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Report to the Chairman, Committee on the Budget, U.S. Senate, and to the Chairman, Committee on the Budget, House of Representatives

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MEDICAID

Sustainability of Low 1996 Spending Growth Is Uncertain

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The Honorable Pete V. Domenici
Chairman
Committee on the Budget
United State Senate

The Honorable John R. Kasich
Chairman
Committee on the Budget
House of Representatives

In fiscal year 1996, federal and state expenditures for Medicaid totaled approximately $160 billion—accounting for roughly 6 percent of total federal expenditures and 20 percent of total state expenditures. Medicaid's annual growth rate for fiscal year 1996, however, was estimated at only 3.3 percent or lower—a substantial drop from the more than 20-percent annual growth rates of the early 1990s.[1] The very low 1996 spending growth rate raised many questions about what led to this steep drop and its implications for future expenditures.

In response to your request about this low growth rate, we (1) examined the dominant factors affecting trends in Medicaid spending growth from fiscal years 1989 to 1995, (2) identified key factors that contributed to the low spending growth rate for fiscal year 1996 and analyzed variations in states' Medicaid spending growth for the most recent 2-year period, and (3) assessed the implication of these factors for future Medicaid spending.

Our findings are based on an analysis of data on state and federal Medicaid expenditures and on federal Medicaid outlays obtained from the Health Care Financing Administration (HCFA). Our trends analysis was based on expenditure and enrollment data for fiscal years 1988 to 1995.[2] Final data for fiscal year 1996 were not available as of June 3, 1997. Our analysis of the 3.3-percent growth rate in fiscal year 1996 was based on federal Medicaid outlays. We also interviewed Medicaid officials from the 18

[1]The 3.3-percent growth rate has been widely used and represents the moneys paid to states by the federal government each month to fund Medicaid. Historically, federal outlays have proven to be a good predictor of Medicaid expenditures—representing the obligated dollar amounts for services provided and program administration in a given time period, whether paid or unpaid. According to HCFA, however, preliminary fiscal year 1996 expenditure data show only about 1.8 percent growth over fiscal year 1995 expenditures.

[2]Fiscal year 1988 was the earliest year for which spending estimates were available on one critical program component—the disproportionate share hospital (DSH) program. Therefore, fiscal year 1989 was the earliest year for which a growth rate could be calculated for this program.

states that accounted for almost 65 percent of federal Medicaid outlays and represented the full range of growth rate trends in state spending observed in the past 2 years. We conducted our review from August 1996 to April 1997 in accordance with generally accepted government auditing standards. For more detailed information on our scope and methodology, see appendix I.

Results in Brief

The Medicaid spending growth rate increased dramatically in the early 1990s, rising to almost 29 percent in 1992, with expenditures growing from almost $60 billion in fiscal year 1989 to $157 billion in fiscal year 1995. Factors that help explain this trend include (1) escalating disproportionate share hospital (DSH) payments made to hospitals that cover a large proportion of low-income and Medicaid beneficiaries, (2) the increasing cost of providing services (the prices paid for services and the average costs of services per beneficiary), and (3) the growing number of program beneficiaries. Each of these factors prevailed to increase spending growth at different times. For example, from fiscal years 1990 to 1992, the contribution of DSH payment increases soared from 6 to 46 percent of total spending growth until those payments were brought under control in 1993. While DSH payment contributions erratically increased and decreased, the impact of additional beneficiaries on overall expenditure growth steadily increased due in part to mandated and optional eligibility expansions. By fiscal year 1995, however, as Medicaid spending growth had abated substantially, the contribution of these factors had decreased.

The dramatically low Medicaid expenditure growth rate in fiscal year 1996 masked wide variations in states' Medicaid growth. One state's Medicaid expenditures decreased by 16 percent, another's increased by 25 percent. Most states, however—accounting for 80 percent of fiscal year 1996 federal Medicaid outlays—had moderate decreases or minimal changes from their previous year's spending growth. A combination of factors—some affecting only certain states and others common to many states—explains the low fiscal year 1996 growth rate. For example, some states' increases in Medicaid enrollment leveled off after the prior year's major state-initiated program expansions. A number of other states we contacted attributed lower growth rates to a generally improved economy and state initiatives to limit expenditure growth through program changes such as managed care programs and long-term care alternatives.

Whether the low 1996 Medicaid spending growth rate of 3.3 percent will be sustained in subsequent years is uncertain. The factors that reduced

growth in fiscal year 1996 will continue to affect future Medicaid spending. The net effect of factors, such as DSH spending and the future economy, however, are unknown. Some of these factors may contribute to higher growth in the near future. For example, DSH payments have already begun to grow again. In addition, if the economy declines, enrollment in Medicaid would probably increase. The possible effects of other factors are less predictable. Welfare reform's effect on expenditure growth is uncertain because states are just starting to implement their new programs. Also uncertain is the amount of money that may be saved from states implementing managed care alternatives.

