09. Federalizing the Administration of Medicaid

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FEDERALIZING THE ADMINISTRATION OF MEDICAID

This chapter presents an argument for the federal domination of Medicaid Administration. Unlike the other chapters, this one includes no counterpoint, no position paper exploring state control of Medicaid Administration due to one participant's inability to sufficiently research the area. While we consider the omission a serious one, there are a few mitigating circumstances. First, the state control perspective is essentially an argument for the status quo which suggests that little which is fresh or innovative would be included. Second, the system of state control for large federally-funded programs that provide local services has been extant in this country for the past decade. Two notable examples, the Comprehensive Employment and Training Act (CETA) and Community Development Block Grants, have long provided us with state control management models.

This chapter starts with a brief account of the role played by the states in the administration of Medicaid. The remainder of the chapter, devoted to building a case for a federally-administered program, investigates thoroughly such areas as ability to respond to the needs of long-term care clients, efficiency, and cost containment under federal control.

States as Administrators

Robert Derzon, former head of the Health Care Financing Administration, told a conference of state administrators, "The job of designing and managing a state Medicaid program is extremely complicated--far more so than practically any other state activity you supervise or operate". There are arguments which suggest that many states cannot in fact operate such a complicated program well.

It is because states have been considered to be weak administratively
that the federal government has attempted to aid state administrative functioning through the grant system. Michael Reagan, an authority on American Federalism, describes eight purposes of federal grants, of which five relate to the administrative function:

(1) Achievement of minimal standards in programs which exist in states at widely differing levels.

(2) Achievement of a critical mass in a given area and avoidance of wasteful state duplication. (i.e., regionalization and economies of scale.)

(3) Improvement of substantive adequacy of state programs through professional technical assistance, because only a few states are able to compete with the national government in attracting outstanding talent.

(4) The stimulation of experimentation for programs and methods which can then be applied nationally to better achieve program goals. (Reagan notes that most such experiments did not well up from the local level. They were, instead, mandated by the federal government. Sometimes experimentation can only be started at the local level if directed from above, owing to the status quo orientation of local elites.)

(5) The improvement of state and local administrative structure and operation. Since the 1930's, federal grants have been important in inducing grant-receiving governments to professionalize their organizational structure and practices. Reagan suggests that "While a few states have always been the equal of the national government....the majority of states have been laggard in adopting modern management knowledge".

State administrative capability may be divided into three areas of consideration: administrative capacity and technological capacity, political capacity, and degree of domination by special interest groups.

(1) Administrative capacity refers to staffing patterns and presence of
sufficient staff to do the job while technological capacity is concerned with the use of a computer or other system which promotes economies of scale in larger operations. Poor administrative and technological capacity can undermine the success of a Federal grant system. Jeffery Pressman, writing on the political implications of the New Federalism, cites a growing skepticism over the success of revenue sharing resulting from a perceived lack of capacity among states in the areas of planning, personnel, and management.\(^5\) The Advisory Commission on Intergovernmental Relations (ACIR) evidences a similar skepticism concerning the efficacy of federal social intervention grants, for successful implementation at the state and local levels depends on the political leadership and the management strength of the localities.\(^6\)

These suspicions are not unfounded. In the area of administrative capacity, for example, the Ohio State Budget for 1976-77 listed only 70 people employed in the entire AFDC (welfare) program.\(^7\) Even New York State, still wealthy by any standards, and long considered a leader among state administrations, has its problems. In a recent interview, an official in the New York State office handling hospitals and nursing homes stated that administrative costs in the state were not only not high, but in fact the managerial staffing pattern had long since been cut as "thin" as possible. The relevant question is, at what point does a reduction in manpower cost more in inefficiency and ineffectiveness than the salaries it saves?

There is also inefficiency in the area of technological capacity. Currently, even with the prospect of ninety percent federal financing for capital installation of high technology data processing systems, and seventy-five percent reimbursement for their operation, not all states have taken steps to initiate such data systems. The Department of Health, Education and Welfare has created a model Medicaid Management Information System (MMIS) for state data
systems to follow. After six years of the program, only 15 states have an MMIS in full operation, and 32 MMIS programs are planned. A full six states have no plans for an MMIS at this time. 8 (Total includes territories.)

