

State Medicaid Budgeting in Hard Times: Implications for Long-Term Care

This qualitative analysis compares the annual Medicaid budgeting processes in Utah and Illinois from the late 1970s until 1985, explaining why Utah cut the proportion spent on nursing homes and Illinois did not. It posits rational, organizational, and political process interpretations of each state's choices. The states implemented Medicaid rationing (through preadmission screening, rate freezes and adjustments, and expansion of alternatives) in significantly different ways. Utah reduced utilization of nursing homes while Illinois contained rates. Such diverse policy choices have aggravated disparities among the states in access to and quality of long-term care. Rational planning for our aging society will have to overcome these growing disparities among state policies.

Although the United States anticipates substantial growth in the need for long-term care services for the elderly well into the twenty-first century, the public financing mechanisms to cover such growth are woefully inadequate. Projections based on the 1980 census, for example, predict the population over age 65 will more than double by 2025, and, because of increasing life expectancy, most authorities agree that those over age 85 will be the fastest growing group among the elderly until 2040. The needs of this growing population segment will be shaped largely by the prevalence of chronic diseases and the residual effects of the shrinking American family.¹ Consequently, the need for specialized long-term care services is expected to increase even more. Liang estimates that nursing home resources will need to grow from the approximately 1.3 million beds existant in 1980 to at least five million beds by 2040, assuming that community care services increase at a much greater rate than this.²

In view of these projections, it is sobering that the federal Medicare program pays only about 3 percent of the nation's nursing home bills, while private sources cover some 46 percent, and the federal and state governments together pay for nearly fifty percent through Medicaid. Home care services are financed almost entirely by private sources.

Medicaid, the single most important source of long-term care (LTC) payment, was not designed for this purpose; rather, it was designed to provide a basic level of health

Sharon Keigher is assistant professor of social work at The University of Michigan, Ann Arbor, Michigan.

care to the poor. As a means tested program, Medicaid serves only the destitute elderly, only in states with relatively generous Medicaid provisions, and usually only after the patient has obtained admission to a nursing home. Indeed, in 1980 only 3.5 million elderly persons were among the 27.3 million users of Medicaid. Twenty states limited Medicaid eligibility only to Supplementary Security Income recipients, and among the rest that cover the medically needy, income and asset limits vary widely.

As early as 1973 nursing homes were receiving almost 35 percent of national Medicaid payments and by 1982 that share had increased to 43 percent. In 1973 the aged were 22.9 percent of all Medicaid recipients and they utilized 37.4 percent of Medicaid expenditures. By 1982, however, the aged had "slipped" to 17.4 percent of all Medicaid recipients, although they were still receiving 36.5 percent of Medicaid expenditures.³ Nursing homes were getting a greater share of Medicaid, but fewer of the aged were getting LTC benefits, despite the fact that Medicaid provisions for home care services had expanded during this time. The erosion in the number of elderly Medicaid beneficiaries has continued into the mid-1980s. It raises serious questions about Medicaid's adequacy as a funding base for long-term care.

While Medicare benefits and expenditures have traditionally been skewed toward hospital based services, Medicaid has favored both hospital and nursing home spending. Throughout the 1970s, as states experienced rampaging inflation, Medicaid programs' loss of buying power was often attributed to these institutions' "insatiable demands for funds."⁴ The states were later saddled with declining resources, the 1981-82 recession, and deliberate policies of the Reagan administration to reduce aid (capping of federal match rates, FFP, and reductions from federal block grants for social services and health). These changes unevenly affected provisions for state institutions, nursing homes, and home care—the basic components of an effective continuum of care—and destroyed the comprehensiveness of Medicaid benefits in most states. The budget decisions analyzed here may well predict the fate of all state managed entitlement programs.

The erosion of benefits and restrictions on the number of beneficiaries imposed on Medicaid during this period raise many questions about the "logic" of state level policy making. How do states decide between granting funds to medical services for children rather than for the elderly, or to hospitals rather than nursing homes? Why did they "let" services to the elderly erode and fragment? The focus of this analysis is on how this erosion occurred and the inevitability of such reductions under current fiscal federalism.

This analysis uses the experience of two states to show how state policy makers' decisions responded to specific incentives indirectly related to providing quantity, quality, or a continuum of LTC services. Analysis of decisions and decision-making processes suggests ways that federal assistance could more effectively protect states' programs for the frail elderly by including incentives to develop comprehensive, cost-effective systems providing a continuum of care. Such systems could protect the health of poor children—future taxpayers—as well as that of the poor elderly. The federal policy implications of this analysis are addressed in the final section.

TABLE 1
Medicaid Expenditures Per Recipient
(in dollars)

	1979 ^a	1982 ^b
Utah	1,183	1,644
Illinois	976	1,264

Sources: ^a Muse and Sawyer, *Medicare and Medicaid Data Book*, 1981, 107.

^b Ruther, et al. *Medicare and Medicaid Data Book*, 1984, 98.

