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Medicaid Spending by States: Variations & Influences ...

Abstract. This brief explores variations in state Medicaid programs. It concludes that the federal matching formula, which provides more generous matching funds for poorer than for richer states, reduces interstate disparities. The brief finds that long-term care expenditures vary to a greater degree than acute care spending; the greatest state-to-state variation in Medicaid spending is the use of the disproportionate share hospital (DSH) program; and high-spending states tend to have higher ...

Variations in Medicaid Spending among States | Urban Institute

State Medicaid Spending Variation in

the amounts states spend out of their own funds per beneficiary or per low-income individual is vastly greater than variation in total Medicaid spending. Connecticut is at the top of the range, spending over $2,400 per low-income individual in 1994—the same as the federal share since Connecticut receives the minimum 50 percent match.

Variations in Medicaid Spending among States

states variation in the amounts states spend out of their own funds per beneficiary or per low income individual is vastly greater than variation in total medicaid spending connecticut is at the top of the range spending over 2400 per low income individual in 1994 the same as the federal share since connecticut

receives the minimum 50

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Average spending per Medicaid enrollee was less for adults and children ($4,141 and $2,492 respectively). For each eligibility group, there is considerable variation across states in per enrollee...

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Variation among states in spending per enrollee for seniors and people with disabilities also is influenced by different state choices about Medicaid-covered services, as most home and...

State Variation in Medicaid Per Enrollee Spending for ...
For example, the data show that

Medicaid spending per enrollee for 2004 varied from $10,199 in New Jersey and $10,173 in New York to $4,089 in Alabama and $3,664 in California—close to a ...

State Variation In Medicaid Spending: Hard To Justify ...

State Variation In Medicaid Spending Hard To Justify there is great variation among states in medicaid spending per low income person this variation has many determinants including state discretion and differences in prices and amounts of services Medicaid Spending By States Variations And Influences

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medicaid spending by states variations and influences Aug 18, 2020 Posted

By Gilbert Patten Media TEXT ID b53afc16 Online PDF Ebook Epub Library drive variation in state medicaid spending some of these factors include for example differences in enrollee characteristics and health status eligibility rules that determine

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Medicaid Spending by States: Variations & Influences ...
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working families low income elderly and individuals with disabilities historically

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New York spent nearly 30% of its own revenue on Medicaid (black bar), up 2.3 percentage points since 2000 (gray bar). Louisiana and Massachusetts both spent 22% in 2017, but Louisiana's ...

Medicaid Spending Is Taking Over State Budgets

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Health care in the United States is more expensive than in other developed countries, costing $2.7 trillion in 2011, or 17.9 percent of the national gross domestic product. Increasing costs strain budgets at all levels of government and threaten the solvency of Medicare, the nation's largest health insurer. At the same time, despite advances in biomedical science, medicine, and public health, health care quality remains inconsistent. In fact, underuse, misuse, and overuse of various services often put patients in danger. Many efforts to improve this situation are focused on Medicare, which mainly pays practitioners on a fee-for-service basis and hospitals on a diagnoses-related group basis, which

is a fee for a group of services related to a particular diagnosis. Research has long shown that Medicare spending varies greatly in different regions of the country even when expenditures are adjusted for variation in the costs of doing business, meaning that certain regions have much higher volume and/or intensity of services than others. Further, regions that deliver more services do not appear to achieve better health outcomes than those that deliver less. Variation in Health Care Spending investigates geographic variation in health care spending and quality for Medicare beneficiaries as well as other populations, and analyzes Medicare payment policies that could encourage high-value care. This report concludes that regional differences in Medicare and commercial health care spending

and use are real and persist over time. Furthermore, there is much variation within geographic areas, no matter how broadly or narrowly these areas are defined. The report recommends against adoption of a geographically based value index for Medicare payments, because the majority of health care decisions are made at the provider or health care organization level, not by geographic units. Rather, to promote high value services from all providers, Medicare and Medicaid Services should continue to test payment reforms that offer incentives to providers to share clinical data, coordinate patient care, and assume some financial risk for the care of their patients. Medicare covers more than 47 million Americans, including 39 million people age 65 and older and 8 million people with disabilities.

Medicare payment reform has the potential to improve health, promote efficiency in the U.S. health care system, and reorient competition in the health care market around the value of services rather than the volume of services provided. The recommendations of Variation in Health Care Spending are designed to help Medicare and Medicaid Services encourage providers to efficiently manage the full range of care for their patients, thereby increasing the value of health care in the United States.

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The balance between state and federal health care financing for low-income people has been a matter of considerable debate for the last 40 years. Some argue for a greater federal role, others for more devolution of responsibility to the states. Medicaid, the backbone of the system, has been plagued by an array of problems that have made it unpopular and difficult to use to extend health care coverage. In recent years,

waivers have given the states the flexibility to change many features of their Medicaid programs; moreover, the states have considerable flexibility to in establishing State Children's Health Insurance Programs. This book examines the record on the changing health safety net. How well have states done in providing acute and long-term care services to low-income populations? How have they responded to financial incentives and federal regulatory requirements? How innovative have they been? Contributing authors include Donald J. Boyd, Randall R. Bovbjerg, Teresa A. Coughlin, Ian Hill, Michael Housman, Robert E. Hurley, Marilyn Moon, Mary Beth Pohl, Jane Tilly, and Stephen Zuckerman.

How much responsibility for providing health care to the poor should be devolved from the federal government to the states? Any answer to this critical policy question requires a careful assessment of the Medicaid program. Drawing on the insights of leading scholars and top state health care officials, this volume analyzes the policy and management implications of various options for Medicaid devolution. Proponents of devolution typically express confidence that states can meet the challenges it will pose for them. But, as this book shows, the degree to which states have the capacity and commitment to

use enhanced discretion to sustain or improve health care for the poor remains an open question. Their failure to attend to issues of politics, implementation, and management could lead to disappointment. Chapters focus on such topics as Medicaid financing, benefits and beneficiaries, long-term care, managed care, safety net providers, and the appropriate division of labor between the federal government and the states. The contributors are Donald Boyd, Center for the Study of the States; Lawrence D. Brown, Columbia University; James R. Fossett, Rockefeller College; Richard P. Nathan, Nelson A. Rockefeller Institute of Government, State University of New York, Albany; Michael Sparer, Columbia University; James Tallon, United Hospital Fund;

and Joshua M. Weiner, the Urban Institute.

In this report, Paul Offner explores the impact of the shift toward greater state responsibility for managing Medicaid. Offner argues not only that the balance has shifted too far toward the states, but also that it would be better if the federal government ran the program entirely.