Background

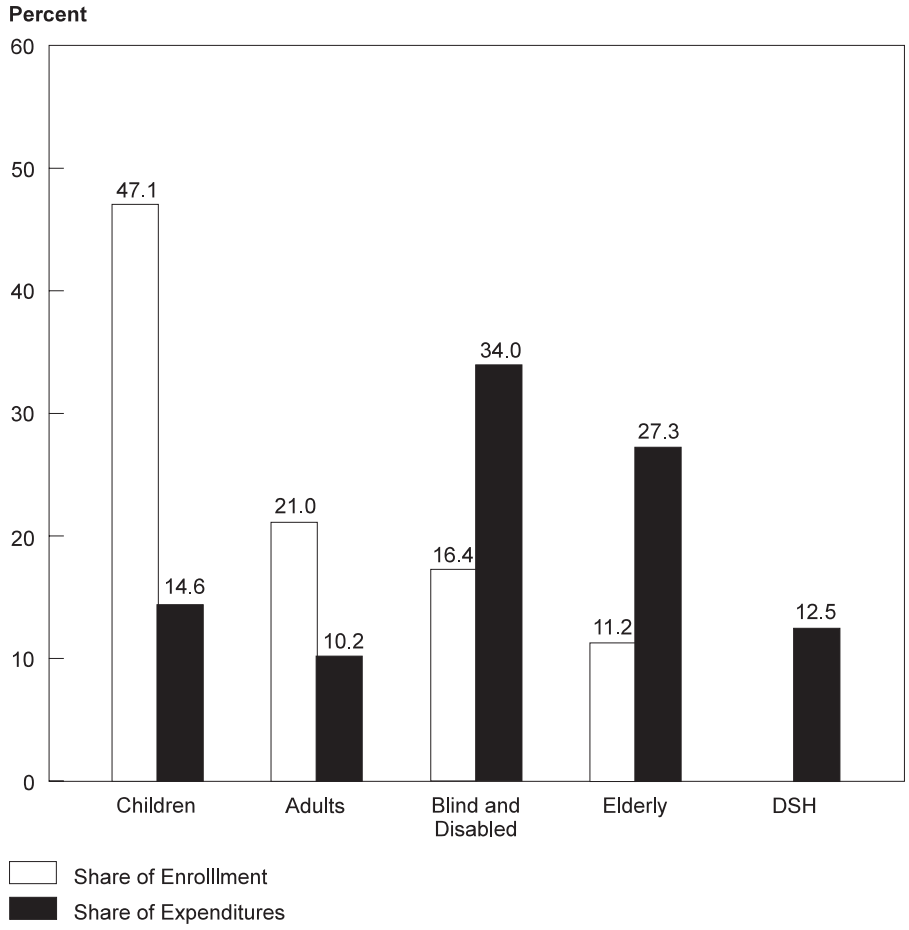
Medicaid, a federal grant-in-aid entitlement program administered by states, finances health care for about 37 million low-income families and blind, disabled, and elderly people. The federal and state governments share funding for Medicaid, with the federal government contributing an average of 57 percent of program costs in 1996.[3] At the state level, Medicaid operates as a health insurance program covering acute care services for most beneficiaries, financing long-term medical care and social services for elderly and disabled people, and funding programs for people with developmental disabilities and mental illnesses.

In 1995, almost 70 percent of total Medicaid enrollment consisted of children and adults, but this group accounted for less than 25 percent of total program expenditures. (See fig. 1.) In the same year, less than 30 percent of the total Medicaid population consisted of blind, disabled, or elderly people, but this group accounted for more than 60 percent of total expenditures. DSH payments accounted for about 13 percent of total payments.[4]

[3]The percentage of an individual state's Medicaid expenditures covered by the federal government can range from 50 to 83 percent.

[4]The DSH program partially offsets costs not covered by Medicaid or private insurance incurred by hospitals serving large numbers of Medicaid and other low-income patients, including the uninsured.

Figure 1: Shares of Medicaid Beneficiaries and Expenditures, by Eligibility Category, Fiscal Year 1995



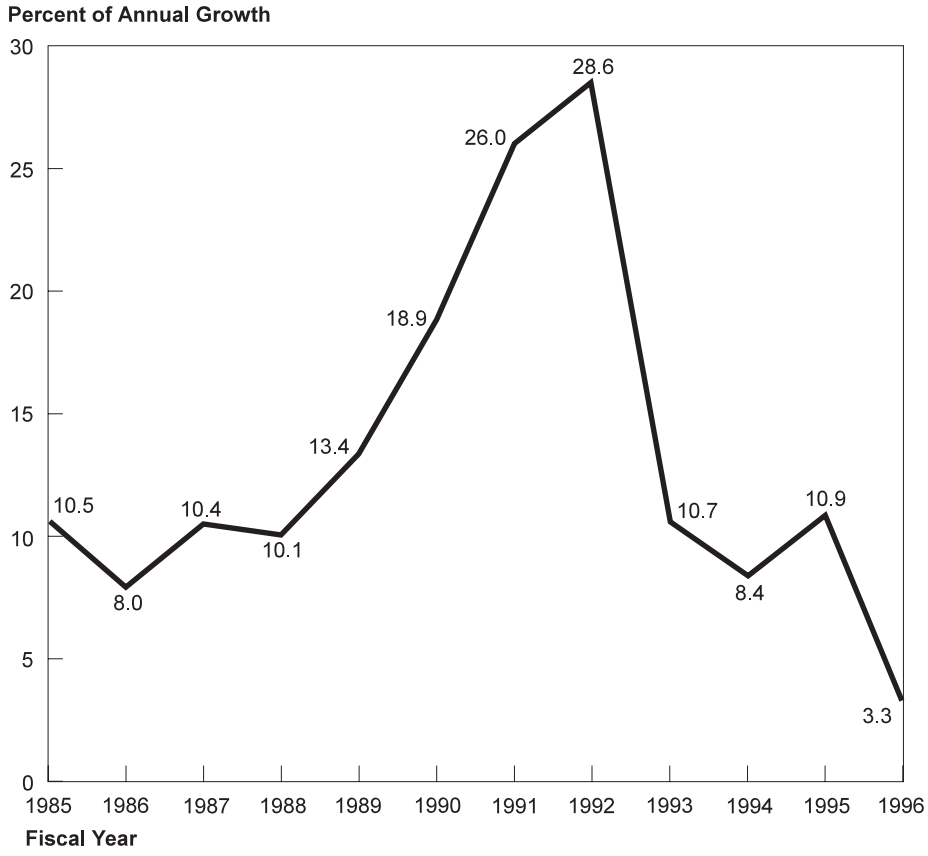
Note: Excludes “other” and “unknown” eligibility categories.