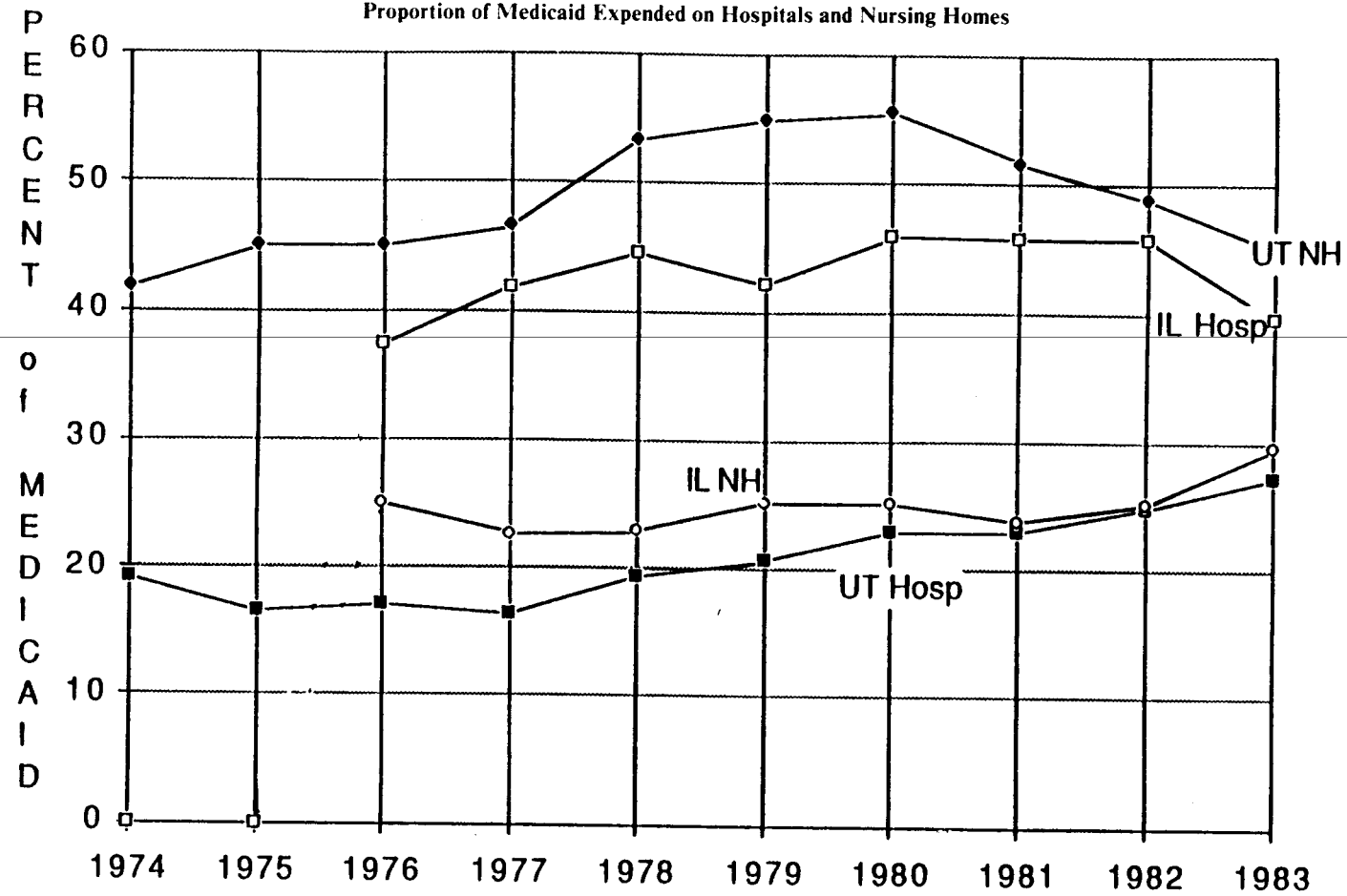
UTAH AND ILLINOIS FIND DIFFERENT SOLUTIONS TO THEIR "MEDICAID CRISES"

Two states which experienced remarkably similar fiscal crises after 1979 were Illinois and Utah. Their differing responses to economic downturn highlight aspects of Medicaid budgeting peculiar to two different "political cultures" that were acutely evident to this author who worked with the state budget offices in both states.⁵ Illinois and Utah each provided relatively "rich" Medicaid programs and similar benefit packages, had a similar proportion of poor people, and a similar urban-rural distribution of population.⁶ There were some important differences between them, however. Illinois is a much larger state than Utah (with nine times greater population), with an ethnically and racially more heterogenous population in its highly industrialized urban areas, more organized labor, and a more competitive political system. Utah, with its largely homogenous Mormon population, more provincial values, sun-belt "right-to-work" orientation, and Republican-dominated political system, has been characterized as a "moralistic" political culture; while Illinois is characterized as an "independent" political culture.⁷ Fifty-eight percent of persons living below the poverty level in Illinois were Medicaid recipients in 1982, compared to only 21 percent of those living below the poverty level in Utah. Medicaid expenditures per recipient were considerably higher in Utah. The annual expenditures, recipients, and per capita expenditures are compared for 1979 on Table 1.

Despite these differences and the regional separateness of the two states, both focused most of their response to fiscal problems on health care spending, medical cost inflation, and growing welfare rolls. Each state's fiscal crisis became a "Medicaid crisis."

Crisis, according to Estes, is a socially constructed concept, a consequence of social perception and definition. A crisis may be said to exist if it is perceived to exist, and the policy makers in Utah and Illinois perceived their Medicaid programs to be in crisis.⁸ They responded with cutbacks they perceived to be systematic and planned, gradually changing overall Medicaid priorities, and particularly long-term care, in different directions. According to traditional comparative studies on state welfare spending, the states' economic and political differences shaped these different priorities.⁹ That work, however, says little about health care spending, and most of it actually predates Medicaid. More importantly, it provides few clues about why or how economic constraints directly shape the choices of individual state agencies or officials.