(2) The second division of administrative capability, "Political capacity" refers to the existence of a well-developed political system, formal and informal, which can effectively foster programs and monitor their implementation, particularly in the case of new or changed programs. In this area, too, there are problems which contribute to less than optimum operation at the state level. Reagan charges that many state legislatures are characterized by low pay, too frequent turnover, and a tendency to hamstring their Governor. 9 In fact, one-third of our state legislatures do not meet in regular sessions every year.

(3) The third area of administrative capability, the question of the domination of states by special interest groups, (SIGs) has two aspects. First, such groups may consist of organizations lobbying for a particular cause. These types of interest groups are positive or negative depending on the perspective of the observer, but, it can be agreed that no one group should have excessive influence over a legislative body. In general, observers seems to believe that special interest groups are stronger in states than in Washington. For example, it has been charged that currently, many state legislatures are dominated by insurance interests,10 certainly of relevance if any further legislation concerning government-financed health insurance is considered.

State governments have also been accused of domination by interest groups in the second sense of that term, that is, as the existing informal economic power structure of the community. It is to this latter sense which Pressman refers when he summarizes several studies which are critical of state government. He reports that states were found to be "unresponsive, institutionally weak, of
low visibility, and dominated by narrow economic interest groups. A specific example of what can happen under such local control is evidenced in the Comprehensive Employment and Training Act of 1973 (CETA), a revenue-sharing grant. CETA replaced earlier categorical programs in manpower training and it was hoped that creative planning would take place through the required "manpower plans". Instead, an interim evaluation of CETA showed that manpower programs were being politicized, that "planning" tended to follow rather than lead the action stage, and that the responsibilities of administration were clearly straining the capabilities of local governments. Over 40 percent of the units submitting plans were initially assessed as performing marginally. In addition to these problems within localities, there were responses in the larger system. Congress began to return to categorical funding in certain sub-areas of manpower, such as youth, because of the need it perceived to address them as "national problems." The analogy to health is clear in the conflict between local administrative control and achievement of national purpose, even under conditions of full and adequate financing.

Although the states are weak in administrative capability and are thus unable to operate a complicated program such as Medicaid, the states themselves often lay blame at the feet of the federal government. They complain of a nightmare of excessive paperwork, overly-detailed, repetitive, rigid and incomplete regulations as well as excessive concern with proofs of compliance over actual service activities. Yet, the states themselves are frequently guilty of the same thing. For example, block grants were instituted to aid localities with a minimum of federal intervention. In the case of the Safe Streets Act of 1968, "four-fifths of the states have adopted policies that
exclude certain activities from funding and encourage others, with the result of reducing local flexibility". Although approvals of amendments to the state plan can be obtained, "the amount of time and paperwork involved...often leaves local officials believing that block grant...decisions are, at best, a ritual".  

The "red tape" the states complain of is misleading, at least insofar as it happens that many of the admittedly difficult regulations are not about program requirements per se. They are often about important new national objectives in fields related chiefly through the administrative function, such as environmental protection and equal employment.

Federal Administration in Health is Required to Achieve Cost Containment

The concept of natural area was first put forth by James Fesler. Basing his arguments on economics and geography, he proposed that the country could be divided in any number of different ways, depending on the category or factor selected; for example, rainfall, or the density of the elderly population. The natural or obvious division lines for one factor would not necessarily match the divisions laid down for another. If problems in society, then, can reveal their own natural regions for handling, we should not be surprised if "The legal areas of particular governments seldom coincide with or wholly embrace the natural areas defined by the problems with which society must deal." We may extend his ideas to suggest that our familiar political subdivisions can actually obscure our vision of the "natural area" of a problem, since we simply assume that it will coincide with the boundaries of those subdivisions. In health, they are presently the states.