Source: HCFA Office of the Actuary merged enrollment (HCFA-2082) and expenditure (HCFA-64) files.

For more than a decade, the national growth rate in Medicaid expenditures has been erratic. (See fig. 2.) Between fiscal years 1985 and 1988, the annual growth rate remained relatively stable, ranging between roughly 8 and 10.5 percent. During the next 3 years, starting in fiscal year 1989, the annual growth rate began to climb substantially, reaching almost 29 percent in fiscal year 1992—an increase of more than $26 billion in expenditures for that year. Medicaid’s growth fell dramatically in fiscal year 1993 to 10.7 percent. From fiscal years 1993 through 1995, the annual

growth rate for the program leveled off at between 8 and 11 percent, which was similar to the growth rate between 1985 and 1988. Then, in fiscal year 1996, the growth rate fell to an estimated 3.3 percent.

Figure 2: Annual Growth Rate in Medicaid Expenditures, Fiscal Years 1985-96



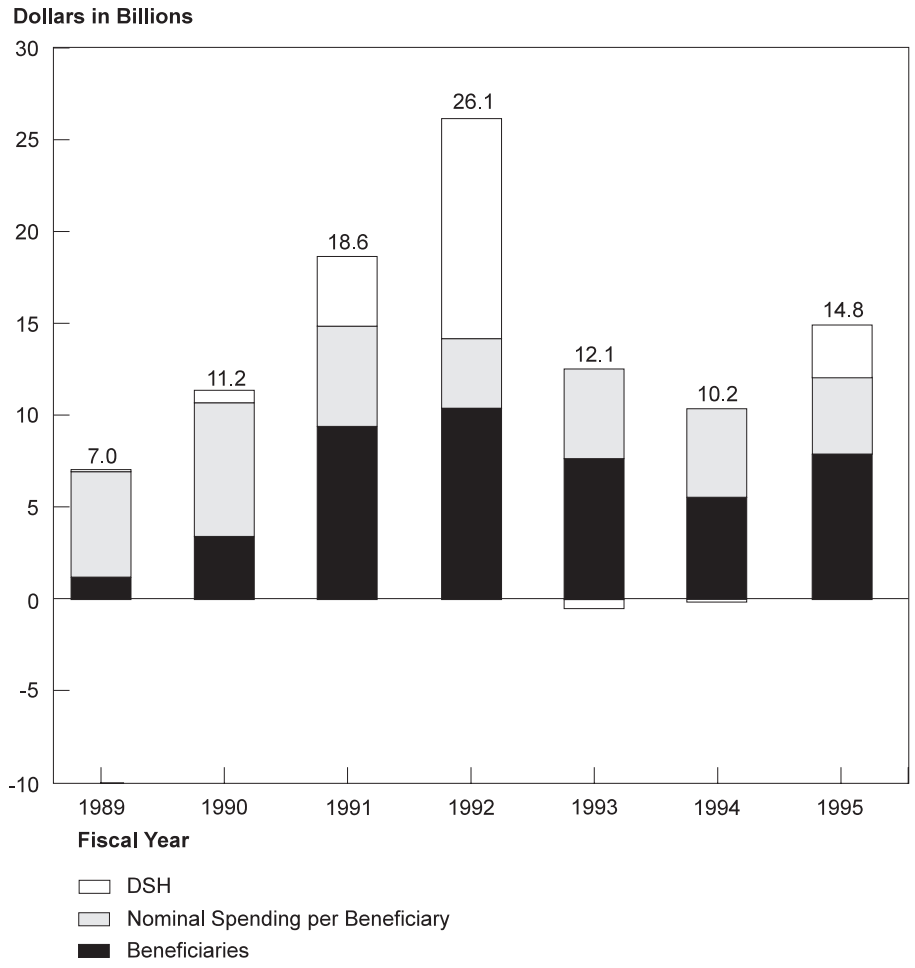
Sources: Fiscal years 1984-95, federal and state current expenditures (HCFA-64, line 6). Fiscal year 1996 data based on federal outlays for Medicaid. (Final expenditure data were not available for fiscal year 1996.)

Dominant Factors Affecting 1989-95 Spending

Three dominant factors affected the 1989-95 growth in Medicaid expenditures: the DSH program, nominal spending per beneficiary (the cost of services),[5] and the growth in the number of program beneficiaries. To better understand the effect of these factors on Medicaid growth rates, we measured the effect of each while holding the others constant. (See fig. 3 and table 1.) For the first 2 years of the 7-year period, nominal spending per beneficiary constituted the largest share of growth in the overall program; by 1992, however, DSH payments constituted the largest share. Increased beneficiary enrollment had a more constant—and increasingly significant—effect on the annual growth rate. Between 1990 and 1994, growth in beneficiary enrollment accounted for 30 percent or more of the total growth in Medicaid spending.

[5]Several different factors, including medical price inflation, reimbursement levels, and quality assurance standards, affect nominal spending per beneficiary, a measure of average cost. At the aggregate level, the demographic makeup of the Medicaid population also affects nominal spending per beneficiary. For example, states with large elderly and disabled populations will have higher-than-average costs.