FIGURE 1
Proportion of Medicaid Expended on Hospitals and Nursing Homes



Source: Annual Reports, Illinois Department of Public Aid and Utah Department of Health

Comparison of budgetary patterns in their annual Medicaid expenditures in the late 1970s and early 1980s reveal that both states shifted the proportion of Medicaid expended for in-patient hospital and for nursing home care. As depicted in Figure 1, between FY 80 and FY 81 the Utah nursing homes' share of the budget began dropping significantly and steadily, while the Illinois hospital proportion began to flatten. Gradually Utah cut the proportion of Medicaid spent on nursing homes while Illinois did not. These contrasting adjustments within the institutional expenditures typify the tradeoffs made by many states, and have significant implications for access of the elderly to LTC. But did this really reflect intentional systematic planning? Or does this difference somehow reflect the political culture described above?

After 1974 the rate of Medicaid growth in Utah for each of these expenditures exceeded the rate in Illinois. Information taken from state budgets and Medicaid annual reports during the period covered by this study, however, show a contrasting pattern of expenditures for nursing homes and in-patient hospital care over time within these total budgets.

From 1979 to 1983, total Medicaid expenditures grew by 57 percent more in Utah than in Illinois (see Table 2). Yet, the growth of nursing home expenditures in Utah (21 percent) was less than half the growth of nursing home expenditures in Illinois (46 percent), and Utah nursing home utilization actually dropped by over 1 percent while in Illinois it grew by 4.6 percent. In contrast, the growth in hospital costs in Utah (94 percent) was over three and one-half times the growth of such costs in Illinois (26 percent). Utilization cannot be reliably compared, because Illinois reported utilization by total number of claims processed, while Utah reported the number served annually in hospitals but changed this to average number served per month in 1983. However, according to reports of the Health Care Finance Administration, per capita spending in Utah was 21.2 percent higher than that in Illinois in 1979, and grew to 30 percent higher by 1982.¹⁰

Thus, while overall Medicaid expenditure containment was stronger in Illinois, Illinois maintained its proportional balance of expenditures within Medicaid, and nursing home utilization kept pace with population growth. In Utah the mix of services changed markedly. In neither case was the impact on utilization easy for decision makers to discern empirically.

The gross expenditure patterns in this case alone suggest significantly different cost containment strategies. In Utah the nursing homes' share of Medicaid shrank because of utilization reductions, even though reimbursement rates were regularly increased. In Illinois nursing homes maintained their share of Medicaid, and utilization even increased slightly, but rate increases were postponed for a full 30 months. Why did the states choose such different cost containment strategies? And why, despite the best intentions and declarations to the contrary, did their decisions still reinforce the privileged position of the health care institutions?

Methodology

To identify exactly the forces states were responding to as they gradually shaped these different strategies requires critical analysis of specific budget decisions. Knowledge of

TABLE 2
Rate of Growth in Medicaid Expenditures

	1979	1983	Percent Change	Percent change in Deflated \$
UTAH				
Medicaid total	\$85,107,200	\$125,800,000	47.8	(24.7)
Nursing home expenditures	\$46,737,800	\$56,452,700	20.8	(38.5)
Nursing home utilization: average number served per month	4,355	4,295	(1.4)	—
Hospital expenditures	\$17,687,400	\$34,330,600	94.1	(1.1)
Hospital utilization ^a	N.A.	N.A.		—
ILLINOIS				
Medicaid total	\$1,185,978,000	\$1,547,958,800	30.5	(33.3)
Nursing home expenditures	\$305,105,300	\$445,109,800	45.9	(25.7)
Nursing home utilization: annual patient days (in millions)	19,500	20,400	4.6	—
Hospital expenditures	\$500,518,000	\$630,692,000	26.0	(35.8)
Hospital utilization: number claims	389,883	434,828	11.5	—

^aUtah changed its measure of hospital utilization during this time, from number served annually to number served monthly. Thus hospital utilization data are not comparable, nor can they be compared with Illinois

Source: Utah Division of Health Care Finance Annual Reports and Illinois Department of Public Aid Annual Reports.

states' intentions, as well as their outputs and the consequences of decisions are necessary to such an understanding.

This analysis utilized a variety of data sources to obtain such information. Interviews were conducted with 35 to 40 decision makers and observers in each state between November 1983 and January 1985 to explore the perceived "causes" of the trends in each state's expenditure history. Annual reports of state and program performance, policy background documents, analyses, minutes of meetings, and other evidence of executive and legislative policy and management decisions were reviewed. Newspaper articles and investigations by "watchdog" groups provided additional background regarding specific decisions and events.

Review of these "facts" quickly revealed a cacophony of explanations for each state's "priorities." No single explanation was found to adequately account for the wide variety of forces posited. Consequently, this paper uses a set of complementary and mutually exclusive interpretive models to frame this analysis. It develops not one, but three separate explanations for the Medicaid budget outcomes in the states—a rational, an organizational, and a political process interpretation—each separate from but embedded in the preceding one. The analytic framework is derived from Allison's analysis of the Cuban missile crisis, but builds also on Marmor's analysis of the politics of Medicare and Martin's examination of the origins of the Texas Medicaid program.¹¹ Each explanation is founded on a set of unique assumptions, focuses on different units of analysis, and identifies a different level of causal factors. Together these interpretations force the analyst to weigh a comprehensive array of causal information. Each of the explanations to follow raises important aspects to be addressed by effective national long-term care policy.