Fesler himself was thinking mainly of two models for "natural areas" beyond the state and local levels: the ad hoc organization of the Tennessee Valley Authority, and the federal government. Although he did not uniformly advocate federalization of programs, he clearly recognized the value of the
central government.

Health is a problem whose natural area has indeed become national. We have seen that providing access to health care is becoming a national priority. It would appear that if we wish to guarantee access to minimum levels of health care to all our citizens, we will have to be willing to pay the bill from the federal treasury. But would it be sufficient to finance health insurance as a grant at a rate of 90 or even 100 percent to effectively induce more uniform state participation? Such financing would be insufficient, because in the absence of state control, the necessary other half of a federal health care system would suffer: cost containment.

Cost containment, in terms of expenditures of public funds, necessitates rational planning and controls to obtain maximal value for the taxpayers' dollars. We may wish to limit the amount of these dollars spent, or we may collectively decide to spend more if we like what we are getting for our money. Cost containment means more, however, in terms of the health care system as a whole. It means resource containment: health care is like any market, in that demand is always potentially infinite. Resources, no matter how abundant, are scarce in the face of potential demand. No society can have all the health care it can possibly consume.

Currently, health resources are allocated in part by some states' relative unwillingness to finance access to health resources for all of their people. If the federal government steps in to increase their access by adopting the proposed medical insurance plan, or takes an even broader step to guarantee that financial access to all of us through national health insurance, we will quickly face the dilemma long ago anticipated by the Committee on the Costs of Medical Care. First, demand may increase beyond the supply capacity of our present health systems, resulting in rationing by
queues or lack of access to some individuals for arbitrary reasons. Second, the system may expand to meet the demand, but for a price in public expenditures which would be far in excess of our willingness to pay. In sum, government financing will create demand pressures which will require vigorous measures to contain.

A national program to plan the distribution of resources and to ensure the careful use of available health resources is thus necessary for the success of federal financing of health for the poor and elderly. The need for rational health planning has been foreseen and acted upon by Congress in one guise, the creation of Health Systems Agencies (HSAs), independent regional agencies acting under federal authority to study and plan for local health needs. Other cost control measures are essentially administrative in nature. Ensuring efficient delivery of services, overseeing appropriateness of utilization, and setting fair but not excess wage rates are but a few examples. Finally, the systems of health financing and administrative controls must be effectively linked with the planning by the HSAs, and it is likely that federal administrators would be the more motivated to work cooperatively with the federally-sponsored HSAs.

Why can we not leave states to initiate vigorous cost control measures on their own? The record shows that states are variable in every respect, and for the reasons outlined in previous sections, will be variable in their response to cost containment as well. If some states participated in control efforts, there would be improvement, but the result will be far less than it should be from the number or strength of the states involved. The energetic efforts of the states which move forward in financing, planning, or controlling health care will be drained off by those which do not. This is because health is an action area characterized by significant economic externalities— that is, health policies in one state have significant fiscal impacts on other states.
Externalities occur when the action taken by an individual decision-making unit imposes unavoidable (and usually unplanned) benefits or costs on others, and no feasible method of compensation in return can be arranged. Fuchs gives the example of vaccinations. Not only do they protect the recipients against a communicable disease, they also collectively reduce the chances of an epidemic and thus the chances of unimmunized persons getting the disease. Conversely, consider the impact on a pregnant woman living near the border of a state which did not provide a preschool rubella immunization program.

Externalities take place equally in cost containment and in provision of care. Physicians in particular may well migrate to obtain higher status and salaries where individual states institute measures to limit their fee schedules or induce them to work in cooperative arrangements such as HMO's. While members of the middle class population would not be expected to migrate merely to obtain covered medical services in their younger years, they already do migrate at retirement age to more amenable climates and may well begin to do so if faced with the possibility of needing extended care in time to plan for it. Taxpayers, too, can migrate.

In contrast, under federal administration such migration could be a positive event. For instance, at this time, persons with arthritis and certain lung disorders consume expensive hospital and SNF care, but many are unable to take the simple expedient of moving to a state with a more therapeutic climate, such as Arizona. Under federal administration, they could move and be confident of retaining their eligibility for care.

