). These behavioral patterns are influenced by belief systems, including social values and norms. Formal institutional arrangements are associated with “formal constraints” according to North (1990), shedding light on the means by which policy preferences are shaped and outcomes determined. Analysis of formal institutions, however, fails to capture the nuances of the broader social context. The role of informal institutions, appreciating cultural norms and bias, provide the context in which formal institutions are situated.

Federalism as a Formal Institution

The complexity of U.S. policy making institutions coupled with the growing pressures on the health care system challenge policy-makers to devise ways to achieve health care reform. To better understand the present state of American health policy, an understanding of political ideology and the framework through which public policy must negotiate is necessary. U.S. governing authority is divided among institutions at the roots

and branches; separation of powers among the legislative, judicial and executive branches of government; and, federated power between the national government and the states.

Traditionally, institutions are accepted as mechanisms which order politics, establishing the rules and practices of the political process. Institutions embody a sense of stability. These rules and practices contribute to institutional frameworks which tend to remain stable over time; resisting pressures to change within the context of an ever-changing political climate (Orren and Skowronek 2004: 17-18). How do political institutions influence Medicaid policy making? Since Medicaid is influenced by politics at both federal and state levels, is Medicaid prone to change? Are states suitable “laboratories” for innovative Medicaid policies? Institutional approaches to the study of policy making consider policy as a product of three forces: institutional arrangements, political process and historical precedents (Mettler 2002: 232). I explore the role of ideology set within the institutional framework, both formal and informal, relative to U.S. health policy making.

Theoretically, federalism helps us to better understand the unique characteristics of larger, national public-policy making compared to local, state-driven policy, particularly important in the understanding of Medicaid. Smaller decision making bodies, resulting from devolution of power, encourage flexibility and creativity to meet changing needs and facilitate the ability to gain consensus. Consequently, larger decision making bodies, characterized by centralized power, enhance equality of the constituents, facilitate participation by highly skilled professionals and exhibits more stability and coherence. At its core, federalism draws attention to the importance of location of the political debate (national versus state) and the characteristics associated with contentious

policy-making in each policy arena. Federalism holds particular relevance for the Medicaid program, which is shaped by national and state-level policy institutions.

Political scientist E.E. Schattschneider (1975) states, "...the outcome of all conflict is determined by the scope of its contagion...one way to restrict the scope of conflict is to localize it, while one way to expand it is to nationalize it" (2, 10). Conflict expansion is one mechanism to uproot entrenched interests, creating unbalance in the policy structure. Retaining a narrow scope of conflict may avoid disruption to existing policy or minimize opposition to policy change. Defining the appropriate arena for policy debates may enhance power and support for policy outcomes. "If national consensus exists, national action can follow; if it does not, individual states can act by achieving state-level consensus" (Anton 1997: 702). The smaller scope of conflict associated with state policy making enhances responsiveness to both policy change and potentially implementation of new policy due to gridlock at the federal level.

Federalism's Influence in Health Care

Characteristics of American federalism have changed over time. From the mid nineteenth century through the Progressive era, jurisdictional distinction between state and national powers was a trademark of American dual federalism (Patterson 2005: 82). The Great Society of President Johnson illustrates blended state/federal efforts of cooperative federalism (Patterson 2005: 90). Starting with Nixon's New Federalism, the federal government's effort to curb social welfare spending gradually shifted greater authority to state Medicaid programs. The Reagan presidency re-initiated the swing of the ideological pendulum in a decidedly conservative direction. Reagan sought to diminish the federal role in social welfare programs. Reagan undoubtedly understood the

relationship between a strong economy and political success. Reagan issued tax cuts to stimulate capital production, thrusting the country into an era of deficit spending, but providing short-term economic gains (Caporaso and Levine 1992: 79-99; Skowronek 1997: 421; 428). However, retrenchment of the federal role in social welfare policy during the Reagan years spurred state innovation and development (Nathan 2005: 1460).

The Medicaid program is a seminal example of federalism at play in U.S. health policy. Using Medicaid as evidence, scholar Richard Nathan contends the oscillation of power between the federal government and the states fueled development of the U.S. public welfare sector (2005: 1459). Furthering Nathan's argument necessitates consideration for two important factors. First, temporality conditions the influence of federalism on health policy change. Federalism contributed to the defeat of national health reform for much of the twentieth century, yet provided latitude for states to develop innovative state health care programs. Second, the passage of the 1965 amendments to the Social Security Act were a response to failures in the private welfare sector and not an unmitigated desire to extend the government's role in social welfare policy.

Over the course of the twentieth century, federalism has both fueled and thwarted development of the public welfare state. Federalism may limit national health reform due to diverse state interests pressing upon the national policy process. However, failed national reform allows states to become policy change agents, subjecting state policies to more localized political conflict (Gordon 2003). National reform efforts of the early and mid-twentieth century were whittled down to the "three-layer cake" of Medicare (Parts A and B) and Medicaid (Gordon 2003: 118). Federalism not only complicates national

reform, but contributes to persistent, incremental policy making, often creating the “...illusion of progress while making the goal of national health insurance more elusive” (Gordon 2003: 287). Conflict between governing structures at the roots and branches complicates efforts to change the public welfare state, with particular importance for Medicaid as a dual federal/state program.

Federalism as a Mechanism for Changing Health Policy

Research reveals that while the national government is better suited to address issues of redistribution, state governments appear more sensitive to economic conditions (Anton 1997: 701-702). Research analyzing national government expenditures found that federal expenditures tend to support redistributive programs while state spending leans toward developmental programs. State government appears more sensitive to economic change and better able to detect the impact of state policy decisions (Anton 1997: 701-702). In the case of health care, state-based initiatives may influence national reform efforts (National Governor’s Association 2005: 5). A World Health Organization report reiterates the challenges confronting broader health system change, yet recognizes the potential impact of smaller, innovative change to support system-wide improvements in health and quality of care (World Health Organization 2002: 42).

As a federal/state partnership, Medicaid must navigate through national and state policy making processes, assuming characteristics as a redistributive program at the national level and a developmental program at the state level. The importance of federal funding supporting state Medicaid programs is undeniable (Gold et al. 2001; Sparer 2004). Federal Medicaid funding plays a critical role in financing access to health care for millions of impoverished individuals. Simultaneously, state Medicaid programs serve

as epicenters for development and implementation of innovative health care strategies for program beneficiaries.

Federalism provides a mechanism to overcome institutional and political barriers associated with broader health care reform efforts. The Clinton administration's failure to pass a national health care plan led to a conviction of reform and the development of state level initiatives (Oliver and Paul-Shaheen 1997). Research analyzing factors supporting state health care reform demonstrate the presence of two broad frameworks supporting state-level change (Oliver and Paul-Shaheen 1997). First, contextual conditions provide the framework for factors that are more stable and institutionalized in nature. These conditions include socioeconomic factors (levels of income, employment and education; economic status of the state), political factors (political culture and disparity or cohesiveness of bipartisan efforts), institutional factors (resources, historical health reform efforts, organizational characteristics of the health policy community). Second, dynamic factors are the more fluid elements influencing policy outcomes. These factors include leadership, ideas and power.

While the importance of institutional factors cannot be over looked, dynamic factors such as, leadership, ideas, and power significantly influence change (Oliver and Paul-Shaheen 1997). Leadership provided the vehicle by which attention and identification of resources were achieved. Ideas provided the platform for the development of solutions and power created a climate by which resources were procured to convert ideas into action. The ability to modify and alter power may be directly influenced by the size of the decision making unit, an inherent characteristic of federalism and essential to understanding Medicaid policy making (Stone 2002).

National policy-making takes place in a much larger, contentious policy arena compared to state policy-making. As the federal government shifts responsibility for Medicaid programs to the states, the states possess the latitude to tailor policies for local constituents, contributing to greater variation in program administration among the states.

Research reveals institutional factors play a key role in broadening the scope of conflict by including those entities and individuals more open to reform; however, policy making authority continued to reside within a smaller network of leaders and stakeholders, who provide stability to the health policy process in the event of policy change (Oliver and Paul-Shaheen 1997). In this study, state health care reform did not occur spontaneously; but, occurred as a result of constituency interests within each political system. Constituency interests influence state leaders to pursue policy change creating an environment that successfully nurtured reform efforts (Oliver and Paul-Shaheen 1997).

State innovation may be a catalyst to break through persistent barriers of national reform, fueling health policy change from the “bottom up.” A 2005 report from the National Governors Association states,

Bold ideas are needed to address the health care system’s most serious problems and change the conventional thinking that meaningful reform can only be driven from the top, through federal policy changes. Instead, similar to welfare reform, health care system change should be demonstrated through innovation and experimentation by states. States are small enough to tailor solutions unique to their cultures, institutions, and health care markets, but large enough to experiment with system-wide reforms (2005: 5).

The role of federalism in health policy may serve as a means to bridge institutional and political divides that have been barriers to past national health care reform efforts,

potentially supporting policy approaches that facilitate citizen involvement as empowered participants in the political process.

Retrenchment of federal entitlement spending combined with a weakening private welfare sector presents opportunity for innovative state reform (Alonso-Zaldivar 2005). State level reform may serve as a means to the eventual passage of national health care initiatives (Oberlander and Marmor 2001). This is illustrated by the pursuit of universal health insurance coverage in Maine, Vermont and Massachusetts; efforts that have influenced recent national health reform efforts (Kaiser Family Foundation 2010c). Considering both institutional structure and the growing health care needs of societal members, state policy making is challenged to use federalism as a mechanism for policy change rather than a barrier sustaining the status quo.

State-level health care reform, as a mechanism to achieve broader reform, is not without serious drawbacks. Devolution of power is often associated with inequity among states. As described earlier, state Medicaid programs are sensitive to the economic climate with demands for services escalating during economic decline. It is well documented that states with the greatest income disparity among its residents demonstrate higher mortality rates compared to states with less disparity (Kawachi 2005: 30; Kuttner 1996: 111-112). While states may be appropriate venues for innovation, disparity among states becomes an unavoidable consequence of structural federalism.

Minimally modifying Medicaid, such as sharing administrative responsibility between the federal and state governments, may lessen state disparity and reduce administrative costs by consolidating program oversight and billing practices. Known for low administrative costs, Medicare could serve as a model for more centralized

administrative strategies, creating a greater resource pool for redistributive efforts (Moon 2003: 358). Yet, even incremental approaches, such as shifting isolated elements of the Medicaid program from state-level to the national level, may be politically challenging. Shifting responsibility to the federal government broadens the scope of conflict, subjecting increases in federal expenditures and program oversight to a much broader pool of policy opponents (Moon 2003: 357). While federalism contributes to state variance, policy gridlock at the national level may implicate the states as venues for action.

Ideology and Social Welfare Policy

Health policy reform is challenged by institutional structure, partisan politics and intra-party cohesion (or fragmentation) (Peterson 2005: 213-214). While formal institutions, such as federalism, provide the framework for public policy making, the role of ideology is increasingly challenging the process. Political parties serve as an organizing mechanism through which private interests are broadly encompassed within the two competing party platforms (Schattschneider 1975: 41). Political parties are in a constant state of suppression and expansion, suppressing divisive issues and sustaining or expanding issues that drive party unity (Sundquist 1983: 307). Similarly, a party out of power may use conflict expansion to focus the critical eye of the public on the party in power (308). American policy making is characterized by the dominance of a two-party system with the Republican or conservative perspective favoring limited government intervention in favor of the private market. The Democratic or more liberal view tends to more readily consider government intervention as a means to obtain and secure equity among societal members.

It is expected that partisan ideology influences state welfare policy with liberal states providing more generous support compared to conservative states (Buchanan, Cappelleri, and Ohsfeldt 1991: 68). Research demonstrates political ideology significantly influences state welfare policy (Hwang and Gray 1991: 294). However, research examining contextual factors influencing state Medicaid spending finds the economic climate and state wealth are more influential in state spending on Medicaid than political factors (Buchanan, Cappelleri, and Ohsfeldt 1991). Redistributive policy has been associated with increased partisan and ideological conflict and less legislative success compared to more growth oriented, developmental policy (Wong 1989: 538, 543).

Historically, health care legislation has been stifled by partisan debate with liberal and conservative perspectives of welfare economics going toe-to-toe. Partisan efforts to gain support and resources within the political arena challenge the ability to formulate cohesive coalitions to support desired policy agendas. The contentious two party political system in the U.S. tends to slice public policy making along predictable party lines, creating a rather stable policy debate, minimizing vast deviations from the status quo (Baumgartner and Jones 1993: 22). Groups opposing national health reform have created an ideological divide among policy makers, influencing the way public problems are defined and policy solutions developed (Marmor 1973). Recent research finds that policy advocates remain committed to an issue over time, continually assessing the policy environment and the policy positions of opponents and taking advantage of political space when possible (Baumgartner et al. 2009). Policy rivals jockey for position, inhibiting the policy scale from dramatically tipping in one direction or the other (36). A

lack of substantial policy change provides evidence of domination by a single perspective (47).

Throughout the course of the twentieth century, conservative opponents of national health reform framed policy change efforts as encroachment upon individual liberty, intrusion of the government on the private lives of citizens. Opponents framed government-sponsored health care as an assault on individual choice and a limitation of freedom, capitalizing on a cultural proclivity toward classical liberalism prevalent in the U.S. Most notably—opponents of national health insurance portrayed the expansion of national insurance coverage as a movement toward “socialized” medicine, creating dissonance between traditionally accepted American values and ideological frameworks associated with national health reform. Partisan belief therefore is not solely an ideology, but an actual policy making tool, influencing how the needs of societal members are addressed.

Social welfare policy, such as Medicaid, seeks government intervention in lieu of the private market, pitting ideological perspectives of individual responsibility against the government role. Political ideology colors the types of policies enacted, serving as a barometer for the waxing and waning role of government in the public sector and the associated parties in power. Consequently, welfare programs are particularly vulnerable to ideological conflict (Soss and Keiser 2006). Both market and political factors have conditioned the structure and mechanisms by which Medicaid managed care has been implemented in the states (Plein 2003: 26-27). Ideology provides the backdrop for political debate while institutions provide the stage upon contentious policy making takes place.

The Role of Informal Institutions in Policy Making

As mentioned, informal institutions include the social context in which formal institutions are constructed. In this instance, informal institutions include socio-cultural norms that frame Medicaid policy making. Societal norms about Medicaid, as a means-tested public program, influence the political pressures exerted upon it. An examination of policy determinants cannot be fully understood without consideration for the broader role of informal institutions. These informal institutions help to explain the scope and breadth of policy options that surface in the policy arena.

Policy issues arise as subjectively determined problems. The subjective lens through which issues emerge is influenced by socially accepted beliefs. These social norms and beliefs create the context in which more formal policy making takes place.

Policy analysis must embrace an interpretive epistemological perspective, mindful that “policy problems are products of subjective human judgment...” (Dunn 2004: 75). Policy problems are socially constructed; therefore, the lens through which judgments are formed and problems identified is malleable, leading to varied and changing solutions (Dunn 2004). The policy analyst is challenged with a rather daunting task, developing an appreciation for the problem structure as a precursor to formulation of a policy solution. In other words, how did this problem come to be defined as a policy issue? Culturally unique perspectives of health and disability drive the perception of policy problems and the development and selection of policy solutions.

The Social Context and Public Policy making:

Implications for Disability

Informal institutions are circumscribed by social and cultural perspectives. Social policy in America idealizes autonomy, highlighting individualism over community and holding personal achievement as the epitome of success and accomplishment. The pursuit of autonomy is premised upon self-sufficiency and self-reliance. These social norms are important for individuals with disability:

In a society where individual independence is valued highly, perhaps more so than mutual dependence, possible reduction in individual mobility caused by the interaction of disease with the patient's physical environment will have profound effects on lifestyle and the pursuit of individual aims (Chamberlain, Buchanan, and Hanks 1979: 51).

As a result, those less independent, whether an artifact of intrinsic and/or extrinsic factors, experience reduced opportunities for choice, hindering attainment of equitable states of welfare.

Conceptual Complexity of Health and Disability

To understand the importance of researching Medicaid policy making, particularly policies influencing individuals with chronic illness and disability, an appreciation for factors contributing to the perceptions of health and disability is needed. Early perspectives of disablement viewed the process at the level of the individual. In this regard, approaches to care and associated health policies were directed toward treating the person. More contemporary perspectives view disablement as the interaction between the person and the environment. Hence, approaches to care and associated policies must no longer focus solely at the person-level, but should consider broader

environmental factors, as well. This conceptual shift directly influences the policy options considered and the solutions adopted.

Health is a complex, multi-variant construct influenced by the interwoven relationship among the individual, cultural and societal forces. These exogenous forces are not static over time, but subject to change, influenced by new knowledge and changing societal attitudes. An appreciation for the complex perspectives shaping perspectives of health in American society may shed light on current health care issues at the fore. There are two prominent models guiding perspectives of health and disability in the U.S.: the biomedical model and the social model.

The Medical Model

The traditional medical model of health care, prevalent in the industrialized nations like the United States views health as the presence or absence of disease (Weiss and Lonnquist 2002). If an individual is free of disease, he/she is presumed healthy. A conceptual dichotomy is thus created—the absence of disease equates to health and the presence of disease equates to sickness. Consequently, disease and disability are situated as a cause and effect relationship. “The medical model views disability as a problem of the person, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by medical professionals. Management of the disability is aimed at cure or the individual’s adjustment or behavior change” (World Health Organization 2001: 20).

Implications of the medical model for individuals with chronic illness and disability are substantial. Dominance of the medical model marginalizes sociological and environmental perspectives of disability that may influence health policy outcomes.

Narrowed person-level perspectives of health, constrain alternative health care strategies that may better support overall quality of life for individuals with chronic illness and disability. In theory, managed care envisions more cost-effective use of health care resources by supporting preventive approaches to preserve or improve states of health. Health policy decisions that focus on tertiary treatment of disease, insufficiently addresses the broader array of factors contributing to quality of life for individuals with chronic conditions and disability.

The Social Model

Efforts by disability rights activists and the disability rights movement challenge the long held paradigms of the medical model, framing disability as a person-level problem. Alternatively, the social model views disability as a social issue, not a medical condition. Social constructs of disability perceive limitations in social integration as external to the individual, present as socially constructed barriers. “Disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment” (World Health Organization 2001: 20). Therefore, a socially defined problem requires a socially defined solution. A framework of this nature situates disability as a public policy issue, placing perspectives about human rights as the focal point by which policies are viewed. The Union of Physically Impaired Against Segregation (UPIAS) issued the following statement,

In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairment by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society (Bickenbach et al. 1999: 1176).

Changing perceptions about the social and environmental components of disability have led to a broader appreciation for factors contributing to disablement. Perceptions of

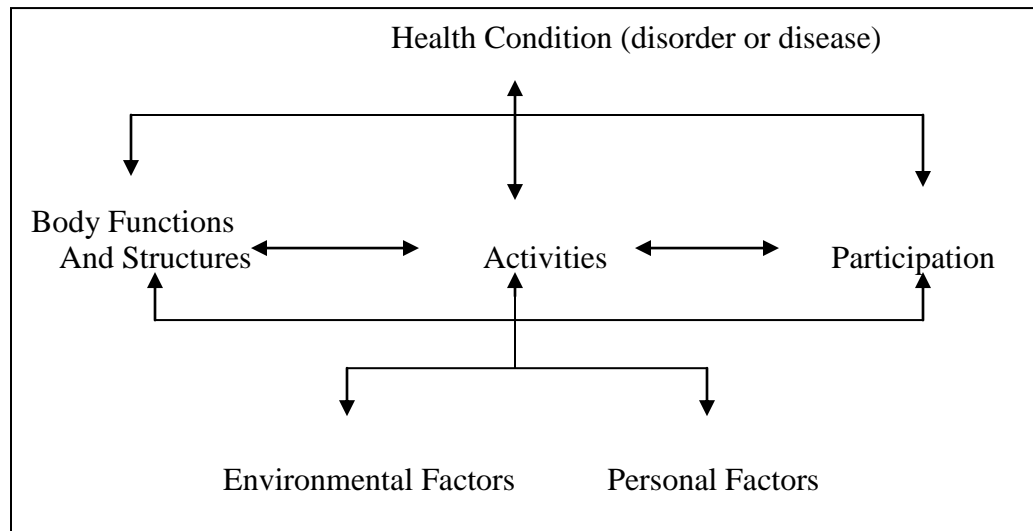
disability must look beyond the level of the individual. Social constructs of disability lead to philosophically based perceptions of equality and quality of life with significant consequence for public policy issues (Renwick, Brown, and Nagler 1996).

Merging the Medical and Social Models

One movement, undertaken by the World Health Organization (WHO), has been development of the International Classification of Functioning, Disability and Health (ICF). The ICF provides a conceptual model of disability situating individual impairment within the environmental context. WHO has supported the development of the ICF framework over the course of twenty-seven years, evolving as a tool to describe states of health and disability. The ICF departs from the more simplistic person-level approach, to a descriptive framework that seeks to understand “components of health” as opposed to “consequences of disease” (World Health Organization 2001: 4).

In this model, disability is not a dichotomous person-level or social-level framework. Instead, the ICF describes the interaction between a person’s health condition and environmental and personal factors that contribute to disablement. A visual interpretation of the interaction between components of the ICF framework is provided in figure two below (18).

Figure 2: Components of the ICF



The World Health Organization graciously permitted reproduction (December 2007)

The ICF integrates the medical and social models by appreciating the role of environment as an influential factor in health and well-being. The ICF seeks to capture a more descriptive assessment of the disability phenomena. In contrast to past disability frameworks focusing on causality, the ICF represents a paradigm shift with the potential to influence a spectrum of policy issues.

The Implications of Policy on Disablement

Conceptual perspectives of health influence approaches to health care. Health care systems have not adapted to reductions in acute conditions and the increase in chronic conditions (World Health Organization 2002: 29). Interests entrenched in fee-for-service reimbursement mechanism tend to focus on acute care services, hindering strategic development of chronic care and preventive care paradigms. A difficult cycle develops in which costly acute care expenditures are followed by the use of high cost institutional and government services for chronic debility. Ultimately, available

expenditures for health promotion are limited and compound the financial costs of chronic illness (Institute for Health and Aging 1996).

Research funding disproportionately supports clinical research with limited support investigating the environmental aspects of disablement or the evaluation of intervention strategies that support functional ability and social engagement (Field and Jette 2007: 5). Resource allocation is often influenced by political pressure rather than disease burden. Resulting inefficiencies skew resources toward high-cost intervention strategies (advancing technology and pharmaceuticals) compared to lower-cost interventions, such as improved training and education (World Health Organization 2002: 35-36). John Fiorillo (2003), senior consultant for the Robert Wood Johnson Foundation stated, “The way we deal with the chronic patient and the chronic elderly patient is the bellwether for our health care system. If the system can’t deal with the chronically ill by providing high-quality affordable care, the system is not going to succeed.”

Policies for health and disability in the U.S. present a stark contrast with those of other industrialized countries. In the U.S., inability to work due to disability is determined irrespective of rehabilitative potential (Pope and Tarlov 1991: 251). Correspondingly, resources tend to be skewed toward income support, often perpetuating dependency versus rehabilitation and reintegration into the workforce (Hahn 1986: 129). Of the \$226 billion dollars spent by the federal government on disability programs in 2002, only 1.5% was designated for education, training and unemployment (Goodman and Stapleton 2007: 68). In several European countries, disability and eligibility for income assistance is made following assessment of rehabilitative potential and modifications to the work site are supported through public funds. In the U.S., employers

are offered tax incentives to enhance workplace modifications. A comparative assessment of six countries revealed the U.S. was the only country lacking a health care mechanism supporting reintegration into the work force (Pope and Tarlov 1991: 251). European approaches toward disability embrace broader social and ethical considerations contributing to socio-economic costs influencing policy outcomes (Pope and Tarlov 1991: 252).

Changes in institutional perspective may help to break down the barriers which characterize and label groups of people. The national “Healthy People 2010” initiative establishes goals and objectives to facilitate improved health and well-being of individuals in the United States. Two broad policy goals drive efforts to improve health and prevent disease. The first goal is to improve quality of life and maximize years of healthy life. The second goal is to “eliminate health disparities” (United States Department of Health and Human Services 2007). The national health goals are particularly salient for Medicaid beneficiaries with chronic illness and disability. Maximizing quality of life and eliminating health disparity for vulnerable societal members in the United States possesses significant implications for federal and state Medicaid policy. Failure to obtain health insurance in the private sector relegates low-income individuals to seek care through the public sector, specifically the Medicaid program, and for some individuals with disabling conditions, Medicare³.

³ Individuals with certain medical conditions, such as End Stage Renal Disease qualify for Medicare benefits after a 24 month waiting period.

Health Care Strategies for Chronic Illness and Disability: Implications for Medicaid Policy

A comprehensive 1991 Institute of Medicine report, *Disability in America*, highlights disablement as an interaction between the individual and the environment (Pope and Tarlov 1991). Physical barriers, such as limited access to public transportation and public buildings continue to plague individuals with impaired mobility (Field and Jette 2007: 3); however, since the 1991 IOM report, progress has been made. Technological advances as well as universal approaches to physical design have assisted in this process (Field and Jette 2007: 2). The implication of merging the environmental context with disablement extends beyond physical structure, encompassing policy outcomes, such as Medicaid policy, that substantially influences daily life. Social context influences “the physical, social and attitudinal environment in which people live and conduct their lives” (World Health Organization 2001). Hence, the role of policy on processes of health and disablement gain added importance.

Key elements important in health care strategies for individuals with chronic illness and disability are paraphrased below:

- Preventive strategies are necessary as a means to sustain states of health, warding off decline and secondary complications of illness
- Utilization of coordinated, interdisciplinary approaches to care, extending beyond general, acute care providers must include diagnostic specialists, long-term care, home health care, respite care, rehabilitation services, medical equipment and assistive technologies, among others
- Timely access to acute care is needed to prevent exacerbation of health conditions (Ireys, Thornton, and McKay 2002)

Researchers note paucity in literature relative to the assessment of managed care for Medicaid beneficiaries with chronic illness and disability. One particular area lacking

research is examination of varied Medicaid beneficiary needs as a means to inform program planning and policy (Ireys, Thornton, and McKay 2002: 37).

Findings from the Robert Wood Johnson Foundation report, “A Portrait of the Chronically Ill In America, 2001” demonstrate that individuals with chronic conditions are lacking significant information and knowledge to facilitate self-care strategies and enhance compliance with best practices of medical intervention (Bethell, Lansky, and Fiorillo 2001). Some chronic illness and disability is preventable with early and appropriate health care intervention, postponing or reducing complications contributing to disablement.

Appreciating the needs of individuals with chronic conditions is particularly relevant for state Medicaid policy. Since Medicaid beneficiaries possess higher rates of chronic illness and disability, interruptions in access to care due to changing financial status or changing state policy may contribute to inadequate provision of health services and poorer health outcomes. As the understanding of disablement and chronic illness has changed over time, policies supporting those changes are needed.

Although Medicaid and Medicare policy has demonstrated increased support for community and home-based care over institutionalized care (consider the “Katie Beckett option”), policies may create unintended consequences, as well⁴. For example, Medicare policy stipulates that durable medical equipment will be covered for use “in-home,” creating disincentives for work and community independence (Field and Jette 2007: 8;

⁴ Acute illness in infancy left Katie Beckett ventilator-dependent. Coming from a middle-class family, Katie could only qualify for Medicaid while living in an institutional setting. By waiving income requirements for parents of children with disability, TEFRA supports home-based care as an alternative to institutionalized care (Crowley and Elias 2003: 14)

14). Policies, particularly Medicaid policy, directly influence the health of program enrollees and consequently, their quality of life.

The importance of Medicaid policy making in the lives of program enrollees is exemplified by the Missouri Medicaid cuts of 2005. A survey of program enrollees following the cuts, revealed respondents planned to reduce the use of goods and services including health care, food and utilities, or planned to seek health care services via hospital emergency rooms. Fifty-nine percent of survey participants indicated recent inability to pay for prescription drugs or loss of coverage for prescription medication. Forty percent lost dental services and fifty percent could not get eye glasses (Feltman and Hill 2006: 9). These programmatic cuts reduced or eliminated key services, including dental and vision care, and the provision of durable medical equipment, such as walkers which support functional levels of independence, all of which are particularly important for individuals with chronic illness and disability.

The impact of programmatic cuts to state Medicaid programs appears particularly salient for women and individuals with chronic illness and disability; characteristics associated with higher rates of poverty, thereby meeting program income criteria (Lustig and Strauser 2007; Parish and Ellison-Martin 2007). Research demonstrates that Medicaid beneficiaries report substantial difficulty affording prescription drugs, dental and mental health services and medical equipment (Hanson et al. 2003). While Medicaid does provide health insurance for individuals with low-income, health care costs continue to usurp a large portion of income for this vulnerable group.