STATE SIZE, FISCAL CAPACITY, AND TIMING: RATIONAL PROCESS EXPLANATIONS

Assuming that each state operated as a unitary, rational actor making cost-efficient calculations and budget tradeoffs, several significant contextual factors might explain the different choices made by Utah and Illinois. When their "Medicaid crises" began, the choices available to each were limited by the amount of fiscal pressure, the presence of Medicaid slack, the demand for Medicaid and for nursing home beds, and the potential savings in short-term rather than long-term expenditure cuts. Overall, Utah's Medicaid cutbacks were less severe than Illinois', partly because Utah began cutting back earlier, in 1979, before the 1981-82 recession. Overcapacity in its nursing home industry, and an elastic and generally low demand for welfare facilitated this.

In contrast, the Illinois crisis occurred during the height of the recession, and substantial cutbacks began in fiscal year 1982. Its welfare utilization rate was already high (three times that of Utah) and little Medicaid slack existed, especially in nursing homes. But Medicaid cuts had to be made anyway, because of the magnitude of the state's projected deficit. This forced-choice produced cuts across-the-board.

Both states each year sought rational, defensible Medicaid cutbacks of an amount determined by the state's projected deficit. In Utah, Medicaid had been rising by 20 to

30 percent annually in the late 1970s, and nursing home expenditures, which comprised 55 percent of all Medicaid, suggested several obvious reasons: a retrospective full-cost reimbursement method, empty beds, and system overcapacity. Intermediate Care Facilities (ICF) expenditures were neither mandatory nor necessary in all cases. Programs could be instituted to reduce nursing home utilization by keeping the elderly in their own homes, a more humane and cost-effective alternative, and by generally curtailing unnecessary use.

Nursing home reductions were initially made in the 1980 budget, with new preadmission screening mechanisms to limit Medicaid eligibility. A flat-rate reimbursement method adopted in 1981 was designed to promote competition and efficiency among the state's 93 proprietary facilities. From 1979 to 1984 systematic reductions occurred in nursing home utilization. Proportional shifts in Medicaid expenditures began to appear by 1981 (see Figure 1). With slack in its nursing home expenditures, Utah saw an opportunity to save money by shifting Medicaid state funds to the "Alternatives to Nursing Homes Program." It began to do so by increasing the small appropriation to this program in the Division of Aging in 1979 and 1980.

Illinois had fewer options. Medicaid increases had been running only 5 to 15 percent per year, partially kept down by a carefully constructed nursing home reimbursement formula. Nursing homes utilized about 25 percent of Medicaid and these rates were kept very low. Medical care facilities on average were much older than in Utah, and public assistance use generally was two and one-half times greater than in Utah. Projecting a critical budget shortfall in FY 82, Illinois postponed noticeable cutbacks in all Medicaid services until 1981. But when it began, it cut everything.

A Department of Public Aid (DPA) study determined there were about 5,000 "excess" hospital beds in the Chicago area, so DPA reduced reimbursement to these hospitals by prospectively reducing their "allowable" rates of utilization—a full three years before Medicare implementation of Diagnostic Related Groups (DRGs). Nursing home utilization was not similarly reduced. Since the governor's budget also closed three state institutions for the mentally ill and developmentally disabled, community nursing home beds were needed to absorb most of these patients, as well as those discharged early from community hospitals. Illinois was already "constrained" by very tight occupancy in nursing homes (96 percent), yet it did not begin to expand home care services until FY 84. Rather than shift to "alternatives to nursing homes" during the recession, Illinois' seemed to opt for "no care at all."

The Utah cutbacks then, while perceived as difficult, were relatively modest when compared to those in Illinois, particularly in view of Utah's lack of attention to hospital cost-containment. Utah did seem to make rational long-range choices that promoted competition in health care and particularly reduced nursing home utilization. Illinois imposed severe short-term cutbacks on all Medicaid services, satisfied that unnecessary hospital utilization was being reduced, but conscious that nursing home occupancy was critically tight. While Utah could absorb the reduced nursing home utilization, similar utilization cutbacks in Illinois would have caused grave dislocations for patients.

Yet, it remains unclear if these outcomes are really the ones decision makers were seeking. Given the fiscal pressures, how did Illinois manage its "full" nursing homes?

Why did it wait so long to impose cutbacks? And why didn't Utah do something about hospital costs? These questions do not yield especially rational answers, so this analysis turns next to the organizational interpretations.

**“WHERE YOU SIT IS WHERE YOU STAND:”
ORGANIZATIONAL PROCESS EXPLANATIONS**

Assuming that states are not “unitary actors,” but rather sets of autonomous, competitive agencies each with unique organizational missions, perspectives, routines and survival instincts, it is significant that the agencies in each state had quite different notions about cost containment. Early realignment of agency functions had significant influence on cost containment decisions later.

The Medicaid crisis in Utah fueled a legislative initiative to separate the Division of Health from the larger Department of Social Services into an autonomous Department of Health. Within four months of the eruption of the Medicaid crisis in the 1979 legislative session, Medicaid functions formerly scattered throughout Department of Social Services (DSS) were consolidated under central management in the new department. (Functions included provider payment, nursing home standard setting, quality assurance, facilities licensure, survey and certification.) Bringing standards and their enforcement “more realistically” into line with the “reduced” resources of the new department was intended to force economies. Only client eligibility determination for Medicaid remained in the DSS, as can be seen in Table 3.