Figure 3: Annual Increases in Medicaid Expenditures by Growth Factor, Fiscal Years 1989-95



Sources: Medical assistance program expenditures (HCFA-64), excluding administrative costs and territories; beneficiary enrollment (HCFA-2082); and DSH estimates from the Urban Institute.

Table 1: Shares of Medicaid Expenditure Growth by Factors, Fiscal Years 1989-95

Factors	Percentage share of total expenditure growth[a]						
	1989	1990	1991	1992	1993	1994	1995
Nominal expenditures per beneficiary	82	64	29	14	41	51	59
DSH[b]	3	6	21	46	–4	–1	14
Beneficiary growth	15	30	50	40	63	51	27
Total expenditure growth	100	100	100	100	100	100	100

Note: Does not include administrative costs or payments to U.S. territories.

[a]Percentages may not add to 100 due to rounding.

[b]DSH payments were first reported as a separate expenditure category in fiscal year 1993. The DSH shares for 1989 to 1994 used for this analysis are estimates made by the Urban Institute, in part based on HCFA-64 data. The DSH share for 1995 is based on HCFA-64 data.

Table 2: Annual Medicaid Expenditures, Growth, and Growth Rate, Fiscal Years 1989-95

	1989	1990	1991	1992	1993	1994	1995
Growth rate (percent)	13.6	19.1	26.7	29.6	10.6	8.1	10.8
Annual growth (dollars in billions)	$7.0	$11.2	$18.6	$26.1	$12.1	$10.2	$14.8
Total medical assistance expenditures (dollars in billions)	$58.5	$69.6	$88.2	$114.3	$126.4	$136.6	$151.4

Note: Does not include administrative costs or payments to U.S. territories.

Between fiscal years 1990 and 1992, the DSH program had its most dramatic effect on Medicaid growth rates: its share of the overall Medicaid expenditure growth increased from 6 to 46 percent. A number of states increased their share of federal Medicaid dollars in fiscal years 1991 and 1992 through certain creative financing mechanisms such as using provider taxes and donations to obtain federal matching funds for Medicaid.[6] States used the DSH program along with these financing mechanisms to increase federal funds. As a result, DSH payments skyrocketed: In 1990, they were just above $1 billion; by 1992, they had increased to $17 billion. To limit these payments, the Congress placed restrictions on the DSH program and on the use of provider taxes and donations as revenue sources.[7] DSH payments were limited to a national

[6]See Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994); Michigan Financing Arrangements (GAO/HEHS-95-146R, May 5, 1995); and State Medicaid Financing Practices (GAO/HEHS-96-76R, Jan. 23, 1996).

[7]Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) and the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66, section 13621).

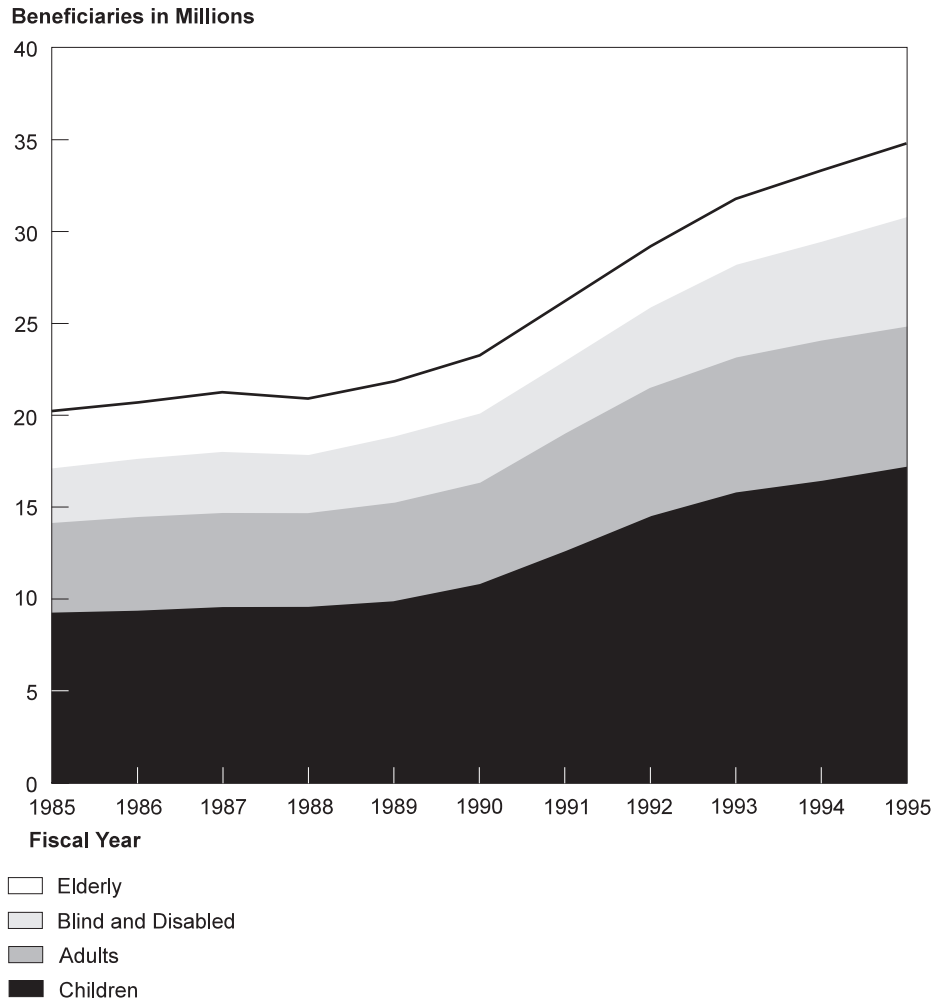
target of 12 percent of total Medicaid expenditures, excluding administrative costs. If a state's DSH spending exceeded this target, its DSH payments were frozen until they equaled 12 percent or less of the state's medical assistance expenditures. These restrictions greatly curbed payments, leading initially to less DSH spending and reduced Medicaid spending growth in fiscal years 1993 and 1994. Even as states' DSH spending began to conform to the 12-percent target, however, aggregate state DSH payments began to increase again as total Medicaid spending grew. As a result, in fiscal year 1995, the DSH program share of expenditure growth grew to 14 percent.