The inclusion of optional Medicaid services such as occupational, physical and speech therapy are determined by each state. Rehabilitation services play a key role in

maximizing functional independence in individuals with chronic illness and disability (Ireys, Thornton, and McKay 2002). Using 2006 data, the Kaiser Family Foundation's Medicaid database indicates twenty-eight states include services for occupational therapy, thirty-three include physical therapy and thirty-four provide services for speech, hearing and language disorders. However, these services are often included with coverage limitations and/or co-payment requirements (Kaiser Family Foundation 2006a). A study examining the impact of Medicaid budget cuts in four states reveals that cuts were agency initiated, not legislatively mandated, and often targeted optional benefits offered through state Medicaid programs, such as rehabilitative services which may directly influence the health and well-being of individuals with chronic illness and disability (Bailit, Burgess, and Roddy 2004: 11).

Rehabilitation services support health beyond detection of disease. A diagnosis of disease does not convey how a person functions with that disease. "Diagnosis alone, for example, cannot answer questions about health services utilization, need for care, treatment matching or outcome evaluation" (Ustun et al. 2003: 566). Outcomes of performance assessments have been correlated with predictive ability to assess mortality, falls, institutionalization and health service utilization (Guralnik, Fried, and Salive 1996). An appreciation for functional performance, combined with knowledge of physiological systems and environmental factors contributing to disablement renders rehabilitative professionals as excellent resources supporting health care strategies that promote independence and quality of life. Therefore, Medicaid policy limiting access to rehabilitative services possesses important implications for Medicaid beneficiaries with chronic and disabling conditions.

Cost-effective health care strategies for Medicaid beneficiaries with chronic illness and disability are essential to controlling overall Medicaid costs. However, the needs of individuals with chronic illness and disability differ substantially from other Medicaid populations. Medicaid provides access to health care for a diverse population, spanning from children to older adults, whose health care needs are equally as diverse. Appreciating the varied needs of Medicaid enrollees may lead to policies supporting more efficacious approaches to care.

Perspectives of Health and the Social Context

Perspectives of health and disability are guided by the social context, influencing approaches to health and health care. Strategies to facilitate and support health must move beyond narrowed confines of pathophysiology and embrace health as a complex, multi-dimensional entity. U.S. social welfare policy is supported by ideological beliefs idealizing autonomy, highlighting individualism over more altruistic perspectives. In a capitalist democracy, the welfare of societal members is theoretically situated within the private market, reducing the moral obligation to societal members as a whole. A loss of independence, irregardless if due to person-level or environmental factors, may reduce opportunities for choice and limit efforts toward equitable states of personal welfare. As unlimited demands are placed upon limited public sector resources, funding choices reflect societal priorities; balancing responsibilities between the private realm of the individual and the public realm of societal obligation (Field and Jette 2007: 9).

Certainly, health behaviors may be viewed on an individual level as personal choice and policy making, contributing to the formation of behaviors that influence

health. However, broader socio-cultural factors influence those personal choices. Four areas directly contributing to individual health choices are (Weiss and Lonnquist 2002):

1. Consumer products-the type of products that are available, such as “heart healthy” food items, and the associated availability of those healthful items
2. Product safety-such as manufacturer inclusion of airbags in automobiles
3. Socio-cultural beliefs and associated policy, for example accessibility requirements for public buildings
4. Media messages, promoting images of independence or dependency

Thus, the social context influences not only personal choice options, but the social acceptability of the choices made. In a broad sense, the U.S. creates a paradox by which national efforts to improve health efforts are stymied. A focus on the individual and the ability to exercise personal choice and judgment may inhibit strategies that positively contribute to the greater good and well-being of societal members. Individual policy making occurs within the backdrop of the larger socio-cultural landscape, influencing the realm of local and national policy solutions that are considered.

Utilitarian perspectives frame societies as the sum of their parts, each person fulfilling a role as a unitary, rational actor (Hollenbach 1989; McCollough 1991). Perspectives of this nature are embodied in social contract theory in which rational individuals engage socially for mutual benefit and governance through law (Nussbaum 2006: 3; Hollenbach 1989: 71). What are the implications of these socio-cultural perspectives for individuals with disability? How is variance in physical and mental ability among societal members reflected in public policy making? Social contract theory assumes equality of power and resources sustaining the quest to attain dignity and social engagement (Nussbaum 2006: 29; 36). Hence, circumstances of dependency characterized by diminished physical and mental capacity are excluded from consideration by social contract theorists (Nussbaum 2006: 33).

Political philosopher John Rawls adds a dimension of morality to perspectives of social justice using the Veil of Ignorance. According to Rawls, to achieve distributive justice and a universal perspective of social rule personal bias about a situation must be removed as if wearing a “veil of ignorance” (Stone 2002: 54). However, his theoretical position assumes equality among participating societal members for whom mutual agreement is achieved (Nussbaum 2006: 66-67). This social perspective, even those defining morality, fail to address variation in individual condition and societal induced inequity.

Social justice within the realm of contractarianism permits exclusion, failing to provide social justice for all societal members (Nussbaum 2006: 78). In contrast, communitarian perspectives highlight cooperation and compromise as a means to reconcile pluralistic interests and support the broader social good (Hollenbach 1989: 71). Communitarianism is characterized by fulfilling social relationships premised upon reciprocity, fueling meaningful experience unconstrained by perspectives of equitable contribution or gain (Nussbaum 2006: 85; 90). Hence, a truly just society is one that embraces inclusion and cooperation, avoiding discrimination premised upon individual gain and reconciled through welfare (Nussbaum 2006: 118). From this perspective, access ramps are not merely artifacts of regulatory compliance, but a pursuit of social justice on behalf of societal members.

Social justice extends beyond individual rights (Hollenbach 1989: 87). The Civil Rights movement was more than securing equal rights associated with citizenship; it was a means to forge relationships with others premised upon dignity and freedom. “The freedom and dignity of persons are achieved in communal relationships with other

persons, not in isolation” (Hollenbach 1989: 87). For individuals with chronic conditions and disability, the social context frames the development of communal relationships. Policies that promote exclusion, such as Medicare’s “in-home” requirement for medical equipment, directly inhibit social engagement and hence encroach upon individual freedom and dignity. “Quality of life not only is a state for individuals to achieve, but is inseparable from the underlying social and economic conditions with which individual and collective states of well-being cannot be achieved” (Renwick, Brown, and Nagler 1996: 131).

Conclusion

As a federal/state partnership, the Medicaid program is simultaneously subjected to national and local environmental pressures. State Medicaid policy making and Medicaid program planning plays an increasingly critical role in the lives of a particularly diverse and vulnerable Medicaid population (Ireys, Thornton, and McKay 2002: 37). The financial challenges confronting both the private and public healthcare sectors in the United States are not simply an issue of the elderly, the poor or ethnic minorities; they influence every member of American society.

Policy analysis demands a holistic and systematic approach to help illuminate complexities associated with public problems. Without a comprehensive and continual assessment of the problem structure, the solution will always miss the mark. While perspectives of universalism support inclusion, consideration for group difference as a means to obtain inclusion is understandable (Young 2006: 261). Group difference ought to be the standard for inclusion, not exclusion. Policy objectives that strive to prop up those who are different in an effort to achieve “normalcy” marginalize heterogeneity for

the sake of homogeneity. Alternative approaches might consider deconstructing existing institutions to better appreciate varied interests (Young 2006: 261). In other words, greater variation in the voices influencing policy choices will minimize the adoption of policies that negatively influence segments of the population. The objectives of policy-making then shifts from redressing differences among groups to the appreciation for the varied needs of societal members. Consequently, health policy-making for individuals with chronic conditions and disability necessitate perspectives beyond more traditional biomedical approaches.

The social context possesses the potential to reshape perspectives of health and disability, creating new policy solutions to public problems. Hence, Medicaid policy that limits or eliminates services particularly important for individuals with chronic illness and disability fails to adequately meet the health care needs of this population that contribute to social engagement and quality of life. Formal institutions are ultimately the byproduct of informal socio-cultural beliefs; and while difficult to change, change is possible (Nussbaum 2006: 410). Appreciating the reciprocal influence between formal and informal institutions permits opportunities for changing societal attitudes to influence public policy making.

While socio-economic conditions and formal institutions influence Medicaid policy making, these policy decisions reflect broader socio-cultural beliefs regarding health and disability. Societal perspectives of health and disability possesses salient policy implications, ranging from the influence upon basic rights associated with citizenship, “life, liberty and the pursuit of happiness,” to the determination of social

welfare policy and paradigms of care. Conceptual constructs of disability shape the approaches developed and adopted at clinical and policy levels.

Chapter 3

Medicaid Design and Emerging Problems

*...a state exists for the sake of a good life and not for the
sake of life only...*

Aristotle

Richard McKeon

The Basic Works of Aristotle, (1941)

The Origins of Medicaid

The signing of the Medicare and Medicaid legislation in 1965, culminated nearly sixty years of political debate, characterized by struggles for and against the role of the United States government in health care. This uncertainty, particularly in a climate of escalating environmental pressure in the public and private welfare sector, continues to this day. Is there a social obligation to provide health care for individuals excluded in the private market? And, why is state Medicaid policy- gaining increasing importance? A historical review leading to the passage of the Social Security amendments of 1965, instituting Medicare and Medicaid, describes a journey culminating with one of the most significant pieces of legislation to influence United States health policy.

The Path Toward 1965

The path toward passage of 1965 Medicaid legislation is complex, characterized by the interaction between public and private welfare states, and situated within social norms and values. Over time, past political decisions become institutionalized, circumscribing available policy decisions in the future. Political scientist Paul Pierson defines this as path dependence “...dynamic processes involving positive feedback, which generate multiple possible outcomes on the particular sequence in which events unfold” (2004: 20). An appreciation for historical sequence helps to illuminate not only the spectrum of forces influencing the policy process, but also viable policy options available to policy makers.

Early 20th century social welfare programs typically were developed and implemented at the state level. The United States industrial revolution fueled the organization of labor and new expectations of entitlement. Established in 1906, the American Association for Labor Legislation (AALL) actively lobbied for state social welfare programs. Composed of physicians, businessmen, lawyers, professors, labor leaders, politicians and social workers, this group represents diverse interests, yet, unified in support for social welfare reform. By 1915, initial success attributed to the AALL included ratification of workmen’s compensation by thirty states, supporting health care for workers of industrial accidents (Corning 1969). Buoyed by legislative success, the AALL extended efforts toward the development of state health insurance programs.

Efforts to elicit state-based support were directed toward three sources: elected officials, private interest groups and the public at large. Although early support was garnered from notables such as Theodore Roosevelt, with consideration by the American Medical Association (AMA), ultimately voter defeat at the polls led to the collapse of the

AALL health care initiatives. The health care initiatives supported by the AALL in the early twentieth century appeared antithetical with socio-cultural attitudes of liberalism and autonomy, limiting the scope of viable public health care policies. “By conditioning public attitudes toward what is expected of the individual and what is the responsibility of the government, the public philosophy can influence the way in which a nation responds to its social and economic problems” (Corning 1969).

The devastation of the Great Depression catapulted the U.S. from a state of prosperity into a state of economic chaos and uncertainty. President Franklin D. Roosevelt’s “New Deal” epitomized an activist government, serving as a beacon of light in a sea of uncertainty. The establishment of multiple government agencies, in an effort to begin repair of the economic devastation resulting from the Depression, contributed to political support for the implementation of the Social Security Act of 1935. The liberal response to the economic turmoil appeared to open a “window of opportunity” for national health reform. However, concern that inclusion of a national health care policy might deter legislative approval of the Social Security Act of 1935; President Roosevelt was eventually swayed to withhold support for medical legislation (Gordon 2003).

Following F.D.R., President Truman became a champion for compulsory health insurance and breathed new life into reform efforts. In his 1948 State of the Union Address, Truman advocated a health care program that “...would remove the money barrier between illness and therapy.....[and thus] protect all our people equally...” (Marmor 1973). Strong and visible opposition from groups such as the American Medical Association (AMA) and the National Association of Blue Shield Plans constrained Truman’s success. Although Presidents Roosevelt and Truman supported

health policy reform, a lack of broader Congressional support and a public skeptical of government intrusion continued to hold “windows of opportunity” closed. Three other attempts at universal health care, by Presidents Nixon and Carter in the 1970’s and Clinton in the 1990’s, met a similar fate. Reform opponents framed government-sponsored health care as an assault on individual choice and a limitation of freedom. Through time, health care reform has become ensnared in partisan debate. The political tug-of-war over the role of government in social welfare policy remains balanced upon an ideological fulcrum.

Over the course of the twentieth century, public policy fueled corporate and entrepreneurial investment in the health care industry (Starr 1992; Esping-Andersen 1990). Public policy helped to institutionalize employer-based health insurance as the dominant source of coverage in the United States (Gordon 2003: 76-89). The Revenue Act of 1942 permitted employers to reduce tax burden through deduction of health insurance costs. The Taft-Hartley Act of 1947 provided a mechanism for employers to contribute to benefit packages without assuming the administrative burden. Funds were then used to purchase health insurance for workers and dependents.

The growing importance of health care benefits for employees provided additional support for the alignment of labor with private interests (Morone and Jacobs 2005: 144-147). While not particularly popular with labor interests early on, eventually the legislation of the 1940’s served to align labor with those of employers and insurance companies. Employer-sponsored health insurance became a key bargaining chip as labor unions negotiated for employee health benefits. Public policies contributed not only to the development of the private welfare state, but framed the private welfare state as a

viable (preferable, according to proponents of the private welfare state) alternative to government intervention (Hacker 2002; Gottschalk 2000).

U.S. health policy has been distinctive not only in the absence of a national health policy, but the presence of an existing and extensive private welfare state; a private welfare state that handles many of the benefits provided by governments of other industrialized nations (Hacker 2002: 7). However, like the private market, failures in the private welfare state do occur. Growing gaps in private health insurance coverage fueled the 1965 amendments to the Social Security Act establishing two public health insurance programs for specific populations in the United States.

While employer-sponsored health insurance covered working-age adults, retired adults and the nation's elderly were left shouldering the burden of escalating health care costs (Engel 2006; Starr 1982). This active and vocal constituency helped revive national health care reform efforts. Although stalled in committee, the 1957 Forand Bill, introduced by Rhode Island Representative Aime Forand, proposed hospital coverage for Social Security beneficiaries (Engel 2006). Due to continued health reform opposition, the failed Forand Bill led to a more narrowed focus, the poor elderly. Although, incremental in nature, 1960 Kerr-Mills Act successfully expanded state welfare programs. Introduced by Oklahoma Senator Robert Kerr and Arkansas Representative Wilbur Mills, the Act targeted the elderly poor by instituting federal funding contributions to state programs (Gordon 2003).

Persistent attempts to institute hospital insurance for adults age 65 and older resulted in the introduction of the King-Anderson bill of 1962; and, the reintroduction of the bill in 1964. With growing public support in favor of the program now known as

Medicare, President Kennedy committed his support to making Medicare a “cutting edge issue.” By 1964, Democratic control of both the White House and Congress created an opportunity for change.

The electoral outcome of 1964 guaranteed the passage of legislation on medical care for the aged. Not one of the obstacles to Medicare was left standing. In the House, the Democrats gained thirty-two new seats, giving them a more than two-to-one ratio for the first time since the heyday of the New Deal. In addition, President Johnson’s dramatic victory over Goldwater could be read as a popular mandate for Medicare. (Marmor, 1973: 59).

The resulting legislation provided hospital and physician insurance, Medicare A and B, respectively, and a federal-state program for the poor, Medicaid (Engel 2006).

Medicare (Title XVIII) is a federal program supporting the health care needs of adults age sixty-five and older and Medicaid (Title XIX), is a federal/state partnership providing health insurance for individuals with low-income. While the initial objective of the Medicaid program was to support individuals receiving cash assistance, the program has expanded over the years to include low-income individuals and individuals with disability who are not receiving welfare assistance, but fall through the cracks of the private welfare sector (Alliance for Health Reform 2006: 3; Kaiser Family Foundation 2007a).

The Structure of Medicaid

Unlike the universal entitlement of its sibling Medicare, Medicaid is a means-tested program, in which program eligibility is established by each state according to income (Friedman 1995). Once qualified, all individuals who meet the state determined Medicaid eligibility criteria are entitled to the Medicaid services offered by that state (Rosenbaum 2002: 6350). In turn, states providing services to Medicaid eligible beneficiaries are legally entitled to receive federal funding helping to offset program

expenditures incurred by the states (Alliance for Health Reform 2006: 81; Wachino, Schneider, and Rousseau 2004: 5). Consequently, projecting future program expenditures is difficult, influenced by the number of eligible beneficiaries and the services received. At present, there are no predetermined expenditure limits; program costs increase according to demand by eligible beneficiaries (Wachino, Schneider, and Rousseau 2004: 5).

While Medicaid does not cover all impoverished individuals, it does support more than forty percent of the nation's non-elderly poor (Kaiser Family Foundation 2007a: 5). Beneficiaries must fall into certain categories, such as pregnant women and children, parents of needy families and elderly and disabled individuals receiving Supplemental Security Income (SSI), all of whom must meet specific, state determined income criteria (6). The criteria to establish SSI benefits are quite restrictive, meaning that only those with more severe disabling conditions qualify for benefits (Rosenbaum 2002: 637). These individuals lack access to health insurance in the private market or would incur such high premiums, insurance would be cost prohibitive.

Due to established income criteria necessary to qualify for state Medicaid programs, individuals tend to cycle on and off Medicaid. As personal financial circumstances change, so too will compliance with Medicaid eligibility (Lewin and Altman 2000: 50). Additionally, this "cycling" challenges continuity of care as individuals may fluctuate between Medicaid coverage and periods without insurance. Appreciating that individuals with Medicaid tend to be in poorer health compared to individuals with private insurance (Kaiser Family Foundation 2007a: 7), periods of time in which individuals are uninsured may have a more profound influence on health status.

Medicaid also serves as the primary source of long-term care insurance coverage in the United States., paying nearly fifty percent of all nursing home costs in the country (Wachino, Schneider, and Rousseau 2004: 13). Medicare provides only limited long-term care coverage following acute care hospitalization (Walker 2002: 5). While the private sector is expanding accessibility to long-term care insurance, availability is typically associated with larger companies, full-time employment status, white-collar workers and those living in urban areas (Pfundner and Dietz 2004). As the population ages, even greater strain will be placed upon Medicaid as demand for long-term care increases and fiscal pressures continue to mount.

State participation in Medicaid is not mandated by the federal government, but is a decision of each state. Currently, all states have Medicaid programs, although Arizona held out until 1982 (Kaiser Family Foundation 2006b: 1). Statutory requirements mandate state Medicaid programs provide coverage for fourteen services, including in-patient care, out-patient services, physician and laboratory services. Additionally, states may opt to provide up to thirty-four additional goods and services at state determined levels (Center for Medicare and Medicaid Services 2007). Optional services include optometry exams and eyeglasses, prosthetic devices, rehabilitation services and home and community-based services (Alliance for Health Reform 2006; Kaiser Family Foundation 2007a: 10). As states exercise greater latitude in manipulating services and cost-share for beneficiaries, implications for health outcomes have varied widely. Policies that successfully meet the needs of vulnerable populations, particularly those with chronic conditions and disability, will most likely provide adequate support to other populations. Consequently, policies that negatively have an impact on individuals in poorer health

may be detrimental to other populations of enrollees, as well (Lewin and Altman 2000: 180).

Even with the social stigma of “welfare” program compared to its sibling Medicare, Medicaid has achieved a greater degree of flexibility and ingenuity compared to its more stable and less flexible Medicare counterpart (Brown and Sparer 2003: 34). The Medicare Modernization Act of 2003, implementing prescription drug coverage for seniors, was the most substantial change to Medicare since passage in 1965. In comparison, Medicaid began undergoing change shortly after inception, gradually transforming under the influence of environmental forces.

While the private health insurance sector is rife with exclusions and carve-outs, federal law prohibits Medicaid from excluding care to beneficiaries with certain conditions (Rosenbaum 2002: 636). For example, Medicaid is the largest health care financing mechanism for beneficiaries with HIV/AIDS (Inglehart 2003: 2141; Rosenbaum 2002: 635) and pays a substantial portion of public funding for the treatment of mental illness and substance abuse (Kaiser Family Foundation 2007a: 11). As a chronic, disabling condition, HIV/AIDS demonstrates significant associations with poverty (Kates 2006) and unlike private health insurance policies, Medicaid does not exclude coverage for acute care mental health services. Undoubtedly, Medicaid plays a critical role in the public welfare sector and in the broader U.S. health care system. As the federal government transfers greater authority to the states, Medicaid is uniquely positioned to serve as a catalyst for innovative approaches to health care (Kaiser Family Foundation 2007a: 4).

Changing Medicaid Legislation

While statutory policy is often viewed as fixed, Medicaid, particularly compared to Medicare, appears remarkably changeable in response to fluctuating socio-economic and political conditions. While discussion of legislative amendments and new statutes associated with the Medicaid program follows, the present review is not exhaustive. It is intended to illustrate two key points: the sensitivity of Medicaid policy to environmental conditions and a shifting of authority for Medicaid from the federal government to the states. The discussion includes only successful legislative change to Medicaid policy. Appreciation for the potential influence of unsuccessful legislative policy, that may indirectly spark or influence the policy agenda, must also be taken into consideration.

Passage of the 1965 amendments to the Social Security Act, instituting the Medicare and Medicaid programs provided a framework for program design and implementation. A mere two years after passage of Medicaid, escalating program expenditures prompted calls for reform. While the initial statute mandated Medicaid coverage for Aid to Families with Dependent Children (AFDC) populations, the Social Security Amendments of 1967 limited eligibility to 133.3% of state AFDC criteria levels, attempting to target the neediest populations. Additionally, concern over the number of young adults failing military health screenings, prompted development of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medicaid benefit for children under age twenty-one. Essentially, EPSDT encompassed a comprehensive Medicaid health benefits package for children (Health Care Financing Review 2005-2006: 1; Kaiser Family Foundation 2005b). Five years later, the Social Security Amendments of 1972 established the Supplemental Security Income (SSI) program for aged, blind and

disabled individuals. States were required to include these individuals in state Medicaid programs. States were also given authority to annually adjust Medicaid spending levels as necessary, countering initial statutory mandates requiring states sustain consistent funding levels from year to year (Kaiser Family Foundation 2006d).

While the Democratic administration of President Johnson successfully ushered in Medicare and Medicaid, the Republican administration of President Nixon, began to change the complexion of the public welfare state, with gradual implications for the Medicaid as a federal/state partnership. The Nixon presidency (1969-1974) brought about a new era in government. Promoting “New Federalism” as an effort to streamline the federal government, Nixon instituted the first health care block grant by combining a number of separate public health grants. Nixon also expanded state authority over use of federal funds with reduced federal oversight (Bovbjerg, Wiener, and Housman 2003: 30).

The Reagan presidency (1981-1989) espoused government as the problem, not the solution, to economic challenges facing the nation (Skowronek 1997: 414). Continuing the New Federalism ideology of the Nixon years, President Reagan supported greater use of block grants in combination with reductions in federal funding (Bovbjerg, Wiener, and Housman 2003: 30). The Medicaid budget during Reagan’s presidency declined by 5.9% (Engel 2006: 181). While sixty-three percent of impoverished individuals were covered by Medicaid in 1976, the number was reduced to slightly over fifty percent by 1984 (184). Concern over declining reach of the Medicaid program precipitated a series of expansionary Congressional statutes, broadening eligibility particularly for children and pregnant women in the mid to late 1980’s.

Medicaid legislation is not simply a story of program reduction, but often a mix of programmatic expansions and contractions. Concern over increasing expenditures associated with Medicare and Medicaid, prompted passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981. OBRA “eighty-one” reduced federal funding rates to state Medicaid programs and “...totally eliminated many federal restrictions ...” (Schneider 1998). In other words, less funding would be provided to the states in combination with increased state discretion to determine eligibility criteria and reimbursement rates for some populations. OBRA eighty-one legislation no longer mandated Medicaid hospital payments equal those of Medicare payments, but permitted additional payment to hospitals serving a greater share of Medicaid patients (disproportionate share hospitals—DSH)⁵ (Mechanic 2004).

OBRA eighty-one instituted two new Medicaid waiver programs. Federal waivers grant states cost-neutral program experimentation to meet the health care needs of low-income residents, eliminating many Medicaid regulatory guidelines (Lewin and Altman 2000: 35). Waiver 1915(b) permits states to mandate enrollment of certain populations in managed care. Waiver 1915(c) permits states to provide home and community care services for individuals in place of institutionalized care (Kaiser Family Foundation 2006d). These waiver programs provide states greater latitude with which to implement state Medicaid programs.

Medicaid waivers have existed since program inception in 1965 (Kaiser Family Foundation 2005b). Approved by the Secretary of the Department of Health and Human

⁵ Disproportionate share hospitals receive special consideration for funding due to the larger proportion of care provided to low-income individuals compared to other hospitals. Criteria for consideration as a disproportionate care provider and funding levels are determined at the state level (Centers for Medicare and Medicaid Services 2007a).

Services, these waivers often are used as a mechanism to obtain federal funding for populations not typically included in Medicaid eligibility criteria, such as poor adults without children. Section 1115 waivers are a common mechanism to test the use of managed care as a cost-saving mechanism, then use program savings to expand Medicaid coverage (Kaiser Family Foundation 2005b). The 1115 waiver program permits broader, state mandated enrollment in Medicaid managed care (Kaiser Family Foundation 2001). The 1115 waivers are driven by efforts to implement broad-based programmatic reform. Compared to 1115 waivers, section 1915 waivers are narrower in nature, permitting state exclusion from specific Medicaid requirements. Waivers are specifically designed to enhance state innovation, permitting states to tailor Medicaid services to constituency need (Department of Health and Human Services 2001).

The Tax Equity and Financing Responsibility Act (TEFRA) of 1982 supports opportunities for children with disabilities living at home to qualify for Medicaid benefits without meeting Supplemental Security Income (SSI) requirements (Kaiser Family Foundation 2006d; Engel 2006). Known as the “Katie Beckett option,” a portion of TEFRA includes support for children with disabilities in the home environment, avoiding institutionalization. In contrast, TEFRA “eighty-two” provides states authority to implement cost-sharing for some Medicaid beneficiaries. The rationale for initiating out-of-pocket payments, even nominal payments of one dollar for Medicaid enrollees, was to deter excessive use of health care services. “Within a year, sixteen states adopted co-payments, twenty eliminated at least some optional Medicaid services, and fourteen reduced the rolls of eligible recipients” (Engel 2006: 169). As a cost-containment effort, legislative changes to the Medicaid program during the Reagan presidency reflect the

more conservative political motives of the Oval Office as a means to curtail inflationary economic pressures (171).

Legislation in the mid-1980's gradually expanded state coverage for pregnant women and young children and permitted state Medicaid programs to pay Medicare premiums for dual eligible beneficiaries, those older adults with low-incomes who qualify for both Medicare and Medicaid (Centers for Medicare and Medicaid Services 2007b; Kaiser Family Foundation 2002). Legislation also demonstrated a gradual shift of program authority from the federal government to the states, permitting states greater latitude over the determination of Medicaid eligibility criteria and services provided to enrollees in state Medicaid programs.

Dramatic reductions in Medicaid enrollees followed the welfare policy changes of the mid-nineties. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 sought to curb the states' Medicaid maximization strategies⁶ and cap Medicaid payment to disproportionate share hospitals (Coughlin and Zuckerman 2003: 167; Kaiser Family Foundation 2002: 176). The Personal Responsibility and Work Opportunity Act of 1996 (PRWOA) repealed the linkage between welfare benefits and eligibility for the Medicaid program (Kaiser Family Foundation 2006d). States demonstrated up to a fifty percent decrease in Medicaid enrollees.

The Balanced Budget Act (BBA) of 1997 initiated a phase-out of cost-reimbursed finance mechanisms to federally qualified health centers, reduced payments to disproportionate share hospitals and allowed states to mandate managed care for

⁶ Medicaid maximization refers to state strategies used to maximize federal funding contributions to the states. A more detailed discussion is provided in Chapter 4 of this study.

Medicaid enrollees without obtaining federal waivers (Public Law 105-33). However, BBA “ninety-seven” also expanded Medicaid coverage by instituting the State Children’s Health Insurance program (SCHIP) permitting states to cover children under state Medicaid programs whose family income exceeds Medicaid eligibility criteria (Kaiser Family Foundation 2006d).

As a means to curb federal spending, President Bush signed the Deficit Reduction Act of 2005 (DRA) on February 8, 2006. Passed in the House by six votes and approved in the Senate following a tie-breaking vote by Vice President Dick Cheney, the DRA provides states greater latitude in limiting Medicaid eligibility and services and supports greater cost-sharing by program recipients (Artiga et al. 2006). The Deficit Reduction Act (DRA) of 2005, intended to reduce federal spending on Medicaid, provides for a number of changes to the program, altering processes associated with administration and implementation.

While a substantial portion of the DRA details the means by which federal outlays will be reduced, there are portions of the DRA that provide for increased outlays for specific populations or programs. For example, the DRA provides increased funding for some children with disabilities and home and community-based programs. Federal funds will be provided to states with 2006 budget shortfalls in the SCHIP programs (State Children’s Health Insurance Program) and for health care to victims of Hurricane Katrina (S.1932 2006). The DRA legislation also launched the Medicaid Integrity Program, housed within the Center for Medicare and Medicaid Services. Modeled after the Medicare Integrity Program, DRA legislation provides additional federal staffing and

financial resources supporting identification and elimination of Medicaid fraud and abuse in state programs (Wachino and Rudowitz 2006).