In Illinois, the Medicaid responsibility for nursing home reimbursement, certification reviews, and standard setting remained in the DPA. However, in 1981, as the Medicaid cutbacks began, DPA presciently transferred responsibility for quality assurance to the Department of Public Health (DPH), whose shrinking staff was increasingly unable to adequately perform nursing home survey and certification reviews between 1981 and 1984. The Illinois Legislative Investigating Commission observed in 1984 that DPH was down to 94 positions in the long term care program in FY 83, having lost 47 Full-time equivalents (FTEs) and \$678,900 since FY 81. It further noted erosion in staff training, speed of investigations, and an increase in complaints being

**TABLE 3
How Each State's Main Agency Realigned Functions**

	Utah	Illinois
Single State Medicaid		
Agency	DSS - > DH	DPA No change
Eligibility	DSS No change	DPA No change
Provider payment	DSS - > DH	DPA No change
Standard setting	DH no change	DPA No change
Quality assurance	DH no change	DPA - > DPH

DSS = Department of Social Services
 DH = Department of Health
 DPA = Department of Public Aid
 DPH = Department of Health

filed.¹² Investigations by the Better Government Association and Illinois Citizens for Better Care revealed that both lack of enforcement staff and corruption of the integrity of inspectors and other state officials were reasons for the scandalous conditions (including accidental deaths) which dominated the news during this time.¹³

The reorganizations led to routinization of new combinations of functions, and gradually to new priorities. The consolidation of all Medicaid functions within one department in Utah allowed that department to prioritize tasks according to directives imposed by external forces (especially the legislature). Where pressure to constrain Medicaid costs had been minimal until 1979, "lack of control" of standard setting was seen as having encouraged standards that exceeded the state's ability to pay and thus were excessively high. After reorganization, central management reduced the quality assurance standards commensurate with the reimbursement-rates, reducing staffing ratios where reasonable and refusing payment where facilities exceeded them. As the external pressure continued, controls on service utilization had to be imposed next.

The same external forces prevailed in Illinois, despite the fragmentation of Medicaid functions in state government. Departments tended to abdicate rather than seek responsibilities like quality assurance, that did not contribute to the priority objective, cost containment. Interviews with officials at the Bureau of the Budget and the DPA suggested that DPA was under tremendous external pressure to contain costs. Having deferred responsibility for quality assurance in 1980 to DPH, DPA could focus primarily on rate containment. The Department of Public Health, which was literally responsible for overseeing minimal standards in all health care facilities, paid no special attention to DPA recipients. It reduced staff doing nursing home survey and certification to meet cost containment demands, right at the point when it received these additional responsibilities.

These differences in functional responsibilities had many implications. The Utah Health Department, responsible for comprehensive management of Medicaid, was committed to doing well what they knew how to do. Nursing home owners, who were primarily interested in their marginal per patient costs, were able to maintain per diem reimbursement rates in negotiations with departmental staff. Since negotiation of rates was conducted privately, neither the owners association or the department objected to reducing nursing home utilization. Consequently, Medicaid eligibility criteria were restricted and preadmission screening instituted. The department further reduced nursing home utilization by discouraging and diverting admissions and even publicly considering "putting people out." The atmosphere of "crisis" dominated the press. Governor Scott Matheson himself admitted in an interview with the author at the end of his term:

We got this publicity about throwing people out of nursing homes that had a tremendous impact on people staying out of nursing homes initially. We were the [unwitting] beneficiaries of scaring everybody. . . . I'm not sure that is good public policy, but we got people to thinking twice before they put their mom and dad in.

Nursing home utilization dropped most rapidly (6.3 percent) between FY 81 and FY 82. Other agencies and interest groups now had less influence on Medicaid matters, but

did not oppose this drop in utilization. Rather, they pressured the Health Department to seek a Medicaid waiver under Sec. 2176 of the Omnibus Reconciliation Act of 1981 to expand home- and community-based care. This was obtained in late FY 82.

In Illinois, with two-thirds of Medicaid expenditures for hospitals, the Bureau of the Budget and DPA were determined to place as many patients as possible in the least expensive settings. Savings would come from utilization reduction in hospitals and the closure of three state mental institutions. To deinstitutionalize so rapidly the Department of Mental Health (DMH) "needed" community nursing home beds, but neither DMH nor the local public health departments had the staff to provide enough followup to compensate for the reductions in inspections by DPH.

Thus service quality, which is affected by both reimbursement rates and utilization, was eventually impaired in Illinois. (It is confusing that Illinois claimed it had cut hospital utilization, something it did not actually control. In actuality it adjusted the reimbursement formula by limiting the number of reimbursable patients per hospital.) In nursing homes, reimbursement rates remained static as utilization and crowding increased. As the DMH closed more state institutions, its staff pressed harder to find community beds for clients. Interviews with DPH, DMH, and Better Government Association staff, and Legislative Investigating Commission reports suggest that state agencies were forced by the overall expenditure limit and the Department of Mental Health's urgent need for those beds to "look the other way" as quality enforcement diminished.

