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# STATES IN A REFORMED HEALTH SYSTEM: LESSONS FROM NURSING HOME POLICY

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by Michael S. Sparer

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*Prologue: Even in a society that strongly favors limiting the powers of central government, there is general agreement that Washington must establish the basic framework of a reformed health care system if universal coverage is to be achieved. But what role should states play in a reconfigured health care system? This is a critical question as the Clinton administration fashions its health care policy. Given Bill Clinton's long tenure as the governor of Arkansas, he seems inclined to grant states greater flexibility and perhaps more responsibility in the future. One reflection of this inclination is the administration's decision to approve Oregon's controversial proposal to guarantee medical services for its poor population by rationing care. Great variations separate how individual states craft and administer their health care programs, what demands they place on providers, and the generosity they extend to patients. Variation between New York and Alabama is to be expected. But what about the great variation that separates large industrial states with broader tax bases and more liberal commitments to social welfare? Specifically, what about, as author Michael Sparer characterizes it, the "wildly inconsistent" nursing home policies of California and New York? This variation is not limited to eligibility and benefit policy, but exists in reimbursement policy and quality of care oversight as well. How much variation is too much, and what measure of uniformity should the federal government exact in these matters? Sparer became interested in the often neglected issues surrounding federalism when he practiced law for seven years in New York City's legal department. Much of his legal work centered on intergovernmental litigation. Sparer completed a doctorate in political science at Brandeis University last year. Currently he is an assistant professor of health policy at Columbia University's School of Public Health.*

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**Abstract:** Most serious health system reform proposals include a prominent role for states, despite documented variation in costs, delivery systems, and health status among states. As policymakers search for an approach that will reform the health system and minimize inappropriate interstate variation, the experience of nursing home policies and politics in two states—New York and California—can offer useful lessons about underlying reasons for variation and how to ensure equitability amidst state differences. These two states are examined as case studies because they have the nation's two largest Medicaid programs yet have approached their long-term care systems very differently. The differences in their nursing home policy approaches suggest that state-based health system reform be pursued with caution, lacking further study of state variations.

States play a key role in the American health care system. The Medicaid program, for example, delegates to state officials broad authority to determine who in their state receives coverage, what medical services are covered, and how much providers are paid for delivering care. Medicaid also requires state treasuries to finance nearly 45 percent of the programs' rapidly increasing bill.<sup>1</sup> State officials perform numerous other tasks as well, from supervising the nation's private insurance system, to regulating the quality of care rendered by most medical providers, to developing initiatives to ease the plight of the uninsured.

One consequence of this state-based system is wide interstate variation in all phases of health care policy. In California, for example, a family of three with income below \$11,208 can receive Medicaid, while that same family in Alabama needs income below \$1,488 to qualify.<sup>2</sup> In New York a typical nursing home receives more than \$120 per day per Medicaid recipient (the highest nursing home rate in the continental United States); a similarly situated facility in California receives only \$65 per day per recipient.<sup>3</sup> And in fiscal year 1990–1991 California's Medicaid program spent approximately \$8.7 billion on more than four million recipients, while New York's program spent over \$14.3 billion on only 2.4 million recipients.<sup>4</sup>

Policymakers need to consider carefully the role states should play in a reformed health care system. Should we revise the division of labor between the states and the federal government? If so, should states be given more authority or less? A reform package could significantly limit state discretion and emphasize instead a federally financed and administered system of national health insurance (Medicare for all). Another approach would give states, acting as "policy laboratories," increased authority to test various reform efforts. Perhaps the Employee Retirement Income Security Act (ERISA) should be amended to expand state discretion to impose employer mandates.<sup>5</sup> State agencies could be allowed to more rigorously "manage" competition among competing health plans. Yet another scenario would retain some state-based discretion but would ensure greater federal control of state-level decisionmakers, as in the Canadian system.

Policymakers evaluating these options need to consider which approach

is most likely to produce useful variation. The good and bad variations of state-based systems: How do they do? How successful are they about the capacity to reform them with policy?

Remarkably few studies of state government are quantitative. Research on economic, and community development, and supporting one or another policy option is encouraged for a comparative analysis, particularly where it is difficult to quantify. This study describes better than most what offers the best way to reform.

For this reason, the study of New York and California's Medicaid programs, the nation's two largest, offers insights into the problems inherent to nursing home care, not only a start, but a suggestion about the appropriate approach.

### Policy In New York

Between 1961 and 1966, welfare clients negotiated with state commissioners. By 1966, the typical rate of nursing home care was \$120 per day per recipient. The reason for such a high rate was that, with few exceptions, nursing homes were negotiating for higher rates.