Subtitle A of Title six of the DRA details the means by which reduction in the federal portion of the Medicaid program will take place (S.1932 2006). By enhancing state discretion in determining program benefits, permitting increased cost-share by program recipients, lowering payments for outpatient prescription drugs and tightening processes for asset distribution to qualify for long-term care, the Congressional Budget Office anticipated an overall federal savings of twenty-six billion dollars by 2015 (Congressional Budget Office 2006: 2). The projected savings encompasses additional outlays provided for special populations and programs noted above.

The Centers for Medicare and Medicaid Services (CMS) hold responsibility for oversight of DRA changes with the Secretary of Health and Human Services possessing authority to grant or deny state specific requests for programmatic change. While some components of the DRA require mandatory state compliance, other aspects are left to the discretion of the states. For example, states are required to place limits on pharmacy expenditures and to extend the “look-back” period for transferring assets, as a component of qualifying for Medicaid, to five years (S.1932 2006). Other elements, such as increasing premiums and cost-sharing for beneficiaries are determined at the state level (Rudowitz and Schneider 2006: 5; 15-19). Public policy, such as the DRA, provides states more authority to modify Medicaid eligibility and services, and supports greater cost-sharing by program recipients, substantially influencing the health of America’s most vulnerable population (Artiga et al. 2006).

Medicaid is clearly a more permeable public health policy compared to its more static counterpart, Medicare. The scope and breadth of each Medicaid policy change is manifested in the lives of program enrollees. As states become a focal point of Medicaid policy making, the examination of factors influencing state policy outcomes is an important step toward understanding state variance and the repertoire of policy solutions available to the states.

Disability and the Private Market: Implications for Medicaid Policy

Health insurance in the United States is uniquely piecemealed compared to national insurance programs of all other industrialized nations. As noted by political scientist Jacob Hacker (2002), these entrenched interests have been shaped by public policy decisions through time. The health insurance industry behaves rationally, seeking to maximize utility. From an insurance perspective, healthier individuals equate to lower risk, enhancing profit-driven motives. The individual with disability typically presents with higher risk and greater medical expenditures; hence, these individuals may have greater difficulty securing affordable insurance and are at greater risk for becoming uninsured. They become victims of market failure and “risk segmentation,” financially prohibiting purchase of private insurance or limiting choice to publicly subsidized coverage (Blumberg and Nichols 1998). Risk segmentation means that competing plans may disproportionately enroll either high-risk or low-risk plan members (Knutson 2007: 394).

The predominance of the U.S. private welfare state conditions health insurance as a commodity in the private market. As such, health care is subject to assumptions inherent in the market competition model (Rice 2003). These assumptions include:

- Perfect information
- Homogeneity of goods
- Freedom to enter and leave the market
- Sufficient buyers and sellers
- No significant externalities

Grounded in uncertainty and technocratic complexity, the health care market defies these assumptions. It is increasingly evident this contributes to substantial market failure in health care, that is, the inability to secure goods and services in the private market. Due to the uncertain nature of medical needs, health insurance emerges as a solution to ameliorate the unknown.

Health insurance buffers consumers against the true cost of care, such that consumers are accountable for only a portion of actual costs, and creates perverse incentives. The result is a phenomenon called moral hazard, in which lower price facilitates increase in demand. Adverse selection also challenges the private health insurance market. Those with the greatest expenditures or health needs will seek insurance providing the best coverage, even at a higher cost. As premiums rise, healthier plan participants may leave a plan in search of lower cost plans. Health care plans may have difficulty sustaining higher costs participants with fewer lower cost participants. To combat the issues associated with adverse selection, insurance payers resort to experience rating, in which those with higher costs are charged higher premiums, thereby discriminating against those most in need. Tactics such as redlining, underwriting and optionally renewable policies are exclusionary practices placing control of costs in the hands of the insurance industry often to the detriment of health care consumers.

Ultimately, market failure may limit access to health insurance. The National Council on Disability commissioned a study to investigate barriers to health insurance and services for people with disabilities. “They (disabled) have the poorest access to private sector coverage, with its exclusions, limitations, and restrictive underwriting practices” (National Council on Disability 1993). Approximately fifteen percent of persons with disabilities lack insurance. Those covered under the public health insurance system receive care in a paradigm that “fosters dependence rather than independence and isolation rather than integration” (National Council on Disability 1993). Often the type of services covered by insurance does not coincide with the needs of people with disabilities. For example, personal care services and assistive devices may not be covered or covered with limited provisions.

Medicare and Medicaid cover certain services only when they are provided in specified settings or by designated providers. These limitations mean that persons with disabilities have little choice in how their care is provided and may be required to enter an institution to access needed services. Without coverage for certain services, such as personal care, individuals may require institutionalization (Lewin-ICF 1993: xii).

As indicated, market failures in the private sector inhibit insurance coverage options for those with higher health care risks. Publicly financed coverage and the health care strategies associated with public health care programs may be the only viable option for some individuals.

The U.S. health care system is an amalgamation of private and public mechanisms created to support the health care needs societal members. The Medicaid program plays a particularly important role in U.S. health care by supporting the most vulnerable segment of the population. However, with a dual locus of control at both federal and state levels, Medicaid is subject to a multitude of socio-economic and political pressures.

As innovators in health care reform, states must develop new approaches to meet the needs of Medicaid beneficiaries.

As the administrative authority for Medicaid shifts from the federal government to the states, states are challenged to navigate through both public and private health care sectors in response to constituent demand and converging environmental pressures. Medicaid emerged as a public response to failure in the private market, forcing the government to seek “custom-made” goods and services (Kettl 1993: 15-16). While efficiency is the paramount objective in the private market, complex issues such as equity may be as important or more important in the public sector. Implementing innovative health care strategies in state Medicaid programs forces states to become more prudent purchasers of care (Hurley and Zuckerman 2003: 228). Kettl (1993) stated, “The real issue is not how to choose between the market or government. It is, rather, how to strike the best balance between them—and how to manage the problems that this balance creates...in the search for this balance, seeking the public interest is paramount” (38; 40). This approach does not advocate a “command and control” framework for the administration of Medicaid, but a “steer and negotiate” approach (World Health Organization 2008: 103) in which the public sector negotiates with the private sector on behalf of program enrollees.

To support the role as “smart buyer” the government must better define its needs; improving specificity regarding the goods and services it is seeking in the private sector. The government must work diligently to assess the producers in the private sector and to monitor the goods and services that are purchased (Kettl 1993-182). States may use contractual obligations to assure access to providers, establish quality and performance

standards. It is believed state purchasing power combined with managed care strategies enhances state purchasing power compared to fee-for-service purchasing mechanisms (Hurley and Somers 2003: 81). States are increasingly developing the role of “smart buyer,” seeking new approaches to health care for Medicaid beneficiaries, including the use of managed care.

Due to increasing enrollment and costs of federal disability programs, the Government Accounting Office (GAO) made modernizing federal disability policy a priority in 2003. In 2007, a forum of experts from the public, private and non-profit sectors, convened to address this issue. Forum participants support the innovative role of state programs, yet acknowledge the need to develop a broader mechanism, a national system, not to homogenize efforts, but to better coordinate policies and services (General Accounting Office 2007: 4-7). The Institute of Medicine also supports mechanisms to coordinate disability research, better channeling strategies toward critical issues and avoiding duplication and waste of limited resources (Field and Jette 2007: 6). Efforts to address the future health care challenges in the United States will require a better understanding of vulnerable populations and their health care needs, appreciating not only acute care, but the growing role of chronic conditions and disability. With an ever-increasingly contentious policy arena, innovation at the state level combined with coordinated efforts at the federal level may combine to serve as policy change agents.

Medicaid’s Role in the Health Care Safety Net

Low-income, under and uninsured individuals in the United States seek health care through an amalgam of providers, institutions and financing strategies composing the health care safety net (Lewin and Altman 2000). Medicaid is an essential component

of this network. An assessment of the United States health care safety net by the Institute of Medicine determined that variability in state policy combined with a lack of coordination among health care providers position the health care safety net as a fragile and fragmented mechanism of care for individuals outside the employer-based health insurance system (Lewin and Altman 2000).

Literature demonstrates that managed care may constrain available resources necessary for uncompensated care (Davidhoff et al. 2000). Uncompensated care includes care for which a provider does not expect payment or does not expect to collect on the amount due; in other words, the sum of charity care plus “bad debt” (Congressional Budget Office 2006). Research indicates that non-profit hospitals scaled back on uncompensated care in response to expansions in Medicaid managed care. This is believed to be due to reduced payment rates for service to Medicaid managed care enrollees (Davidhoff et al. 2000: 264). While states employ Medicaid managed care to use resources for program beneficiaries more effectively, fewer resources are available to safety net providers for uncompensated care of the uninsured. Consequently, Medicaid policy decisions are similar to throwing a pebble in a pond; the effects ripple far beyond program beneficiaries, themselves, influencing broader health care systems and economic factors within a state.

The Emergence of Managed Care

It was not until the Great Depression, when threats to the financial stability of medical providers due to non-payment, fueled support for health insurance programs. During much of the twentieth century, the private health insurance industry helped shape reimbursement mechanisms for health care. Grounded in a fee-for-service payment

mechanism, reimbursement strategies rewarded the use of medical services. The more x-rays provided to a patient, the more reimbursement received by the medical provider. Fee-for-service payment mechanisms are commonly considered “indemnity plans” (Rice 2003: 152). Technically, indemnity plans are fixed payments to a beneficiary per medical service received. The beneficiary then pays the medical provider. As medical providers accepted the role of private health insurance programs, they helped shape the structure of indemnity programs. Indemnity providers establish fixed payments for care. Therefore as health care costs increase, the consumer, not the provider, bears the brunt of escalating costs (Starr 1982: 291-292).

True indemnity plans place the policy holder in the center of financial risk. To avoid this risk, service plan arrangements escalated in popularity. Service plans provide payment directly to the medical provider with the beneficiary responsible for deductibles and co-payments (Shi and Singh 2004: 196). However, “indemnity” has developed more of a colloquial meaning, distinguishing fee-for-service from managed care payment mechanisms (Rice 2003: 152). Although less precise, this more common understanding of indemnity versus managed care is used in this study. Ultimately, indemnity or fee-for-service payment systems distance consumers from the costs of health care and render medical providers as gate-keepers for services, factors which have contributed to the escalating costs of care (Starr 1992).

Employment-based health care insurance and the associated tax benefits helped to entrench fee-for-service mechanisms in the United States. Revisions to the Internal Revenue Code of 1954 omitted funds paid by employers for employee health insurance from inclusion as taxable income (Mushkin 1955; Hacker 2002). Furthermore,

employers were permitted to deduct costs associated with provision of employee health coverage (Agrawal and Veit 2002: 14). The growth of private insurance through employment based coverage provided care for the middle-class while continuing to support the physicians control over treatment (Starr 1982).

The adoption of Medicare in 1965 provided health insurance for Social Security retirees while sustaining fee-for-service reimbursement mechanisms. Additionally, professional dominance by physicians inhibited health care competition, controlling both the demand and supply for health care services (Agrawal and Veit 2002: 14). The growth of third-party payment mechanisms, particularly employer sponsored health insurance, buffers both health care provider and health care consumer from the true costs of care (15).

Managed care is an economic strategy merging the American propensity for market-based policy solutions with access to a predominantly market-based health insurance industry (Enthoven 1993: 25). The idea of prepaid health care plans preceded the emergence of managed care. Early prepayment plans such as Ross Loos and Kaiser Permanente in California, started in 1929 and the 1930's, respectively, providing health services to select groups and individuals. These plans survived despite strong opposition from the medical professional community (Enthoven 1993: 27) who perceived managed care as a threat to the integrity of medical policy making (Mechanic 2004: 79).

Professional organizations, such as the American Medical Association, considered prepayment groups "socialized medicine" (Starr 1982). These prepaid group practices demonstrated reductions in health care costs due to reduced acute care expenditures (hospital costs), but provided levels of care equal to or exceeding that of fee-for-service

strategies. Prepayment group practice demonstrated increased use of preventive care with a positive influence on health care outcomes (Mechanic 2004: 79). In addition to group prepayment plans in California, early innovators also included the District of Columbia, Washington and New York (Enthoven 1993; Mechanic 2004).

Escalating health care costs during the 1970s fueled President Nixon's push for health care reform. While reimbursement strategies supported intervention for acute care, efforts to support preventive care were marginalized. "The traditional system, (President) Nixon said, 'operates episodically' on an 'illogical incentive' encouraging doctors and hospitals to benefit from illness rather than health" (Starr 1982: 396).

The Health Maintenance Organization (HMO) Act of 1973 served to legitimize prepayment mechanisms in health care (Mitka 1998). As a cost-containment strategy by the Nixon administration, the HMO Act of 1973 required employers with more than twenty-five employees at the federal minimum wage requirement to include a federally qualified HMO as a benefit option, if requested by a local health maintenance provider. Federally qualified HMOs agreed to provide a minimum benefits package, open enrollment and community rating.

While the Nixon administration was unable to implement substantial change in the health care system, individuals in the private sector developed a new strategy to infuse competition in the health care sector. Paul Ellwood, a pediatric neurologist and Alain Enthoven, a health economist, envisioned a health care system in which the government would oversee competition among private health plans to insure large groups of the population. Competition among plans would help to reduce health care costs. Known as the "Jackson Hole Group" the plan formulated by Ellwood and Enthoven was

known as managed care. The objective of this new approach was not only to contain health care costs, but to then use the savings to cover the uninsured. Managed care was formulated as a mechanism to pursue universal health care by inducing competition among private health care actors and to embrace more cost-effective preventive health care strategies (Kilborn 1998).

The conceptual model of managed care envisioned by early pioneers, such as Ellwood and Enthoven, differs from the profit-driven managed care organizations garnering attention in the 1990's (Mechanic 2004). Employers limited choice of health care plan options from the more prevalent fee-for-service plans to managed care plans; professional groups reported reduced autonomy; and, media reports focused on the denial of services to plan members. Late twentieth century efforts to reduce costs marginalized the importance of quality of care (Agrawal and Veit 2002: 37). However, public outcry questioning quality of care and reductions in provider choice associated with managed care plans fueled new changes in the managed care industry. Medical providers learned to negotiate with managed care plans and public opinion forced managed care companies to shift attention toward quality of care (Mechanic 2004: 81). Likewise, managed care forced medical providers to justify need for services, reducing unnecessary care, and further develop mechanisms for services outside of the acute care setting, helping to reduce health care expenditures (Agrawal and Veit 2002: 41). The managed care paradigm has gradually influenced approaches to health care across the United States.

The Growth of Medicaid Managed Care

As pressures mount on state Medicaid programs, managed care is being used as a cost-containment tool. The expansion of Medicaid managed care has fueled concern over

the appropriateness of managed care for all Medicaid populations, particularly those with special needs (Hurley and Zuckerman 2003: 223). State Medicaid policies define the services allowed, services excluded and co-payment fees, disproportionately affecting state Medicaid enrollees with chronic illness and disability who are the highest users of health care services. Consequently, more efficacious approaches to care for state Medicaid enrollees with chronic illness and disability contributes to overall program efficiency.

Use of managed care approaches to care did not substantially expand in state Medicaid programs until the mid-nineteen nineties. Arizona was a pioneer in the use of Medicaid managed care. Although Arizona did not implement a state Medicaid program until 1982, the state used managed care as the foundation for the newly adopted state Medicaid program (Highsmith and Somers 2000: 388). In the same year, Michigan began using primary care case management (PCCM) in the state Medicaid program. Primary care case management pays additional fees to physicians to coordinate and monitor care for plan members, even though health services are still provided through the fee-for-service payment mechanism. In other words, the physician receives payment to act as the gatekeeper for services, but services are reimbursed as rendered (388).

Federal legislation, particularly during the mid-nineteen eighties, played a substantial role in expanding state authority over state Medicaid programs, yet also expanded mandated populations for inclusion in state programs, such as pregnant women and young children. Increasing health care expenditures combined with federal legislation expanding eligibility, fueled Medicaid's growing consumption of state budgets (Highsmith and Somers 2000: 389). Federal legislation in the early nineteen nineties,

tightening payments to DSH providers, placed additional constraint on state budgets. Consequently, growing numbers of managed care organizations contracting with state Medicaid programs enhanced available supply to the states (389). States turned to managed care approaches as a means to curb escalating health care costs.

The Balanced Budget Act (BBA) of 1997 lifted the waiver requirement needed to mandate enrollment in state Medicaid managed care programs, excluding children with special needs, Native Americans and Medicare beneficiaries (Silberman et al. 2002: 259). This means policy making authority for the implementation of Medicaid managed care now rested solely with the states; approval at the federal level was no longer necessary (Kaiser Family Foundation 2001). While it would be expected greater state autonomy over state Medicaid managed care programs would enhance growth, expansion was tempered in the late nineteen nineties by withdrawal of managed care organizations from state Medicaid programs. In 1997, nearly twice as many commercial managed care plans exited state Medicaid programs compared to 1996 (Felt-Lisk 1999). Although some states experienced a loss of commercial plans serving Medicaid enrollees; the number of commercial plans entering state Medicaid managed care markets was slightly higher than the number of plans exiting Medicaid markets, resulting in a slight net gain of commercial plans participating in state Medicaid managed care programs. Shifting authority for Medicaid to the states speaks to the importance of state policy making and the influence of factors such as, state purchasing power, program reimbursement rates and state administrative requirements that influence private sector participation in state Medicaid programs (ibid).

Medicaid competes with the private sector for health care services. Dwindling profits, influenced by increasing administrative and health care costs fueled the exit of commercial managed care organizations from state Medicaid programs. Escalating health care costs driving up private sector health insurance premiums, also pressure Medicaid to increase provider payments, as well (Smith and Ellis 2001: 5). As health care premiums rise in the private sector, pressure on commercial organizations participating in Medicaid managed care increase, as well. Managed care organizations withdrawing from Medicaid programs noted inadequate state payment rates as a significant factor (Highsmith and Somers 2000: 390). Varied health care costs across the country combined with diverse health care needs of Medicaid populations challenge state Medicaid programs to tailor payment rates that appreciate contextual variance.

While Medicaid managed care is more prevalent in urban areas, research indicates comprehensive Medicaid managed care can be implemented in rural areas across the country (Felt-Lisk et al. 1999). Although greater strategic planning is required to account for fewer providers, less experience with managed care and travel needs of plan members, research revealed full-risk Medicaid managed care was implemented in ninety-four percent of areas with less than seven residents per square mile in the sample studied (Felt-Lisk et al. 1999: 241). Implementation of Medicaid managed care in rural areas incurs greater costs due to the considerations mentioned above. Although cost-savings have been noted, savings may be less in rural areas (Felt-Lisk et al. 1999: 245). Medicaid managed care remains a viable option for state policy-makers as escalating pressures converge upon state Medicaid programs.

Conclusion

Efforts early in the twentieth century to institute universal health insurance programs were met with staunch resistance from medical providers, fearing encroachment on their control in the supply and delivery of health care services (Starr 1982). Backed into a financial corner by the Depression, medical providers, physicians and hospitals considered third party payment as a means to buffer self-interests from broader economic fluctuations. In more recent times, public financing of health care has served as a catalyst for corporate and entrepreneurial investment in the health care industry (Starr 1992). Massive growth in the health care industry fostered the ability of special interest groups to mobilize substantial resources to influence the political system.

The U.S. health care industry is characterized by a complex web of private sector stakeholders, driven by capitalistic motives, and public sector programs, developed to support those excluded from the private market. Dr. Philip R. Lee, a former assistant secretary for health and scientific affairs of the U.S. Department of Health, Education and Welfare in a 1967 National Advisory Commission on Health Manpower Report, “Medical care in the United States is more a collection of bits and pieces (with overlapping, duplication, great gaps, high costs, and wasted effort), than an integrated system in which needs and efforts are closely related” (Alford 1975: 231). Due to failures in the private market, government programs, such as Medicaid, provides medical access to care for those excluded in the market.

Using managed care as a “one size fits all” approach to health care will not meet the needs of all Medicaid beneficiaries. The diversity of Medicaid beneficiaries alone, contributes to differential outcomes of policy decisions within and among states. The

examination of state Medicaid policy and the use of managed care speak to the importance of state policy making that may lead to or deter alternative health care strategies for the nation's most vulnerable population. Converging pressures in health care will force all states to confront an increasingly fragile health care system and the public necessity for reform.

Chapter 4

Use of Managed Care to Address Medicaid's Emerging Problems

Health care resembles an already over-sized teenager who keeps popping the financial seams on his clothing, is already the largest kid in the class, and gives every sign of continuing to grow until there isn't any space left in the room for anyone else

Henry J. Aaron

Conference on Health Care Challenges

Facing the Nation,(2004)

The federal/state Medicaid program is very susceptible to national and state policy cross-pressures. Concurrently, challenging economic cycles contribute to escalating demand for Medicaid, a significant component of the health care safety net. At the same time, a constrained economic climate leaves Medicaid vulnerable to federal and state funding cuts. Changes to state Medicaid policy in response to environmental conditions are significant because they affect the well-being of a growing number of

impoverished Americans. Why is Medicaid vulnerable to changing socio-economic conditions? And, how do conditions at the federal level influence state Medicaid policy making relative to conditions at the state level? What do these changes mean for beneficiaries with chronic illness and disability? Converging environmental pressures challenge state policy-makers to sustain program integrity for constituents needing a health care safety net, particularly during times of economic constraint.

The very frailties of the private health care market in the United States, characterized by escalating expenditures, declining access and coverage, necessitate more flexible state Medicaid policy. State Medicaid programs must balance increasing demand with escalating expenditures. To cope with increasing program costs and refrain from increasing taxes, states reduce the numbers of beneficiaries and services provided and/or increase the financial contribution by Medicaid enrollees. Instituting greater cost-share on low-income individuals, however, may contribute to adverse outcomes, particularly for a population exhibiting poorer health status as a whole (Wright et al. 2005). Short-term financial savings by state Medicaid programs may occur at the expense of Medicaid beneficiaries, compromising health and contributing to overall increases in acute care expenditures (Ku and Wachino 2005).

By definition, managed care provides comprehensive care through negotiated pricing. Conceptually, managed care possesses the potential to better address the needs of individuals with chronic illness through the inclusion and coordination of a broad range of services and providers (Institute for Health and Aging 1996: 13). Introducing managed care in the Medicaid program offers the promise of providing “mainstream”

access to providers and services available to privately insured individuals and Medicare beneficiaries while controlling health care costs (Gusmano et al. 2002).

More cost-effective health care directed toward the high costs of chronic illness and disability appear particularly appealing to constrained state budgets. However, a diverse Medicaid population means a blanket approach to managed care may not be appropriate for all Medicaid populations. The expansion of Medicaid managed care presents an opportunity to control costs without reducing the number of beneficiaries and sacrificing necessary services. Managed care theoretically provides more efficient utilization of available health care resources, potentially minimizing reductions in programmatic reach and services.

Changes in Medicaid policy exhibit a disproportionately greater affect on beneficiaries with chronic illness and disability due to greater service utilization (Ireys, Thornton, and McKay 2002: 39). While Medicaid provides health care for a population of low-income individuals, the needs among eligible groups vary substantially. Medicaid managed care policies that better support the needs of individuals with chronic illness and disability are likely to support the needs of other beneficiaries, as well.

The Cost of Medicaid

Containing Medicaid Costs at the Federal Level

In 2009, federal outlays for Medicare, Medicaid and Social Security accounted for approximately 45% of federal spending, an increase of 20% since 1975 (Congressional Budget Office 2009). In 2004, health care spending alone absorbed sixteen percent of the gross domestic product (GDP) (Smith et al. 2006), the highest of any industrialized nation, yet the U.S. ranks thirty-seventh of the 191 member states on World Health

Organization (WHO) health indicators (World Health Organization 2000). In 2005, Medicaid accounted for eighteen percent of national health care expenditures (National Association of State Budget Officers 2006: 46).

A growing number of uninsured adults and escalating health care costs will increasingly challenge national and state government. The Chairman of the Federal Reserve, Ben Bernanke, stated “Reform of our unsustainable entitlement programs should be a priority. The imperative to undertake reform earlier rather than later is great” (Aversa 2006). In addition to Medicaid reductions resulting from the Deficit Reduction Act of 2005, presidential initiative via the federal budget continues to extend fiscal belt-tightening for the Medicaid program. “More than four-fifths of the Medicaid saving proposals in the [Bush] Administration’s new budget [fiscal year 2007] would reduce federal Medicaid expenditures by shifting costs directly from the federal government to the states” (Schneider, Ku, and Solomon 2006: 1).

As the federal authority over the Medicaid program, the Center for Medicare and Medicaid Services proposed new rulings in an effort to curb Medicaid spending. Under the auspices of the U.S. Health and Human Services Secretary, the Center for Medicare and Medicaid Services would eliminate Medicaid payment for the school transportation of students with significant medical need, shifting costs to schools and families, as schools comply with federal law requiring transportation of these students to educational institutions (Vock 2008). Although the ruling was rescinded in 2009 (Federal Register 2009), this example demonstrates Medicaid’s vulnerability to a multitude of environmental and institutional pressures.

As Medicaid has expanded through the years, concern has risen over the potential for public programs to crowd out private insurance. President George Bush's veto of the renewal and expansion of the State Children's Health Insurance Program (SCHIP) on October 3, 2007 was influenced by those very concerns. Research analyzing expanded public health insurance in four states during the 1990's indicated crowding out was not a factor for public program expansion for individuals with incomes below 100% of the federal poverty level (FPL) (Kronick and Gilmer 2002). Crowding out was detected for individuals with incomes between 100% and 200% of the FPL; however, the extent of crowding out is undetermined (235). As the private welfare sector gradually contracts opportunities for employer-sponsored health insurance; the importance of identifying and filling health insurance gaps via the public welfare sector gains further importance.

Efforts to reduce federal entitlement spending often focus on Medicaid because of its cost and growth rate. As a health care program, state Medicaid programs provide a menu of health care services to all individuals meeting eligibility criteria. Policy solutions that suggest capping federal Medicaid funding would change the identity of the program. Placing a cap on federal Medicaid funding to the states would create two scenarios—over or under funding. State Medicaid programs cannot limit the number of beneficiaries—those who meet eligibility guidelines must receive benefits. Therefore, program costs are difficult to predict. Instituting caps on federal funding means the federal government would end up paying too much or too little to state Medicaid programs. While over funding may not be deleterious to beneficiaries, under funding may lead to the omission of needed services for qualified beneficiaries (Wachino, Schneider, and Rousseau 2004: 5). There are portions of the Medicaid program, such as

the State Children's Health Insurance program (SCHIP) and payments to hospitals serving greater numbers of poor, known as disproportionate share hospitals (DSH), in which federal funds are now capped; however, implementing Medicaid in its entirety as a capped program, such as through block grants, would drastically alter program integrity as we know it today (Wachino, Schneider, and Rousseau 2004: 7).

Containing Costs at the State Level

Jointly supported by federal and state funds, Medicaid is subject to cost-containment efforts in both political arenas. Nearly seventy-five percent of states have experienced declines in the federal medical assistance percentage (FMAP) during 2006 and/or 2007 and all states have implemented some degree of cost containment strategy during the same period (Kaiser Family Foundation 2006c). When combined with federal contributions, Medicaid is the single greatest expenditure for state budgets (Boyd 2003: 59) forcing states to reconcile reduced federal revenue either through cuts in Medicaid or other programs or by increasing taxes. Research indicates states agencies commit inadequate resources to gauge the impact of budget cuts on state Medicaid care programs, particularly managed care programs (Bailit, Burgess, and Roddy 2004: 12)

Reductions in the federal medical assistance percentage rates (FMAP), declining Medicaid enrollment and state cost containment policies have helped to slow escalating Medicaid expenditures in recent years. Peaking at an annual growth rate of 12.4% in 2002, rates progressively declined to 2.8% in 2006 (Kaiser Family Foundation 2006c). More recently, program growth averaged 7.9% in fiscal year 2009, more than twice the predicted rate and the highest rate in six years (Kaiser Family Foundation 2010b). Although the 2009 American Recovery and Reinvestment Act (ARRA) pumped federal

funds to state Medicaid programs, state funding for Medicaid remained difficult due to remarkable state budget shortfalls (ibid).

An escalation in state Medicaid spending is believed to be influenced, in part, by Medicare legislation passed in 2003 (Kent 2006). The Medicare Modernization Act (MMA) of 2003 instituted a funding mechanism known as the “clawback.” Low-income elderly individuals who qualify for both Medicare and Medicaid are typically referred to as “dual eligibles.” Implementation of the MMA shifted prescription drug spending for dual eligibles from state Medicaid programs to the federal Medicare program. To help fund the MMA, the federal government requires states to make monthly payments to the federal government to offset the federal government’s coverage of prescription medication for individuals dually enrolled in Medicare and Medicaid. State payments to the federal government do not include any federal match funds. Five states, including California, Texas, Kentucky, New Jersey and Missouri, have filed a lawsuit against the federal government citing the “clawback” will cost states more money than would have been spent for dual eligible drug coverage through state Medicaid programs. These states argue the “clawback” rates used to calculate state payments are based upon data collected prior to implementation of state cost containment mechanisms (Kent 2006). In other words, state payments to the federal government are calculated at an inflated rate.

