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Decline in Spending Growth Due to a Combination of Factors

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Medicaid: Decline in Spending Growth Due to a Combination of Factors

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss recent Medicaid spending trends and their potential implications for future outlays. My comments are based on work that we have in progress at the request of the Chairmen of the Senate and House Budget Committees. Their request was prompted by an interest in what contributed to the precipitous drop in the annual growth rate of Medicaid spending from over 20 percent in the early 1990s to 3.3 percent in fiscal year 1996.

My remarks today focus on three issues: (1) the variation in Medicaid spending growth among the states, especially for the most recent 2-year period, that culminated in the 3.3-percent growth rate in fiscal year 1996; (2) key factors that contributed to the decrease from previous years' growth rates; and (3) the implications of these and other factors for Medicaid expenditures in the future. Our findings are based on our analysis of Medicaid expenditure data published by the Department of Health and Human Services' Health Care Financing Administration and our review of federal outlays as reported by the Department of the Treasury. We also contacted Medicaid officials in 18 states that represent a cross-section of state spending patterns over the past 2 years and that account for almost 70 percent of Medicaid expenditures.

In brief, we found no single pattern across all states that accounts for the recent dramatic decrease in the growth of Medicaid spending. Rather, a combination of factors—some affecting only certain states and others common to many states—explains the low 1996 growth rate. For example, several states saw substantial drops in their 1996 growth rates associated with circumstances such as a sharp reduction in very high levels of disproportionate share hospital (DSH) payments to conform with binding restrictions on such payments or the leveling off of their Medicaid enrollment following planned expansions in prior years. Such circumstances are unlikely to recur to dampen spending increases in future years. Moreover, the vast majority of states experienced declines in their growth rates that were moderate to limited. The experiences of these states reflect a number of factors at work, including a generally improved economy and state initiatives to limit expenditure growth, such as implementing managed care for primary and acute care services or alternative programs for long-term care. With an improved economy and declining unemployment, the number of people eligible for Medicaid decreased. In addition, a dramatic slowdown in price increases for medical services helped states control costs for certain services provided

through Medicaid. While the magnitude of the effect of states' programmatic changes—such as managed care programs and long-term care alternatives—is less clear, there is evidence that they helped to restrain program costs. However, it is likely that the 3.3-percent growth rate is not indicative of the growth rate in the years ahead. Just as a number of factors converged to bring about the drop in the 1996 growth rate, so a variety of factors—including a downturn in the economy—could result in increased growth rates in subsequent years.

Background

Medicaid, a federal grant-in-aid program that states administer, finances health care for about 37 million low-income people. With total federal and state expenditures of approximately $160 billion in 1996, Medicaid exerts considerable fiscal pressure on both state and federal budgets, accounting for roughly 20 percent and 6 percent of total expenditures, respectively.

For more than a decade, the growth rate in Medicaid expenditures nationally has been erratic. Between 1984 and 1987, the annual growth rates remained relatively stable, ranging between roughly 8 and 11 percent. Over the next 4 years, beginning in 1988, annual growth rates increased substantially, reaching 29 percent in 1992—an increase of over $26 billion for that year. From this peak, Medicaid's growth rates declined between 1993 and 1995 to approximately mid-1980 levels. Then, in fiscal year 1996, the growth rate fell to 3.3 percent.

No Single Spending Trend Across States

The 3.3-percent growth in 1996 federal Medicaid outlays masks striking variation among the states. Growth rates ranged from a decrease of 16 percent to an increase of 25 percent. Such differences in program spending growth across states has been fairly typical. In addition, there are often some states that experience large changes in growth from one year to the next because of major changes in program structure or accounting variances that change the fiscal year in which a portion of expenditures are reported. To determine the stability of the growth rate among states, we compared states' growth rates in fiscal year 1995 with those in fiscal year 1996. Our analysis revealed that states could be placed in one of five categories, as shown in table 1. (See app. I for specific state growth rates.)

Table 1: Changes in Growth Rate of Federal Medicaid Outlays, Fiscal Years 1995 and 1996

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 account for 16 percent of 1996 federal outlays experienced substantial decreases in fiscal year 1996 growth compared with fiscal year 1995's. However, 80 percent of 1996 federal Medicaid outlays were in states that either experienced moderate decreases or minimal changes in their fiscal year 1996 growth. Although five states' fiscal year 1996 growth rates increased, those states did not have much impact on spending growth patterns because their combined share of Medicaid outlays is only 4 percent.