In 1966, however, the state charged New York nursing homes more uniform rates. Medicaid should pay no more than \$65 per day per recipient, owners, fearing rates would be threatened to stop, threatened to stop operating their nursing home beds.

is most likely to minimize inappropriate interstate variation and maximize useful variation. To make this judgment, one needs to do more than define good and bad variation. One needs as well to know more about the "black box" of state-based politics. Why do states make the policy choices that they do? How successful are such choices? And what do such choices tell us about the capacities of state governments and the wisdom of entrusting them with policy-making authority?

Remarkably few efforts have been made to study the choices and capacities of state governments. Moreover, most research on state variation is quantitative. Researchers typically begin with data on the states' political, economic, and cultural conditions and end with statistical analyses supporting one or another hypothesis. This fascination with multiple regressions is encouraged, I believe, by the number of states: Fifty seems too many for a comparative case study but just perfect for a comparative statistical analysis, particularly with all of the data now available. Unfortunately, it is difficult to quantify the realities of state politics, and the existing literature describes better than it explains. While old-fashioned, the case study still offers the best way to understand states' choices and capabilities.

For this reason, I present a case study of nursing home politics in New York and California. I take this approach because these states, which have the nation's two largest Medicaid programs, resolve so differently the trade-offs inherent to nursing home policy making. Also, this comparison, while only a start, suggests important lessons about state-level policy making and about the appropriate state role in a reformed health care system.

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#### Policy In New York, 1966-1974: Pluralism Prompts High Costs

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Between 1961 and 1966, nursing homes in New York that accepted welfare clients negotiated reimbursement rates with county social services commissioners. By and large, providers did well in these negotiations, and the typical rate guaranteed reimbursement well above providers' costs. One reason for such successful negotiations was simply supply and demand: With few homes willing (or able) to care for the indigent aged, and with a large number of indigent aged in need of institutionalization, the homes were negotiating from a position of strength.

In 1966, however, with the enactment of Medicaid, the state legislature charged New York's Department of Health with the task of establishing a more uniform reimbursement system. The department decided that Medicaid should pay only for nursing homes' "reasonable costs." Nursing home owners, fearing rate decreases, opposed the new system. Some facilities threatened to stop accepting Medicaid patients. Given the undersupply of nursing home beds, the threat of boycott was taken seriously. As a result,

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the department allowed nursing homes to receive their cost-plus rates until they could increase their costs to match the rate.<sup>6</sup> The political influence of the industry thus was established early on.

Nursing home owners recognized, of course, the inflationary incentives inherent in a cost-based reimbursement system: the higher a provider's costs, the higher its reimbursement. For this reason, nursing homes used the interim between the old and the new reimbursement systems to increase their costs significantly. By the time Medicaid officials implemented the new system in 1968, provider costs had surpassed their old negotiated rates. Indeed, Medicaid reimbursement rates were soon escalating dramatically. Between 1967 and 1975, for example, the average Medicaid nursing home rate increased more than 150 percent. By 1974 the average Medicaid rate in a skilled nursing facility was \$40.62 per patient per day (and some homes received more than \$70 per day). In California, by contrast, the maximum rate then paid to a nursing home was \$18.42 per patient per day.<sup>7</sup> But New York was not the only state to adopt a reasonable-cost reimbursement system. Why then was cost inflation in New York so severe? Four factors seem most relevant.

**Health care unions.** During the mid-1960s unions representing New York's nonprofessional health care workers emerged as powerful players in New York politics. These unions used their political clout to obtain dramatic wage increases for their members: 24 percent in 1966, 25 percent in 1968, and similar increases during the early 1970s.<sup>8</sup> For a work force long accustomed to sweatshop salaries, the new era offered reason to rejoice.

Interestingly, the generous wage increases were inconsistent with the spirit (if not the letter) of New York's Medicaid reimbursement formula. More specifically, state law supposedly limited Medicaid reimbursement for 1968 wages to 1966 wages, adjusted for inflation. The negotiated increases clearly exceeded inflation. Nonetheless, Department of Health officials improvised and developed a concept called the "substitute labor price movement" (or "slip-ems"), under which negotiated wage increases were substituted for inflation-based increases and were reimbursed in full. Since department officials themselves wrote the reimbursement regulations, they were entitled to amend them; after all, the increases were purportedly necessary to avoid a political and medical catastrophe (a strike). The real loser was the federal government, which paid half the tab. But federal officials never complained, and wages continued to rise.