State Medicaid expenditures vary by location and by Medicaid beneficiary group. In 2004, the average spending per Medicaid beneficiary range from \$2535 in California to \$7662 in Maine (Kaiser Family Foundation 2007a). Costs for an adult Medicaid enrollee without a disability are fifteen percent of those for adult enrollees with a disability (14). Costs for Medicaid enrollees with disability are higher than for any other

population covered in the program, including dual eligible elderly enrollees (14).

However, adjustment of Medicaid expenditures to account for the poorer health status of Medicaid enrollees demonstrates Medicaid is more cost-effective compared to private insurers (13) with substantially lower administrative costs (Kaiser Family Foundation 2005a). Medicaid's per capita growth rate is nearly half that of private sector insurance premiums (ibid).

Medicaid is an instrumental funding source for health care safety net providers. Medicaid serves as the largest funding source for community health centers and finances more than forty percent of long-term care expenditures in the United States (Kaiser Family Foundation 2007a: 3-4). As gaps in the U.S. health care system become more visible, Medicaid is often used to plug the holes. However, Medicaid is plagued by incongruity between an escalating and diverse demand and limited resources (Weil 2003: 15). As escalating health care costs challenge state budgets, state policy-makers must grapple with a growing demand for Medicaid and associated program expenditures. Challenges confronting state Medicaid programs potentially affect millions of residents in every state, as political officials attempt to reconcile the many demands for limited public resources.

State Budgets and the Role of Federal Funding

Federal Medicaid funding directly influences state economies (Kaiser Family Foundation 2004a; Wachino, Schneider, and Rousseau 2004). Predetermined federal medical assistance percentages (FMAP) are used to compute federal funding contributions to each state. The FMAP is a mathematical formula calculated by dividing the average state per capita income by the national average to determine federal funding

for each state's Medicaid program (Wachino, Schneider, and Rousseau 2004: 3). FMAP rates are higher for low income states compared to high income states. FMAP creates incentives for states to commit resources to health care; consequently, reductions in state Medicaid spending reduces federal funding to the states (Kaiser Family Foundation 2005a).

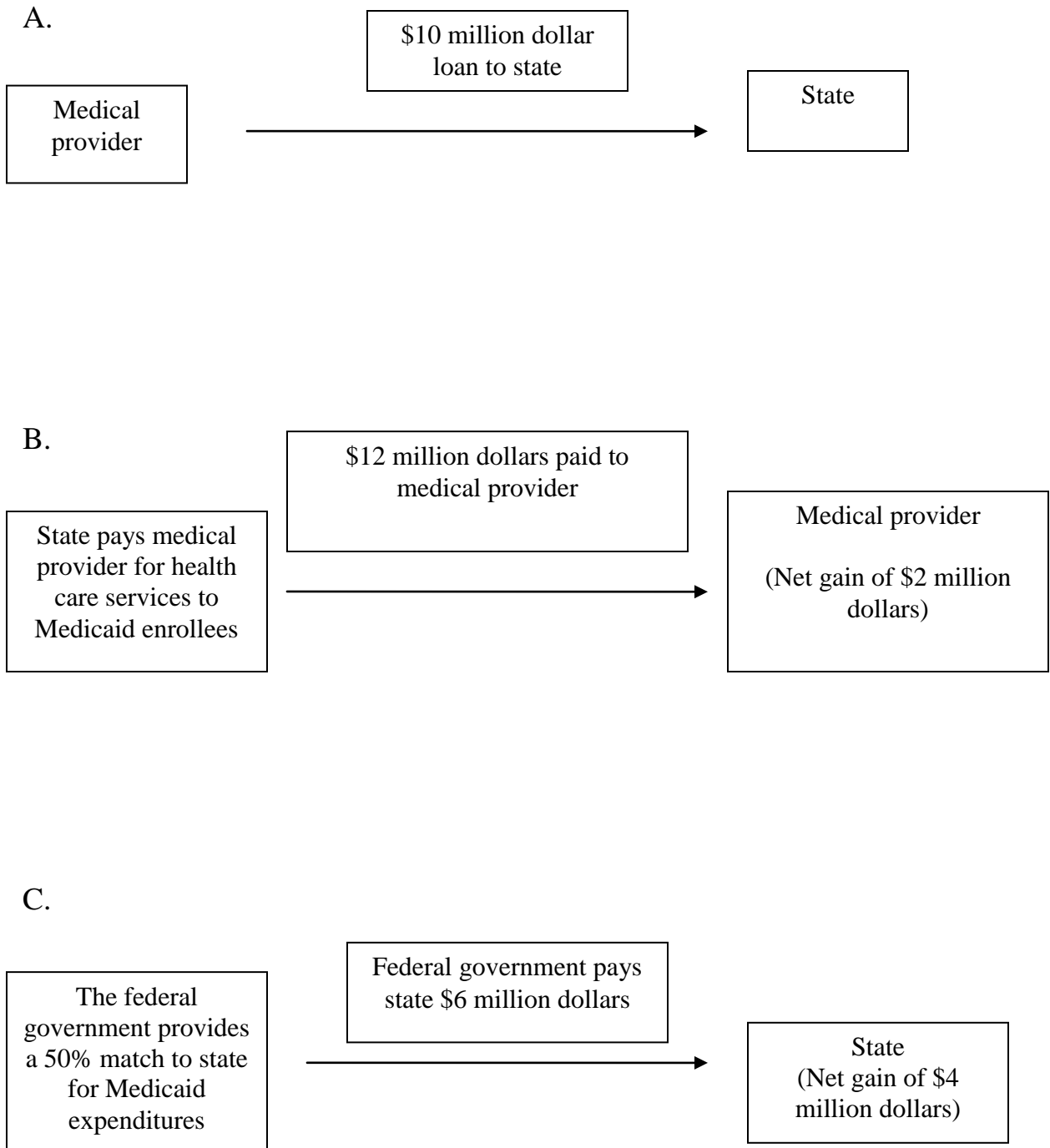
At the time of program inception, the federal Medicaid match (FMAP) was designed to be no more than 83% of state Medicaid expenditures and no less than 50%. Average FMAP for fiscal year 2008 for the fifty states is 59.63% (Department of Health and Human Services 2007). While there are no states receiving the maximum FMAP contribution, there are thirteen states at the fifty percent FMAP level; states that would actually receive lower rates of federal funding without the statutory minimum (Wachino, Schneider, and Rousseau 2004: 4). Initial program guidelines required states to include specific groups in the federal assistance program, specifically recipients of Aid to Families with Dependent Children (AFDC) and low-income individuals with blindness and disability (Kaiser Family Foundation 2006b). However, the federal match is applied to all state expenditures associated with mandatory and optional Medicaid beneficiaries and services included in state programs (Wachino, Schneider, and Rousseau 2004: 4).

Maximizing Federal Funding

States have developed mechanisms to increase federal funding for health care without contributing additional state funds, a process referred to as "Medicaid maximization," a practice which the federal government has tried to curb over the years (Wachino, Schneider, and Rousseau 2004: iii). States have maximized federal revenues by securing funds from medical providers, thereby inflating state Medicaid commitment

as a means to increase federal funding, then returning the funds back to the providers. Federal contributions are based upon state Medicaid spending, not revenues (Coughlin and Zuckerman 2003: 153). Therefore, intergovernmental transfers (IGTs) or donations from providers boost state spending, elevating match funds from the federal government. Researchers Coughlin and Zuckerman (2003) provide an excellent example, paraphrased as follows: Say a health care provider loans ten million dollars to the state. The state then pays the provider twelve million dollars in Medicaid payments. If the state's FMAP is fifty percent, the state will receive six million from the federal government. The provider made a loan amount of ten million dollars, but received twelve million dollars in state Medicaid payment, a net gain of two million dollars. The state added two million dollars of its own money to the loan amount to make Medicaid payments to the provider, but gained six million dollars from the federal government, a net gain of four million dollars. All federal match funds go toward the general state coffer, to be used as determined by the state (153). A diagram of the Medicaid maximization process is presented in figure 1, below.

Figure 1. Example of Medicaid Maximization



A similar mechanism utilizing a Medicaid regulatory loophole known as the upper payment limit (UPL), permitted states to reimburse providers at an elevated rate, then upon receipt of federal match funds, require providers to return a portion of the reimbursed funds back to the state (Department of Health and Human Services 2001). The Omnibus Reconciliation Act of 1986 permitted states to make payments to hospitals serving greater numbers of low-income patients (DSH or disproportionate share hospitals) at rates exceeding payment for Medicare patients. As a means to elevate federal funding, states unilaterally determined distribution of DSH payments, with some states diverting funds for needs other than health care (Coughlin and Zuckerman 2003: 154). Although legal at the time, these financing mechanisms substantially increased federal expenditures generating general revenue for states to be used at state discretion.

The Congressional Budget Office estimates 7.4 billion dollars or five percent of federal Medicaid spending were paid through UPL financing mechanisms in 2002 (Wachino, Schneider, and Rousseau 2004: 24-25) and DSH payments alone, significantly contributed toward sky-rocketing Medicaid expenditures in the early 1990's (Coughlin and Zuckerman 2003: 154). Research estimates that DSH and UPL payments to the states increased federal funding by an average of 3% above established FMAP rates (Coughlin, Bruen, and King 2004: 252). The additional federal payments are applied to state revenue, not earmarked to health programs; therefore, the quality of state Medicaid programs could be potentially unchanged in light of the increased federal Medicaid funds received (Coughlin and Zuckerman 2003: 165).

Funded through general tax revenue, the federal government has a vested interest in the oversight and integrity of the Medicaid program (Wachino, Schneider, and

Rousseau 2004: 10). Likewise, federal funding has significant implications for state budgets. The shared Medicaid funding strategy has a profound effect on both federal and state budgets, creating a rather contentious federal/state partnership with millions of Medicaid beneficiaries caught in the midst of the battle.

Clearly, the challenges just described, demonstrate the complexity of the Medicaid financing mechanism. While the FMAP rates can exacerbate state disparity, use of Medicaid maximization strategies can complicate the situation even further. State Medicaid programs garner more federal funding than any other state program (Kaiser Family Foundation 2004a: 3). Combining both federal contributions and state funds, states spend more on health care than any other program, exceeding state funding for education (Boyd 2003: 59). State Medicaid programs have a relatively greater economic impact on state economies due the federal match funds than any other state program. Consequently, the use of state revenues to pay Medicaid providers directly renders state health sectors particularly sensitive to changes in state and federal funding policy, with immediate impact in the health care industry (Kaiser Family Foundation 2004a: 3).

Federal funds are an inextricable component of the Medicaid program. However, in the context of an ever changing economic climate, the federal/state Medicaid partnership may be slow responding to environmental pressures (Wachino, Schneider, and Rousseau 2004: 21). Federal match contributions are fixed at an annual rate, based upon state income levels averaged over the prior three years (Prah 2005). The proportion of state budgets committed to Medicaid facilitates program expansion during economic growth, yet renders the program vulnerable to cuts as states seek to balance budgets during challenging economic climates. From this perspective, federal funding is

conditioned by state Medicaid programs. When states increase Medicaid funding, federal funding increases; when states reduce Medicaid funding, federal dollars decrease compounding state economic woes. Medicaid tends to be more sensitive to the fluctuating economic climate compared to its Medicare counterpart (Wachino, Schneider, and Rousseau 2004: 21-23).

Economic Consequences of the FMAP

Reducing federal Medicaid funding directly influences state programs. The 2005 FMAP in Missouri, for example, was 61.2% (Wachino, Schneider, and Rousseau 2004: 8). This computes to \$1.57 in federal funding per \$1 in state funding. Consequently, states carefully weigh efforts to restrain Medicaid costs which elicit reductions in federal funding. The current economic climate may mean federal Medicaid funding is insufficient to meet demand (Wachino, Schneider, and Rousseau 2004: 23). The implication of reduced federal funding extends beyond the Medicaid beneficiaries, themselves. State cuts in Medicaid expenditures also means diminished federal matching funds going toward state budgets (Wachino, Schneider, and Rousseau 2004: 23).

The 2005 Medicaid cuts in Missouri were projected to contribute to the loss of nearly 9500 jobs and a loss of nearly \$700 million dollars in economic activity (Ferber 2005: 1). Expansions and contractions in state Medicaid spending directly influence federal funding to the state (Kaiser Family Foundation 2004a). Cutbacks in state Medicaid funding may exacerbate the growing numbers of uninsured, further straining resources of local safety net providers. As numbers of the “severely” poor escalate in the U.S. (McClatchy Newspapers 2007), states will be forced to reconcile reductions in federal funding while confronting increasing demand.

Some have questioned the sensitivity of FMAP to varied rates of state poverty and state tax burden (Wachino, Schneider, and Rousseau 2004: 28). As states continue efforts to contain Medicaid costs, the FMAP may no longer provide a fiscal buffer for states during economic downturns. As Medicaid funding mechanisms change over time in response to a changing economic climate, reductions in entitlement spending are occurring in tandem with declining private sector health insurance, placing state Medicaid programs in the center of a tightening financial vise.

While FMAP does redistribute money among states, the effect does not eliminate disparity in state spending due to variance in state wealth (Holahan 2003: 130-131). Variations in state spending have a resultant influence on the scope and breadth of services and beneficiaries covered in each state (Holahan and Pohl 2003: 206). Each state participating in Medicaid is required to provide services to mandatory populations such as pregnant women, parents and children in families below certain income levels and low-income elderly and disabled, and provide fourteen basic health care services. While most states have included some degree of optional services and populations, research demonstrates that a majority of states have not significantly expanded Medicaid programs beyond that required by federal guidelines (Holahan and Pohl 2003: 211). States that have made the biggest strides in expanding Medicaid programs tend to be wealthier states, states with higher average per capita income, and those whose populations are better educated (Holahan and Pohl 2003: 206-207). While the FMAP contributions deter reductions in state funding of public health programs, the federal match does not adequately compensate for variance in state fiscal resources, leading to inconsistency in services and populations served among state Medicaid programs.

It is important to consider the effect of FMAP as states try to curb Medicaid expenditures (Boyd 2003: 67). Assume a state has a FMAP rate of seventy-five percent. This means a state spending twenty-five cents on Medicaid yields a federal government contribution of seventy-five cents towards that state's Medicaid expenditures. Therefore, to save one dollar in state Medicaid spending, the state actually has to trim the state Medicaid program back by four dollars, to compensate for the money lost from the federal match. As noted above, state efforts to curb Medicaid spending tends to exacerbate state fiscal challenges by reducing federal match funds (Wachino, Schneider, and Rousseau 2004: 23). To some extent, the current Medicaid funding mechanism can deter more cost-effective approaches in state Medicaid programs and render state Medicaid programs vulnerable to changes in federal entitlement spending. As the federal government faces an escalating federal deficit, resultant policy decisions will continue to challenge the integrity of state Medicaid programs.

Research reveals that Medicaid does possess a supportive constituency, actively influencing state Medicaid policy outcomes (Brown and Sparer 2003; Hoadley, Cunningham, and McHugh 2004). However, that constituency may be less effective as state economic constraints increase (Hoadley, Cunningham, and McHugh 2004: 154). Economic forces and conditions demonstrate a significantly greater impact on state Medicaid spending compared to political factors, such as state index of liberal ideology and party competition (Buchanan, Cappelleri, and Ohsfeldt 1991: 68-71). Ultimately, a constrained economic climate forces states to enact seemingly less noxious policy changes to state Medicaid programs, such as scaling back services or reducing provider reimbursement, to preserve program enrollment. These reductions that may be restored

without legislative approval as economic conditions improve. These changes, however, potentially compromise quality and access to care (Hoadley, Cunningham, and McHugh 2004: 153). Literature demonstrates particular sensitivity of state Medicaid program to economic conditions. Consequently, during a constrained economic climate, Medicaid must compete for limited financial resources with other public programs on both federal and state levels.

Federal Medicaid funding is the largest source of revenue to the states. However, states are increasingly gaining discretion over design and administration of state Medicaid programs (Kaiser Family Foundation 2005a). Reductions in federal funding means states must contribute additional resources or reduce Medicaid beneficiaries and services (ibid). “As the debate over Medicaid’s future continues, care should be taken that any modifications to its financing structure do not jeopardize the many benefits it brings to low-income Americans, states, and the nation’s health care system” (Wachino, Schneider, and Rousseau 2004: iii). States more dependent on federal funding and revenue from the health care industry are disproportionately affected by reductions in federal funds (Kaiser Family Foundation 2004a: 4). Medicaid policy decisions made at the federal and state level directly influence the integrity of the nation’s health are safety net.

Socio-economic Pressures on State Medicaid Programs

An unprecedented convergence of environmental pressure is fueling substantial change in state Medicaid policy. Research reveals that all fifty states and the District of Columbia have implemented strategies to contain growth and limit expenditures of the Medicaid program (Smith et al. 2004). These changes include cost controls on

pharmaceuticals, holding or reducing payment rates, implementing or raising beneficiary co-payments, imposing or expanding eligibility restrictions and/or limiting benefits (Smith et. al., 2004: 20-31). Missouri Medicaid cuts enacted in January 2005 cut more than 100,000 people from the program within the first year (Feltman and Hill 2006: 5) and eliminated services, including rehabilitation, audiology and optical services, among others (Missouri Department of Health and Human Services 2005). Recent reports indicate the uninsured rate in Missouri approached sixteen percent in 2006; three times the national average (Franck 2007: A1); an increase that coincides with the Medicaid cuts enacted in 2005 (McBride 2007).

Literature demonstrates that reductions in state Medicaid spending contributes to increased expenditures for uncompensated (Mann and Artiga 2004: 15). In 2003, Oregon obtained a federal waiver with proposed expansion of the Medicaid program called the Oregon Health Plan (OHP). New premiums and co-payments were applied to all enrollees, including previously exempt populations, such as the homeless and those without any income. Following changes to the OHP, nearly one-half of participants ended up leaving the program. The primary reason cited by those who left centered on the inability to afford the premiums and co-pays. Those leaving the program for financial reasons also indicated the need to postpone or avoid seeking care, cutting back on medications and demonstrated an increased use of hospital emergency care. While the Oregon Medicaid program instituted cost-sharing as a means to finance program expansion, the policy changes forced many eligible individuals to forgo participation (Wright et al. 2005).

Analysis of the 2003 changes to the Oregon Medicaid program revealed that efforts to reduce Medicaid expenditures by reducing services and increasing cost share actually reduced the number of beneficiaries in the program and contributed to increased emergency room visits by the uninsured (Mann and Artiga 2004: 15). Appreciating voters' distain for tax increases, states have increasingly relied on programmatic change to reduce Medicaid expenditures. Some of these programmatic changes occur to the detriment of enrollee's health care needs.

Data indicates cost-sharing may adversely affect access and health care of low-income individuals (Wright et al. 2005). Short-term financial savings may occur at the expense of Medicaid beneficiaries, compromising health and contributing to overall increases in health care expenditures. Increasing financial cost sharing on behalf of beneficiaries has a direct correlation with utilization and access to care.

The rationale for using 'cost consciousness' to drive down health costs may not work with people living in poverty, Rowland [Executive Director of the Kaiser Commission on Medicaid and the Uninsured] said. Families living on 16,000 likely would just forego medicine or a doctor's visit instead of paying a premium, she said (Vock 2006).

The complexity associated with individualized state Medicaid programs necessitates critical examination of potential outcomes associated with policy change, particularly relevant for individuals with greater health care utilization, those with chronic illness and disability (Field and Jette 2007: 277).

Literature indicates greater cost-sharing for individuals with low-income does not improve the ability to discriminate between necessary and unnecessary services; but yields a reduction in both, potentially deleterious for individuals with chronic illness and disability. A meta-analysis indicates that fourteen of eighteen studies confirmed higher

cost-sharing had a “negative effect on appropriate utilization of health services...” (Neuman and Rice 2003: 3-4). The cost-sharing mechanisms exhibit a regressive effect for individuals with low-income, meaning the co-payments are disproportionately greater for those with less income. Consequently, the financial effect on Medicaid enrollees, individuals already impoverished are more severe.

Studies in the U.S. and Canada have demonstrated that increasing cost-share for low-income individuals contributes to initial reductions in expenditures due to decreases in service utilization; however, resultant adverse effects on health contribute to the use of more intensive (and expensive) services in the long run (Ku and Wachino 2005). Co-payments of \$1 to \$3 dollars for prescription medication resulted in inability to purchase medications and related hospitalizations and emergency room visits (ibid: 6). Due to increased service utilization, Medicaid beneficiaries with disability and chronic conditions disproportionately bear this burden (Ku and Broaddus 2005: 4).

The Patient Protection and Affordable Care Act (PPACA) of 2010 will expand state Medicaid programs. This expansion is expected to reduce the number of uninsured resulting in reduced costs for uncompensated care. It is expected that nearly 95% of expansion costs will be funded by the federal government easing the financial burden on the states (Holahan and Headen 2010). The increased responsibility of state Medicaid programs to serve a larger proportion of the U.S. population means the services provided by those programs, the use of cost-sharing and the reimbursement rates to providers gain added importance. Future federal funding levels will be crucial to sustain the integrity of state Medicaid programs.

As public policy, the Medicaid program is subject to cross-pressures of changing demography, the market economy and the political environment. Increasing beneficiary contribution, tighter eligibility criteria and reductions in services may be inevitable outcomes of contracting social welfare programs (Smith et al., 2004). U.S. policy makers are challenged to better understand how these pressures and associated policy decisions influence America's vulnerable populations.

Demographic Pressures

Although working-aged Americans rely heavily on employer-based health insurance, accessibility to coverage varies substantially across employment sectors. While eighty-five percent of professional and managerial occupations have access to employee health insurance, only forty-six percent of individuals in the service sector and twenty-four percent of part-time employees have access to employer-sponsored health insurance (United States Department of Labor 2007: 12). Additionally, access rates and actual participation rates yield different outcomes. Participation rates for the employment sectors noted above are sixty-seven percent for professional and management occupations, twenty-eight percent for service sector occupations and twelve percent for part-time employees (United States Department of Labor 2007: 12). Although employers may offer employment-based health insurance, high employee contributions or increasing deductibles may limit employee participation (Reinhardt 2005). The growth of quality jobs which offer private health insurance is directly linked to strength of the economy. More prosperous economic times tends to increase numbers of people gaining private health insurance, while constrained economic growth contributes to reductions in employee coverage (Burbank-Schmitt 2006: 1).

Overall, employment-based health insurance is gradually retrenching (Kaiser Family Foundation and Health Research and Educational Trust 2005). Recent data indicates the declining number of employer-sponsored health insurance programs in combination with relatively stagnant Medicaid enrollment contributed to an overall increase in the number of uninsured in the U. S. (Holahan and Cook 2006: 1). Data indicate forty-seven million people in the United States are without health insurance (DeNavas-Walt, Proctor, and Smith 2007: 18), primarily occurring in family units with an employed individual (Holahan and Cook 2006). While the uninsured rate for non-Hispanic Whites did not significantly change from 2005-2006, the rate for Black and Hispanic populations did significantly increase, contributing to the overall increase in the uninsured population (DeNavas-Walt, Proctor, and Smith 2007: 19). Consequently, the rates of uninsured and unemployed individuals are important considerations for state Medicaid policy making. The growing number of adults aged eighteen to sixty-four needing a health care safety net is occurring at a time of unprecedented financial constraint. Environmental challenges pressuring the private welfare sector highlight the critical role of the public welfare sector.

Private health insurance policies are characterized by policy limits and exclusions, often pricing private insurance beyond the means of many individuals with disability. A 2004 Medical Expenditure Panel Survey, demonstrated that a mere point two percent of the disabled adult participants had individually purchased health insurance (Field and Jette 2007: 228). The National Council on Disability commissioned a study to investigate barriers to health insurance and services for people with disabilities. “They (disabled) have the poorest access to private sector coverage, with its exclusions,

limitations, and restrictive underwriting practices” (Lewin-ICF 1993: x). Exclusion in the private market increases reliance on the public welfare sector.

Literature demonstrates that individuals without health insurance have poorer health outcomes. As individuals are cut from the Medicaid program; the potential risk for adverse health outcomes increases. “The Institute of Medicine estimates that at least 18,000 Americans die prematurely each year solely because they lack health coverage” (Kaiser Family Foundation 2004b). Cancer patients without insurance are diagnosed later and demonstrate higher mortality rates. The American Cancer Society devoted an entire year of advertising resources to the issue of the uninsured, a risk factor that may exceed tobacco as a contributor to cancer causing illness (Sack 2007).

Extensive evidence supports the relationship between chronic illness and disability and individuals of low-income (Allen and Croke 2000). As indicated earlier, this relationship is bidirectional; poverty influences disability by limiting access to health care resources while the costs of disability may contribute to poverty (Lustig and Strauser 2007: 195). Medicaid beneficiaries with disabilities incur expenditures twelve percent higher than elderly beneficiaries and eighty-five percent higher than non-disabled adult beneficiaries. Although composing less than fifteen percent of the Medicaid population, beneficiaries with disabilities incur forty percent of total Medicaid spending (Kaiser Family Foundation 2007a). The prevalence of having three or more chronic conditions is more than three times greater for individuals with disability compared to non-disabled adults (Kronick et al. 2007: 12). Consequently, individuals with disability and three or more chronic conditions dependent on Medicaid for health insurance, account for nearly seventy percent of the acute care expenditures in the Medicaid program (Kronick et al.

2007: 23). Beneficiaries with the highest health care utilization are individuals with disability and multiple chronic conditions.

Literature indicates that Medicare and Medicaid provide health insurance for nearly fifty percent of U.S. adults age twenty-five to sixty-four years old with disability (Steinmetz, 2006:8-9). Medicaid serves as the only means to health insurance for more than forty-percent of the nation's non-elderly poor (Kaiser Family Foundation 2007a: 5). The proportion of Medicaid beneficiaries with disability is escalating, growing by more than fifty-percent from 1973-1998 (Sulewski, Gilmore, and Foley 2006: 158). Of all individuals living with a disability, women comprise the largest group of disabled persons living in poverty (Parish and Ellison-Martin 2007: 109), requiring that Medicaid policies appreciate the health care needs of this growing constituency. Additionally, greater levels of functional limitation are associated with a greater reliance on public health insurance programs (Field and Jette 2007: 228). While chronic conditions are the leading cause of disability and death in the United States, chronic illness "...is largely absent from the national health policy agenda" (Inglehart 2002: 7). Clearly, both state disability and poverty rates contribute to the demand for state Medicaid programs as a social safety net.

Economic Pressures

States are faced with a dual hardship—reductions in federal support for Medicaid accompanied by a faltering private sector health insurance base. States are challenged to develop policy solutions that are politically viable. Political opposition to increasing taxes constrains policy choices amenable to voter preferences and in the case of Medicaid, tends to leave the program more susceptible to reductions, than its sibling,

Medicare. While Social Security retirement and Medicare are considered the “third rail” in American politics, meaning that an elected official’s support for program cuts may result in a backlash at the polls, the Medicaid program supports a less influential and cohesive constituency. Cutting federal support for the Medicaid program negatively influences state economic status and potentially contributes to increasing the number of uninsured individuals in our country. A decline in federal funds forces states to confront a greater share of Medicaid expenditures. Ultimately, with tightly constrained state budgets, over fifty million Medicaid beneficiaries may be shouldering much of the burden.

The economic environment inversely influences enrollment in state Medicaid programs. A growing economy slows state Medicaid spending growth due to a slowed growth in program enrollment, while a slowing economy increases program enrollment and associated costs. Medicaid enrollment in 2007 exhibited a .5% decline, partly due to proof of citizenship requirement for eligible Medicaid beneficiaries implemented with the Deficit Reduction Act of 2005. Conditions worsened near the end of 2009 with remarkable declines in state revenue and escalating numbers of Medicaid enrollees. Nearly all states had enacted cuts in Medicaid programs (Smith et al. 2009) Clearly, state Medicaid programs are sensitive to the economic climate. Predications about state Medicaid programs are subject to economic realities of the present day.

The pressure of tightening market forces on social welfare programs is not isolated to particular geographic regions of the country, but has become a national phenomenon. The economic climate directly influences the integrity of the health care safety net. For example, the troubled housing market, which started declining in 2007,

generates lower sales tax of homes and challenges states to offset declines in revenue through reductions in state spending (Prah 2007). In light of the greatest state revenue declines in history, nearly all states confronted substantial budget shortfalls in 2009 (McNichol, Oliff, and Johnson 2010). While primary, secondary and higher education combined, accounted for 31.4% percent of 2007 state spending, Medicaid alone accounted for twenty-two percent (Prah 2007). Volatility in the economy, including current escalations in home foreclosures, is reducing state income at a time when increased unemployment rates are increasing demand for Medicaid. During fiscal constraint, states are confronted with the need to simultaneously support competing demands. As the two most expensive programs, health care and education challenge state policy makers to make difficult funding choices.