The Utah Health Department—singularly accountable for Medicaid budget constraint and eager to establish a strong track record for efficiency—adopted a nursing home flat-rate reimbursement method, while budgeting for quality inspections as before. Nursing home utilization declined, but quality controls remained high. Interestingly, however, the alternative home care programs that had been promised never grew to any substantial degree. The Alternatives to Nursing Home program found few potential recipients who met the categorical guidelines the Health Department prescribed under its waiver, and the DSS Division on Aging could not persuade the Health Department to broaden the eligibility criteria. Health had little interest in financing the expansion of programs operated by DSS, and DSS found it easier to obtain incremental financing by dealing directly with the legislature. By 1984 the Health Department had still not spent Medicaid on home health care for more than a handful of clients.

In both states the tradeoffs between nursing home rates, utilization, and quality became increasingly difficult to make as fiscal pressure continued. The Illinois DPA maintained nursing home access at the expense of quality, while Utah's Health Department made quality a higher priority than access. In neither case did incentives exist, in the form of any marginal funding capacity, to facilitate a reasonable accommodation between the health and welfare departments to establish a stable range of less expensive but acceptable non-institutional options.

The quality of care issues that are revealed by the organizational process analysis—secondary kinds of impacts—raise serious questions about officials' perceptions of quality of care and system adequacy—perceptions that are only partly shaped by organizational perspective. They might also have been shaped by decision makers' personal

interests and "stakes" in policy outcomes. In seeking explanations for these value-laden tradeoffs, these political dimensions must also be addressed.

THE STAKES AND SKILLS OF THOSE PLAYING THE NURSING HOME BUDGET GAME: POLITICAL PROCESS EXPLANATIONS

Assuming that individual actors have personal and professional commitments, beyond their identity with an agency or "the good of the state," the cutbacks described above can be further viewed as the result of a mixture of conflicting preferences and unequal power among active, committed players in the Medicaid budget game. Here the organized advocates' opportunities to influence short-term outcomes depend on their alliances with key actors, the vigor with which they get their priority issues on the public agenda and participate in central budget skirmishes, and the nature of the negotiations and deals made. Cutbacks result from various "games" and the differential effectiveness of various players.

In both Utah and Illinois, as in most states, the governors were pivotal in initiating the budget process. Each had to present a budget to a legislature dominated by the opposition party, but since a governor's clout depended heavily on the strength of his legislative support, Governor James Thompson of Illinois had distinct advantages.

Utah's Governor Scott Matheson, a Democrat, was opposed in both houses by a "veto-proof" Republican majority, which severely limited his executive resources. His disadvantage was compounded when in 1979 he inadvertently recommended a Medicaid budget that turned out to be 25 percent "short" of the legislature's projected need. The Republican legislature was furious about having to find money to rectify his "error." Matheson deflected the issue by supporting their proposal to establish a separate Health Department and appointing a highly respected local physician as director whom everyone supported. The appointee, Dr. James Mason, promised a "black box" solution to Medicaid spending and quickly became the key actor in Utah health care politics.

Dr. Mason was especially responsive to the legislature's Republican majority, particularly the Health and Social Services appropriations subcommittee whose chairman also chaired the board of the largest hospital corporation in Utah (where, coincidentally, Dr. Mason had previously worked). He carefully solicited public support for the department's various competitive cost-containment proposals, which just happened to work very effectively on nursing homes. His staff consulted with legislators, including several employed by or on the boards of hospitals, in negotiating reimbursement rates privately with each industry. He quickly established a positive image of himself and the new department by showing Medicaid savings from his initiatives. He even gained the support of a coalition of client advocates (including the governor) for imposing nursing home preadmission screening, and discouraging nursing home use. Dr. Mason's familiarity with the hospital industry may well explain his department's lack of initiative around hospital cost controls. No cost containment was imposed on hospitals until after he left for a post with the federal government in December 1983.

Jim Thompson, on the other hand, had greater legislative support than Scott Matheson, and relied heavily on his seasoned budget director, Robert Mandeville, to keep

tight control of Medicaid spending. Skill and eight years of experience gave them command of the process. Even before the election his administration managed relations with the health care industries with extreme strategic care. Governor Thompson's administration carefully postponed budget reductions until after his reelection in November 1982, when "suddenly" a devastating state budget shortfall required massive Medicaid retrenchment.

Interviews with staff at DPA and the Bureau of the Budget indicate that during the 1984 legislative session the administration caught the hospital association off guard and reneged on a commitment to pay hospital revenue reconciliations (deferred from FY 82 to FY 83) as had been done in several previous years. This left the hospitals some \$146 million short for the first six months of FY 1985. Although the hospital association sued in December 1984 and won an immediate settlement, the administration had bought itself valuable time in which to stabilize budget balances. Such is the nature of budget victories accomplished by shrewd budgetary game players.

After his 1982 reelection, Governor Thompson totally controlled the budget game. Key legislators admitted they could do little but react, making the governor "wear the jacket" for problems, as fund balance estimates "swung wildly." Declaring that all Medicaid provider constituencies would share equally in the state's fiscal dilemma, the governor's staff privately negotiated the best rates possible with each industry. Since the nursing home industry's "image" was vulnerable and its cohesion was fragile (it had six major associations representing it in Springfield), the governor's aides easily fragmented the providers' solidarity by offering reimbursement concessions that a few associations could not accept. One budget analyst modestly admitted in an interview with the author, "Right now the industry is split. We split them. . . . There are astute politicians on the governor's side too."