**Expensive nonprofit nursing homes.** Beginning in the late 1960s New York issued "moral obligation bonds" to nonprofit organizations to finance the construction of nearly ninety nursing homes.<sup>9</sup> The goal was to counteract the business orientation of the rapidly growing nursing home industry. The newly built nonprofit facilities were, however, elaborate and expen-

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#### Policy In New York

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inflationary incentives the higher a provider's nursing homes used the cost-plus systems to increase rates. Officials implemented the new systems to increase their old negotiated rates. Rates escalated dramatically. Medicaid nursing home rates rose to an average Medicaid rate in 1975 of \$100 per day (and some homes charged as much as \$150 per day).<sup>7</sup> But New York's cost-plus reimbursement system was so severe? Four factors

contributed to the rise in rates: (1) the political influence of unions representing New York City workers as powerful players in the state's political clout to obtain dramatic rate increases in 1966, 25 percent in 1967, and 15 percent in 1968.<sup>8</sup> For a work force long unemployed, the reason to rejoice.

(2) the inconsistent with the Medicaid reimbursement formula. Medicaid reimbursement for nursing homes was based on the negotiated increases of Health officials. Officials "substitute labor price increases for wage increases were not reimbursed in full. Since Medicaid reimbursement regulations, they argued that rate increases were purportedly justified by a strike. The real cost was paid by the state. But federal officials would not raise.

(3) the rise in the late 1960s New York City workers' organizations to finance the strike. The goal was to counteract the rise in the nursing home industry. The state, elaborate and expen-

sive; construction costs were 50-100 percent higher than those incurred by privately built facilities.<sup>10</sup> Put simply, the state gave the nonprofits money to build expensive homes and then based Medicaid rates in large part on the high construction costs.

**Fraud and abuse.** Significant nursing home fraud existed in New York in the pre-1975 era. The extent of the fraud was attributable to three factors: (1) the cost-based reimbursement system, which encouraged homes to inflate costs so as to inflate reimbursement; (2) the paucity of Medicaid auditors (until the mid-1970s, there were fourteen auditors for more than 800 facilities); and (3) the lack of penalties if inflated costs were uncovered.<sup>11</sup> Of course, some owners operated high-quality and extremely reputable facilities. But others engaged in all sorts of financial trickery to inflate their costs legally, particularly their capital costs.

**Decentralized governmental administration.** New York State's Department of Health was not the only governmental bureaucracy involved in the Medicaid reimbursement system. For example, nursing homes were required to submit Medicaid bills to their local social services department. The counties would then pay the bills and submit claims to the state for the state and federal share.<sup>12</sup> But the counties, especially the three counties in New York City, were utterly unprepared to perform this administrative task. There were simply too few people with too few resources to do the job right.<sup>13</sup> City workers generally paid any and all bills, no questions asked, and left efforts to verify and audit to the state. Since, as discussed earlier, the state Department of Health also had little audit capability, audits were few.

Because the counties paid the bills, however, they also exercised significant de facto influence over policy. Counties used that authority on occasion in ways helpful to nursing homes, even if it meant stretching and altering legal requirements. For example, nursing homes often complained that Medicaid recipients failed to pay their share of their nursing home bill. In the late 1960s, in an effort to encourage nursing homes to accept Medicaid patients (many of whom were languishing for months in overcrowded public hospitals), New York City officials decided to reimburse nursing homes for amounts the homes were unable to collect from recipients. This policy, clearly illegal, continued until 1982, when a federal audit uncovered the practice. State officials had long known of the policy but chose not to intervene until ordered to do so by the federal government.

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#### Policy In New York, 1974-1975: Scandals And Budget Crises

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In late 1974 *The New York Times* began an extended exposé of New York's nursing home industry. According to the *Times* and the investigators who followed up on the newspaper's allegations, some nursing home owners

were stealing millions from the Medicaid program, operating homes that provided scandalously poor care, and using political connections to further their criminal schemes. Around this same time both New York City and New York State faced daunting fiscal crises. The city's crisis was particularly acute; in 1975 it nearly went bankrupt. While the state was never in danger of bankruptcy, in January 1976 Governor Hugh Carey faced a \$900 million budget deficit and decided to slash state spending. Not surprisingly (given the ongoing nursing home scandals), the nursing home portion of the Medicaid budget was an attractive candidate for cutbacks. As a result, state officials enacted a series of nursing home cost containment measures.