Political Scientist Charles Barrilleaux and public policy analyst Mark Miller (1988) examine the influence of market forces on Medicaid policy making. The researchers reveal that the supply of medical providers plays a significant role in demand for services and the state commitment to Medicaid spending. A 1% increase in providers resulted in a greater than 1% increase in demand for services (1099). While increased supply of providers positively influences demand, greater numbers of providers contribute to decreased state Medicaid spending. The inverse relationship between providers and demand with spending is due to the attraction of physicians to wealthier areas. Although demand increases, the overall proportion of state wealth spent on Medicaid is less than poorer states. The authors explain that diverse provider groups may exert less cohesive pressure in the policy process, failing to favorably influence policy making supporting their interests (1099-1100). More recent research contends that while

Medicaid serves a diverse population, the program has unexpectedly garnered a growing constituency (Brown and Sparer 2003). Although varied in beneficiary demographics, Medicaid's outreach to vulnerable populations, financial support of safety net providers and influence on state economies may contribute to growing political clout (41-42).

Environmental Pressure and State Medicaid Managed Care Programs

Escalating health care expenditures have catapulted health care programs such as Medicaid to the forefront of state level policy agendas. Analysis of Medicaid managed care represents a state-driven policy approach striving to effectively utilize resources to meet demand. The expansion of Medicaid managed care presents an opportunity to enhance efficient utilization of resources helping state Medicaid programs meet increasing demand for the health care safety net.

State Medicaid managed care tends to fall into two categories: risk-based plans and primary care case management plans. In risk based plans, also known as prepayment or capitation, a managed care organization is paid a negotiated rate per enrollee in exchange for the provision of health care services. In primary care case management plans (PCCM), fee-for-service payments are made to a medical provider for care of the enrollee. In addition, the provider is compensated a fee per member to serve as coordinator of care for that individual (Lewin and Altman 2000: 32). Traditional fee-for-service financing mechanisms, prevalent in Medicaid, inhibit incentives to seek alternative intervention strategies. Resources tend to be invested in tertiary care; the treatment of health conditions post onset. Theoretically, managed care models strive to keep individuals healthy by incorporating preventive care strategies in an effort to reduce or deter more intensive and expensive tertiary care intervention. From this vantage point,

managed care is ideally situated to support and sustain health as a means to achieve more cost-effective approaches to care.

Medicaid managed care is used to some degree in forty-eight states in the U.S., excluding Wyoming and Alaska (Center for Medicare and Medicaid Services 2006: 4). For example, in 2003 15.5% of all Missouri Medicaid dollars were paid through capitation (prepayment mechanisms). Arizona was the last state to implement a state Medicaid program in 1982, yet in FY2003 spent more Medicaid dollars through managed care payment mechanisms than any other state, nearly eighty-five percent (Lewin Group 2006: 4). Five other states spending more than thirty percent of Medicaid dollars using prepayment mechanisms include Pennsylvania, Michigan, New Mexico, Oregon and Hawaii (4). Medicaid managed care has been found to reduce program costs, particularly as states develop managed care strategies over time (Lewin Group 2004a).

Traditionally, Medicaid fee-for-service reimbursement rates have been held below rates for other public and private health plans, gradually contracting the number of providers rendering care to Medicaid beneficiaries. While some states, like Massachusetts, implemented more substantial reform, essentially subsidizing universal health insurance for state residents, financial and political constraints may inhibit adoption of similar plans by other states. A more incremental approach may be needed. As the use of managed care in state Medicaid programs continues to grow, the use of purchasing strategies through prepayment or case management theoretically presents an opportunity to control Medicaid costs without reducing beneficiaries or sacrificing necessary services.

If managed care is done right, however, it could offer a much better array of services than the fee-for-service system, *especially* for people with disabilities and

chronic illness. The potential of managed care to provide flexibility of services, investment in prevention, coordination of care, and a more active role for consumers could mean much more to people whose daily lives may be profoundly affected by the nature of the health care they receive (Kronick and Dreyfus 1997: 2).

Variance in health care needs associated with the diverse Medicaid population means that reimbursement mechanisms must adequately account for the influence of chronic illness and disability to adequately support equity and quality of care.

Historically, managed care has attracted healthier enrollees due to lower out-of-pocket costs. As a cost-efficiency mechanism, increasing use of managed care for the varied populations in state Medicaid programs demands greater attention to more equitable reimbursement strategies (Kronick and Dreyfus 1997: 1; 15). Risk adjustment premised upon demographics, such as age and gender, without regard to health status will not adequately support health care strategies that maximize quality of life or cost-efficiency (Kronick and Dreyfus 1997: 2). From this perspective, health-based risk adjustment encourages intervention strategies promoting efficient, quality care for plan members across the spectrum of need, paying higher reimbursement rates for individuals with more complex needs compared to healthier plan members.

States are challenged by the need to tailor payment rates that span across a spectrum of diagnoses and ability. While managed care is premised upon price negotiation for comprehensive care, the public sector has experienced difficulty aligning payment with the health care needs of beneficiaries. Often, the government has overpaid for healthier individuals and underpaid for those with more complex health care needs. A better understanding of the diverse needs of beneficiaries may guide development of more appropriate reimbursement mechanisms. A more static state prepayment structure

may inhibit inclusion of individuals with chronic illness and disability whose needs are more complex and costly (United States General Accounting Office 1996: 6).

Managed care may potentially provide a more comprehensive, cost-effective strategy of care for individuals with chronic conditions and disability compared to traditional fee-for-service reimbursement mechanisms (Kronick et al. 2007: 3). Research demonstrates an additional thirty percent of Medicaid costs associated with Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) beneficiaries may be conducive to capitation (Lewin Group 2006: 10). The SSI population, with a substantial prevalence of chronic conditions and primary provider costs, appear particularly appropriate for managed care. Assessing 2003 TANF expenditures in Missouri demonstrates that slightly over a half a million dollars of current fee-for-service expenditures could be appropriate for capitation; and, over three-quarter of a million dollars in SSI expenditures (12-14). States must learn to be prudent purchasers of health care services, tailoring reimbursement rates across a spectrum of beneficiary need.

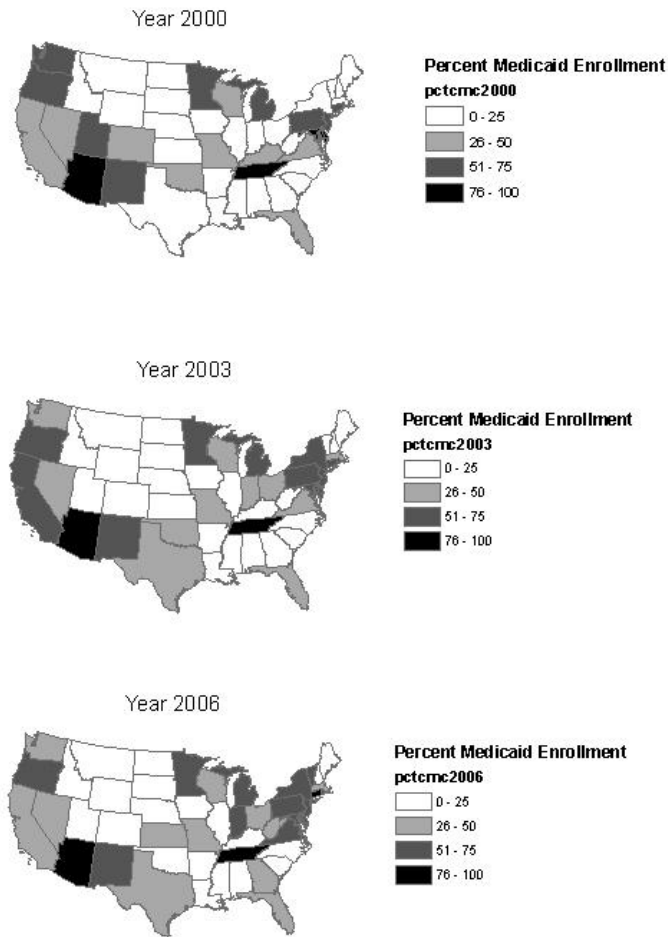
In 2008, the average enrollment in comprehensive Medicaid managed care programs relative to Medicaid enrollment among all states is slightly under 45% (Kaiser Family Foundation 2010a). These are state programs that establish prepayment plans with medical providers to provide comprehensive services to Medicaid enrollees. Table 1 provides the percent of Medicaid enrollment in comprehensive managed care plans by state in 2008 (ibid) (Appendix A).

Figure 3 illustrates the change in state enrollment in comprehensive Medicaid managed care programs over time. The maps demonstrate the gradual adoption of

comprehensive Medicaid managed care, particularly evident among neighboring states in the Northeast and middle Atlantic regions of the United States.

Figure 3. The Adoption of Comprehensive Medicaid Managed Care over Time

State Adoption of Comprehensive Medicaid Managed Care Over Time



Conclusion

Converging environmental pressures are challenging state policy decision-makers and driving changes to public programs such as Medicaid. The significance of public policy in the health of impoverished individuals is undeniable. As the only industrialized nation without some form of universal health insurance, vulnerable populations in the United States, such as the poor, uninsured and underinsured, are gradually being squeezed from both public and private markets.

States are employing cost-control mechanisms, including changes in Medicaid eligibility criteria and services covered, in response to socio-economic pressures. Pursuit of alternative health care strategies such as managed care, particularly for Medicaid beneficiaries with chronic conditions and disability whose health care needs drive a substantial portion of Medicaid expenditures, will be essential as environmental pressures converge on state Medicaid programs (Kronick et al. 2007: 36). A health care payment system that does not adjust for variance in health care needs leads to risk segmentation. State Medicaid payment systems may create perverse incentives for managed care plans to avoid high-cost enrollees, such as individuals with chronic illness, disproportionately attracting healthier plan members and exacerbating inequity for individuals with greater health needs. Similarly, adjusting payment according to risk, allows states to better use resources without contributing to escalating expenditures, particularly important in an environment of escalating socio-economic pressure.

Medicaid plays a crucial role in filling gaps associated with the private welfare market, yet, without some alteration in the existing financing structure of the Medicaid program, gaps in the public welfare sector will only escalate. Federal Medicaid

contributions via FMAP are slow to respond to changes in the economic climate and fail to reconcile variance among the states. Fee-for-service financing strategies inhibit the use of more comprehensive and preventive health care strategies possible in managed care approaches. However, managed care financing strategies that do not appreciate the differential health needs among program enrollees will result in insufficient support for individuals with chronic conditions and disability. Efforts to better coordinate Medicaid services that maximize quality of life and improve cost-efficiency will directly influence future program expansions and contractions. These changes necessitate change in health care systems and the policies that guide them and a close examination of different managed care strategies across the states.

Chapter 5

Variations in Medicaid Managed Care across the States

*The failure to address the economic repercussions
of chronic conditions by revising health policies
and health services endangers the economic
prosperity of all nations.*

World Health Organization, (2002)

Policy change requires pressures both internal and external to the political system to break through thresholds of existing obstacles to major policy change (Baumgartner et al. 2009: 11). While it is essential to understand the conditions that contribute to the stasis of health policy, it is equally important to understand mechanisms contributing to policy change. As an institutional structure, federalism permits developmental and innovative policy making at local levels. State Medicaid programs are increasingly gaining latitude from the federal government permitting state-level determination for the structure and implementation of state programs. As states gain greater autonomy in the implementation of Medicaid, the potential for programmatic variation increases.

Federalism structurally organizes political power between and among geographically defined units (Rubin and Feeley 2008: 170). In the U.S., the states are not

simply administrators of federal policy, but independent policy making agents (Dye 1990: 4). From this perspective, federalism implies relevance for the relationships among neighboring states, as states possess the latitude to determine policy paths. Do states learn about Medicaid policies from each other? Geographical relationships among states are therefore important considerations when examining state-level variance. Separating powers between the federal government and the states implicates the states as autonomous policy-makers, possessing the ability to self-determine state policy. Consideration for the role of geographic relationships in state policy-making may enhance understanding of factors influencing state adoption of Medicaid managed care.

Explaining Variation in State Medicaid Programs

A historical absence of national health care reform spurred innovative initiatives by state governments to confront a health care system plagued by increasing costs and escalating numbers of uninsured. Sharing power between the federal and state government contributes to variability in the resources available and the Medicaid policies implemented by each state. Research examining the influence of economic, political and institutional factors on state welfare policy found state wealth significantly predicted state social welfare spending with wealthier states spending more on social welfare programs than poor states (Lewin Group 2004a: 22). It appears federal spending, such as federal contributions provided to state Medicaid programs, tends to exacerbate disparity among states. The research noted that wealthier states receive higher per capita federal contributions due to higher welfare spending compared to poor states; however, federal funds comprise a greater proportion of resources available for social welfare in the poor states. In other words, while richer states have higher per capita social welfare

expenditures, poorer states have a greater dependency on federal assistance compared to wealthier states. “States with higher per capita incomes have not only a greater ability to pay for services but, typically, fewer low-income people to serve” (Holahan 2003: 130). In fact, higher state incomes produce greater increases in state spending compared to spending associated with federal and state funds combined. This means federal funding contributions to state Medicaid programs (known as FMAP) do not sufficiently reconcile spending variances among states.

The portion of state spending on Medicaid varies substantially. In 2005, Wyoming spent 7.7% of its total expenditures on Medicaid while Tennessee spent 35.7%. On average, states spent 22.9% of total state expenditures on Medicaid (National Association of State Budget Officers 2006a: 50). The economic climate significantly influences state Medicaid spending. A constrained economic climate reduces resources for the Medicaid program and occurs simultaneously with increasing demand. This is the countercyclical nature of Medicaid spending (Boyd 2003: 67), in the sense that spending increases during economic downturns.

State Medicaid programs markedly influence state economies. An analysis of the economic impact of Medicaid in Missouri reveals that each one million dollars spent on Medicaid generates \$3.1 million dollars in business activity and forty-two jobs (Ferber 2004: 6-7). In addition, a decline in state economy increases demand for Medicaid. Researchers estimate that a one percent increase in unemployment, from 4.5% to 5.5% percent, would increase overall Medicaid enrollment by 1.5 million people, producing a subsequent increase in federal and state spending approaching three billion dollars (Holahan and Garrett 2001: 2-3).

The proportion of population covered by state Medicaid programs varies across the country and is influenced by the private welfare state, the proportion of state residents with employer-sponsored health insurance. Research exploring factors contributing to state variation of employer-sponsored health insurance reveal rates of minority population, unionization, size of firms and type of labor force (full-time compared to part-time) substantially explain variation in state rates of employer-sponsored health insurance (Shen and Zuckerman 2003). As expected, states with lower rates of employer-sponsored health insurance tend to have higher rates of uninsured.

Characteristics of a state's workforce affect the types of firms attracted to the state, influencing rates of employer-sponsored insurance (248). States with a higher-skilled workforce tend to attract firms providing health insurance benefits. States with a less skilled work force are associated with fewer employment-based insurance opportunities coupled with limited resources available to support public programs, such as Medicaid (Shen and Zuckerman 2003: 250). Consequently, states are challenged to promote economic growth while simultaneously developing public programs to confront the growing health insurance gaps of its constituents. States pursue developmental policy to enhance economic growth, yet engage in redistributive policy to support constituent needs, even at a negative economic cost (Peterson 1981).

Public policy, such as Medicaid, provides the mechanism by which states attempt to ameliorate health insurance failures of the private welfare sector (Holahan 2003: 122). For the general population, rates of employer-sponsored insurance are better predictors of state uninsurance rates than rates of population covered by public health programs. However, for low-income populations, rates of employer-sponsored health insurance and

rates of public health insurance coverage are important for predicting uninsurance rates (Holahan 2003: 126-128). Hence, state Medicaid programs must be cognizant of both the private and public insurance base and the potential influence on demand for state Medicaid programs.

While states with greater numbers of Medicaid enrollees may be an indicator of greater demand for the health care safety net, analyzing Medicaid enrollment rates must be approached with caution. Medicaid provides financial support for health care services; it does not guarantee access to care. In fact, low Medicaid reimbursement rates may constrain access to care. In 2003, Medicaid reimbursement was sixty-nine percent of the Medicare reimbursement rate and even less compared to private insurance (Cunningham and May 2006). Research indicates the number of physicians not accepting new Medicaid patients increased from 19.4% in 1996-1997 to 21.0% in 2004-2005. This means greater numbers of program enrollees receive care from fewer providers (ibid).

The Center for Studying Health System Change reveals that over twenty percent of physicians surveyed, reported not accepting *new* Medicaid patients in 2004-2005, a rate five to six times higher compared to individuals with private insurance and Medicare, respectively (Cunningham and May 2006). Existing Medicaid reimbursement rates have been held below rates for other public and private health plans, gradually contracting the number of providers rendering care to Medicaid beneficiaries. As states modify Medicaid policy, altering services provided and eligibility criteria, appreciation for policy outcomes that may actually exacerbate the number of uninsured and underinsured individuals in need of a health care safety net must be considered.

Managed care has experienced varied degrees of success in Medicare and Medicaid; however, state purchasing power may be used to enhance participation. For example, Minnesota requires all Minnesota health plans to participate in Medicaid managed care to obtain HMO licensure (Holahan, Rangarajan, and Schirmer 1999: 9). In addition, Minnesota tailors negotiated managed care rates to secure access for high risk beneficiaries, countering adverse selection and holding companies accountable for efficiency and quality of care (Holahan, Rangarajan, and Schirmer 1999: ii). Assessment of HealthChoices, Pennsylvania's Medicaid managed care program reveals substantial cost savings, low administrative fees and the provision of services exceeding those rendered under a fee-for-service approach. The successful implementation of the HealthChoices program has contributed to sustaining integrity of service and reach to beneficiaries while other states have implemented Medicaid reductions (Lewin Group 2005: ii).

The Pennsylvania HealthChoices program demonstrates improved case management and disease management approaches and enhanced sensitivity of special needs compared to more traditional fee-for-service strategies. Research comparing the comprehensive HealthChoices managed care program with fee-for-service and primary care case management services to Medicaid beneficiaries in Pennsylvania revealed the comprehensive managed care program excelled in cost-effectiveness and quality of care, including the ability to better address the health of individuals with special needs (Lewin Group 2005). Health care expenditures in the HealthChoices program demonstrate an average annual increase that is 3% lower than the fee-for-service Medicaid beneficiaries.

Low provider payment has plagued Medicaid since inception. Health care providers may elect to participate in state Medicaid programs, thereby influencing access to care. Lower fees, particularly with regard to commercial insurers and Medicare, contribute to reduced access due to limited providers. Provider payments have actually increased under the Pennsylvania HealthChoices program compared to the traditional fee-for-service reimbursement mechanism (Lewin Group 2005). In addition, Pennsylvania established access standards for managed care providers. For example, urban HealthChoices enrollees must have at least two primary care providers accessible within thirty-minutes; or, one hour for rural enrollees (ibid). A study of pediatric mental health services revealed that Pennsylvania counties with a HealthChoices program demonstrated increased rates of outpatient services compared to fee-for-service. Overall, outpatient mental health services are provided at higher rates for children in urban areas compared to rural areas; however, service provision remains higher for HealthChoices enrollees compared to fee-for-service clients even in rural areas (Robertson and Husenits 2007) .

Fee-for-service is a mechanism for the reimbursement of health care services. As such, strategies to monitor the quality of those services, to hold providers accountable for health outcomes, never sufficiently developed. As a managed care system, HealthChoices is obligated by the Center for Medicare and Medicaid Services and the State of Pennsylvania to track health outcomes, establish standards of care, and implement independent and consumer driven quality assessment mechanisms (Lewin Group 2005). Although primary care case management is considered a form of managed care, quality standards are remarkably less developed compared to comprehensive managed care programs (ibid). Mechanisms such as the Consumer Assessment of Health

Care Providers and Systems (CAHPS) a public-private partnership with the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ). Managed care programs, such as HealthChoices, conduct annual consumer surveys, comparing outcomes among participating managed care programs. The 2009 report provides outcomes associated with service provision and consumer satisfaction for each region of the state participating in the HealthChoices program (Pennsylvania Department of Public Welfare 2009).

A comparison of Wisconsin Medicaid beneficiaries to fee-for-service beneficiaries indicated improved performance on quality measures for the managed care group (Lewin Group 2004b: 12). States have demonstrated innovative approaches to support the varied needs of program beneficiaries. Research of Medicaid managed care in four states exhibited varied outcomes influenced by the type of individuals served by Medicaid, geographic disparity contrasting rural versus urban areas and the types of managed care programs included in state Medicaid programs (Coughlin and Long 2004). The researchers discovered that implementation of managed care for Medicaid beneficiaries enrolled through TANF, yielded little improvement in access and utilization patterns. For beneficiaries with disability, managed care demonstrated improved access for rural enrollees, but not for urban enrollees (82-83). Continued research is needed to assess the expansion of Medicaid managed care as a mechanism to sustain program integrity in an environment of growing state fiscal constraint.

Policy Diffusion among States

Political ideology and institutions implicates the importance of geography in the policy making process. Geographic patterns of “red states” and “blue states” are a

prominent media tool demonstrating ideological relationships among the states. As noted earlier, federalism holds particular relevance for geography, as states develop policies independently of the federal government. The geographic influence on policy making has been demonstrated in economic terms, such as the influence manufacturing plant closings or closing of military bases. However, the influence of geography factors influencing Medicaid policy making is underdeveloped. As states gain greater authority to tailor the Medicaid program, a better understanding of spatial relationships among states may shed light on influential factors contributing to state Medicaid policy making.

The adoption of managed care by state Medicaid programs varies substantially. Health care costs are typically identified as the culprit driving state programs to adopt managed care. Yet, while health care costs consistently increase across the United States, substantial variance in the use of managed care in state Medicaid programs exists. Escalating health care expenditures alone, cannot explain the variance in the adoption of managed care in state Medicaid programs. Policy diffusion literature is aimed at understanding the conditions supporting the adoption of new policy (Walker 1969: 881). Policy diffusion is not simply emulation of existing policy or policy adoption driven by competition among states. It is a learning process, a critique of existing policy that informs policy making in a new context (Mooney 2001: 120).

Research demonstrates a significant relationship between state wealth and state spending on social welfare programs (Lewin Group 2004a). Similarly, seminal work in policy diffusion contends the adoption of new policy by states is influenced by the availability of slack resources (Walker 1969). Interestingly, more recent investigation finds little evidence that state wealth, political ideology or the policies of contiguous

states significantly predict policy adoption by states (Karch 2007: 44). Outcomes of this research reveal national policy was a statistically powerful predictor of innovative policy adoption by the states (44). This research suggests that vertical diffusion (top down or bottom up) may be more influential in state policy making compared to horizontal diffusion (the adoption of state policy influenced by existing policies in other states) (Karch 2007: 41). A better understanding of potential factors influencing policy making is needed.

There are two conceptual mechanisms by which horizontal diffusion occurs. First, policies spread laterally (horizontally) among agents who are in competition with one another. For example, one state may modify local tax code relative to a neighboring state in an effort to attract business and industry. Economist Charles Tiebout (1956), frames government policy making as competitive in nature with constituents behaving as rational actors, actively pursuing residency based upon preferences of available public goods (418). Scholars have argued that state welfare policies are influenced by the policies of other states, such that states will resist setting welfare benefits too high, avoiding an influx of impoverished individuals to the state (Peterson and Rom 1989: 725). An alternative perspective contends policies may spread among agents as a result of policy learning. Federalism provides states authority to develop local policy, a means by which states may learn from the experiences of one another. States may pursue policies that have proven successful in other states or purposefully avoid policies that appeared as failures. As the federal government has increasingly relinquished control of the Medicaid program to the states, the role of spatial relationships gains added importance.

Research analyzing the geospatial characteristics of Title IV of the 1935 Social Security Act, Aid to Families with Dependent Children, demonstrated that neighboring states influence state welfare policy making more than state poverty rates, Democratic control of state institutions, per capita income, or ethnic composition of welfare enrollees (Rom, Peterson, and Scheve 1998: 36). From this vantage point, states with more generous welfare benefits may become “welfare magnets” attracting impoverished individuals in pursuit of better benefits (Peterson and Rom 1989: 725). States then behave as rational actors, establishing welfare policy in response to its neighbors, deterring escalation in demand (Rom, Peterson, and Scheve 1998: 36). Thus a “race to the bottom” would ensue. States would lower welfare benefits to avoid the economic strain of attracting constituents who might escalate welfare demand.

More recent literature challenges perspectives of welfare migration. Political scientist Thomas Dye notes that public welfare recipients lack resources necessary to comply with mobility assumptions supported by Tiebout. In fact, the low-income are the least mobile constituency members (Dye 1990: 19). Dye contends state welfare policy is more a function of aggregate wealth within a state than pursuit of individual public good preferences (1990: 18). Geospatial models used to assess welfare policy among states have been further developed to analyze low-income migration patterns due to better economic opportunity versus better welfare benefits (Berry, Fording, and Hanson 2003: 329). Outcomes from a 2003 study suggest that economic opportunities are a much greater draw for low-income individuals than state welfare benefits (2003: 345). Consequently, state efforts to spur economic growth and development appear to elicit state competition more than social welfare policy.

Research demonstrates like attributes of neighboring states, including similarities in economic, geographic and demographic conditions, relative to distant states influences policy diffusion (Mooney and Lee 1995: 605). Findings indicate that early abortion reform, prior to *Roe v. Wade*, demonstrate significant regional diffusion patterns. Research of an early twentieth century welfare program, Mothers' Aid, was initially governed at the state level, but later served as the model for development of the federal Aid to Families with Dependent Children (AFDC) program (Allard 2004). Outcomes revealed statistically significant diffusion among states, with states implementing more generous programs in response to programs of neighboring states. This research highlights the importance of temporality in diffusion theory. While competition may be influential for well-established programs, policy learning may be particularly influential during early program adoption.

New social welfare programs are a response to surrounding political, economic and social conditions, which mitigate the impact of competitive pressures. When adopting new programs, therefore, states will turn to their neighbors for innovations, program models perceived to be successful, and legitimacy for a new social welfare initiative (Allard 2004: 522).

Research indicates policy learning and competition among states does occur and does so in regional, geographic patterns.

Political scientists William Berry and Brady Baybeck (2005) investigate competing hypotheses of horizontal diffusion, examining interstate competition versus policy learning as determinants of state welfare benefits. Outcomes reveal state welfare benefit decisions are predicated upon policy learning, by which contiguous states tend to learn and establish welfare benefit levels relative to those established in neighboring states (2005: 518). The policy learning/competition dynamic is premised upon the

assumption that state policy making is influenced by geographic proximity. Two spatially based models, the neighbor model and the fixed region-models, contend that geographic proximity influences policy making (Berry and Berry 1999: 175).

Growing evidence refutes state competition as a significant determinant of state welfare policy making (Berry, Fording, and Hanson 2003; Allard and Danziger 2000; Hanson and Hartman 1994). Social learning theory contends that learning or emulation occurs in a social context due to the observation of others (Jencks and Mayer 1990; Bandura 1977)⁷. Political scientist Jack Walker's seminal work on policy diffusion (1969) contends that social learning provides an expedient, rational means of policy making. He further posits that patterns of diffusion are regional in nature. Initial adopters are followed by adoption by neighbors resembling "spreading ink-blot on a map" (Walker 1973: 1187).

Interestingly, Karch (2007) finds limited evidence that state wealth, political ideology and policies of contiguous states are significant predictors of policy adoption by states (44). However, national policy did prove to be a statistically powerful predictor of innovative policy adoption by the states (44). The research conducted by Karch (2007) suggests that vertical diffusion (top down or bottom up) may be more influential in state policy making than horizontal diffusion (the adoption of state policy influenced by existing policies in other states). However, this research may not account for the influence of temporality on outcomes. The twenty-eight states adopting medical savings account programs did so between 1993 and 1997, a period of time before the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation took effect. In this regard, substantial state diffusion occurred prior to the federal mandate,

⁷ Albert Bandura is often credited for the genesis of social learning theory

challenging vertical diffusion as a causal influence in the spread of state medical savings accounts.

Policy Diffusion and Medicaid

Due to the variation in the adoption of Medicaid managed care, I propose state programs are influenced by horizontal diffusion, specifically policy learning. The United States Medicaid program encompasses both vertical and horizontal policy diffusion. The Medicaid program possesses a dynamic statutory history, with the federal government implementing budgetary and policy change at the national level. However, as a federal/state partnership, the Medicaid program also provides states latitude to develop innovative policy solutions and tailor state Medicaid programs which may then disseminate to other states.

Political scientist Virginia Gray finds that diffusion patterns vary by policy area and state fiscal status may distinguish innovative states from laggards (1973: 1182). Analyzing survey data from state administrators reveals that influential forces in state policy making varies by policy area (Light 1978: 147). Data indicate the state level social service sector is influenced more by the national government than by other states. Policy diffusion from the national government to the states is also influenced by state dependence on federal fiscal support (Light 1978: 152). The more dependent a state on federal funding, the more influential national policy appears to be at the state level.