Governor Thompson's interest in Medicaid was always in keeping spending within the "bottom line," thus protecting his electability. He manipulated the state revenue balance by carefully managing the Medicaid cash flow averaging over four million dollars per day. At any given time, only his staff knew exactly what that balance actually was. In addition, the critical cooperation of nursing homes helped to sustain the rest of his cutbacks.

Governor Thompson had one additional political advantage because the Illinois' Constitution allows his budget to be presented to the legislature relatively late in the session (in early March). This allows the legislature little time for reaction or input, while allowing the governor maximum time to fine-tune his revenue estimates. The Utah governor publishes his budget recommendations in December, a full seven months before the start of the fiscal year, and Utah's entire legislative appropriations process is completed by February or March. Illinois' additional time is of great political advantage to the governor.

Lobbyists and Advocates

Lobbyists usually find increased opportunities when partisan politics become more competitive.¹⁴ In Illinois, Governor Thompson could "play off" the Democratic major-

ity against the health care interests, while allowing himself to be "used" by both. The volatility of the partisan majority in Illinois (which normally creates opportunities for program advocates), forced a retreat to the status quo during their period of fiscal retrenchment. Elected officials found cuts "across-the-board" were the easiest to make and defend. In Utah, with virtually no political competition, and with hospital interests very heavily represented (in both parties) on the appropriations committee, the nursing home association had little clout.

The constituents of the "health" (or medical care) policy arena tend to be the provider interest groups, while the "welfare" policy arena draws the poor people's advocates. Despite the structural differences in the nursing home industries, in both states the patterns of general distrust and antagonism between the nursing home and consumer advocates proved to be strikingly similar. In Utah nursing homes comprised a homogenous industry, nearly all locally owned, with only one provider association. Consumer organizations (the Senior Citizens Coalition, American Association of Retired Persons, community action agencies) actually pressed for nursing home expenditure cuts, hoping to free up funds for the Division of Aging's Alternatives to Nursing Home program. They felt little in common with the "greedy" nursing home industry.

The Illinois nursing home industry, on the other hand, was very heterogenous, including some 900 for profit, not-for-profit, county-owned facilities, and affiliates of large corporate chains. Four major associations and two smaller ones lobbied for the industry, although only 400 facilities belonged to any one organization. As the recession eased, some specialized consumer groups, who were acutely concerned that the industry's quality was deteriorating, lobbied with the industry for rate hikes. But this was a fragile alliance and support was given only in exchange for support of regulatory reforms pressed by Democratic legislative leadership.

The greater size of the nursing home industry in Illinois led to specialization of services and associations, and required more specialized reimbursement considerations, and highly specific lobbying. Yet, in both states, the interests of consumer and industry advocates sustained uneasy and sometimes downright hostile coexistence, even when they recognized the marginal gains possible by cooperation. Their lack of basic trust and common ground made resolving the problems of rates, access, and quality simultaneously impossible during financial hard times.

Long-term care policy making in the states is thus hampered by various actors' lack of sustained interest, fragmented commitments, and fragile alliances. While, for example, specialized nursing home consumer advocates existed in Illinois (Illinois Citizens for Better Care and the Better Government Association), their interest in quality assurance was thoroughly undercut by DPA's determination to keep rates low, and the industry's intransigence in the face of frozen reimbursement rates. Newspapers frequently featured stories about patient neglect and deaths, fraud and kickbacks, and the state's lack of regulatory enforcement.¹⁵ In addressing the basic unmet needs of nursing home residents, consumer advocates risked alienating the providers, elected officials and state bureaucrats, and even the public at large. Development of provider allies was vital, but very tricky. Consumer advocates' cooperated with cutbacks in Utah in return for promises of alternative programs, but ultimately there was little expansion of com-

munity-based services. Yet, it is unlikely that consumer advocates would have accomplished more by being more demanding.

In summary, then, the Utah and Illinois cases show how readily state officials will find ways to ration the biggest Medicaid services when forced to. Utah reduced Medicaid expenditure rates by discouraging nursing home use, appealing to fundamental "family values" and admonishing citizens to keep elderly parents at home, while placating the nursing home industry with a potential for financial gain through rate adjustments. Its success prevented sustained cutbacks in other service areas. Without similar "opportunities," Illinois cut all Medicaid services across the board by playing off various interests against one another. Indirectly it further discouraged the use of nursing homes by allowing their collective public image to deteriorate through scandalous press coverage, and by escalating the administrative costs nursing home operators endured to participate in Medicaid.

CONCLUSIONS AND POLICY RECOMMENDATIONS

State Medicaid cutbacks during a budget crisis reveal the basic weaknesses of current American long-term care policy. Presented with fiscal problems they cannot solve without heroic efforts to contain Medicaid expenditures over a sustained period, policy makers inevitably allow erosion of either nursing home access or quality to occur, and with this, fragmentation of any other care for the elderly that might exist.

These states' choices in time of crisis underscore the need for a nationwide "floor" or entitlement system that would guarantee a minimal standard of security for the elderly against the costs of long-term care. States are simply unable to sustain a rational continuum of long-term care services in the context of so many Medicaid pressures.

Federal financing could prevent this erosion by better targeting of various incentives through Medicaid. This summary will show how the three levels of issues outlined above could be addressed by a national program of LTC block grants.

The sequence of state decisions points to the importance of timing in the confluence of events and forces generated by the economy which create the context for change in individual states. A state's range of choices is restricted by its tax capacity, available revenue reserves, FFP rates, and prior commitments in health and welfare budgets. Changes in these fundamental resource conditions create the potential for dramatic policy change. The losses in states' LTC financing capacity created by this recession, which have since been compounded by Medicare prospective payment and early hospital discharges, and the greater functional needs of those recently entering nursing homes, indicate that fiscal problems for long-term care facilities can only get worse in the next recession.