Nominal spending per beneficiary constituted the largest share of Medicaid expenditure growth in fiscal years 1989, 1990, 1994, and 1995 but accounted for only one-third or less of the growth in 2 other years. In years in which the share of nominal spending per beneficiary was relatively small, DSH payment growth was high. Conversely, in years in which the share of nominal spending was high, DSH payments were low.

Beneficiary enrollment also consistently contributed to Medicaid's growth rate in the years that we examined. In fiscal years 1991, 1993, and 1994, increased enrollment accounted for at least half of increased Medicaid expenditures. After several years of static growth, the number of Medicaid beneficiaries grew from about 22 million in fiscal year 1988 to 30 million in fiscal year 1992; by fiscal year 1995, enrollment had grown to over 36 million. (See fig. 4.) This growth was due in part to federal mandates that expanded eligibility to pregnant women and children and to certain other low-income women and children who met financial but not categorical eligibility standards. In addition, some states have used managed care demonstration waivers to expand coverage to uninsured individuals.[8]

[8]States have used the authority of demonstration waivers under section 1115 of the Social Security Act (42 U.S.C. 1315(a)) to mandate enrollment of some or all Medicaid beneficiaries in managed care and expand eligibility for enrollment to uninsured individuals who would not otherwise qualify for Medicaid. See Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995) and Medicaid: Statewide Section 1115 Demonstrations' Impact on Eligibility, Service Delivery, and Program Cost (GAO/T-HEHS-95-182, June 21, 1995).

Figure 4: Medicaid Enrollment by Eligibility Category, Fiscal Years 1985-95



Note: Excludes “other” and “unknown” categories of eligibility.

Source: Beneficiary enrollment file (HCFA-2082), fiscal years 1985-95.

A Combination of Factors Affected 1996 Spending Growth

After relatively stable growth rates between fiscal years 1993 and 1995, the Medicaid growth rate dropped to an estimated 3.3 percent in fiscal year 1996. No single spending growth trend was evident in the states, and no single factor explained the decrease in growth for 1996, according to our analysis. Rather, a combination of factors—some of which are unlikely to

recur and others that seem part of a larger trend—have affected Medicaid's growth rate.

No Single Spending Trend Common to States

The 3.3-percent growth rate in fiscal year 1996 federal Medicaid outlays masked striking variation in states' Medicaid growth. Growth rates ranged from a decrease of 16 percent in one state to an increase of 25 percent in another. Such differences in states' program spending growth have been fairly typical. In addition, some states often have large changes in growth from one year to the next because of major program changes or accounting variances that change the fiscal year in which a portion of expenditures is reported. To determine the stability of states' growth rates, we compared these rates for fiscal years 1995 and 1996. We then placed states in one of five growth rate categories, as shown in table 2. (See app. II for states' specific growth rates.)

Table 3: Changes in Growth Rate of Federal Medicaid Outlays, Fiscal Years 1995-96

Fiscal year 1996 growth rate compared with fiscal year 1995's	Number of states	Percentage of 1996 federal outlays	States
Decreased substantially	10	16	Colorado, Florida, Hawaii, Louisiana, North Carolina, Oregon, Rhode Island, South Carolina, Tennessee, Wyoming
Decreased moderately	20	48	Alabama, California, Idaho, Illinois, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, Vermont, Washington
Changed minimally	16	32	Arizona, Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, Utah, Virginia, West Virginia, Wisconsin
Increased moderately	3	2	Alaska, Maine, New Mexico
Increased substantially	2	2	Indiana, New Hampshire

Ten states that collectively accounted for 16 percent of 1996 federal Medicaid outlays had substantially decreased growth in fiscal year 1996 compared with fiscal year 1995. However, 80 percent of 1996 federal Medicaid outlays took place in states whose fiscal year 1996 growth either moderately decreased or minimally changed. Although five states' fiscal year 1996 growth rates increased, those states did not greatly affect spending growth trends because their combined share of Medicaid outlays was only 4 percent.

A number of factors have led to Medicaid's decreased spending growth rate in fiscal year 1996. Some of these—such as the prior implementation of cost controls and a leveling off in the number of program eligibles

following state-initiated expansions—continue to affect the growth rate in some states. Other factors, such as improved economic conditions and changing program policies—for example, increased use of alternatives to institutional long-term care—also affected many states' low growth rates.

Several Factors Affecting Spending Growth Will Probably Not Recur

The large decreases in some states' growth rates in 1996 are largely due to three factors not expected to recur: substantially decreased DSH funding, slowdowns in state-initiated eligibility expansions, and accelerated 1995 payments in response to block grant proposals for Medicaid.

After the Congress enacted new limits in 1991 and 1993, DSH payments declined nationally in 1993, stabilized in 1994, and began to grow again in 1995. Louisiana, however—a state that has had one of the nation's largest DSH programs, accounting for 30 percent of the state's total Medicaid expenditures in fiscal year 1995—has not followed this trend. Louisiana's 1996 growth rate decreased substantially as its DSH payments continued to decline. The state's federal outlays decreased by 16 percent in 1996 because its DSH payments dropped dramatically.