Volden, Ting and Carpenter (2006) have developed models to help distinguish policy diffusion through learning compared to simultaneous policy adoption. These models use temporality and the adoption of policies beyond the centrist range to capture policy learning across states compared to intrastate policy learning and adoption. This

type of research possesses significant implications for federalism. Detection of policy learning among states is consistent with principles of federalism in which states possess autonomy to develop and adopt innovative policy solutions. Research efforts that focus on intrastate policy mechanisms may fail to appreciate exogenous factors contributing to state policy making efforts. Conversely, a lack of horizontal diffusion may implicate the central government as a potential policy arena of choice for some issue areas. In other words, constrained ability to draw upon the policy experiences of other states yields greater dependence on the national government as a policy change agent (Volden, Ting, and Carpenter 2006: 2).

While competition models inform our understanding of variance among geographic areas (people move to areas with desirable policies), alternative perspectives suggest migration contributes to “convergence” among fiscal policies of geographic areas (migration contributes toward increasing constituent homogeneity with fiscal policies becoming more alike) (Annala 2003; Scully 1991). In this regard, convergence contradicts Tiebout’s competition theory which is premised upon geographic variation. From Tiebout’s perspective, people move to areas implementing preferred public policies. Therefore, heterogeneity is reinforced by migration patterns. Convergence proposes the opposite. Migration patterns facilitate the adoption of similar policies by geographic units, contributing to the convergence of policy and an increasing homogeneity among geographic units. The research did not find statistically significant convergence of health and hospital expenditures; however, state welfare policies converged at rates faster than all other fiscal variables (Annala 2003: 159).

Further research assessing the convergence of state fiscal policy found that state revenue growth, operationalized using growth in tax rates, and state economic growth, assessed via gross state product, appears to be influenced more by neighboring states than expenditure growth (Coughlin, Garrett, and Hernández-Murillo 2006). This relationship exists regardless of similarities in demographic characteristics. Conversely, expenditure growth was found to be associated with states sharing similar economic and demographic characteristics. States continually have to balance the use of resources to support allocational, developmental and redistributive policies. The ability to support the health care needs of Medicaid enrollees in a more efficient manner facilitates use of state resources for growth-oriented efforts. This is particularly relevant for state adoption of Medicaid managed care programs.

State Medicaid programs are only partially funded by the federal government through the FMAP. Substantial portions of states' budgets are used to support Medicaid programmatic costs. While state spending appears to be influenced more by "like" states than by contiguous states; state growth appears to be influenced more by neighboring states than by "like" states. Declining revenues experienced in many states in recent years has directly contributed to reductions in state Medicaid programs. While federal stimulus funding prohibited states from tightening Medicaid eligibility criteria in 2009, a key mechanism states use to reduce enrollment and program costs, states have cut in other areas, such as lowering reimbursement rates or reducing services (Grover 2010).

State revenues play an important role in state Medicaid programs. Theoretically, Medicaid managed care provides a more cost-efficient mechanism to provide comprehensive health care services to program enrollees. Using Medicaid managed care

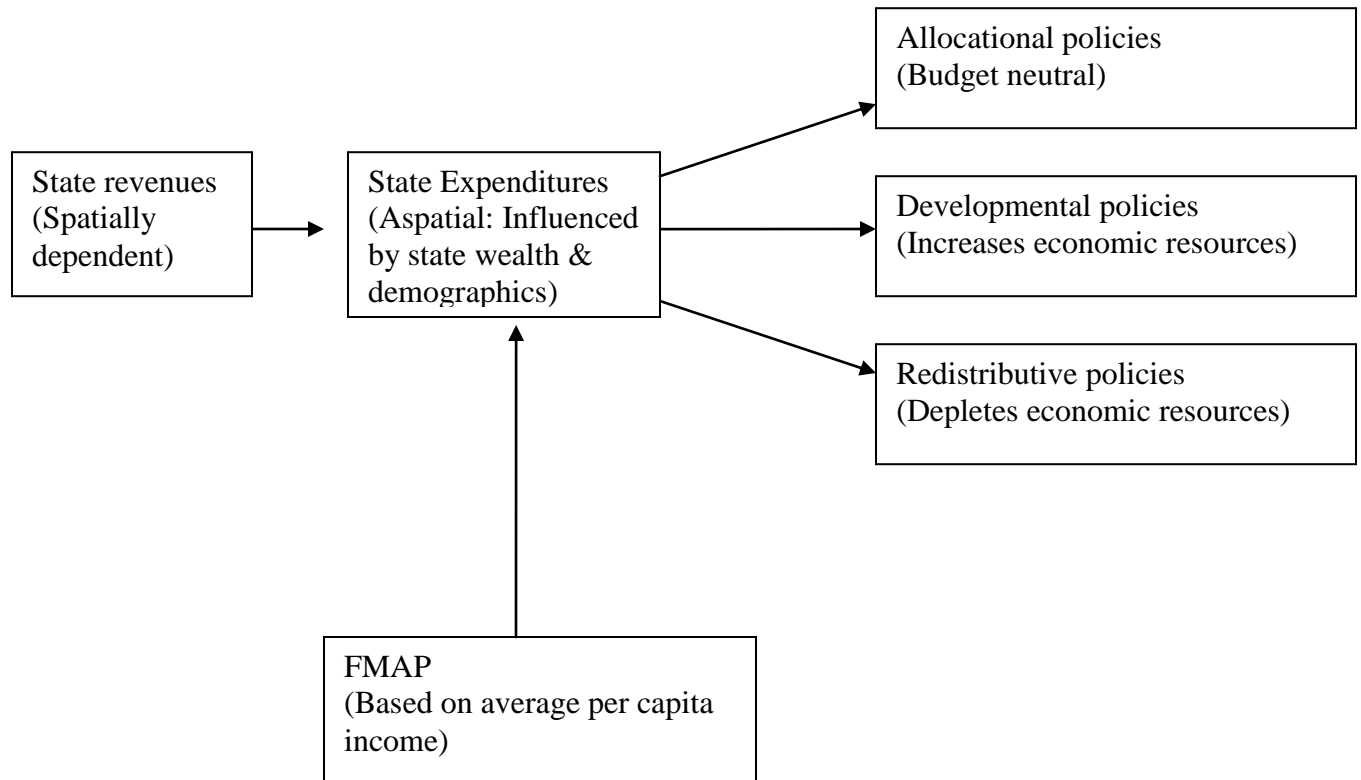
as a means to support program enrollment and preserve services for enrollees may have direct consequences for state revenue growth, particularly during depressed economic climates. Economic competition among neighboring states to drive revenue growth directly influences resources available for state Medicaid programs.

Previous research found state wealth to be a significant factor in social welfare spending (Lewin Group 2004a; Holahan and Pohl 2003). While wealthy states may spend in a manner similar to other wealthy states, that wealth is influenced by economic competition among neighboring states. The demand or need for social welfare programs is not empirically associated with a greater use of redistributive programs (Sharp and Maynard-Moody 1991: 947). Available resources for redistributive policies are directly influenced by state economic growth. In this regard, states with lower economic growth may possess fewer resources to support redistributive programs.

While the federal contribution helps to support state Medicaid programs, the funding percentages (FMAP) is based upon state personal income and may be insufficient to permit a state to adopt innovative programs or to reconcile disparity in state economic growth. This federal-state Medicaid formula is especially critical when considering the relationship between disability and poverty. A state with higher rates of poverty will likely exhibit higher rates of disability and a greater demand for Medicaid. Combined with lower economic growth, neighboring states exhibiting these characteristics will be more dependent on federal contributions for state Medicaid programs than states exhibiting greater economic growth. Appreciating the variation in economic growth among states, lower growth states may possess fewer economic resources to implement

alternative strategies, such as Medicaid managed care, which serves as a mechanism to expand state programs. This relationship is illustrated in figure 4.

Figure 4. Spatial Relationships and State Policy



While state expenditures are influenced by income and demographic characteristics, state revenues and economic growth are influenced by the economic growth of neighboring states. States do compete with each other economically and research demonstrates that revenue-producing policies, such as tax policies, are influenced by neighboring states (Hernández-Murillo 2003). While states may not engage in a “race to the bottom” in regard to social welfare policy, economic growth between neighboring states may ultimately influence state resources available for social welfare policies.

The Medicaid program represents an important case for analysis. As the federal government shifts greater authority for the Medicaid program to the states, the

importance of tailoring state Medicaid programs to meet the varied needs of beneficiaries, particularly individuals with chronic illness and disability holds greater significance. Assessing the presence or absence of interstate policy diffusion may enhance our understanding of policy determinants influencing state Medicaid programs. The presence of horizontal diffusion means the devolution of programmatic authority for Medicaid from the federal government to the states will permit states to draw upon the experiences of others to creatively develop policy solutions to state Medicaid issues. The absence of horizontal policy diffusion means the shift of authority for Medicaid from the federal government to the states may actually inhibit state response to the converging environmental pressures confronting state Medicaid programs, particularly important for states more dependent on federal welfare funding.

Policy diffusion serves as a mechanism by which policies reach state policy agendas. Research finds that events at the national level significantly influence state policy making, supporting the influence of vertical policy diffusion (Karch 2007). The national spotlight on a unique state policy influences policies of other states (100-101). As federal authority over the Medicaid program recedes, states are positioned to adapt to these national changes in unique ways. The manner in which states respond is not dictated by the federal government, but left open-ended, to the discretion of the states. It is not national attention that is fueling change at the state level, but a retrenchment by the federal government that is forcing states to pursue alternative state Medicaid policies. Therefore, factors influencing the adoption of Medicaid managed care may be driven less by vertical diffusion mechanisms, necessitating attention to the role of horizontal

diffusion as an influential factor in the adoption of managed care by state Medicaid programs.

The utility of spatial analytical methods as a tool to inform policy analysis is still developing. Consequently, limited research has been conducted to evaluate the role of spatial relationships in state Medicaid policy making. Spatial analysis is one mechanism that may be used to detect differential outcomes of policy decisions. Analysis of Medicaid decisions in Ohio indicate state-level policy changes will exert varied impact among counties within the state. Outcomes reveal non-random clustering of beneficiaries according to demographic characteristics. For example, policy decisions to reduce Medicaid payment rates to long-term care facilities will differentially impact counties with higher percentages of elderly beneficiaries (Greenbaum and Desai 2005: 15). Spatial analysis and the use of spatial weighting provides an analytical approach to examine the consequences of policy decisions that may be used to inform the policy making process (Desai, Greenbaum, and Kim 2009).

Conclusion

Over time, state Medicaid programs vacillate between expansion and retrenchment in concert with changes in economic climate. Additionally, policy diffusion, both vertical diffusion and horizontal diffusion, provide opportunities for change in state policy. The adoption of managed care in state Medicaid program represents a significant paradigm shift from traditional, fee-for-service provision of health care services and reimbursement mechanisms.

Innovative states, such as Pennsylvania and Florida, specifically targeted Medicaid managed care programs for individuals with disability and chronic disease.

States understand the importance of developing new approaches to care for beneficiaries whose chronic conditions consume 70-80% of state Medicaid budgets. Other states, such as South Carolina, are following suit, developing approaches to the provision of Medicaid services that better support the needs of populations with special needs (Hurley and Somers 2003: 85-86)

A number of exogenous forces may contribute to state policy making, including policy-decisions made by other states. As a federal/state partnership, federalism is an inherent component of Medicaid, linking geography to policy making as states tailor policy to unique circumstances (Gimpel and Schuknecht 2003). Assessing the presence or absence of interstate policy diffusion may expand consideration for policy determinants beyond socio-economic and political system characteristics. Spatial analysis provides a mechanism to better understand state policy choices and the differential effects of those decisions.

As policy change agents, states exert remarkable influence on the health of low income constituents, particularly those individuals with chronic conditions and disability. The adoption of alternative approaches to care, such as comprehensive managed care, may be implemented in a manner that supports health outcomes as well as cost-efficiency. States must behave as “prudent buyers” and serve as advocates on behalf of Medicaid beneficiaries to assure standards for access, cost-efficiency and health outcomes are salient characteristics of Medicaid managed care programs. While states demonstrate remarkable variation in the adoption of Medicaid managed care, clearly states, such as Pennsylvania, recognize the importance of balancing quality of care and cost-efficiency.

Chapter 6

Research Design and Results

What we have in the United States is not so much a health-care system as a disease-care system

Senator Ted Kennedy, 1994 (Telegraph.co.uk 2009)

This research is motivated by the importance of understanding why some states use comprehensive Medicaid managed care for enrollees with chronic illness and disability more than others. Medicaid is one of the most costly programs for all state budgets. As a redistributive program, Medicaid uses valuable financial resources to support constituent health care needs, diverting resources from economically-driven growth efforts. As a proven cost-reducing mechanism to provide health care services, it would be expected that all states would use managed care, particularly for high-cost program enrollees, such as those with chronic conditions and disability. Interestingly, state variation in the use of Medicaid managed care for individuals with chronic illness and disability exists, yet the reasons underlying this disparity are poorly understood.

What contributes to the remarkable variation in the use of Medicaid managed care among the states? Sustaining and improving health through the efficient provision of care, particularly for enrollees with chronic illness and disability who incur higher health care costs, means greater cost savings for state budgets. The use of panel regression

analyses used in this study is intended to more fully explain the adoption of comprehensive Medicaid managed care as a result of redistributive and developmental policy determinants; and, demographic factors influencing program demand. A better understanding of factors influencing variance in the use of Medicaid managed care at the state level is underdeveloped, important in the lives of program enrollees, and particularly relevant in regard to fluctuating economic climates.

Financial and economic characteristics, including state Medicaid expenditures, provide an indicator of fiscal resources used to support constituency health care needs. Peterson claims state wealth is a key factor in redistributive policy making, with wealthier states expending greater resources on social welfare programs (Peterson 1981). A second redistributive factor in state Medicaid programs is the federal contribution to state Medicaid programs, known as the federal medical assistance percentage or FMAP. FMAP is a substantial source of income for state Medicaid programs. The FMAP is calculated upon state per capita income relative to the national average. Federal contributions are lower to states with higher per capita income and higher to states with lower per capita income (Wachino, Schneider, and Rousseau 2004: 3). However, total federal contributions are influenced by state Medicaid spending (Kaiser Family Foundation 2004a). States with lower FMAP contributions, yet higher Medicaid expenditures, receive more federal dollars than states with higher FMAP percentages and smaller Medicaid budgets. In other words, states that spend more on state Medicaid programs receive more federal dollars.

Political system characteristics provide another indicator that may be used to assess the influence of redistributive policy making, as evidenced by ideological

tendencies toward greater or lesser support for social welfare programs (Hwang and Gray 1991; Plotnick and Winters 1985). Ideology was found to significantly influence social welfare policy, more than education and transportation policy. In particular, more liberal political ideology, measured as the political part of the governor and party control of the state legislature, was associated with increased support for social welfare policy compared to more conservative political perspectives (Hwang and Gray 1991).

While the Medicaid program is a key component of the health care safety net, Medicaid also possesses substantial economic considerations for state economies. Peterson frames developmental policies as those supporting economic growth, influenced by supply and demand and creating policies which enhance competitiveness of a geographic area (1981). State growth in personal income is a crucial marker of state economic activity and will be used in this study to capture developmental characteristics of state growth. State estimates of personal incomes serve as an important indicator to assess state economic status and often used to inform budgetary planning (Bureau of Economic Analysis 2009: I-3). This study uses the change in state personal income (1999-2000, 2002-2003 and 2005-2006) to capture economic characteristics over time. State economic growth directly influences fiscal resources to expend on redistributive programs.

A panel regression analysis, examining data from the fifty states in years 2000, 2003 and 2006 will examine why some states use comprehensive Medicaid managed care for high cost enrollees with chronic conditions and disability, and others do not. The ability to discern influential redistributive or developmental policy determinants may

inform the use of Medicaid managed care for populations with special needs. This study will explore the following hypotheses:

- H₁: States with greater relative wealth, those with lower FMAP, will have a higher percentage of comprehensive state Medicaid managed care programs for individuals with disability.
- H₂: More politically liberal states will have a higher percentage of comprehensive state Medicaid managed care programs for individuals with disability as a means to support and expand state redistributive efforts via Medicaid policy.
- H₃: States with higher growth rates in personal income will have a higher percentage of comprehensive state Medicaid managed care programs for individuals with disability

The analysis of redistributive and developmental policy determinants provides a mechanism to explore the role of socio-economic and political system factors in state Medicaid policy making. As states increasingly gain autonomy over state Medicaid programs, fiscal challenges confronting state budgets possess greater implications for state welfare programs. While state Medicaid programs are a crucial mechanism supporting the health of vulnerable populations, program integrity is tethered to vacillating political and economic climates.

In addition to factors associated with redistributive and developmental policy, I propose policy diffusion is an important consideration in the examination of policy determinants. While literature demonstrates that states learn from the experience of neighbors when developing social welfare policy, states are in competition with one another from an economic perspective. Hence, a “race to the bottom” may not explain

diffusion of state welfare policy; however, efforts to enhance economic growth resulting in competition among neighboring states may implicate approaches to state welfare policy making. Research demonstrates that economic growth is a more appealing draw for low-income individuals compared to state welfare programs (Berry, Fording, and Hanson 2003). In this regard, economic opportunity provides a mechanism to reduce demand for public welfare programs by growing the private welfare sector through economic development.

Literature reveals economic competition among contiguous states influence revenue growth (Coughlin, Garrett, and Hernández-Murillo 2006), a key determinant of state resources available for redistributive policy making. Appreciating that contiguous states compete economically, it is plausible that neighboring states would implement more economically efficient approaches to social programs, as a means to maximize economic growth. The examination of spatial autocorrelation provides a systematic approach to detect non-random patterns, identifying statistically significant associations in a variable of interest relative to location. I therefore propose the following hypothesis:

H₄: States with Medicaid managed care programs for enrollees with disability will demonstrate spatial associations.

States with lower rates of Medicaid managed care, demonstrating a lack of expansion, may be influenced by neighboring states, as well. Examining spatial patterns of states with limited use Medicaid managed care may assist in examining a “non-event.” In other words, spatial patterns demonstrate neighboring states with like enrollment levels whether they are higher enrollment levels or lower enrollment levels.

Since the Balanced Budget Act of 1997, the federal government has been delegating greater authority to the states to implement and expand Medicaid managed care initiatives without mandating federal waivers (Public Law 105-33 1997). Greater autonomy combined with the prospects of enhanced cost-efficiency in the provision of Medicaid services would logically appear enticing to all states. However, one factor that may inhibit the diffusion process is that managed care requires a price-competitive market. Price competition assumes participation by an adequate number of providers to support negotiated pricing among competitors (Enthoven 1993: 29). As the federal government continues to relinquish control for Medicaid to the states, more rural states may be poorly positioned to adopt more efficient health care mechanisms, such as managed care. Fewer providers may inhibit price competition upon which managed care is premised.

Data: Selection and Measurement

Panel time-series regression analyses will be used to examine socio-economic, policy system and policy diffusion determinants influencing the use of managed care in state Medicaid programs. Variables representing policy determinants include the federal medical assistance percentage (FMAP) and Medicaid expenditures as a percent of total expenditures by state as redistributive factors; and, growth in personal income as an indicator of state wealth, a latent variable signifying economic growth resulting from developmental policy-making. Political system characteristics will be measured using state ideology scores. Higher ideology scores indicate more liberal states. More liberal state ideology scores would be associated with a propensity toward redistributive policies (Plotnick & Winters, 1978; Hwang & Gray, 1991), such as those associated with

Medicaid. In addition, two demographic variables, percent uninsured and percent of people with disability were included in the structural model to capture characteristics of the population served by the Medicaid program. Both the uninsured rate and the percent of people with disability indicate demand for state Medicaid programs.

This panel study of the fifty states will use data for years 2000, 2003 and 2006, with one exception. The observation for state Medicaid spending as a percent of total state spending is missing for Wyoming in 2000; data for 2002 were substituted. The dependent variable is the percentage of a state's Medicaid managed care programs providing comprehensive benefits for adults with disabilities. The data dictionary for the variables in the model may be found in Appendix B. The statistical model to examine the dependent variable is:

$$\begin{aligned}
 \text{Dependent variable} &= B_1 + B_2 \text{FMAP}_{it(\text{Redistributive})} + \\
 &B_3 \text{Medicaid Expenditures}_{it(\text{Redistributive})} + \\
 &B_4 \text{Ideology}_{it(\text{Redistributive})} + \\
 &B_5 \text{Income Growth}_{it(\text{Developmental})} + \\
 &B_6 \text{Percent uninsured}_{it(\text{Demographic})} + \\
 &B_7 \text{State disability}_{it(\text{Demographic})} + \text{error}
 \end{aligned}$$

In this model i represents the state, t represents the year (Gujarati 2003: 647-648).

Validity and Reliability of the Study Design

This study explores relationships among socio-economic, political and policy diffusion determinates to better understand state adoption of Medicaid managed care. Bound by balanced budget requirements, state policies must continually weigh developmental and redistributive policy choices. Studies examining social welfare policy

have similarly included analysis of both socio-economic and policy system variables (Plotnick and Winters 1985; Barrilleaux and Miller 1988; Hwang and Gray 1991). This study also draws upon policy diffusion literature as a means to expand the analysis of policy determinants. From the early work of economist Charles Tiebout (1956) and political scientist Jack Walker (1969) to more recent work by political scientist Andrew Karch (2007) and Scott Minkoff (2008), policy diffusion explores conditions by which policies spread from one state to another, through learning or competition, an exogenous force beyond intrastate factors.

The Lewin Group study (2004a) investigated the influence of state wealth on social welfare programs over time. The fifty-state analysis included the following: independent variables: state economic indicators, rates of poverty and unemployment as indicators of demand for social welfare, federal funding by state, as well as dummy variables for state and time effects. In a study investigating influential forces on U.S. health care safety net providers, the Institute of Medicine examined price competition, measured as the concentration of health care providers; the demand for the safety net, operationalized as state uninsured rate; and, state wealth and tax base (Lewin and Altman 2000: 81-91).

The influence of spatial relationships public welfare policy making has been examined in varied ways. Political scientists William Berry and Brady Baybeck (2005) investigate competing hypotheses regarding interstate competition versus policy learning in the determination of state welfare benefit levels. Outcomes reveal state welfare benefit decisions are predicated upon policy learning, by which contiguous states tend to influence benefit levels of each other (2005: 518). Volden, Ting and

Carpenter (2006) developed analytical models to help discern policy diffusion through learning across governments versus within governments (game theoretic learning versus decision theoretic learning). Karch uses a statistical proxy to assess geospatial relationships, by calculating the percentage of neighboring states who have implemented a specified policy in the prior year (2007: 220). While he finds significant relationships for vertical diffusion versus horizontal diffusion, the statistical model used will not detect negative spatial autocorrelation. In other words, the model will not detect spatial patterns in which states with lower rates of enrollment in Medicaid managed care cluster together. This would be analogous to detection of a non-event, the absence of adopting Medicaid managed care, may in fact demonstrate spatial relationships.

Analyses

A panel regression model including six independent variables was created to assess policy and demographic factors influencing state Medicaid managed care programs for adults with disability. The model specifically assesses the regressors on the percentage of state Medicaid managed care programs for adults with disability. Analyses were conducted using Stata 10.0 statistical software package using a balanced panel design.

Panel regression models require consideration for the presence of latent or unobserved factors, factors that are time-invariant in nature (Wooldridge 2002). The selection of a panel regression model is dependent upon the treatment of these unobserved factors. Fixed effects models assume there may be correlation between observed and unobserved factors (252). In this regard, the unobserved, time invariant factors are associated with observable regressors. While fixed effects panel models are

considered a robust model, including unobservable factors with observable regressors inhibits the ability to detect the influence of time-invariant factors in the model (266). The fixed effects model essentially treats unobserved factors as dummy variables in the model. Inclusion of time invariant regressors in a fixed effects model would create perfectly collinear relationships with the dummy variables (Kohler and Kreuter 2009: 245). Hence, the fixed effects model cannot include time invariant regressors and is appropriate to detect change within an entity over time (within effects model). In this study, a fixed effects model examines the influence of predictor variables within a state over time

In comparison, random effect panel models assume no correlation between the observed regressors and unobserved factors. This model places error for the unobserved factors in the error term of the model. The random effects model therefore permits the inclusion of time invariant regressors and examines change within and between entities. In other words, random effects models identify the influence of regressors, independent variables, between the states and within the states over time (Torres-Reyna 2009).

The Hausman test is used to determine efficiency of the fixed effects model compared to the random effects model. A statistically significant Hausman test indicates a statistically significant relationship between unobserved factors and regressors in the model. This significant relationship violates an assumption of the random effects model, that unobserved errors are independent of the regressors and therefore supports use of the fixed effects model (Wooldridge 2002: 257; 288).

In addition, histograms of the variables in the panel regression model indicates a positively skewed distribution of the proposed dependent variable, the percentage of state

Medicaid managed care programs for individuals with disability. This is also confirmed with the sktest demonstrating statistical significance (skewness, 0.00; kurtosis, 0.226). Practically speaking, states cluster at the low end of the range indicating fewer states exhibit higher rates of comprehensive Medicaid managed care programs specifically for enrollees with disability. This distributional distortion may influence the model estimates and will need to be addressed in the statistical model.

The Hausman test for the panel regression model assessing the influence of policy, economic and socio-demographic factors on the dependent variable was insignificant ($\chi^2 = 8.47$; $p = 0.21$), therefore a random effects model was used. Similar to Ordinary Least Squares (OLS) regression models, a key assumption of panel regression models is the presence of equal error variance or $E=0$. The presence of unequal dispersion of residuals, heteroskedasticity, leads to inefficient estimators. The Breusch and Pagan Lagrangian multiplier test for the random effects model indicates statistically significant presence of heteroskedasticity ($\chi^2 = 33.55$; $p = 0.00$). To address heteroskedasticity in the model the dependent variable was transformed into logarithmic form (Kohler and Kreuter 2009: 221). Due to the number of states without any comprehensive Medicaid managed care for individuals with disabilities, generating the log of the dependent variable created seventy-six missing observations, a substantial reduction in sample size.

Additional post-estimation diagnostics include assessing autocorrelation of the unobserved factors with the model regressors. Due to gaps in the years included in this study, a sequential time variable was established in which year 2000 is equal to a “1,” year 2003 as “2” and year 2006 as “3.” The Wooldridge test for autocorrelation in the

model with the transformed dependent variable revealed insignificant findings, thus the research hypothesis indicating no presence of autocorrelation is accepted (.725; $p = .405$). Tests for collinearity of the same model include the Lagrange multiplier (LM) test for models that examine a large number of time points relative to sample size. In other words, models examining many time periods for a small number of units. However, this diagnostic test may be distorted by samples with large N (Hoyos and Sarafidis 2006). Alternatively, the Pesaran test of cross-sectional dependence (CD test) has been found to be appropriate with samples characterized by few time periods and an asymptotic N (490). The CD test revealed statistically significant collinearity (2.774; $p = .006$).

The Breusch and Pagan Lagrangian multiplier test continued to reveal heteroskedasticity ($\chi^2 = 19.10$; $p = 0.00$) with the transformed dependent variable therefore the model was run using robust standard errors. Results for the first model, examining the influence of redistributive, developmental and demographic factors on the percentage of state comprehensive Medicaid managed care programs for people with disability are presented in Table 1, below. Outcomes reveal a statistically significant negative relationship for state rates of people with disability. This may be interpreted as a one unit increase in state disability rates is associated with a reduction among the states in the use of comprehensive Medicaid managed care programs for people with disability across the study time periods, holding all other variables constant. This model represents only those states that use some degree of comprehensive Medicaid managed care for people with disabilities. Therefore, of the states that have implemented comprehensive Medicaid managed care for people with disabilities, those with higher rates of people with disability have fewer comprehensive managed care programs.

Table 1. Random effects panel regression model of redistributive, developmental and demographic factors with robust standard errors

	logpctcpro
Constant	5.026*** (0.70)
State Federal Medical Assistance	0.0082 (0.01)
State Medicaid expenditures	-0.010 (0.01)
State ideology scores	0.000 (0.00)
State growth in personal income	-0.004 (0.01)
Percentage of people without health insurance	-0.014 (0.03)
Percentage of people with disability	-0.070* (0.03)
Observations	74
R-sq:	Within = 0.2191 Between = 0.0260 Overall = 0.0756

Note: The dependent variable is logarithmic form of the percentage of comprehensive state Medicaid managed care programs for individuals with disability. Cell entries are panel regression coefficients (robust standard errors in parentheses).

*p<.05 (two-tailed) **p<.01 (two-tailed) ***p<.001(two-tailed)

The Wald χ^2 statistic for the model above is 17.17 ($p=.01$) indicating model fit. In comparison, use of Tobit estimation to analyze the same model reveals a Wald χ^2 of 10.98 ($p=.09$).

To avoid losing the observations of states that have not implemented comprehensive Medicaid managed care for individuals with disabilities, in other words states with values of “zero,” a modified dependent variable was created by adding a “1” to each observation. The log of the dependent variable was then included in the analytical model, thereby retaining the full sample. Although the data are no longer skewed (.537), the Breusch and Pagan test for heteroskedasticity continues to exhibit statistical significance ($\chi^2 = 56.18$; $p = 0.00$). In addition, tests for cross-sectional dependence (CD test) and autocorrelation (Wooldridge) exhibit statistical significance, as well (3.61, $p=.000$ and 6.36, $p=.015$, respectively). To correct for the presence of heteroskedastic, cross-sectionally dependent and autocorrelated standard errors, a Prais-Winsten panel regression with corrected panels and corrected standard errors was conducted (Hoechle 2007). Results are provided in Table 2.