States' capacities to absorb Medicaid retrenchment are varied, but their inability to control technology and their increasing reliance on competitive cost-containment strategies, as well as the Medicare bias toward acute care, have made maintenance of comprehensive services difficult. Presumably Utah's large extended and proximate families absorbed some of the patients discharged from nursing homes and the overbuilt nursing home industry absorbed a reduction in institutional bed use. But Illinois' resources

were not so elastic, so that reductions resulted in less comprehensiveness in all Medicaid, and substantial neglect of its regulatory structures. While the impacts on clients in both cases were obscured, they appear to have been far more deleterious in Illinois.

External fiscal pressure constrained the states' ability to respond in a way that strengthens their capacity to manage a continuum of vital long-term care services. Federal assistance could more efficiently equalize the distribution of services among the states through fixed capitation grants to designated state agencies for establishment of systems of service. These in turn could operate on contract with social/health maintenance organizations.¹⁶ The per capita reimbursement formula could be based on verifiable measures of consumer need: the number of aged, functionally impaired, disabled, and poor persons in the state. Such targeted federal assistance could secure basic resources upon which states could build systems for LTC case management in the community as well as in residential facilities. Without stronger targeted incentives in such assistance, states' organizational structures and political alliances will continue to shape these choices in ways that inevitably favor the institutional providers' at the expense of a balanced system of care.

State governments are structurally limited by the standard operating procedures, orientation, and experience of the agencies of government accountable for programs. In both policy and practice, state agencies tend to filter information about alternatives to serve their own imperatives, thereby reinforcing their own perceptual limitations. These structures also dictate the locus of management control over Medicaid functions and their allocations. The organizational locus of Medicaid in either the welfare or the health care system affects which programs LTC competes with to secure revenues. Should LTC share revenues with hospitals or with income maintenance programs?

Current siting of LTC within Medicaid also pits the needs of the elderly against those of children, but a distinct funding base for LTC would go a long way toward protecting the discrete needs of both the elderly and children. Current state administrative discretion in such matters inevitably favors the distribution of LTC benefits to institutions. Yet, federal funding for LTC that included incentives for states to establish continuity between institutions and home care alternatives would encourage creative development of outcome oriented but locally tailored approaches.

Medicaid advocacy is generally limited to provider interest groups and poverty advocates, neither of whom really represent the middle class elderly who hope to avoid institutionalization. The divergent interests of these polarized constituencies highlight the incompatibility among present approaches to LTC at the state level. Federal incentives could help establish common ground for LTC interest groups, and common premises for a just basis for state rationing.

The "iron triangles" that control rate setting—legislature, bureaucracy, and industry—are highly institutionalized in state Medicaid policy making, and will grow more impenetrable as "privatization" of services is adopted by more states and localities. Choices in the interest of society should be encouraged by democratizing LTC rationing choices. This can be done by making choices more consumer oriented through media exposure. State governments, especially their elected and appointed executives, must be strengthened. Governments must impose a proper balance in the provisions for care,

especially through careful setting of reimbursement rates, standards, and client eligibility in the interests of all society. Otherwise, rates will win, access will lose, and quality of care will remain elusive. Conscientious planners cannot leave such matters to local process and tolerances.

As Somers has observed, "Good long-term care usually involves a creative blend of medical and social services that is possible only where there is a well-developed organizational and financial infrastructure."¹⁷

The fragile continuum of care infrastructures that might have existed in Illinois and Utah were whipsawed to near collapse by the Medicaid crises. Now that the early-80s recession is over, a new equilibrium has been reached in state Medicaid programs. Compounded by the impact of Medicare DRGs, it has resulted in a new reduced amount of institutional care that has already been deleterious in some places. This equilibrium cannot suffice indefinitely. Less costly community care will receive increasing emphasis for a time, but the systemic improvements needed in states cannot be solved by community care alone. Another crisis can only make matters more difficult. Until the nation establishes a more sensible entitlement approach, the disparity of long term care services among the states will only get worse.

NOTES

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12. Illinois Legislative Investigating Commission, *Regulation and Funding of Illinois Nursing Homes: A Report to the General Assembly* (Springfield, IL, April 1984), 47-82.
13. Files and press releases of the Better Government Association, 1981 to 1983. Other Legislative Investigating Commission Reports document shortages and deficiencies in the inspectional functions: *A Map for a Maze: Illinois' System of Funding Residential Schools* (Aug. 1982); *Illinois Nursing Homes* (July 1980); *Lake County Nursing Homes* (Feb. 1977).
14. Dye, "Party and Policy in the States."
15. Typical newspaper articles in the *Sun-Times* during this time included: "Nursing homes target of fraud probe" (4 April 1983); "Create nursing home watchdog, BGA urges" (5 April 1983); "Laura's death spurs a rare call for action" (6 April 1983); "Nursing home cited in connection with man's death" (31 May 1982); "Mental patients pawn in state political game" (June 1982); "Donna's death haunts state officials" (28 March 1982); "Mental patients moved against rules" (25 April 1982); "[Lt. Governor] Ryan aids nursing home owner, gains thousands" (11 July 1982).
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17. Somers, "Long Term Care for the Elderly and Disabled," 47.