Recent slowdowns in state-initiated eligibility expansions also helped to substantially decrease the growth rates in selected states. In the past several years, some states implemented statewide managed care demonstration waiver programs to extend health care coverage to uninsured people not previously eligible for Medicaid. Three states whose 1996 growth rates decreased substantially—Hawaii, Oregon, and Tennessee—implemented most of their expansions in 1994. The increased expenditures due to these expansions continued into 1995 but began to level off in 1996. The number of eligible beneficiaries actually dropped in these states in 1996 partly due to the states applying more stringent eligibility requirements for the expansion population.

States accelerating 1996 payments into 1995 also helps explain the low 1996 growth rate.[9] In 1995, the Congress—as part of a Medicaid block grant proposal—was considering legislation to establish aggregate spending limits that would be calculated using a base year. In response to the anticipated block grant, officials from a few states told us, they accelerated their Medicaid payments to increase their expenditures for fiscal year 1995—the year the Congress considered using as the base. For example, one state, with federal approval, made a DSH payment at the end

[9]Aggregate data show that growth in federal Medicaid outlays was flat in the first 6 months of 1996 and then grew 6 percent in the last 6 months.

of fiscal year 1995 rather than at the start of fiscal year 1996. Another state, whose growth had moderately decreased, expedited decisions on audits of hospitals and nursing homes to speed payments due these providers, according to a state official.

Strong Economic Conditions Have Helped Slow Spending Growth

Improved economic conditions, reflected in lower unemployment rates and slower increases in the cost of medical services, also have helped slow the growth of Medicaid expenditures. Between 1993 and 1995, most states' unemployment rates dropped—some by roughly 2 percentage points. As we reported earlier, every percentage-point drop in the unemployment rate is typically associated with a 6-percent drop in Medicaid spending.[10] Low unemployment rates had reduced the number of people on welfare and therefore in Medicaid, several state officials told us.

In addition, growth in medical service prices has been steadily declining since the late 1980s. In 1990, this growth was 9.0 percent; by 1995, it was halved to 4.5 percent, and in 1996 it declined further, to 3.5 percent. Declines in price inflation indirectly affect the Medicaid rates that states set for providers. States have frozen provider payment rates in recent years, including rates for nursing facilities and hospitals, according to several state officials we spoke with. Such a freeze might not have been possible in periods of higher inflation because institutional providers might have challenged state payment rates in court, arguing that the rates have not kept pace with inflation.[11] With lower inflation, states can restrain payment rates with less concern about such challenges.

State Managed Care Programs and Long-Term Care Policies May Have Affected Spending Growth

Several states that we contacted discussed recent program changes that may have affected their Medicaid expenditures. The states' implementation of managed care programs was most prominently mentioned. The overall effect of managed care on Medicaid spending is uncertain, however, because of state variations in program scope and objectives. According to the Congressional Budget Office (CBO), savings from enrolling beneficiaries in managed care are not likely to be large in

[10]Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, Apr. 4, 1995).

[11]The Boren Amendment, section 1902(a)(13)(A) of the Social Security Act, (42 U.S.C. 1396(a)(13)(A)) requires that states make payments to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded that are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities. Providers in a number of states have used the Boren Amendment to force states to increase reimbursement rates for institutional services.

the long run.[12] States also mentioned initiatives for using alternative service delivery methods for long-term care. These initiatives may have helped to limit the growth in Medicaid costs; however, measuring their effect is difficult.

Although some states have been using managed care to serve portions of their Medicaid population for over 20 years, many of the states' programs have been voluntary and limited to certain geographic areas. In addition, these programs tend to target women and children—rather than those who may need more care and are more expensive to serve such as people with disabilities and the elderly.[13] Only a few states have mandated enrollment statewide—fewer still have enrolled more expensive populations—and these programs are relatively new. Arizona, which has the most mature statewide mandatory program, has perhaps best proven an ability to save money with managed care by devoting significant resources to its competitive bidding process.[14] Other states, however, have emphasized objectives besides controlling total spending in moving to managed care. In recently expanding its managed care program, Oregon expanded eligibility and increased per capita payments to promote improved access and quality and to look to the future for any cost savings. Tennessee also expanded eligibility to formerly uninsured populations with its demonstration waiver. Although initially achieving cost savings per beneficiary by setting low capitation rates for health plans, the state raised its rates in subsequent years.

Managed care has not significantly affected the moderate expenditure growth decreases in Minnesota, which has high managed care market penetration, and in California, which is in the midst of a large expansion, according to officials in the respective states. About 40 percent of Minnesota's Medicaid beneficiaries—mainly women and children living in urban areas—were enrolled in managed care plans in 1996, said an official. Because enrollment in managed care has been mandatory for these beneficiaries for several years, any dollar savings have been accounted for. Significant additional savings from managed care are not expected unless the elderly and disabled beneficiaries are mandated to enroll in managed care plans for both Medicare and Medicaid and for long-term care

[12]Statement of Paul N. Van de Water, Assistant Director for Budget Analysis, CBO, on Baseline Projections for Medicare and Medicaid before the Subcommittee on Health and Environment, Committee on Commerce, House of Representatives, Feb. 12, 1997.

[13]Medicaid Managed Care: Serving the Disabled Challenges State Programs (GAO/HEHS-96-136, July 31, 1996).