Ernest Saward lists four general types of economic regulations, all of which have been used in the health care field: (1) subsidization of individuals
or groups, as in Medicare and Hill-Burton; (2) quality control, as in accreditations and PSRO's; (3) entry restrictions, as in licensure and more recently the certificate-of-need programs; and (4) rate or price regulation, as in Medicaid's fee schedules or Maxicap proposals. It is clear that all of the regulations would be useless if all that need be done to avoid them was to leave the area.

In testimony to a House subcommittee, a spokesman for Rhode Island argued that the nation needed to go beyond health policy to national financing because of the external blocks his state had encountered in establishing universal health coverage. Since so many of Rhode Island's citizens work for out-of-state employers, the state was stymied in regulating the employers' health insurance rates and benefits. Karen Davis supports the principle of regionalization along the natural market areas for health as marked out by the HSAs; she believes that strong roles for state governments in a program of national health insurance could interfere with this type of regional organization. For example, residents of eastern Arkansas may turn to Memphis for specialized health services, rather than Little Rock. A federally-run program would be best able to handle both these problems, because it would be freer to set guidelines within state or HSA boundaries, or to transcend them when justified. Because states compete, the federal government is now prone to overvalue equality (treating everyone the same, making no exceptions) at the expense of equity (making individual adjustments to achieve fairness).

Finally, while it is true that if all states were to willingly act in concert, we would have a better chance of a successful cost containment program, it is unfortunately also true that most states cannot be relied on to implement creative cost containment measures on their own. Special interest groups, as discussed above, are more active at the state than the federal level. The record shows that virtually every major cost control mechanism
has found its impetus, and often its inception, at the federal level. Outstanding are Health Maintenance Organizations (HMO's) or pre-paid group practice; the Regional Medical Programs which preceded the HSAs, experimental reimbursement systems, Professional Standards Review Organizations (PSROs); and the National Health Service Corps to attract physicians to medically underserved areas.

In contrast, the state record on cost containment is spotty. Loebs describes the situation of utilization review through PSROs, intended to monitor both quality of care delivered and cost containment through utilization review of services to Medicaid clients. According to Loebs, "Despite the potential savings to the states through the implementation of a utilization review system, about half of the states had no functioning utilization review system before the local PSROs were organized. In 1974, planning legislation instituted the Certificate of Need program, under which a facility must demonstrate a real service need in its area for its projected establishment or expansion. Prior to the legislation, most states took little action to control the needless and expensive proliferation of facilities which was going on.

In summary, the evidence suggests that federal administrative control is the best mechanism for achieving the essential nationwide standards for policies in cost containment.

A Federal Administration Would Be Efficient And Responsive

Consider some of the findings on Medicaid reported to the House Subcommittee on Oversight and Investigations:

1. Information (pertaining to surgical rates) as reported by states was "so inconsistent as to preclude any detailed
analysis." The Subcommittee could not determine, for example, if a rate decrease was an actual effect or due to differences in reporting.

2. Data indicated a 16-fold difference in surgical rates between two states; also the rates for Medicaid as a whole are above the rates for the rest of the population. 24

3. States were unable to justify the necessity of the procedures.

4. The Subcommittee viewed as particularly disturbing, the inability of many states to be accurate and consistent or to report at all. (Italics theirs.) 25

Although the Subcommittee faulted the Department of Health Education and Welfare (DHEW) for failing to require the states to submit the needed data, the principal blame for deficiencies in administration of the program was placed in the system itself:

There is too great a division of labor and responsibility in the Medicaid program. This fosters a lack of accountability. The Federal Government helps finance and monitors the States' efforts. The states monitor their fiscal agents, whatever State agencies are responsible for health and welfare. And, finally, the state agency often subcontracts with a private company for the actual administration of the program. Apart from but related to this chain of responsibility, the Professional Standards Review Organizations (PSROs) are supposed to determine the necessity of elective procedures. To whom they are responsible remains unclear. 26

