Editor's Note

There is a long-standing debate over the whether the states can or should take the lead in health care policy. Are state-based programs more accountable, more efficient, more responsive to local market conditions, and more innovative? Are the states effective policy laboratories, either for the federal government or for other states? Or are state-based programs inevitably inequitable, given the extraordinary interstate variation that is endemic to state-based programs? And are state officials more likely than their federal counterparts to be captured by partisan interest groups?

Despite the partisan rhetoric over the merits and demerits of federalism, there are surprisingly few studies which provide useful evidence on these enduring questions, and most of that sparse literature focuses on policies explicitly designed to aid the uninsured. In this issue of *JHPPL*, however, there are four articles that consider very different kinds of state-based health care programs.

The lead article, by Colleen Grogan (our book review editor) and Michael Gusmano, examines how a Medicaid managed care initiative in Connecticut led safety-net providers to focus more on their own role in the new competitive environment and to be less assertive and less effective in their long-standing role as representative of the poor and the uninsured. This is an important contribution to the general literature on interest group politics in the states as well as an equally important addition to our understanding of whether and how the poor have a political voice. The article builds off a longer project Grogan and Gusmano engaged in

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that examines whether advocates for the poor effectively represent their constituents. Grogan and Gusmano tell this story in a book titled *Healthy Voices, Unhealthy Silence: Advocacy and Health Policy for the Poor*, and this issue of the journal contains two reviews of this book, one by Deborah Stone and the other by Jonathan Engel.[1]

Fred Hellinger then examines a new federal program designed to encourage nonprofit hospitals to provide more charity care and other "community benefits" in exchange for their nonprofit tax status. Hellinger notes, however, that sixteen states have enacted similar rules, either requiring hospitals to explicitly report their community benefit activities or more aggressively imposing on the hospital industry-specific standards for meeting the community benefit test. The issue here is the utility of the states as policy laboratories. Will the federal government be guided by lessons suggested from the state initiatives? While the jury is still out, the evidence offered by Hellinger suggests that federal officials, so far anyway, have paid little attention to the state laboratory.

Derek DeLia and colleagues next provide a fascinating examination of the unintended impact of a certificate of need reform in New Jersey. Their case study evaluates the state's effort to expand hospital capacity to perform cardiac angiography. The policy assumption was that the new facilities would serve large numbers of previously underserved populations, especially low-income black patients. It turned out, however, that the new facilities were located primarily in the suburbs and were more successful in attracting patients away from the long-standing inner-city facilities, and it was those inner-city facilities which were forced by these new competitive pressures to now serve more minority patients, thereby reducing disparities in access, albeit in a far different way than initially predicted by the state.

Finally, Edward Miller and colleagues consider the arcane world of Medicaid nursing home reimbursement methodologies. As the authors note, state officials try to develop methodologies to further a host of policy objectives (including the standard fare of better care and better access at lower costs), but the unintended impact is a multitude of complicated rules that often increase the administrative burdens (on both the states and the nursing facilities) without necessarily achieving many of the intended policy outcomes. The article is an important addition to the literature on state-based bureaucratic politics.

1. As the book review editor, Colleen Grogan recused herself from any participation in the process of finding or editing the reviews of her jointly authored book. As editor in chief, I selected the two reviewers and supervised the review process.

These articles each provide a cautionary tale. The state-based Medicaid managed care initiative in Connecticut had the unexpected impact of reducing an already flimsy voice on behalf of the poor. The state-based nursing home reimbursement methodologies are extraordinarily variable without any clear evidence that they are meeting policy goals. The state-based certificate of need reform in New Jersey achieved its ultimate goal (increased access) but did so through an entirely unexpected route. The federal government is implementing a program to pressure nonprofit hospitals to provide more community-based services, but is doing so with little regard for the long-standing history of similar state-based initiatives. Taken together, the articles may not resolve the debate over the intergovernmental division of labor, but they do provide some telling glimpses into the underexplored world of state-based health care policy making.

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