[14]Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs (GAO/HEHS-96-2, Oct. 4, 1995).

services. In contrast, California officials consider their program to be budget neutral in the short run because they have set their capitation rate at 100 percent of fee-for-service. In the long-term, however, they believe it will reduce the rate of cost growth. Given the varying objectives, states' experiences to date provide limited information on the ability of managed care to help control state Medicaid costs and moderate spending growth over time.

Some states we contacted are trying to control long-term care costs, which, for fiscal year 1995, accounted for about 37 percent of Medicaid expenditures nationwide. These states are limiting the number of nursing home beds and payment rates for nursing facility services while expanding home- and community-based services, which can be less expensive alternatives to institutional care. For example, New York is trying to limit its long-term care costs by changing its rate-setting method for nursing facilities, establishing county expenditure targets to limit growth, and pursuing home- and community-based service options as alternatives to nursing facilities, according to a state official. Our previous work has shown that such strategies can help control long-term care spending if they have controls on the volume of nursing home care and home- and community-based services—such as limiting the number of participating beneficiaries and having waiting lists.[15]

Implications for Future Spending Growth

Many of the factors resulting in the 3.3-percent growth rate in 1996—such as DSH payments, unemployment rates, and program policy changes—will continue to affect the Medicaid growth rate in future years. Some of these factors, however, may contribute to higher—not lower—growth rates, while the effect of others is more uncertain.[16]

Factors that may lead to increased growth in Medicaid expenditures include the following:

- DSH payments: Without new limits, DSH payments will probably add to the growth of the overall program. Although Louisiana's adjustments to its DSH payments substantially reduced its 1996 spending, other states' DSH spending began to grow moderately in 1995 as freezes imposed on additional DSH spending no longer applied. Although DSH payments are not

[15]Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

[16]CBO has estimated that federal Medicaid expenditures will grow by 8 percent in 1998 and by an average of 7.8 percent between 1997 and 2007.

growing as fast as they were in the early 1990s, these payments did begin to grow again in 1995 and will probably parallel the growth in the overall program.

- The economy: Even though the economy has been in a prolonged expansion, history indicates that a robust economy will not last indefinitely. The unemployment rate is not expected to stay as low as it currently is, especially in states with rates below 4 percent. Furthermore, any increases in medical care price inflation will undoubtedly affect Medicaid reimbursement rates, especially to institutional providers.
- Growing numbers of elderly people: While states have succeeded somewhat in dealing with long-term care costs, increasing numbers of elderly people will inevitably lead to increased program costs. The number of elderly over 65 years of age is estimated to grow from 31 million in 1990 to 39 million in 2010, an increase of 26 percent. Alternative service delivery systems can moderate that growth but not eliminate it.

Other factors may dampen future spending growth but by how much is unclear. The recently enacted welfare reform legislation makes people receiving cash assistance no longer automatically eligible for Medicaid.[17] As a result, the number of Medicaid enrollees—and the costs of providing services—may decrease because some Medicaid-eligible people may be discouraged from seeking eligibility and enrollment apart from the new welfare process. States may need to restructure their eligibility and enrollment systems, however, to ensure that people who are eligible for Medicaid continue to participate in the program. Restructuring their systems will undoubtedly increase states' administrative costs. The net effect of these changes remains to be seen.

The potential for cost savings through managed care is also unclear because experience is limited and state objectives in switching to managed care have not always emphasized immediate cost containment. Yet many hope that managed care will, over time, help constrain costs. Although Arizona's Medicaid managed care program has helped limit program growth, cost savings have been mainly due to considerable effort to promote competition among health plans. Sustaining this competition in the future will challenge the state's managed care program.

[17]Traditionally, Medicaid enrollment has been linked to the financial assistance process for Aid to Families With Dependent Children. Individuals enrolled in this program would automatically be enrolled in Medicaid as well. Under the Personal Responsibility and Working Opportunity Reconciliation Act of 1996 (P.L. 104-193), states may choose to separate the two processes.

Agency and Other Comments

We provided a draft of this report to HCFA's Administrator. HCFA officials generally agreed with the conclusions in the report concerning the factors that affected Medicaid spending growth in the last 7 years and the implications for future spending growth. They pointed out, however, that while DSH payments grew significantly in fiscal year 1995, preliminary expenditure data for fiscal year 1996 show that DSH payments dropped about 20 percent for that year. In addition, state Medicaid estimates for DSH payments through fiscal year 1998 show about a 1-percent average compound annual growth from fiscal years 1993 to 1998. HCFA officials believe that although DSH payments present opportunities for accelerating Medicaid spending growth, it is too early to conclude that their growth is likely to parallel overall program growth. They also noted that preliminary fiscal year 1996 expenditure data show only a 1.8-percent growth over fiscal year 1995. In addition, HCFA officials had technical comments, which we have incorporated in the report as appropriate.

We provided relevant sections of the draft report to Medicaid officials in eight states mentioned in our report to illustrate the impact of the various factors on Medicaid spending growth. Officials from five states responded, generally agreeing with the accuracy of the information. Officials in Arizona and Tennessee commented that their managed care programs had realized cost savings, contrary to CBO's opinion that savings from enrolling beneficiaries in managed care are not likely to produce savings in the long run. In particular, Arizona officials cited our report on their managed care program that discussed program savings. In our report, however, we noted their savings were attributable to their ability to implement a strong competitive bidding system among managed care plans. Continued savings, we believe, are likely to depend on the state's ability to maintain competition among the plans.

We are sending copies of this report to the Secretary of Health and Human Services. Copies will also be made available to others on request.

Please contact me on (202) 512-7114 if you or your staff have any questions. Other major contributors to this report are listed in appendix III.