Table 2. Prais-Winsten panel regression model of redistributive, developmental and demographic factors with corrected panels and corrected standard errors

	logpctcpro
Constant	4.336 (3.18)
State Federal Medical Assistance	-0.074 (0.04)
State Medicaid expenditures	0.005 (0.02)
State ideology scores	0.004 (0.01)

State growth in personal income	0.059 (0.03)
Percentage of people without health insurance	0.102* (0.05)
Percentage of people with disability	-0.004 (0.07)
<hr/>	
Observations	150
R-sq:	0.1897

Note: The dependent variable is logarithmic form of the percentage of comprehensive state Medicaid managed care programs for individuals with disability. Cell entries are panel regression coefficients (corrected standard errors in parentheses).

*p<.05 (two-tailed) **p<.01 (two-tailed) ***p<.001(two-tailed)

Analysis of the full sample demonstrates positive association with rates of uninsured; however, the frequency of true zeros in the dependent variable requires consideration for alternative analytical models that may be better suited for corner solution outcomes (Wooldridge 2002). Tobit models are particularly sensitive to heteroskedasticity (520). Use of Tobit to analyze the model using the untransformed dependent variable with jackknife standard errors demonstrates an F statistic of 2.08 (p=0.07). Research indicates the Poisson regression model may be a more appropriate model for non-negative skewed dependent variables (Nichols 2010). A Poisson regression model, analyzing the influence of redistributive, developmental and demographic factors on the percentage of comprehensive state Medicaid managed care programs for individuals with disability, using jackknife standard errors indicates

improved model fit ($F=2.64$; $p=0.03$); although, no statistically significant relationships were found.

Due to the skewed distribution of the dependent variable in the first model, a second model was developed to address the use of comprehensive managed care in state Medicaid programs from a slightly broader perspective. Instead of assessing comprehensive Medicaid managed care specifically for people with disabilities, a broader model using state enrollment rates in comprehensive Medicaid managed care will be used. The same regressors were included in the second model. The Hausman test was again found to be insignificant ($\chi^2=4.40$; significance level of 0.62) therefore a random effects model was used. The sktest revealed borderline skewness (0.050), but significant kurtosis (0.00). The Breusch and Pagan test for heteroskedasticity exhibits statistical significance ($\chi^2=99.58$; $p=0.00$). The CD test reveals collinearity among the model regressors (3.194, $p=0.001$) and the Wooldridge test for autocorrelation was also statistically significant (42.08, $p=0.00$). The dependent variable was modified by adding one, to retain the full sample size, and transformed into logarithmic form in the model. Tests for non-normal and autocorrelated errors were statistically significant, (75.50, $p=0.00$ and 10.78, $p=0.00$, respectively). The CD test for cross-sectional dependence demonstrated insignificant outcomes (1.04, $p=0.30$). A robust random effects model with standard errors was used. Results are presented in Table 3, below.

Table 3. Random effects panel regression model of redistributive, developmental and demographic factors with robust standard errors

	logpctcmc
Constant	6.15*** (1.36)
State Federal Medical Assistance	-0.075*** (0.03)
State Medicaid expenditures	-0.011 (0.02)
State ideology scores	0.020 (0.01)
State growth in personal income	0.000 (0.03)
Percentage of people without health insurance	0.023 (0.03)
Percentage of people with disability	-0.032 (0.05)
Observations	150
R-sq:	Within = 0.0073 Between = 0.3395 Overall = 0.2949

Note: The dependent variable is log of the percentage of state Medicaid enrollees in comprehensive managed care programs. Cell entries are panel regression coefficients (robust standard errors in parentheses).

*p<.05 (two-tailed) **p<.01 (two-tailed) ***p<.001(two-tailed)

The second model reveals a statistically significant negative relationship between Federal Medical Assistance Percentage and the percentage of state Medicaid enrollees in

comprehensive managed care programs. This may be interpreted as states with higher FMAP rate (states with lower per capita income) are associated with lower rates of enrollment in Medicaid managed care programs. The dependent variable in this model is less skewed (24% of the dependent variable values are “0”). The F statistic indicates appropriate model fit ($F=3.50$; $p=.01$). In comparison, analysis of the untransformed dependent variable using a Poisson model yields an F statistic of 0.41 ($p=0.87$). An additional analysis of the percent enrollment in comprehensive Medicaid managed care using a Tobit model and the untransformed dependent variable is presented in Table 4, below.

Table 4. Tobit panel regression model of redistributive, developmental and demographic factors with jackknife standard errors

	pctcmc
Constant	65.06* (28.81)
State Federal Medical Assistance	-0.832 (0.51)
State Medicaid expenditures	-0.229 (0.44)
State ideology scores	0.468* (0.21)
State growth in personal income	0.306 (0.37)
Percentage of people without health insurance	0.291 (0.69)
Percentage of people with disability	-0.320 (0.85)
Observations	150

Note: The dependent variable is the percentage of state Medicaid enrollees in comprehensive managed care programs. Cell entries are panel Tobit regression coefficients (jackknife standard errors in parentheses).

* $p < .05$ (two-tailed) ** $p < .01$ (two-tailed) *** $p < .001$ (two-tailed)

The Tobit model reveals a statistically significant relationship between ideology and the enrollment in comprehensive state Medicaid managed care programs. While the direction of the coefficients in the OLS panel regression and Tobit panel regression models may be compared, the magnitude of the co-efficient effect sizes are not equivalent (Wooldridge 2002). Literature indicates the use of Tobit for models in which the dependent variable possesses a number of true zero values is not recommended (Siegelman and Zeng 1999: 170). In addition, the F statistic for the Tobit model is 2.07 ($p=0.07$).

Lastly, a third model was developed to further assess the influence of redistributive, developmental and demographic factors on an even broader dependent variable, the percentage of the state population enrolled in Medicaid. The dependent variable for the three analytical models is defined as:

- Model 1: the dependent variable is the percentage of comprehensive state Medicaid managed care programs for individuals with disability
- Model 2: the dependent variable is the percentage of state Medicaid enrollees in comprehensive managed care programs
- Model 3: the dependent variable is the percentage of the state population enrolled in Medicaid

Each model uses the same independent variables. Broadening the dependent variable provides an interesting opportunity to assess variance in the use of Medicaid managed care for people with disability relative to more prevalent state Medicaid programs in use across the country.

The Hausman test for the third model was statistically significant in this model violating assumptions of independence between observed and unobserved factors; therefore a fixed effects model was used. The sktest revealed significant skewness (0.012) and insignificant kurtosis (0.933). The modified Wald test for fixed effects model is significant for heteroskedasticity (96944.30, $p=0.00$). The dependent variable was transformed into logarithmic form; however, the full sample was retained since all states administer a Medicaid program. Tests for heteroskedasticity continued to be significant even with use of a transformed dependent variable (0.00, $p=0.00$). The Wooldridge revealed significant autocorrelation (27.00, $p = 0.00$) in the model; however, the CD test for collinearity was insignificant (1.6, $p = 0.100$). The model was rerun using robust standard errors. Results are presented in Table 5.

Table 5. Fixed effects panel regression model of redistributive, distributive and demographic factors with robust standard errors

	logpctmen
Constant	1.278*** (0.30)
State Federal Medical Assistance Percentage	0.004 (0.00)
State Medicaid expenditures	0.011*** (0.00)
State ideology scores	0.006*** (0.00)

State growth in personal income	-0.006 (0.0)
Percentage of people without health insurance	0.003 (0.01)
Percentage of people with disability	0.024*** (0.01)
<hr/>	
Observations	150
R-sq:	Within = 0.4745 Between = 0.3104 Overall = 0.3259

Note: The dependent variable is the logarithmic form of the percentage the state population enrolled in Medicaid. Cell entries are panel regression coefficients (robust standard errors in parentheses).

*p<.05 (two-tailed) **p<.01 (two-tailed) ***p<.001(two-tailed)

In the third model, variables representing state Medicaid spending, ideology and state disability rates exhibit statistically significant positive relationships with the dependent variable. These outcomes may be interpreted as follows:

- A one unit increase in state Medicaid expenditures, as a percentage of total state expenditures, is associated with an increase in the percentage of the state population enrolled in Medicaid over time, holding all other variables constant.
- A one unit increase in a state ideology scores, a movement toward more liberal ideology, is associated with an increase in the percentage of the state population enrolled in Medicaid over time, holding all other variables constant.

- A one unit increase in state percentage of population with disability is associated with an increase in the percentage of the state population enrolled in Medicaid over time, holding all other variables constant.

Spatial Patterns

Geographic patterns among states relative to state Medicaid managed care programs indicate the presence of spatial autocorrelation. The panel regression dataset was reshaped into wide format to assess geographic patterns for each time period included in the study. ArcGIS was used to join attribute data of each the contiguous forty-eight states, excluding Washington D.C., to a state shape file, downloaded from the U.S. Census Bureau (2009). An Albers Equal Area Conic projection was established.

The local Moran's I statistic or LISA statistic describes the weighted correlation between the value of a variable for one location with the average value of the neighbors on the same variable (Anselin 2003: 61). While the LISA statistic identifies specific geographic areas of autocorrelation, the global autocorrelation statistic, Moran's I, calculates autocorrelation for all observations under study (Anselin 1996). Moran values range from -1 to 1 with 0 indicating no spatial autocorrelation. Geoda software was used to calculate the univariate LISA statistic assessing spatial patterns of comprehensive Medicaid managed care programs for enrollees with disability relative to neighboring states. The LISA statistic permits the ability to assess the strength of spatial patterns at the unit of observation, in this study, the state (Anselin 2003: 99).

The Moran's was calculated upon queen contiguity, meaning autocorrelation was weighted using common sides and vertices. Queen contiguity was selected to capture maximal contiguity of shared borders between states. LISA statistics were computed

using 999 permutations, meaning the test statistic was calculated following an established number of possible permutations for each observation (102). Significance of the LISA statistic was set at $p = .01$ meaning statistically significant spatial patterns must be present at the more stringent significance level compared to the default setting of $p = .05$ (102).

Assessing the global Moran's I for the percent of Medicaid managed care programs for enrollees with disability yields moderate to low correlations for all three time periods: 2000 data = 0.270, 2003 data = .302 and 2006 data = .136. The global statistic was also calculated using a broader dependent variable, the percentage of comprehensive managed care enrollees out of total Medicaid enrollees by state. The global Moran's I statistic for the 2000 data using the broader dependent variable is .438. In this regard, Delaware demonstrates a moderate correlation with its neighbors in the enrollment of Medicaid beneficiaries in comprehensive managed care programs while Montana and Mississippi exhibit moderate correlations with neighbors relative to low enrollment in comprehensive Medicaid managed care programs. The global Moran's I statistic for the 2003 data is .464. Delaware continues to demonstrate moderate correlations with neighboring states with respect to higher rates of comprehensive Medicaid managed care enrollment, while Montana, Wyoming, Mississippi and Georgia exhibit lower rates of comprehensive Medicaid managed care enrollment. The global Moran's I statistic for the 2006 data is .396. Using 2003 data, local spatial autocorrelation of the percentage of comprehensive Medicaid managed care program for enrollees with disability and the percentage of Medicaid enrollees in Medicaid managed care programs is presented in Appendix C and D, respectively. These maps visually

identify patterns of association among the states. A state and its contiguous neighbors possessing similarly high (or low) values for a variable of interest demonstrate positive spatial autocorrelation. A state with a high value of a variable of interest and contiguous neighbors with low values of the same variable (or a state with a low value and contiguous neighbors with high values) indicate negative spatial autocorrelation. A discussion of the study outcomes and conclusions is presented in the final chapter.

Chapter 7

Discussion and Conclusions

We can't solve problems by using the same kind of thinking

we used when we created them

Albert Einstein

(Church 2007)

Medicaid fills a critical void for vulnerable populations, especially for those with chronic conditions and disability who are underserved in the employment-based health insurance market. As a theoretical model, managed care is intended to reduce complications from chronic conditions, shifting the focus from traditional tertiary paradigms, which focus on specialized care following diagnosis, toward more cost-effective primary approaches to care; care that strives to sustain or improve health. Strategies to better meet the health care needs of Medicaid enrollees, particularly those with chronic illness and disability is particularly important as states confront increasing demand and significant fluctuations in the economic climate. The findings from this study highlight the need to consider demographic, redistributive and policy system indicators that influence state Medicaid programs. Further research to determine the influence of neighboring states on the adoption of Medicaid managed care is needed.

Demographic factors influence not only the adoption of comprehensive Medicaid managed care for enrollees with disability, but overall enrollment in state Medicaid

programs. Specifically, state disability rates significantly influence state Medicaid programs in varied ways. Of the states implementing comprehensive managed care programs for Medicaid enrollees with disability, those states with higher disability rates offer fewer programs. States with fewer high-cost Medicaid enrollees implement alternative care strategies, such as managed care. Considering all states with and without comprehensive Medicaid managed care programs for enrollees with disability, no statistically significant outcomes were found.

Redistributive factors also play a significant role in state Medicaid programs. The FMAP negatively influences state enrollment rates in comprehensive managed programs. As a redistributive mechanism, the FMAP is used as a proxy for state wealth, a factor that may influence the adoption of alternative Medicaid programming. The negative influence of the FMAP on managed care enrollment is cause for concern about the effectiveness of FMAP in supporting innovations in the Medicaid programs of states with lower per capita incomes.

The enrollment rate of state Medicaid programs is significantly influenced by redistributive and demographic policy indicators. More liberal political ideology and higher state spending on Medicaid influence higher enrollment rates in state Medicaid programs. In addition, states with higher rates of populations with disability also experience higher enrollment in state Medicaid programs.

As a cost-containment strategy, it would be expected that all states would be interested in curbing Medicaid expenditures. However, outcomes from this study demonstrate significant variations in state Medicaid programs across the country. As the federal government shifts program authority to the states, the variation among states may

increase. In addition, Medicaid policies are particularly sensitive to economic volatility and subject to fiscal scrutiny at federal and state levels. Consideration for policy indicators influencing state policy-making may be particularly relevant for supporting the diverse needs of program enrollees.

This study uses panel regression analyses to better understand policy determinants influencing state Medicaid programs, particularly the use of comprehensive managed care for enrollees with chronic illness and disability. Through policy decisions, state Medicaid programs determine program eligibility, services provided and reimbursement rates to health care providers, influencing access and quality of care for program enrollees. Innovative approaches to the care of chronic conditions require a policy mechanism flexible enough to accommodate change. State Medicaid programs possess that flexibility. Research to better understand influential forces in state Medicaid policy making contributes to more informed assessment of policy solutions and the opportunity to enhance quality of life for program enrollees.

The positively skewed distribution of the proposed dependent variable, the percentage of comprehensive state Medicaid managed care programs for people with disability, indicates a limited number of state programs actually include enrollees with special needs in comprehensive managed care health programs. Consequently, the methodological challenges of the skewed distribution necessitated consideration of more broadly defined outcome measures, specifically the percentage of state Medicaid enrollees in comprehensive managed care programs and the percentage of the state population in state Medicaid programs.

The outcomes for the statistical models using each of the three dependent variables are discussed next. The first model, analyzing the percentage of state comprehensive Medicaid managed care programs for enrollees with disability, revealed a statistically significant negative relationship with percentage of state population with disability. To address the presence of heteroskedasticity, the log transformation of the dependent variable omitted all states with “0” values. This means outcomes only pertain to those states that do enroll individuals with disability into comprehensive Medicaid managed care programs. With this in mind, the analysis reveals that states with higher disability rates exhibit fewer programs for individuals with disability. Although counter-intuitive at first glance, states with a smaller percentage of population with disabilities may exert less demand, less pressure on the system, resulting in increased opportunity for programmatic change. In addition, these outcomes indicate that Medicaid enrollees with disability are not provided the same access to Medicaid programs as other program enrollees.

To analyze the entire sample, a “one” was added to the dependent variable values, then the log transformation of the dependent variable was used in the analytical model. While no statistically significant relationships were found in the Poisson model analyzing the influence of redistributive, developmental and demographic factors on the percentage of comprehensive state Medicaid managed care programs for individuals with disability; state disability rate was found to be statistically significant using a sub-set of observations with non-zero values. State disability rate appears to negatively influence the number of comprehensive Medicaid managed care programs for the same population among states that already offer these programs.

These outcomes are particularly relevant in light of the shrinking employer-based private welfare sector and an aging population that may contribute to greater demand on state welfare programs. Individuals with disability possess higher health care expenditures. Excluding this population from Medicaid managed care fails to capitalize on strategies that may provide comprehensive health care services needed by this population, in a manner that is more cost-efficient compared to fee-for-service strategies. As the private sector scales back employer-sponsored health insurance and an aging population pressures social welfare programs such as Medicaid, more efficient means to support the health care needs of program beneficiaries is needed.

The research hypotheses predicting the influence of redistributive (FMAP and liberal ideology) and developmental (growth rates of personal income) policy indicators on the use of comprehensive Medicaid managed care programs for people with disabilities must be rejected. In this regard, demographic factors including state disability and uninsurance rate are more influential in state rates of comprehensive Medicaid managed care programs for people with disability than policy factors.

The second panel model broadened the dependent variable to assess policy and demographic indicators on the percent of state Medicaid enrollees in comprehensive managed care programs. This dependent variable may or may not include enrollees with disability. In this model the Federal Medical Assistance Percentage exhibits a statistically significant, negative relationship with the outcome variable. This means states with higher FMAP rates, those with lower per capita incomes, are associated with lower rates of enrollees in comprehensive Medicaid managed care programs. Although the dependent variable is broader in nature, this outcome is related to the first research

hypothesis and consistent with the expectation that states with greater relative wealth, using FMAP as a proxy for wealth, will have higher rates of Medicaid managed care compared to poor states. Wealthier states may possess greater resources to implement alternative Medicaid programs compared to poorer states.

A third panel model broadened the outcome variable even further, to assess the influence of policy indicators and demographic variables on overall enrollment in state Medicaid programs. This model exhibits three statistically significant, positive outcomes: state Medicaid expenditures, state ideology scores and state rates of disability. State Medicaid expenditures and state ideology scores were both characterized as redistributive policy indicators. State Medicaid expenditures are an indication of the state use of fiscal resources to support constituency health care needs. This model demonstrates that states spending proportionately more on Medicaid exhibit higher rates of Medicaid enrollment. This may be interpreted as a greater commitment to Medicaid as a redistributive policy. Ideology score is also an indicator of the propensity toward redistributive policy. This model demonstrates that more liberal states have higher rates of Medicaid enrollment. Ideology appears to positively influence overall enrollment rates in state Medicaid programs. While political system characteristics are not predictors of the use of Medicaid managed care, these redistributive factors do influence overall enrollment in state Medicaid programs.

The third model also demonstrates a statistically significant positive relationship between state disability rate and Medicaid enrollment. While disability rate is negatively associated in the use of comprehensive Medicaid managed care programs for enrollees with disability in the first model, the positive association detected in the third model,

overall state Medicaid enrollment rate, is not unexpected. Literature supports the bidirectional relationship between poverty and disability; disablement may contribute to low income and low income may inhibit the use of health care services contributing to disablement. Hence, the third model reveals that states with higher rates of individuals with disability have increased demand for Medicaid and resultant higher rates of enrollment.

The variance in the direction of statistical significance in state disability rates in the first and third model merits further consideration. While disability rates demonstrate increased demand for state Medicaid programs, states with the greatest demand are not implementing more cost-efficient approaches to care. In fact, states with lower rates of constituents with disability are those states implementing more cost-efficient managed care programs. This study supports the incongruity between the demand for state Medicaid programs and the approaches the states use to support the health care of state Medicaid enrollees. States with greater demand and a need to implement more efficacious approaches to care are not implementing such strategies. These outcomes suggest that states exhibiting greater numbers of individuals with low-income and disability may be least able to implement alternative approaches to care.

Use of federal waivers, particularly the 1115 waiver programs, permitted states to implement Medicaid managed care programs as a means to expand program reach. As a cost-containment mechanism, the adoption of Medicaid managed care is also believed to help sustain program integrity during constrained economic climates. The negative association of FMAP on enrollment in state comprehensive Medicaid managed care programs alludes to the insufficient redistribution of resources to less wealthy states

inhibiting the implementation of more efficacious programs such as, Medicaid managed care.

Descriptive statistics were used to demonstrate patterns of spatial autocorrelation among the states. Examining spatial relationships among states with respect to the percent of comprehensive state Medicaid managed care programs for people with disability yields only moderate correlation for the 2003 data and low correlation for the 2000 and 2006 data. In 2003, Delaware demonstrates a moderate correlation with neighboring states (Maryland, Pennsylvania and New York). This means Delaware and its contiguous neighbors; Maryland, Pennsylvania and New York, possess higher rates of comprehensive Medicaid managed care programs for individuals with disability. Delaware and its neighbors share similar ideological perspectives, typically favoring more liberal political positions. These states also possess lower FMAP rates. In fact, Delaware, Maryland and New York are at the statutory floor of 50%. The FMAP is inversely related to state per capita income; therefore, these are relatively wealthier states, possibly with fiscal resources available to implement more innovative social welfare programs, such as Medicaid managed care. State wealth may also be indicative of the competitive economic activities of neighboring states, supporting the findings of spatial autocorrelation.

Florida demonstrates a negative association with its neighbors, Alabama and Georgia in 2003. Florida does offer comprehensive Medicaid managed care programs for enrollees with disability in contrast to Alabama and Georgia which do not. Florida exhibits a lower FMAP rate compared to Alabama and Georgia and thus greater wealth that may influence resources available for alternative approaches to care. Florida also

exhibits more liberal political ideology scores, compared to neighboring states, a characteristic of more support for social welfare programs.

Examining geographic patterns relative to enrollment rate in comprehensive state Medicaid managed care programs for each time period revealed slightly stronger associations. Spatial autocorrelation for all three time periods demonstrate moderate associations with neighboring states. In 2000, Delaware, Maryland, Pennsylvania and New York possess higher rates of enrollment in comprehensive Medicaid managed care programs. Conversely, Montana and its neighbors, Idaho, Wyoming, North Dakota and South Dakota exhibit low enrollment rates in comprehensive Medicaid managed care programs. Mississippi and its neighbors, Louisiana, Arkansas, Tennessee and Alabama, also demonstrate low enrollment rates in comprehensive Medicaid managed care programs.

In 2003, Delaware continues to demonstrate a positive association with neighboring states. Both Montana and Wyoming now exhibit low rates of enrollment in comprehensive Medicaid managed care relative to neighboring states. Mississippi and Georgia also exhibit low rates of enrollment in comprehensive Medicaid managed care relative to neighboring states. As noted previously, Florida demonstrates negative spatial autocorrelation, exhibiting higher rates of enrollment in Medicaid managed care relative to neighboring states, including Georgia.

By 2006, Delaware no longer demonstrates an association with neighboring states; however, New York and Pennsylvania demonstrate higher rates of enrollment in comprehensive Medicaid managed care similar to neighboring states. Montana, Wyoming and Mississippi continue to exhibit low rates of enrollment in Medicaid

managed care with respect to their neighbors. These states tend to subscribe to more conservative political ideology with less support for social welfare programs.

Detecting statistically significant relationships in the number of state Medicaid managed programs for enrollees with disability is compromised by a large number of states with “0” values. In other words, a large number of states do not offer comprehensive managed care programs to Medicaid enrollees with disability or simply do not offer comprehensive managed care programs at all. Across all three time periods, the percentage of states with “0” values ranges from 43%-52% in the first model, the rate of comprehensive Medicaid managed care programs for enrollees with disability; and, 18%-25% in the second model, state enrollment rate in comprehensive Medicaid managed care. Use of a dependent variable more sensitive to enrollment rates of individuals with disability in state Medicaid managed care programs may substantially influence spatial analyses.

Since the urbanization variable was omitted in the regression models due to correlation with FMAP, maps of 2006 outcomes were developed to visualize state enrollment rates in comprehensive Medicaid managed care relative to rates of urbanization (Appendix E). As one might expect, Montana and Wyoming which exhibit lower rates of Medicaid managed care enrollment are more rural in nature compared New York and Pennsylvania. Although the panel regression analyses did find FMAP to be a statistically significant policy indicator in state Medicaid managed care enrollment, the appearance of variance based upon rates of urbanization depicted in the map illustrate the need for future research.

While the relationship between urbanization and Medicaid managed care is not examined in this study, future work should appreciate the following:

- Managed care plans account for 99% of enrolled workers throughout the United States. Therefore urbanization does not appear to inhibit use of managed care in the private welfare sector (Kaiser Family Foundation and Health Research & Educational Trust 2009: 63).
- Some states have used their purchasing power to mandate managed care organizations include Medicaid enrollees

Considering the prevalence of managed care in the private sector in both urban and rural states, further research will be needed to better understand factors associated with the public sector that influence the use of managed care for Medicaid enrollees. Improved understanding of the public sector, particularly Medicaid policy making, possesses implications for policy approaches and policy solutions under consideration. State Medicaid policy making could utilize purchasing power to influence service delivery, serving as “prudent buyers” and good stewards of public funds.

A map to visualize 2003 state rates of disability relative to use of comprehensive Medicaid managed care for enrollees with disability was also developed (Appendix F). This map displays higher rates of disability and low use of Medicaid managed care for people with disability in Montana, Wyoming, Mississippi and Georgia; and, lower rates of disability and higher rates of Medicaid managed care for enrollees with disability in Delaware. This map provides a visual display of the statistically significant negative relationship between disability and the use of Medicaid managed care for people with disability detected in the panel regression model.

Lastly, a map was developed to visualize associations between the FMAP, the rate at which the federal government contributes to state Medicaid programs and state disability rates in 2006 (Appendix G). It is interesting to consider the visual presentation of the states at the FMAP statutory floor of 50% relative to states in the highest quantile of the FMAP. While thirteen states possess FMAP at the statutory floor, three states (Mississippi, Arkansas and West Virginia) possess FMAPs in the highest quantile. These three states also exhibit state disability rates in the highest quantile while many of the states at the statutory FMAP floor exhibit state disability rates in the lowest quantile. Over time, FMAP has gradually declined. However, the statutory limit for FMAP may inhibit reductions in federal funding to states at the floor and may be insufficient for states most reliant on federal funds to adopt more efficacious strategies for their Medicaid programs.

This study reveals that state disability rate significantly influences the use of comprehensive Medicaid managed care programs for people with disability in a negative direction; a lower rate of state disability is associated with a higher rate of comprehensive Medicaid managed care programs for enrollees with disability. Consequently, outcomes also reveal disability significantly influences overall enrollment in state Medicaid programs in a positive direction meaning that higher state rates of disability are associated with higher rates of enrollment in state Medicaid programs. The FMAP is calculated upon average state per capita income. The adequacy of the FMAP in supporting states with the highest need has been questioned (Holahan 2003). Further research to examine state disability rates as a potential factor for consideration in FMAP calculations will be

needed. Appreciation for state disability rates may provide more adequate redistribution of federal funds to state Medicaid programs.

Conclusions

The U.S. spends fifty-three percent more per capita on health care than the next closest country, Switzerland, which provides universal care to all its citizens (Anderson et al. 2005: 905). The unsustainable growth in health care costs coupled by increasing numbers of under and uninsured individuals has culminated in political efforts to reform the United States' health care system. Recent health care legislation begins to address crucial issues important for the health of low-income populations with disability and chronic conditions. Removing cost sharing for preventive services and acknowledging the need to develop primary approaches to care are topics addressed by the new legislation (Kaiser Family Foundation 2009). How these changes will be implemented in state Medicaid programs and whether these approaches will address the unique health care needs of Medicaid populations with disability and chronic illness is undetermined. A better understanding of Medicaid policy-making and the resultant influence on people with chronic illness and disability is needed and will continue to require further examination with changes to the system.

While the 2010 health care legislation expands the population eligible for Medicaid, reforms also include reductions in Medicaid spending, including reductions in payment to disproportionate share hospitals, increased use of generic pharmaceuticals and the elimination of payment for nosocomial conditions, those resulting from treatment in a health care setting (ibid). These reforms broadly address paradigmatic changes in health care and the influence on state Medicaid programs must be closely monitored. A

better understanding of policy determinants influencing state Medicaid programs is particularly important as states respond to broader system changes.

The health care needs of individuals with chronic conditions and disability extend beyond diagnosis, necessitating intervention that maximizes and sustains functional ability (Lewin and Altman 2000; Institute of Medicine 2000: 181). Theoretically, managed care provides an organized approach to care that seeks to ameliorate the fragmentation among health care services and providers characterizing traditional fee-for-service. The use of managed care case managers to integrate varied medical providers and treatment approaches provides opportunities to influence current treatment paradigms in a manner that better supports the health of individuals with chronic illness and disability. Premised upon negotiated pricing, managed care was designed to encourage competition among providers while promoting quality of care and the provision of comprehensive services (Sutton and DeJong 1998).