For a while it seemed that state officials would actually assume control of the nursing home industry. The Department of Health built up its auditing department, reviewed the books of hundreds of facilities, and uncovered some of the more blatant acts of fraud. It also tightened the nursing home reimbursement methodology, and in July 1976 it refused to sign off on wage increases for health care workers. As a result of these measures, Medicaid payments to nursing homes in 1976 totaled \$2 million less than in 1975.<sup>14</sup>

#### Policy In New York, 1977-1992: Crisis Eases And Pluralism Returns

By mid-1977 the fiscal crisis had eased, and nursing home scandals were no longer front-page news. There was suddenly an opportunity for nursing home owners to revitalize their political fortunes, casting themselves as victims of an overzealous, politically biased regulatory attack. In pressing these claims, nursing homes were aided by bankers (unhappy about nursing home defaults), union leaders (unhappy with declining wages), and key legislators (unhappy that old friends were in trouble). Given the changed atmosphere, state officials repealed several scandal-inspired reforms (such as an effort to reduce retroactively the capital reimbursement received by most providers). State officials also agreed to a 14.5 percent wage increase for nursing home employees.<sup>15</sup> The cost containment era was over.

The declining interest in cost containment did not, however, trigger similar disinterest in quality of care. On the contrary, the scandals encouraged newly formed advocacy groups, such as the Nursing Home Community Coalition of New York, to press hard for regulations on quality of care. In 1979 advocates found an ally in David Axelrod, the newly appointed commissioner of the Department of Health. As a result, nursing homes were soon complying with new and rigorous requirements, in areas ranging from worker training to patient assessment to patients' rights. The quality of care in many of New York's nursing homes began to improve. At the same time, however, facility costs were escalating rapidly, and facilities were demanding (and receiving) significant rate increases.

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#### and Pluralism Returns

Nursing home scandals were an opportunity for nursing homes to cast themselves as the victims of a state attack. In pressing unhappiness about nursing home wage increases, and key issues. Given the changed industry-inspired reforms (such as reimbursement received by 5 percent wage increase at the end of the era was over.

It did not, however, trigger a state response. In fact, the scandals encouraged Nursing Home Commuters' attention on quality of care. Instead, the newly appointed superintendent, nursing homes were targeted, in areas ranging from wages to quality of care. The quality of care improved. At the same time, state government facilities were demand-

There was, indeed, a growing perception that the system was again veering out of control. Nursing home rates were increasingly established via administrative hearings, and facilities hired consultants, lawyers, and others to show that their true costs were significantly higher than first estimated by the department. This system encouraged inequity, as similarly situated homes fared differently in the hearing process. Also, nonprofit nursing homes seemed to do particularly well in the administrative process. Indeed, rates for the nonprofits were, on average, 25 percent higher than for similarly situated proprietary homes.<sup>16</sup> The nonprofits argued that they earned the higher reimbursement by caring for sicker patients. The proprietaries, however, sharply disputed this claim. Finally, nursing homes were increasingly hesitant to admit seriously disabled (and expensive) individuals. As a result, seriously disabled persons increasingly languished in general hospital beds. This practice created significant problems. Not only were such hospital beds needed for other patients, but the cost of hospital care dramatically exceeded that of nursing home care.

In this context, the department developed (with the help of experts at the Rensselaer Polytechnic Institute) a case-mix reimbursement system that would link nursing home payment to the mix of patients within the home (the more disabled the patient population, the higher the reimbursement). Before the new system was implemented, however, it encountered a significant political hurdle. A survey revealed that the prevailing wisdom was wrong—nonprofit nursing homes were not caring for a sicker population than were the proprietaries. Moreover, while the patient population in public nursing homes was unusually sick, public homes' spending was so high that they too would lose under a case-mix system. Both sides argued that the new system would jeopardize their financial stability by shifting huge sums of money from them to the proprietaries.

In response to the political uproar, the Department of Health adopted various policies to ease the transition, and the impact of the new system proved to be far less onerous than first feared. To be sure, nursing homes are today admitting a more disabled patient population, and less sick patients (who presumably should be steered into home health care programs) are now the ones languishing in hospital beds. Meanwhile, Medicaid reimbursement to most nursing homes continues to rise, particularly as homes admit increasing numbers of disabled patients.

The implementation of the case-mix system illustrates nicely the political context of nursing home reimbursement policy in New York. Nonprofit nursing homes originally supported the new system because they thought it would confirm that they treated the most disabled patients and thus would provide them with even greater reimbursement. When that assumption proved to be inaccurate, they revised their position (and their admission

practices) and persuaded state officials to ease the impact of the new system. The lesson: Nursing home reimbursement policy in New York emerged from the pulling and tugging of a pluralistic political environment.

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#### Policy In California: Autonomous Officials Keep Costs Low

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In 1966 newly elected California Governor Ronald Reagan urged state officials to develop policies that emphasized Medicaid cost containment. In response, officials implemented a novel but simple approach: decide how much the state would spend on nursing home care and cap spending at that amount; impose minimal regulatory oversight over nursing home behavior; and permit facilities with low costs to make a profit.