A Convergence of Factors Led to the 3.3-Percent Growth Rate in 1996

A number of factors have led to decreases in the growth rate in Medicaid spending in recent years. 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 influence the growth rate in a handful of states. Other factors, such as improved economic conditions and changing program policies—for example, alternatives to institutional long-term care—also influenced many states' growth rates. The convergence of these factors resulted in the

historically low 3.3-percent growth rate in fiscal year 1996 Medicaid spending.

States With Substantial Decreases in Growth Rates Affected by Several Nonrecurring Factors

The growth rate changes in those states that experienced large decreases in 1996 were largely attributable to three factors: substantial decreases in DSH funding, slowdowns in state-initiated eligibility expansions, and accelerated 1995 payments in reaction to block grant proposals.

In 1991 and 1993, the Congress acted to bring under control DSH payments, which had grown from less than $1 billion to $17 billion in just 2 years.[1] After new limits were enacted, DSH payments nationally declined in 1993, stabilized in 1994, and began to grow again in 1995. An exception to this pattern, however, Louisiana—a state that has had one of the largest DSH programs in the nation—still showed a substantial decrease in its 1996 growth rate as its DSH payments declined. The state's federal outlays decreased by 16 percent in 1996 because of a dramatic drop in DSH payments.

Recent slowdowns in state-initiated eligibility expansions also helped to effect substantial decreases in the growth rates in selected states. Over the past several years, some states implemented statewide managed care demonstration waiver programs to extend health care coverage to uninsured populations not previously eligible for Medicaid. Three states that experienced substantial decreases in their 1996 growth rates—Hawaii, Oregon, and Tennessee—undertook the bulk of their expansions in 1994. The expenditure increases related to these expansions continued into 1995 and began to level off in 1996. Tennessee actually experienced a drop in the number of eligible beneficiaries in 1996, as formerly uninsured individuals covered by the program lost their eligibility because they did not pay the required premiums.

States' acceleration of 1996 payments into 1995 is another explanation sometimes given for the low 1996 growth rate.[2] In 1995, the Congress—as part of a block grant proposal—was considering legislation to establish aggregate Medicaid spending limits, which would be calculated using a base year. Officials from a few states told us that, in response to the

[1]DSH payments are intended to partially reimburse hospitals for the cost of providing care not covered by public or private insurance. A number of states, however, began to use the program to increase their federal Medicaid dollars in conjunction with certain creative financing mechanisms. To constrain these payments, DSH payments were limited at 12 percent of the Medicaid program.

[2]Aggregate data show that federal outlays were flat in the first 6 months of 1996 and then grew 6 percent in the last 6 months.

anticipated block grant, they accelerated their Medicaid payments to increase their expenditures for fiscal year 1995—the year the Congress was considering for use as the base. For example, one state official with federal approval made a DSH payment at the end of fiscal year 1995 rather than at the beginning of fiscal year 1996. An official from another state, which had a moderate decrease in growth, told us that the state expedited decisions on audits of hospitals and nursing homes to speed payments due these providers.

Strong Economic Conditions Helped Moderate the Growth in Expenditures for Most States

Improved economic conditions, reflected in lower unemployment rates and slower increases in the cost of medical services, also have contributed to a moderation in the growth of Medicaid expenditures. Between 1993 and 1995, most states experienced a drop in their unemployment rates—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.[3] States told us that low unemployment rates had lowered the number of people on welfare and, therefore, in Medicaid.

In addition, growth in medical service prices has steadily been declining since the late 1980s. In 1990, the growth in the price of medical services was 9.0 percent; by 1995, it was cut in half to 4.5 percent. In 1996, it declined further to 3.5 percent. Declines in price inflation have an indirect impact on the Medicaid rates that states set for providers. Officials of several of the states we spoke with reported freezing provider payment rates in recent years, including rates for nursing facilities and hospitals. Such a freeze would not have been possible in periods with higher inflation because institutional providers can challenge state payment rates in court, arguing they have not kept pace with inflation.[4] With inflation down, states can restrain payment rates with less concern about such challenges.

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

[4]The Boren Amendment, section 1902(a)(13)(A) of the Social Security Act, 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 that must be incurred by efficiently and economically operated facilities. Providers in a number of states have used the Boren Amendment to compel states to increase reimbursement rates for institutional services above the rates the states had been paying.