A crucial factor that may influence the use of managed care for people with chronic illness and disability is risk adjustment. By adjusting reimburse relative to the severity of an individual's health condition, risk adjustment sensitizes reimbursement strategies according to need. Health care providers serving individuals with greater needs are reimbursed at higher rates relative to reimbursement for less intensive services. Developing risk adjustment strategies for individuals with chronic illness and disability requires appreciation of two factors: the identification of standards of care that best support the needs of varied populations; and, mechanisms of data collection that captures patient encounter and service use; and, the associated costs incurred across populations necessary to inform development of risk adjustment strategies (Sutton and DeJong 1998).

Without adequate risk adjustment, health plans and providers have financial incentives to avoid and underserve individuals with disabilities. With adequate risk adjustment, health plans especially are more likely to compete on price and quality instead of price and risk (DeJong, Palsbo, and Phillip W. Beatty et al 2002).

Assessing health outcomes of Medicaid managed care is difficult. Managed care strategies, such as prepayment mechanisms, no longer provide utilization data traditionally captured under fee-for-service systems (United States General Accounting Office 1996: 6). In other words, capturing frequency of service usage and cost intensity is more difficult and less developed in prepayment reimbursement systems compared to fee-for-service systems.

Risk adjustment strategies have been developed. In particular, a strategy specifically designed for Medicaid enrollees with disability, the Chronic Illness and Disability Payment System (CDPS) predicts variance in medical expenditures based upon diagnosis (Kronick et al. 2000). New York and Pennsylvania, both of whom exhibit statistically significant spatial relationships in the use of comprehensive Medicaid managed care, are leading efforts to assess approaches to care for program enrollees with chronic illness (Center for Health Care Strategies Inc. 2008).

The efficacy of using diagnostic based mechanisms as the foundation for risk adjustment will require further research. Unlike acute illness, chronic conditions are not cured, but managed (Institute for Health and Aging 1996: 11). Chronic care strategies must appreciate the importance of rehabilitative services and medical equipment in sustaining functional levels of independence instead of a more narrowed perspective that seeks to restore function following acute change in health status (DeJong, Palsbo, and Phillip W. Beatty et al 2002). Assessment of survival without appropriate

acknowledgement of functional ability may constrain support for functional levels of independence and quality of life. Individuals with chronic illness must be empowered and educated to adopt healthy lifestyles and to make healthy choices that may buffer or postpone potential debilitating effects of chronic conditions.

As a substantial purchaser of health care services, state Medicaid programs may use purchasing power to effect standards of quality and service delivery. States possess the latitude to tailor Medicaid programs to meet specific need. Both Pennsylvania and Arizona utilize mandatory managed care enrollment for TANF and disabled beneficiaries. “Mandatory enrollment models enable health plans to focus on “serving” rather than ‘selling’” (Lewin Group 2005: 6). Minnesota mandates managed care organizations include Medicaid populations and adjusts reimbursement rates for high-risk enrollees (Holahan, Rangarajan, and Schirmer 1999). These innovative state approaches permit the federal government to focus on the quality of care rather than the provision of care. An editorial by Newt Gingrich and James Frogue (2005)states,

...instead of auditing the process by which they spend their federal Medicaid dollars, the federal government would audit states based on demonstrated improvements in health outcomes, childhood immunizations, or a closing of the gap in racial health disparities. Washington’s role would change from its current focus on oversight of process compliance to auditor of results.

Expansion of Medicaid managed care, by promoting more integrated health care strategies to sustain and enhance quality of life is particularly important for Medicaid enrollees, a program for individuals with low-income who disproportionately possess chronic illness and disability. “Health is both a matter of how long one lives and how well one lives (Ustun et al. 2003).”

Current literature provides evidence of the varied ways Medicaid, as a component of the state health care safety net, is changing under escalating socio-economic pressure.

As states develop policy approaches in response to environmental pressures, policy outcomes will influence millions of Medicaid enrollees. The diversity of health care needs across the spectrum of Medicaid beneficiaries complicates Medicaid policy making. Whether manifested by incremental change or broader reform, the future of Medicaid policy may benefit from an increased understanding of forces influencing policy-making and the examination of efficacy on health outcomes for the vulnerable program enrollees. The well-known political scientist, Harold Laswell, described public policy as “who gets what, when and how.” These decisions are particularly important for impoverished populations, such as those who rely on state Medicaid programs as the primary means for access to health care.

This study clearly reveals the need for more refined data to assess the use of comprehensive Medicaid managed care for enrollees with disability. Analysis of the percentage of comprehensive Medicaid managed care programs for enrollees with disability only captures the use of alternative paradigmatic health strategies in a broad sense. It does not capture the actual number of enrollees with disability in comprehensive managed care programs by state or condition severity of that population. Furthermore, assessing state enrollment rates in comprehensive Medicaid managed care programs does not delineate enrollees with and without disability. A more sensitive outcome measure is needed.

The ability to discern the influence of redistributive and developmental policy indicators may require consideration for additional developmental factors that operationalize state economic growth. While change in personal income is a key marker indicating state economic activity, additional factors, including tax policy, may need to

be considered. States cannot avoid consideration of developmental policy and the resultant influence on resources available for redistributive policy making

Research is needed to further examine the potential influence of neighboring states on the adoption of Medicaid managed care programs. The ability to discern state relationships influenced by economic convergence versus policy diffusion is needed. As mentioned earlier, the role of urbanization in influencing the use of managed care in the public sector relative to use in the private sector requires further examination.

Continuing to research the use of managed care in state Medicaid programs over time will be important. The Medicaid program is particularly susceptible to environmental pressure, including economic and political change, hence longitudinal research will help to assess trends and relationships of policy indicators influencing change over time. As a program for the low-income populations, Medicaid is challenged with substantial diversity and complexity of health care needs characterizing this vulnerable population.

This study does not assess the services offered by the managed care programs nor the adequacy of the programs in meeting the complex needs of individuals with chronic conditions and disability. Traditional fee-for-service Medicaid reimbursement strategies encourage service utilization, deterring alternative approaches to care, even those well supported by empirical evidence (Wagner et al. 2001). While research has compared managed care with fee-for-service approaches, continued effort to examine the health outcomes specifically of enrollees with disability with those in traditional fee-for-service programs will be critical.

The statistical relationships detected in this study contribute to the understanding of state Medicaid programs. This study supports the role of ideology, as an indicator of

redistributive policy making, in providing access to health care for needy constituents. In this regard, political forces serve as dynamic processes influencing the policy agenda and policy outcomes within institutional frameworks, such as state Medicaid programs.

Disability emerged as a significant demographic variable, inversely influencing the use of Medicaid managed care for enrollees with disability and positively influencing enrollment in state Medicaid programs, as well. These factors merit consideration as indicators particularly important in examining state Medicaid managed care programs.

Spatial analysis is needed to determine influence of neighboring states on state Medicaid policy making. These relationships may shed light on influential forces contributing to the adoption of new policies or retention of the status quo. Analysis of geographic relationships is particularly relevant when examining state policy making. Spatial analyses provide an opportunity to compliment aspatial methodology, enriching approaches to better understand the varied use of Medicaid managed care among states.

In addition to the examination of socio-economic and political system variables, economic competition among neighboring states ultimately influences economic resources available for policy making. Studies indicate that Medicaid managed care approaches can reduce costs anywhere from two percent to nineteen percent.

Comparisons among states reveal that per capita Medicaid expenditures decrease as state use of prepayment mechanisms increase (Lewin Group 2005: 9). Over time, as states become more familiar with managed care programs, savings tend to increase (Lewin Group 2004a: 30). External forces, such as downturns in the national economy, may certainly influence enrollment in state Medicaid programs. However, as states gain

greater latitude to modify program design, the expansion of managed care among state Medicaid programs may be influenced by policy-decisions of neighboring states.

Policy analysts should explore and embrace opportunities to discover how conditions at the state level influence the care of Medicaid enrollees, particularly those enrollees with chronic illness and disability. Longino and Murphy (1995) state the ability to adequately address chronic illness requires a philosophical paradigm shift. Traditional medical models of care focus on the detection and treatment of acute illness. Increasing prevalence of chronic conditions will require alternative approaches to care as a means to maximize functional levels of independence and support quality of life. Public bureaus are entrenched in a web of politics and accountable to a variety of stakeholders; however, state-level policy-making possesses the ability to influence paradigms of care by establishing standards for service administration and health outcomes for program enrollees.

State level policies provide the opportunity to integrate successful health care strategies at the local level for persons with disabilities. “The ultimate responsibility for shaping national health systems lies with governments” (World Health Organization 2008: 82). As a program that provides health care access to substantial numbers of individuals with low income and disabling conditions, Medicaid policy making significantly influences the quality of life for program enrollees and influences health system design in each state.

State Medicaid programs highlight the complexity of public policy making, challenging states to balance unlimited demand and limited resources while tethered to a contentious political arena. However, state policy making is more sensitive to the needs

of residents and amenable to change compared to national policy making. The Medicaid program permits state discretion in determining benefits for Medicaid recipients. State governments possess the ability to re-shape and tailor policy strategies to meet the changing needs of constituents.

A better understanding of state Medicaid policy-making possesses important implications for program enrollees and state budgets. As a mechanism to control costs, states are seeking ways to implement Medicaid programs in a more efficient manner. The use of managed care is one approach to curb costs while theoretically, providing health care in manner to improve and sustain health and well-being. While Medicaid redistributes resources to those excluded in the private health insurance market, states must balance the use of fiscal resources to support the health care needs of constituents while simultaneously facilitating economic growth. It is important to deconstruct the influence of state redistributive policy making relative to developmental policy making to better understand factors influencing state Medicaid programs.

Literature has demonstrated the influence of state wealth and political ideology (Barrilleaux and Miller 1988; Lewin Group 2004a; Hwang and Gray 1991; Buchanan, Cappelleri, and Ohsfeldt 1991; Plotnick and Winters 1985; Holahan and Pohl 2003) on state Medicaid programs. However, this study takes a closer look at chronic illness and disablement, characteristics particularly relevant for state Medicaid programs. Outcomes from this study reveal that state disability rates influence not only the use of managed care by state Medicaid programs, but the enrollment in state Medicaid programs, as well. This important policy indicator looks beyond more overt policy characteristics such as state wealth, to uncover more nuanced factors influencing the public welfare sector and

the health and well-being of Medicaid enrollees. Appreciating the relationships between chronic illness, disability, and low-income populations enhances the understanding and emphasizes the importance of state Medicaid programs for vulnerable populations.

Ultimately, state Medicaid policies influence the health and well-being of program enrollees. Traditional models of care assess health and disability according to deviations in physical and mental status. The individual, however, tends to view health according to quality of life and equal opportunities to participate in society. Strategies to facilitate and support health must move beyond confined perspectives assessing causality between symptoms and pathology and embrace the concept of health as a complex, multi-dimensional entity. Redistributive policies, such as Medicaid, facilitate or inhibit the use of alternative strategies of care. These policy decisions ultimately play out in the lives of vulnerable individuals, particularly Medicaid enrollees with chronic illness and disability. In this regard, the policy analyst is challenged with a rather daunting task—developing an in-depth understanding of policy issues and determining an efficacious policy solution. After all, it is our policy decisions that define our priorities and shape our collective identity as a society.

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Appendix A:

Table 1: Percent of Comprehensive Medicaid Managed Care Relative to State Medicaid Enrollment

State	Percent of Comprehensive Medicaid Managed Care Relative to State Medicaid Enrollment
Alabama	0
Alaska	0
Arizona	90.5
Arkansas	0
California	51.4
Colorado	11
Connecticut	0
Delaware	69.5
Florida	35.7
Georgia	56.9
Hawaii	79.1
Idaho	0
Illinois	7.8
Indiana	66.1
Iowa	1.3
Kansas	47.7
Kentucky	19.8

Louisiana	0
Maine	0
Maryland	69.1
Massachusetts	34.8
Michigan	64.2
Minnesota	62.4
Mississippi	0
Missouri	41.5
Montana	0
Nebraska	16.2
Nevada	47.1
New Hampshire	0
New Jersey	72.1
New Mexico	61.9
New York	64.2
North Carolina	0
North Dakota	0
Ohio	71.4
Oklahoma	0
Oregon	73.4
Pennsylvania	52.8
Rhode Island	61.9
South Carolina	26.8

South Dakota	0
Tennessee	100
Texas	43.1
Utah	0
Vermont	91
Virginia	55.7
Washington	53.7
West Virginia	44.6
Wisconsin	52.1
Wyoming	0

Source: Kaiser Family Foundation (2010a)

Appendix B.

Table 2. Data Dictionary for Panel and Spatial Regression Variables

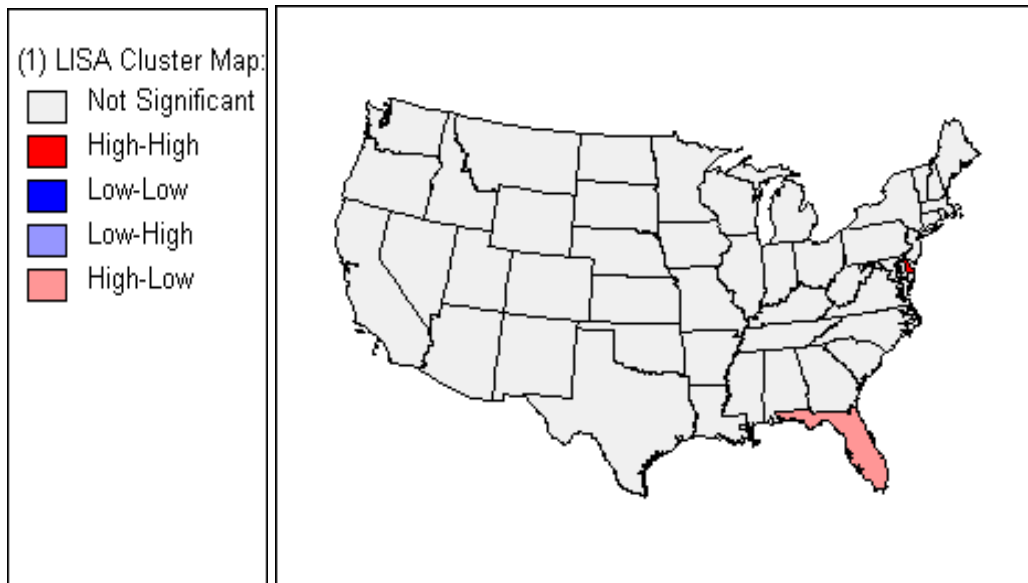
Variable	Variable Label	Definition	Source
Dependent variable: Percentage of comprehensive State Medicaid managed care programs for adults with disabilities	pctpro	Percentage of State Medicaid managed care programs providing comprehensive benefits for adults with disabilities	Centers for Medicare and Medicaid Services (2006, 2003, 2000)
Dependent variable: State enrollment rates in comprehensive Medicaid managed care	pctcmc	Measured as the percentage of Medicaid comprehensive managed care enrollees out of total Medicaid enrollees by state	Centers for Medicare and Medicaid Services (2006a, 2003, 2000)
Dependent variable: Percentage of the state population enrolled in Medicaid	pctmen	Calculated using state Medicaid enrollment rates in 2000, 2003 and 2006 divided by state population estimates	Ellis, Roberts, Rousseau and Schwartz (2008); U.S. Census Bureau (2008).
Independent variable: State Federal Medical Assistance Percentage (FMAP)	fmap	The FMAP formula is calculated upon average per capita income by state relative to the national average.	Data for 2000 and 2003 is from the Department of Health and Human Services (2008). Data for 2006 is from the Kaiser Family Foundation (2007c)
Independent variable: State Medicaid expenditures	mspertext	State Medicaid expenditures as a percent of total expenditures	National Association of State Budget Officers, (2007, 2004, 2001)

Variable	Variable Label	Definition	Source
Independent variable: State growth in personal income	perchin	Change in personal income by state from 1999-2000, 2002- 2003, 2005-2006	Bureau of Economic Analysis (2009)
Independent variable: Citizen ideology, by state	cideo	State ideology scores are computed by averaging the ideological position of Congressional members by district. Higher scores equate to more liberal ideology.	Berry, Ringquist, Fording and Hanson (1998); University of Kentucky (2006)
Independent variable: Percentage of people without health insurance coverage by state	pctunins	Data for 2000 is the two-year average for 1999-2000; data for 2003 is the two-year average for 2002- 2003; data for 2006 is the three-year average of 2004- 2006	2000: Mills (2001) 2003: DeNavas- Walt, Proctor and Mills (2004) 2006: DeNavas- Walt, Proctor and Mills (2007)
Independent variable: Disability status of non-institutionalized civilian population, age 5 and older, by state,	pctdis	Disability is measured by the U.S. Census Bureau through survey questions capturing the prevalence of chronic conditions and resultant limitations in activity	Waldrop and Stern (2003)

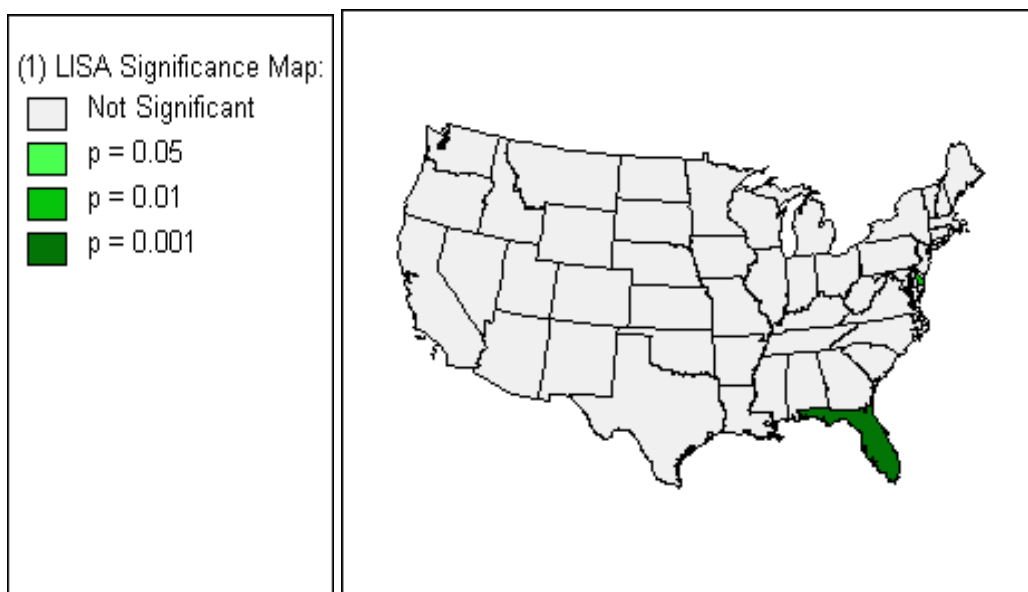
Appendix C:

Maps presented use Albers Equal Area Conic projection and queen contiguity weights.

A LISA cluster map of percent comprehensive Medicaid managed care programs for people with disability, 2003



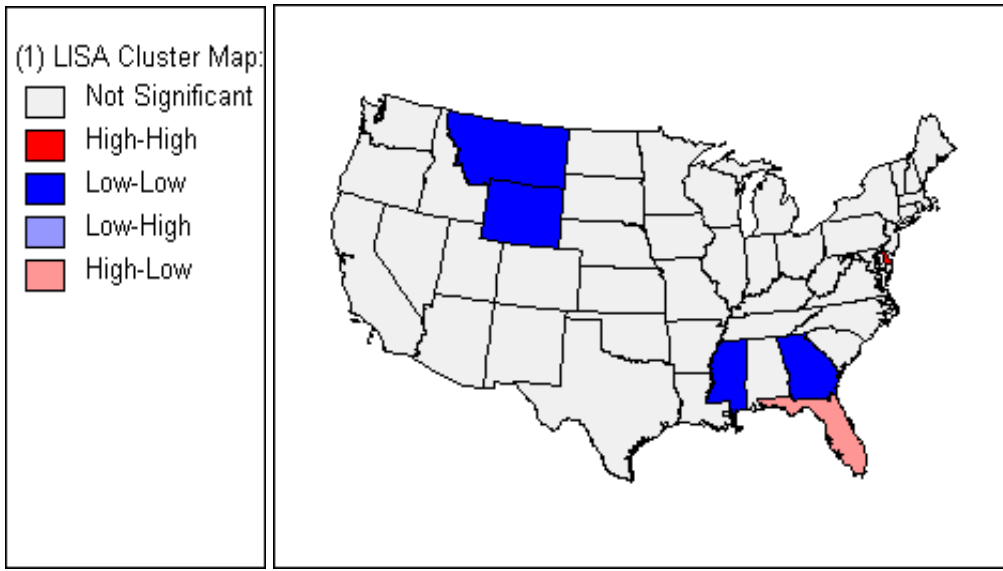
A LISA significance map of percent comprehensive Medicaid managed care programs for people with disability, 2003



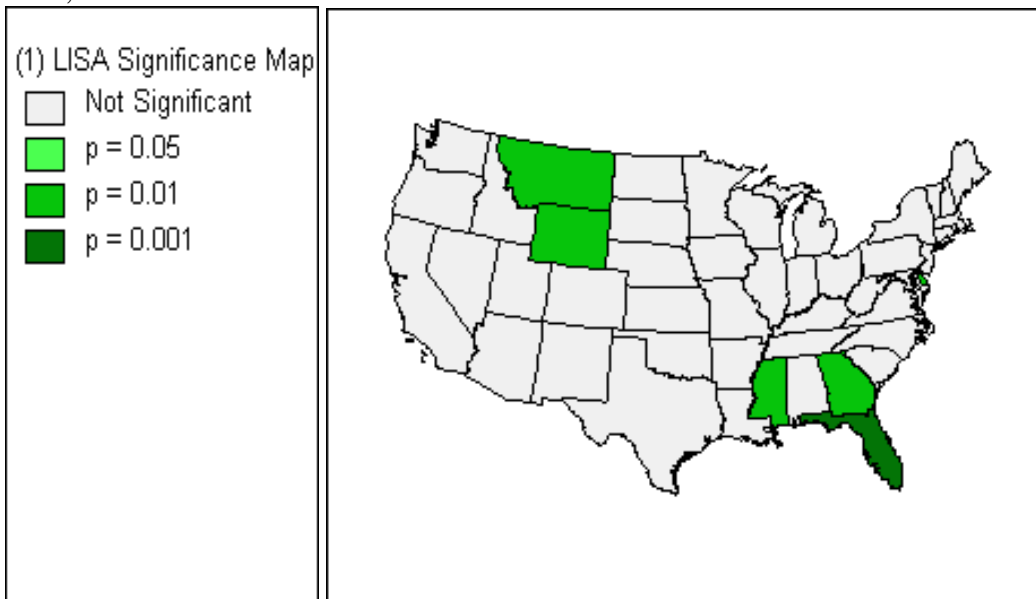
Appendix D:

Maps presented use Albers Equal Area Conic projection and queen contiguity weights.

A LISA cluster map of percent Medicaid enrollment in comprehensive Medicaid managed Care, 2003

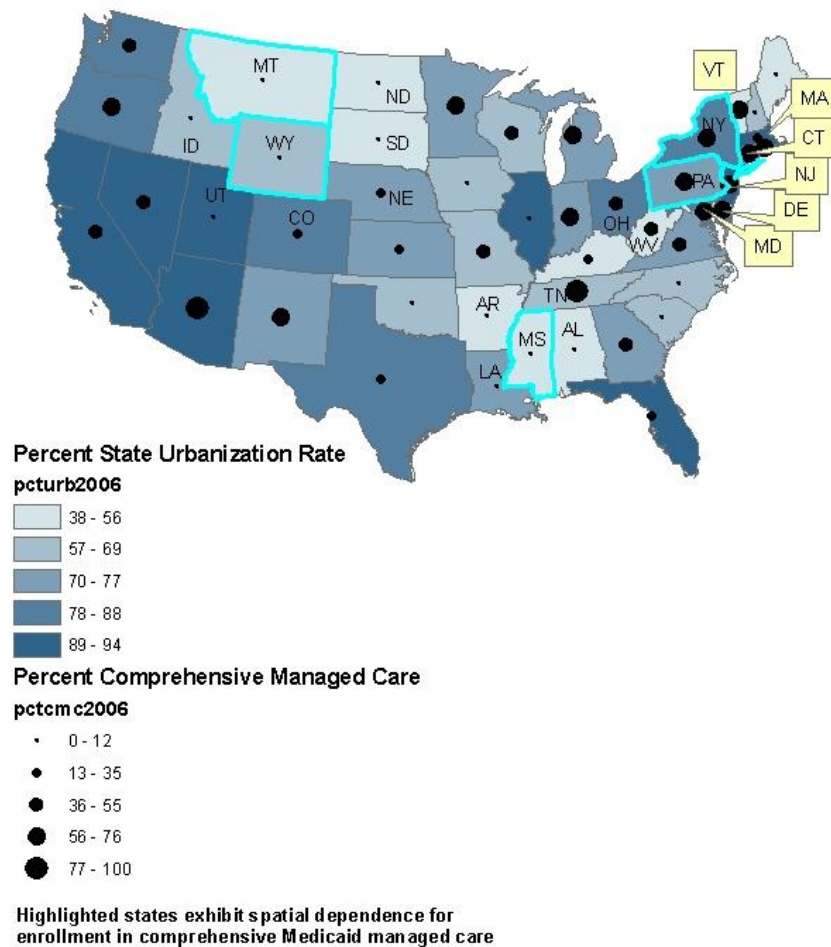


A significance map of percent Medicaid enrollment in comprehensive Medicaid managed Care, 2003



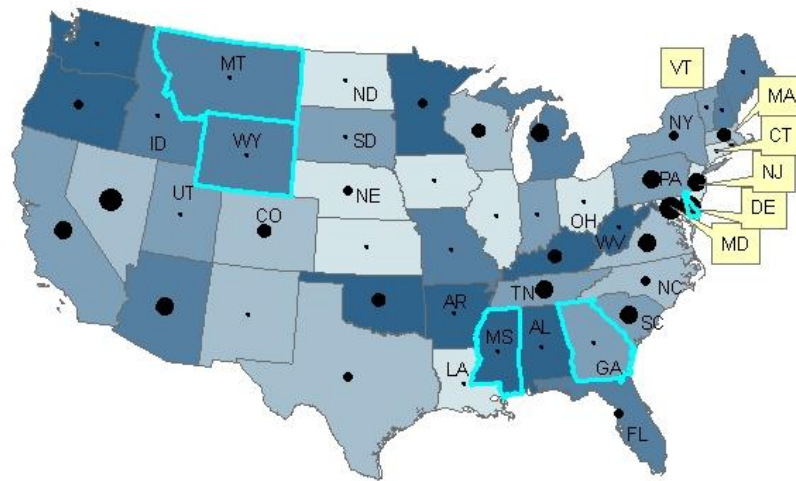
Appendix E:

Comprehensive Medicaid Managed Care Rate Relative To State Urbanization Rate, 2006



Appendix F:

State Disability Rate Relative to Use of Comprehensive Medicaid Managed Care for Adult Enrollees with Disability, 2003



Percent State Disability Rate, quantiles

pctdis2003

- 14 - 17
- 18
- 19
- 20 - 21
- 22 - 26

Percent Medicaid Managed Care for Enrollees with Disability, quantiles

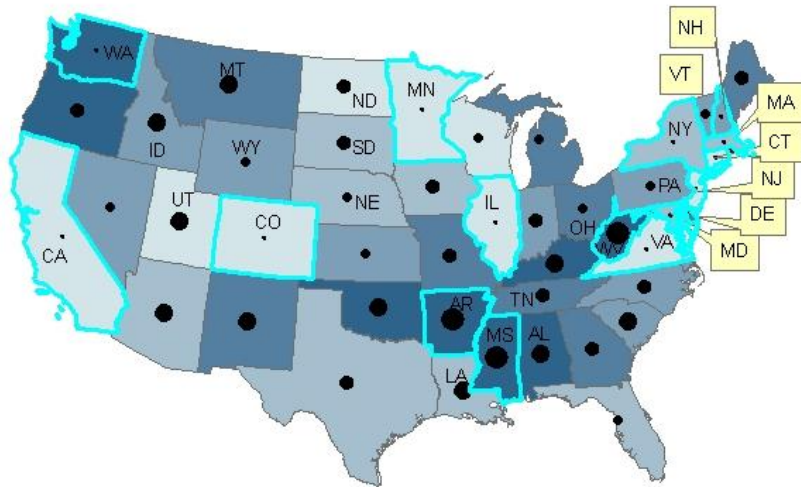
pctcpro2_1

- 0
- 1 - 25
- 26 - 33
- 34 - 67
- 68 - 100

Highlighted states exhibit spatial dependence for use of comprehensive Medicaid managed care for people with disabilities

Appendix G:

State Disability Rate Relative To State FMAP, 2006



Percent State Disability Rate, quantiles

pctdis2006

- 15 - 17
- 18
- 19 - 20
- 21 - 22
- 23 - 26

State FMAP, quantiles

fmap2006

- 50
- 51 - 60
- 61 - 66
- 67 - 71
- 72 - 76

Thirteen highlighted states exhibit FMAP at the statutory floor of 50% and three states exhibit FMAP in the highest quantile