To implement this cost containment policy, however, state officials had to centralize the Medicaid decision-making process. Groups that wield significant political clout in New York (particularly union officials and client advocates) were generally unable to penetrate the decision-making process in California. Instead, these groups lingered on the periphery, occasionally challenging state actions in court but more typically adapting and adjusting to state policies.

Consider, first, reimbursement policy in California in the late 1960s and early 1970s. By state law, nursing homes were to be reimbursed for their "reasonable costs." Early on, however, the state's Finance Department established maximum per diem rates for nursing homes. Facilities received no more than the rate ceiling, regardless of actual costs. Moreover, the Finance Department, with its emphasis on cost containment, kept the rate ceilings relatively low. In 1971 the maximum rate for a nursing home in California was \$14 per day, versus an average of \$22.70 in New York.<sup>17</sup> Unable to influence the administrative bureaucracy informally, California's nursing homes convinced a federal judge to order the state Medicaid agency to hold public hearings on the issue of rate methodology.<sup>18</sup> The agency held the hearings but rejected all requests for a facility-specific reimbursement system, adopting instead an explicitly flat-rate system.

The methodology adopted in 1972, with some minor changes, remains in effect today. The system works as follows. (1) Nursing homes submit cost reports to the state's Medicaid agency, the Department of Health Services. (2) The department audits the reports and determines the median costs for several classes of facilities. (3) The department establishes a reimbursement rate for each class (by taking the median costs for each class from a year earlier and adjusting those figures for inflation). (4) Nursing homes in a particular class receive the same reimbursement rate, regardless of actual costs. If their costs are below the rate, the home keeps the difference as profit. If their costs exceed the rate, the difference represents a loss.

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California in the late 1960s and 1970s to be reimbursed for their actual costs. The state's Finance Department estimated actual costs. Facilities received Medicaid reimbursement. Cost containment, kept the rate of reimbursement for a nursing home in California at \$22.70 in New York.<sup>17</sup> Informally, California's Medicaid agency held a facility-specific reimbursement system.

Minor changes, remains in California nursing homes submit cost containment to the Department of Health Services. The agency determines the median costs for each class from a year and establishes a reimbursement rate for each class from a year. (4) Nursing homes in a class receive a rate, regardless of actual costs. The state keeps the difference as a loss.

The California system produces extremely low reimbursement rates. In 1980 California ranked thirty-eighth among the states in Medicaid expenditures per nursing home resident.<sup>19</sup> Not surprisingly, many nursing home owners would prefer a facility-specific system, in which homes were reimbursed for their actual costs. Nonetheless, the industry, which is dominated by proprietary facilities, has adjusted by keeping employee wages low and by spending relatively little on efforts to improve patient care.

Consider the wage issue. In California only 15 percent of the nursing home work force is unionized. The result is that wages are dramatically lower than in New York, where health care unions represent a potent political force. In 1985, for example, a typical nurse's aide in New York City made \$8.50 per hour; in Los Angeles a typical aide earned approximately \$4.48 per hour.<sup>20</sup> Consider next quality of care. For years, nursing home owners, patient advocates, and state oversight agencies argued that the flat-rate reimbursement system discouraged high-quality care.<sup>21</sup> The system encouraged facilities to spend as little as possible on worker training and patient services. Over time, owners and advocates accumulated allies. Key legislators, union officials, and even the state's auditor general recommended that California adopt a facility-specific reimbursement system. It was clear, however, that without the support of the state Medicaid bureaucracy and the governor, the coalition's efforts would not succeed.

In 1987, however, the dynamics of the policy process changed dramatically for the first time in twenty years. Congress enacted a series of nursing home quality reforms that were to take effect 1 October 1990.<sup>22</sup> The reforms required nursing homes throughout the country to meet minimal standards on several counts, from staff/patient ratios to staff training to patients' rights. The reforms also required states to include the cost of complying with the new standards when developing Medicaid reimbursement rates.<sup>23</sup>

It was soon clear that Congress's actions could undermine California's ability to restrain nursing home costs. Indeed, in January 1990 the California Association of Health Facilities (representing over 800 nursing homes) estimated that California's nursing homes would spend over \$1.3 billion annually to implement the reforms. State officials placed a \$400-\$600 million price tag on the implementation process. (Implementing the reforms in New York cost less than \$10 million per year, because the state already required its nursing homes to meet tough quality standards.)<sup>24</sup>

California officials, anxious to avoid higher nursing home costs, developed a daring strategy: They accepted an important revision in the state's Medicaid reimbursement formula but conditioned it upon a federal waiver. Specifically, the state's executive branch supported a legislative amendment (sponsored by nursing home owners, patient advocates, and union leaders) that would provide nursing homes with an additional \$100 million

per year, to be spent on direct patient care services. However, the legislation contained "poison pill" language: If in 1991 or 1992 the federal government or any court required California to spend money complying with the federal reforms, the new reimbursement scheme would be voided.