State Managed Care Programs and Long-Term Care Policies May Help Restrain Cost Growth

Several states that we contacted discussed recent program changes that may have had an effect on their Medicaid expenditures. Most prominently mentioned was the states' implementation of Medicaid managed care. However, the overall impact of managed care on Medicaid spending is uncertain because of state variations in program scope and objectives. States also mentioned initiatives to use alternative service delivery methods for long-term care. While these initiatives may have helped to bring Medicaid costs down, measuring their impact 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 populations that may need more care and are more expensive to serve—such as people with disabilities and the elderly.[5] 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 the ability to realize cost savings in managed care, cost savings it achieved by devoting significant resources to its competitive bidding process.[6] However, in recently expanding its managed care program, Oregon chose to increase per capita payments to promote improved quality and access and to look to the future for any cost savings. Officials from Minnesota, which has a mature managed care program, and California, which is in the midst of a large expansion, told us that managed care has had no significant impact on the moderate decreases they experienced.[7] Given the varying objectives, the ability of managed care to help control state Medicaid costs and moderate spending growth over time is unclear.

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. They are limiting the number of nursing home beds and payment rates for nursing facility services while expanding home and community-based services, a less-expensive alternative to institutional care. For example, a New York official told us that the state is attempting to restrain its long-term care costs by changing its rate-setting for nursing

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

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

[7]California considers its managed care program to be budget neutral, having no impact on spending one way or another.

facilities, establishing county expenditure targets to limit growth, and pursuing home- and community-based service options as alternatives to nursing facilities. Our previous work showed that such strategies can work toward controlling long-term care spending if controls on the volume of nursing home care and home- and community-based services are in place.[8]

Potential for Higher Expenditure Growth in Future Years

Many of the factors that resulted in the 3.3-percent growth rate in 1996—such as DSH payments, unemployment rates, and program policy changes—will continue to influence the Medicaid growth rate in future years. However, there are indications that some of these components may contribute to higher—not lower—growth rates, while the effect of others is more uncertain.

Without new limits, DSH payments can be expected to grow at the rate of the overall program. While Louisiana's adjustments to its DSH payments resulted in a substantial reduction in its 1996 spending, other states' DSH spending began to grow moderately in 1995 as freezes imposed on additional DSH spending were removed.[9] Although DSH payments are not increasing as fast as they were in the early 1990s, these payments did grow 12.4 percent in 1995.

Even though the economy has been in a prolonged expansion, history indicates that the current robust economy will not last indefinitely. The unemployment rate cannot be 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 influence Medicaid reimbursement rates, especially to institutional providers.

While states have experienced some success in dealing with long-term care costs, the continued increase in the number of elderly people will inevitably lead to an increase in program costs. 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. As

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

[9]States whose DSH spending exceeded 12 percent of their total program spending in 1993 were not allowed to increase DSH spending until it fell below 12 percent of total current program spending.

a result, the number of Medicaid enrollees—and the costs of providing services—may decrease, since some Medicaid-eligible people may be discouraged from seeking eligibility and enrollment apart from the new welfare process. On the other hand, states may need to restructure their eligibility and enrollment systems 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 also remains unclear, as experience is limited and state objectives in switching to managed care have not always emphasized immediate cost-containment. Yet it is hoped that managed care will, over time, help constrain costs. While Arizona's Medicaid managed care program has been effective, cost savings were due primarily to considerable effort to promote competition among health plans. The challenge is whether the state can sustain this competition in the future.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Committee might have at this time. Thank you.

Contributors

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

GAO developed a growth stability index that shows the direction and magnitude of change in the growth rates of federal 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 1995-96 growth rates. For example, Colorado's index of 1.37 ranks it as having the largest decrease.

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

	Percentage growth, fiscal year 1995	Percentage growth, fiscal year 1996	Growth stability index	State ranking based on growth stability index
States and District of Columbia	**11.00**	**3.18[a]**	**1.08**	
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)

	Percentage growth, fiscal year 1995	Percentage growth, fiscal year 1996	Growth stability index	State ranking based on growth stability index
States and District of Columbia	**11.00**	**3.18[a]**	**1.08**	
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]Aggregate growth in federal outlays for Medicaid is 3.3 percent when outlays for territories are included in calculation.

Source: Federal outlays for Medicaid, U.S. Treasury.

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