Since the Subcommittee must deal with the system as it is presently structured, that is as a federal-state partnership, it recommended that DHEW develop and require use of uniform categories of reporting; that Congress tie funds to such reporting, and so on: a typical move toward
more control by mandate. Thus, in our system, if the federal government is dissatisfied with state performance, it has no choice but to create ever tighter restrictions in the use of its funds, combined with expensive systems for monitoring compliance, and threats of grant withdrawal as the motivating force. Such threats, it would seem, are likely to turn a partnership into a duel. Actually withholding funds is a serious decision which federal administrators do not like to make because they are aware of the dependence of state budgets on federal dollars. More importantly, the real victims of the "punishment" may be intended clients of the program, in this case, Medicaid eligibles in need of hospital, medical, or long-term care. Might it not be time, then, to streamline the handling and the accountability of the program in the fullest sense possible, that is, to allow the federal government to operate the program?

The Director of the Indianapolis Urban League asserted to a House Subcommittee that no amount of tinkering with the federal, state, and private system can obscure the need for a single national health system trust fund operated by the federal government with input from general revenues, contributory taxes, or a special surtax. One model suggested was proposed by the Committee for Economic Development. They advocated a tripartite national health insurance system using the existing employer funds and Medicare, with the rest being subsumed under Medicaid, and paid for by a special trust fund overseen by Medicare.

There is much to suggest the effectiveness of the federal government as administrator. It has experience in the provision of good quality acute and long-term care in the Veteran's Administration system. The VA has been providing care to thousands of veterans--often the most indigent of veterans--for fifty years, compiling, in those years, a relative absence of complaints.
The VA also has experience in the purchase of care for veterans in community nursing homes.

In the insurance industry, economists have found that Medicare is operated very inexpensively. Estimates are as low as 2-3 percent of overall operating expenses. There is agreement that administrative costs may not be comparable to private industry because of differences in populations served and in role requirements: private companies pay taxes and advertising, but Medicare has more extensive record-keeping. Also, estimates of efficiency would be expected to vary depending on whether costs are compared to number of benefits paid, total cost of benefits paid, and so forth. Nevertheless, even those who contend non-comparability means the public sector is not definitely more efficient admit that it means the private sector is not so, either. Two economists who sought to carefully investigate insurance expenses by studying a variety of cost breakdowns determined that there are economies of scale in health insurance.

A historical survey of legislation shows that Congress has classically been interested in good management. Five particular achievements will express the point. The first general legislation was the Civil Service Reform or Pendleton Act of 1883, considered to have formed the basis for American personnel administration. In 1912 came the "Report of the Commission on Economy and Efficiency: The Need for a National Budget", which led to the Budget and Accounting Act of 1921, creating the Budget Bureau, now the Office of Management and Budget. The New Deal passed legislation to create administrative structures for the control of government-run businesses following a report submitted by Brownlow's Commission on Administrative Management. A significant legislation in 1946 called the Administrative Procedures Act addressed the need for more standardized procedures in the writing of bureau-
cratic regulations which implement laws. Finally, the Hoover Commission in 1949 made a study, with recommendations, of the organization of the Executive branch of government which was subsequently adopted by the states as well as the federal government. 32

Today the federal government collectively displays an almost overwhelming array of knowledge and skills, much of it directly concerning health care or the art of administration.

--DHEW now has five separate offices concerned with some aspect of long-term care or the aging, such as policy recommendations or maintenance of quality standards in nursing homes.


--The Health Care Financing Administration is merging its Medicaid and Medicare Bureaus in 1979 to strengthen the programs now, and, in view of the interest in the issue, to develop preparedness in the event of a "universal" health insurance program in the future. 33

Since we can only project what Medicaid might be like under full federal financing and administration, similar to Medicare's, it may be most fruitful to contrast the state experience in Medicaid with the federal experience in Medicare.