State officials then began a vigorous lobbying campaign to persuade the Health Care Financing Administration (HCFA) or Congress to grant California a waiver from the federal quality reforms. This effort was particularly intriguing because the primary sponsor of the federal reforms was a Democratic congressman from Los Angeles, Henry A. Waxman. The goal was to persuade Waxman, and others, that HCFA was interpreting the congressional mandate too expansively. According to this argument, if California were required to follow HCFA's "interpretive guidelines," the results would be counterproductive.

Not surprisingly, Waxman was unpersuaded, and legal services lawyers challenged in court the state's failure to implement the reform legislation. A federal judge then issued an injunction ordering state officials to comply with the new law. Despite the judicial decision, state officials were not ready to concede defeat, although they did void the 1990 state legislation that would have provided California's nursing homes with an additional \$100 million in reimbursement. At the same time, the state commenced its own lawsuit against HCFA, challenging as unlawful HCFA's interpretation of the reform legislation. Shortly thereafter, while California's lawsuit was pending, newly elected Governor Pete Wilson made a personal appeal to President Bush.<sup>25</sup> This time the state's lobbying effort paid off, and in early March 1991 HCFA agreed that its "interpretive guidelines" were not mandatory; that it would consider more carefully California's objections to the guidelines themselves; and that California could delay its implementation of the reform legislation pending the "new look."<sup>26</sup>

With this federal concession, the dispute moved back to the courts as legal services advocates challenged the HCFA retreat. Some time later, after much political and judicial maneuvering, the court again ordered the state to comply with the federal law, rendering moot HCFA's argument to the contrary.<sup>27</sup> Following this decision the state agreed to begin implementation, although it insists that full compliance will take time. For this reason, the final chapter in this story is as yet unwritten. It is clear, however, that California officials are fighting extremely hard to maintain their firm hold over Medicaid expenditures on nursing homes.

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### State Discretion And Health Care Policy

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What role states should play in health policy making is at the heart of the debate over health system reform. Consider first the argument that state

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officials should continue to play a significant role in setting health policy. This argument draws strength from four strands of American political thought: (1) that public policy should, where possible, fit local needs and conditions; (2) that local autonomy encourages innovative ideas, enabling such ideas to be "laboratory tested," and allows state officials to evaluate ideas and implement those that work; (3) that the delegation of decision-making authority to the states is democratic; and (4) that state officials have the political wherewithal to block any reforms that limit their ability to set policy, regulate quality, and administer programs.<sup>28</sup>

These arguments are not without merit. First, local needs do differ. The home care system in New York should look different from its counterpart in rural Idaho. Second, states can and do act as policy laboratories. The efforts in numerous states to encourage Medicaid clients to enroll in managed care plans will teach much about the wisdom of imposing a managed care model on public insurance programs. Third, locally administered programs can empower consumers and communities. The neighborhood health clinics first initiated in the 1960s organized and empowered the poor, while at the same time providing communities with better health care.<sup>29</sup>

State and local influence over health care policy is indeed deeply rooted in American social policy. The heritage of the English "poor laws" greatly shaped American welfare policy and established a tradition of local responsibility for the health and welfare of the poor (particularly the so-called deserving poor). During the nineteenth century, for example, several cities established public hospitals, states developed institutions for the mentally ill, and the nation's emerging public health system was administered at a local level. While these early efforts were sporadic and rarely sufficient, the principle of local influence and responsibility became deeply ingrained.

To be sure, the New Deal shifted significant power to the federal government and away from state and local policymakers. But the New Deal neither challenged state autonomy over the public health policy arena nor undermined state control of programs for the poor. To the contrary, while the Social Security Act requires the federal government to set policy for and administer the popular "social insurance" programs, such as Social Security, it permits the states to set policy for and administer the politically unpopular "welfare" programs, such as Aid to Families with Dependent Children (AFDC), mainly because influential southern congressmen insisted upon a locally controlled welfare system to maintain the southern sharecropper economy.<sup>30</sup> As a result, Social Security is administered in relatively uniform fashion around the country, while AFDC is administered under a diverse set of (often punitive) state rules and regulations.