William J. Scanlon
Director, Health Financing and
Systems Issues

Contents

Abbreviations

CBO	Congressional Budget Office
DSH	disproportionate share hospital
HCFA	Health Care Financing Administration

Scope and Methodology

To examine the trends in Medicaid spending from fiscal years 1988 to 1995, we obtained Medicaid enrollment and expenditure data from HCFA. For each fiscal year, we calculated the annual growth rate, the spending growth in absolute dollars, and the Medicaid enrollment growth rate. Using these data, we calculated the share of the overall Medicaid growth represented by the numbers of beneficiaries, per capita nominal spending, and disproportionate share hospital (DSH) payments in each fiscal year.

Because complete Medicaid expenditure data for fiscal year 1996 were lacking when we did our work, we obtained HCFA data on federal Medicaid outlays for fiscal years 1994 to 1996. For each fiscal year, we calculated each state's growth rate. To analyze variations in states' annual spending, we created a growth stability index by calculating the ratio of the state's fiscal year 1995 growth rates to the fiscal year 1996 growth rates. We categorized states on the basis of their growth stability index according to the following five categories regarding the direction and magnitude of their fiscal year 1996 growth compared with their fiscal year 1995 growth: decreased substantially, decreased moderately, changed minimally, increased moderately, and increased substantially.

Using the categories of the growth stability index, we judgmentally selected 18 states that represented a cross section of state spending trends in the past 2 years and accounted for almost 65 percent of fiscal year 1996 federal Medicaid outlays and analyzed their enrollment, expenditure, and outlay data. We contacted state Medicaid officials in these states to identify key factors that contributed to the decrease from previous years' growth rates.

To assess the implications of these and other factors for Medicaid expenditures in the future, we interviewed state officials in the 18 states on their projected growth rates for the upcoming years. We also reviewed the Congressional Budget Office's baseline for Medicaid as of January 1997.

We conducted our review from August 1996 to April 1997 in accordance with generally accepted government auditing standards.

Stability of Growth Rate for Federal Medicaid Outlays, Fiscal Years 1995 and 1996

We developed a growth stability index that shows the direction and magnitude of change in the growth rates of federal Medicaid outlays between fiscal years 1995 and 1996. An index of 1.0 indicates no change in the growth rates for the 2 years. An index greater than 1.0 indicates a decrease in the growth rates. For example, Colorado's index of 1.37 indicates the largest decrease of all the states.

Table II.1: Growth Stability Index for Federal Medicaid Outlays by State, Fiscal Years 1995 and 1996

States	Percentage growth, fiscal year 1995[a]	Percentage growth, fiscal year 1996	Growth stability index	State ranking based on growth stability index
State averages	**11.00**	**3.18[b]**	**1.08**	[c]
Alabama	10.63	3.71	1.07	26
Alaska	2.54	17.60	0.87	49
Arizona	2.70	4.58	0.98	43
Arkansas	8.76	7.50	1.01	38
California	13.73	2.80	1.11	21
Colorado	30.84	–4.66	1.37	1
Connecticut	10.68	11.51	0.99	40
Delaware	24.47	19.65	1.04	35
District of Columbia	–0.51	–1.37	1.01	39
Florida	22.35	–4.28	1.28	4
Georgia	7.82	2.44	1.05	31
Hawaii	31.87	11.46	1.18	9
Idaho	12.99	5.46	1.07	24
Illinois	16.30	1.85	1.14	12
Indiana	–13.34	24.52	0.70	51
Iowa	11.46	–0.02	1.11	17
Kansas	12.67	–2.05	1.15	11
Kentucky	13.36	2.15	1.11	19
Louisiana	1.19	–15.96	1.20	8
Maine	–0.22	10.21	0.91	48
Maryland	15.56	3.36	1.12	16
Massachusetts	11.22	3.50	1.07	23
Michigan	7.86	1.46	1.06	27
Minnesota	13.48	2.52	1.11	20
Mississippi	16.54	3.34	1.13	15
Missouri	8.70	6.81	1.02	36
Montana	7.05	11.76	0.96	46

(continued)

States	Percentage growth, fiscal year 1995[a]	Percentage growth, fiscal year 1996	Growth stability index	State ranking based on growth stability index
Nebraska	6.22	9.89	0.97	45
Nevada	20.88	15.52	1.05	32
New Hampshire	–21.73	0.95	0.78	50
New Jersey	10.16	5.54	1.04	33
New Mexico	13.80	21.30	0.94	47
New York	8.13	6.47	1.02	37
North Carolina	26.51	1.27	1.25	5
North Dakota	11.19	0.08	1.11	18
Ohio	10.94	4.43	1.06	28
Oklahoma	9.22	3.42	1.06	30
Oregon	38.37	4.26	1.33	3
Pennsylvania	7.50	1.62	1.06	29
Rhode Island	18.81	–10.97	1.33	2
South Carolina	16.72	0.71	1.16	10
South Dakota	13.18	–0.03	1.13	13
Tennessee	21.67	0.78	1.21	7
Texas	11.80	4.57	1.07	25
Utah	10.14	11.25	0.99	41
Vermont	18.23	7.40	1.10	22
Virginia	5.24	8.41	0.97	44
Washington	15.39	2.02	1.13	14
West Virginia	–3.19	–1.77	0.99	42
Wisconsin	7.55	3.17	1.04	34
Wyoming	20.88	–1.68	1.23	6

[a]The fiscal year 1995 growth rate may be overstated for some states due to incomplete reporting in fiscal year 1994.

[b]Aggregate growth in federal outlays for Medicaid is 3.3 percent when outlays for territories are included in calculation.

[c]Not applicable.

Source: Federal Medicaid outlays, HCFA.

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