Under Medicare, payments are made through selected private insurance companies, such as the Blue Cross plans, called intermediaries for Part A (Hospital), and carriers for Part B (Medical). Payments are prompt, made within four to six weeks, and are rarely reduced from the amount requested. Payment may be made either to the individual or directly to the provider. Eligibility is established by federal employees stationed in Social Security offices.
Under Medicaid, payments are made by state or local jurisdictions in health or social services, or by a private company under contract with a state agency. Eligibility is determined by state or local employees. Payment must be made directly to the provider, who does not have the option of "topping off" the fee as set by the state. In a study of physicians' reactions to the Medicaid program in California, it was found a wait for payment can easily be one full year. Likewise, California physicians report high rates of unilateral and unexplained reductions in payment from the amounts requested.\textsuperscript{34} The government obviously retains the right to reduce the level of payment from the amount requested by the provider as a means of correcting bills submitted in error. However, reduction rates which exceed tolerance limits needlessly alienate providers and bespeak an administrative machinery in need of improvement. California is, in fact, experiencing high rates of provider dropout.

While Medicare shows excellence in its handling of providers, Medicaid in some ways has a better track record of service to clients. Medicare's clients largely have status eligibility: one is either 65+ or not; furthermore, one may anticipate the arrival of one's eligibility threshold, the 65th birthday. Consequently, Medicare takes advantage of this and achieves some of its administrative cost-effectiveness by placing greater demands on the resources of the applicant clients. With Medicare, any person seeking coverage is advised to apply three months in advance of her 65th birthday. However, the Medicaid population is chiefly characterized by a shifting, situational eligibility: the applicant may be a recently laid-off mother, a teenager who finds herself with an unwanted pregnancy, or a middle-income worker with a chronically-ill child needing extensive, but irregular and unpredictable, care.
Some of the permanently poor retain eligibility on an income basis but are careless about "re-certifying" their eligibility until a felt need for medical care arises. Not all of Medicaid is like this, of course. Many people of long-standing poverty are quite careful about meeting expectations; the nursing home resident who first spends down her resources to become eligible, has then virtually a status eligibility, if she is not expected to be able to return to independent functioning. Nevertheless, Medicaid administration has been arranged such that a disorganized client who waits until the last minute to apply for coverage can still be at the doctor's office in a matter of days.

Under a federally-run combined system, we would anticipate Medicaid's service to providers to be improved to the standards being maintained in Medicare. We would expect the present difficulties caused by the interactions between the two programs to be eliminated, and we would look for the program to demonstrate the responsiveness to clients presently shown by Medicare.

An example of a problematic interaction between Medicaid and Medicare is the latter's 100 days' coverage in a nursing home. This 100 days often leads to administrative difficulties for government bureaucrats, nursing home operators and patients alike in cases of dual eligibility, as state and federal administrators variously interpret the law regarding which level of government should take precedence for financial responsibility. If the structural tendency to competition to avoid the obligation were eliminated, the problem would disappear. A second administrative twist between the two programs is the states' option to "buy-in" to Medicare for the Medicare-eligible Medicaid clients. These clients cannot afford to pay Medicare's cost for
themselves, and it would appear to be worthwhile to the states to pay their fees. Yet many states choose not to, even though the buy-in is not expensive. It may be that the administrative costs of the buy-in program are high enough to cause states to judge the potential gain to be insufficient.

Finally, can a federally-run system adapt to meet the needs of a changing service population, as in the challenge of Medicaid? We would not expect such a program to be as inexpensively run as Medicare is now, but it will still be a step forward from the tangled mess of eligibility, accountability, reimbursement, appeals, audits, reporting and reviews which goes on at every intersection between two negotiating parties in the present Medicaid system.
FOOTNOTES


3 Ibid, p. 70.

4 Ibid., p. 71.


8 U.S., DHEW, Data, p. 97.


10 U.S. Congress, House, Hearings on a Bill for Health Policy, p. 615.

11 Pressman, "Political Implications," p. 34.


16. Ibid., p. 11.


24. These data illustrate how poor administration leads to violation of both goals of the Medicaid program. The poor may not be receiving quality health care, if they are being subjected to large amounts of excess surgery, and the taxpayer does not see his money used efficiently, as overutilization is probably the major source of waste in the Medicaid program.


26. Ibid.

27. Ibid.


30 Ibid.