More recently, state officials have assumed even greater authority over health policy, from supervising the nation's private insurance industry, to

regulating the quality of care rendered by most medical providers, to developing initiatives to ease the plight of the uninsured. And while Medicare is connected to the Social Security system, is considered an "earned right" (and thus not welfare), and is administered in relatively uniform fashion by the federal government, Medicaid is tied closely to AFDC, is viewed as a welfare program, and is administered in diverse ways across states.

Given this history of state influence and authority, and given the sensible arguments for maintaining a significant state role, it is likely that states will be key players in a reformed health care system. Yet the comparison of New York and California suggests skepticism. First, the delegation of significant authority to state officials encourages extraordinary variation, even between similarly situated states. Variation between New York and Alabama is expected; variation between New York and California, with their similar levels of wealth and welfare policies, is not. Second, interstate variation is not limited to eligibility and benefit policy; reimbursement policy and quality of care oversight are also wildly inconsistent.

Third, health policy variation is explained at times by variation in the political environments in which state officials operate. This is particularly so when examining variation between states with similar levels of socioeconomic development and similar political cultures. Medicaid bureaucrats in California have significant autonomy and can ensure that policy is driven by the goal of cost containment. Other policy variables, such as the quality of care of nursing home patients and the wages of health care workers, are secondary. While state officials are not oblivious to such issues, patient advocates and union officials have minimal influence. In New York cost-conscious state officials can occasionally dominate the policy-making process (as they did in 1975 and as they do today), but their influence is temporary and atypical. The result is a system in which patients receive (relatively) high-quality care, employees receive (relatively) high wages, and providers receive unusually high reimbursement.<sup>31</sup> Fourth, state actors are not as free as the laboratory model suggests to test and implement approaches that seem to work elsewhere. Indeed, it is difficult for even the best state policymakers to escape their state's political environment. This is particularly true in states such as New York, where officials operate within a fragmented, decentralized environment dominated by interest groups.

The reformers' task, as such, is to develop policies that maximize the good variation and minimize the bad. For example, the variation described in this case study is inappropriate and irrational. It is absurd that a nursing home in New York receives twice what its counterpart in California receives, and it is equally absurd that a nursing home in California can operate with far less quality oversight than does its counterpart in New York. Federal policies are needed to reduce interstate variation in these

areas, although fees will be vigorously defended by their practices but

But when is variation and develop a health care system? The answer is yes. It is not that compare and contrast but need to know much more before we can make a decision at the level tomorrow.

To be sure, we need to develop a new division of labor. Canada, for example, has had significant success in developing federal principles. The American model of state-based politics will only get worse

*The author acknowledges*

#### NOTES

1. Prospective Payment System Report C-9
2. *Ibid.*, 36, Table 2-1
3. In New York City from *Bureau of Research and Statistics*, New York State Department of Health Services
4. Kirk Stewart, *Cal. Health Care*, 1992; and Ruth Beckman, *Communication*, JAMA
5. Employee Retirement Income Security Act (ERISA), state initiative; employees are generally
6. Interview with William W. Department of Health Care Financing, 1992
7. F.O.R. Hayes, "New Insurance on New York"
8. L. Fink and B. G. *Union, Local 1199*
9. B. Vlodek, *Unlabeled*, 274.
10. B. Spitz, "Medicaid

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areas, although federal legislation that seeks to impose national standards will be vigorously opposed, especially when states not only must change their practices but also must use state dollars to pay for such changes.

But when is variation good? Should states have the flexibility to design and develop a health care delivery system that fits local needs? The intuitive answer is yes. Nonetheless, we need to test this hunch with case studies that compare and contrast state-based delivery systems. In other words, we need to know much more about what happens at the state level today before we can make good judgments about what should happen at the state level tomorrow.

To be sure, we need to look abroad as well as inward in the effort to develop a new division of labor between the states and the federal government. Canada, for example, offers a good model. The Canadian provinces have significant discretion, but they must abide by several overarching federal principles. In the end, however, we can achieve an appropriate American model only if we spend more time studying the black box of state-based politics. Without such an effort, the nation's health care crisis will only get worse.

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*The author acknowledges the suggestions of Lawrence D. Brown and two anonymous reviewers.*

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#### NOTES

1. Prospective Payment Assessment Commission, *Medicaid Hospital Payment*, Congressional Report C-91-02 (Washington: ProPAC, 1 October 1991), 30, Table 2-6.
2. *Ibid.*, 36, Table 2-10.
3. In New York City the average rate is even higher: \$142 per day. New York figures are from *Bureau of RHCF Reimbursement: Average 1991 Rates by DOH Region* (Albany: New York State Department of Health, 12 June 1991). California figures are from Joseph Klun and Eugene Knowful, Rate Development Branch, California Department of Health Services, personal communication, June 1991 and February 1992.
4. Kirk Stewart, California Department of Finance, personal communication, February 1992; and Ruth Bongiovanni, New York State Department of Social Services, personal communication, June 1991.
5. Employee Retirement Income Security Act, 29 U.S.C. 1, sections 1001-1461. Under ERISA, state initiatives to require employers to provide health insurance for their employees are generally prohibited.
6. Interview with William McCann, former assistant commissioner of the New York State Department of Health and former director of the New York State Council on Health Care Financing, 11 October 1990.
7. F.O.R. Hayes, "Nursing Home Care in New York," in *The Impact of National Health Insurance on New York*, ed. M. Lieberman (New York: Prodist, 1977), 110.
8. L. Fink and B. Greenberg, *Upheaval in the Quiet Zone: A History of Hospital Workers Union, Local 1199* (University of Illinois Press, 1989), 122-128.
9. B. Vladeck, *Unloving Care: The Nursing Home Tragedy* (New York: Basic Books, 1980), 274.
10. B. Spitz, "Medicaid Nursing Home Reimbursement: New York, Illinois, and California

- Case Studies" (Health Care Financing Administration Grants and Contracts Report, October 1981), 45.
11. Vladeck, *Unloving Care*, 87.
  12. At that time the federal government was responsible for 50 percent of the Medicaid bill, while the state and local counties each contributed 25 percent. In 1982 the state share of long-term care bills was increased to 40 percent, while the county share was reduced to 10 percent.
  13. Seymour Budoff, former director of the New York City Medicaid program, personal communication, 16 July 1990.
  14. Spitz, "Medicaid Nursing Home Reimbursement," 69.
  15. Fink and Greenberg, *Upheaval in the Quiet Zone*, 177.
  16. C. Rudder, *Case-Mix Reimbursement and the Nursing Home Resident in New York State: Suggestions for Change* (New York: Nursing Home Community Coalition, June 1989).
  17. The Urban Institute, *Understanding the Growth in Nursing Home Care, 1964-1974* (Washington: The Urban Institute, April 1978), Appendix A, F-6 and F-27.
  18. California Association of Nursing Homes v. Williams, 84 Cal. Rept. 590 (Ct. of Appeals, 3d Dist., 1970).
  19. Lewin and Associates, *An Evaluation of the Medi-Cal Program's System for Establishing Reimbursement Rates for Nursing Homes* (Prepared for the Auditor General of the State of California, October 1987), 171.
  20. State of New York, Office of the State Comptroller, *Staff Study on New York State's Medicaid Program* (March 1989), Schedule G.
  21. See, for example, the Commission on California State Government Organization and Economy (the "Little Hoover Commission"), *The Bureaucracy of Care: Continuing Policy Issues for Nursing Home Services and Regulation* (August 1983).
  22. 42 U.S.C. sections 1395i-3(a)-(h) and 42 U.S.C. sections 1396r(a)-(h).
  23. 42 U.S.C. section 1396a(a)(13)(A).
  24. The two California estimates are cited in a letter from John Rodriguez (deputy director, Department of Health Services) to Gerald Moskowitz (regional administrator, HCFA), dated 31 August 1990. The New York estimate is from an interview with Orlando Orozco of the New York State Health Facilities Association, 5 December 1990.
  25. Letter from Governor Pete Wilson to President George Bush, 2 February 1991.
  26. Letter from Kenneth Kizer (commissioner, California Department of Health Services) to Gail Wilensky (HCFA administrator), 11 March 1991.
  27. Valdivia v. Kizer, Civ. no. S-90-1226 (E.D. Cal., 11 October 1992).
  28. I am grateful to Deborah Stone for guiding me to this typology.
  29. K. Davis and C. Schoen, *Health and the War on Poverty* (Washington: The Brookings Institution, 1978), 167-202.
  30. J. Quadagno, "From Old-Age Assistance to Supplemental Security Income: The Political Economy of Relief in the South, 1935-1972," in *The Politics of Social Policy in the United States*, ed. M. Weir, A. Orloff, and T. Skocpol (Princeton, N.J.: Princeton University Press, 1988).
  31. A second, less important explanation for the disparity in expenditures is rooted in New York's decision to fund through Medicaid certain services that California funds through other programs. The clearest example is home attendant services. While California does not provide such services under Medicaid (and New York does, to the tune of \$1.2 billion per year), California does have a \$600 million home attendant program funded through sources other than Medicaid. Interestingly, however, New York's home attendants serve fewer clients, at a much higher cost, than do California's, because New York pays home attendants higher wages, requires them to obtain greater training, and allows them to work longer hours.

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