United States General Accounting Office

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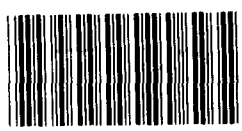
Report to the Chairman, Committee on Finance, U.S. Senate

June 1991

MEDICAID EXPANSIONS

Coverage Improves but State Fiscal Problems Jeopardize Continued Progress



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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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June 25, 1991

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

This report responds to your request concerning the effects of 1984-89 legislation expanding Medicaid eligibility and improving services. Since half of these changes targeted low-income pregnant women and children, we focused primarily on these groups. Our analysis addresses resulting changes in state Medicaid programs and numbers of people receiving services. We also examined the financial effects of these changes, and of Medicaid as a whole, on the states.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time we will send copies of this report to the Secretary of Health and Human Services, the Administrator of the Health Care Financing Administration, the Director of the Medicaid Bureau, interested congressional committees, and other interested parties and make copies available to others upon request.

Please call me on (202) 275-5451 if you or your staff have any questions about this report. Other major contributors are listed in appendix IV.

Sincerely yours,

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

Executive Summary

Purpose

Since 1984, the Congress has enacted a series of modifications of the Medicaid program, expanding eligibility and improving services. These expansions helped to reverse the effects of earlier cutbacks, which had severely reduced access to medical services for low-income families. But the states have expressed concern at the cost of these expansions and of the entire Medicaid program.

At the request of the Chairman of the Senate Finance Committee, GAO examined the effects of the recent federal legislation, focusing particularly on changes affecting low-income women and children. The analysis also addressed states' concerns, by examining the extent to which Medicaid contributes to their fiscal stress.

Background

Medicaid was established in 1965 as a federal/state means-tested entitlement program of medical assistance for certain persons with low income. Eligibility and coverage standards are determined jointly by the federal government and the states. Traditionally, eligibility for Medicaid has been linked to actual or potential receipt of cash assistance under the Aid to Families with Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program. Thus, eligible persons have to meet the requirements of the cash assistance program in terms of age, blindness, disability, or membership in a family with dependent children. Qualifying for AFDC is the primary means through which most pregnant women, infants, and children become eligible for Medicaid.

Since 1984, each year has seen at least one piece of legislation expanding Medicaid, with half of these initiatives targeting low-income pregnant women and children. States have been required to (1) add services addressing their special needs, (2) create new Medicaid eligibility categories specifically for these groups, and (3) expand existing AFDC categories by modifying eligibility criteria relative to family structure and employment status.

Between 1984 and 1989, state expenditures for Medicaid increased by more than 60 percent. Believing that the congressional mandates had contributed substantially to the rise in cost, 49 state governors signed a formal request in August 1989 for the Congress to impose a 2-year moratorium on Medicaid expansions.

Results in Brief

Since 1984, Medicaid has expanded in response to federal legislation, and more low-income women and children are receiving services. Gains

are most evident in states whose coverage in 1984 was relatively limited. The changes have reduced disparities among states in access to Medicaid services for pregnant women and children.

The states' costs for these gains were relatively modest. Low-income women and children are not expensive to serve compared with recipients overall—$900 per capita annually versus $2,400 on average. Also, in some instances federal funds have substituted for state funds, as states have transferred resources and/or beneficiaries to Medicaid from other programs.

However, the Medicaid program as a whole contributed to state fiscal stress during this period. It is the second largest program in most states and generally the fastest growing. Judging by the last 6 years, it appears that future expansion of Medicaid access could be jeopardized by the combined effects of budget shortfalls, recession-related increases in levels of need, and more costly Medicaid mandates.

Principal Findings

States Support Expansions of Services for Pregnant Women and Children

Most states went beyond the new congressional mandates targeting low-income women and children. The greatest changes occurred in states that in 1984 most limited Medicaid eligibility and services for low-income persons. On average, these states now exceed mandated coverage levels for both groups, have introduced new services at a rate above the national average, and have begun to reduce barriers faced by pregnant women in getting and keeping access to prenatal care. Most states, for example, have simplified Medicaid's application process and decentralized it to clinics and other sites convenient to applicants.

In turn, these program expansions led to increases in the numbers of pregnant women and children served. Although nationwide the gains were slight, they were significantly greater in states that initially had the most limited programs.

Pregnant Women and Children Not the Main Cause of Increased Medicaid Spending

While services to pregnant women and children increased, these accounted for less than a third of the rise in Medicaid provider payments between 1984 and 1989. The aged, blind, and disabled increased from 24 to 27 percent of Medicaid recipients and in 1989 accounted for 73 percent of the expenditures.

Medicaid as a Whole Exacerbates State Fiscal Stress

During this period of program expansions, Medicaid expenditures rose at an average annual rate of 10 percent, while total state revenues increased at a rate below 8 percent. As the second largest component of state budgets, Medicaid thus contributed added financial stress. This was especially significant where regional (and, more recently, national) economic slowdowns have added to state fiscal problems.

Costs of Medicaid Expansions Likely to Increase Substantially

Subsequent Medicaid expansions—resulting from phased-in or delayed implementation—are likely to prove much more costly than those implemented in the 1984-89 period. Recent mandates call for gradual extensions of coverage to older children and immediate expansion of screening programs and follow-up care. Medically necessary treatment for problems identified during pediatric screening now must be provided, whether or not it is covered otherwise by the state's Medicaid program. Although they retain various controls, the states believe this requirement will cause major cost increases. Mandated changes involving other recipient groups, especially the elderly and disabled, also are expected to increase expenditures significantly.

The impact of some of the 1984-89 expansions on state budgets was minimized because similar services already were being provided under state-financed programs. Thus, federal funds substituted, to a varying extent, for state funds. This option may be less readily available for subsequent changes, because overlap with existing programs is less.

Future Expansions May Be Offset by Program Cuts

State options for financing increased Medicaid costs are limited: higher tax revenues, reduced funding for other programs, or fund-shifting within the Medicaid budget. Between 1984 and 1989, states generally employed a combination of these three approaches to fund program expansions.

Absent higher tax levies, or in conjunction with them, states will need to reduce budgets for other programs or shift funds within Medicaid to finance further cost increases. Recent experience indicates that either

approach has the potential of limiting low-income families' access to medical services. To help finance recent Medicaid expansions, for example, some states reduced or eliminated funding for public clinics, or cut back portions of their Medicaid programs by such actions as limiting enrollments or discontinuing optional services. Given the fiscal problems of many states, reliance on such fund-shifting approaches may become more widespread.

Recommendations

GAO is making no recommendations.

Agency Comments

GAO did not solicit agency comments.

Contents

Figures

Abbreviations

ACIR	Advisory Commission on Intergovernmental Relations
AFDC	Aid to Families with Dependent Children
AFDC-UP	Aid to Families with Dependent Children--Unemployed Parent
CBO	Congressional Budget Office
COBRA	Consolidated Omnibus Budget Reconciliation Act
DEFRA	Deficit Reduction Act
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IRCA	Immigration Reform and Control Act
MCCA	Medicare Catastrophic Coverage Act
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
QMB	qualified Medicare beneficiary
RRS	representative revenue system
RTS	representative tax system
SSI	Supplemental Security Income

Introduction

Medicaid is the largest government health program financing health care for the poor. Because of rapidly rising costs, the administration and the Congress agreed on program cutbacks during the early 1980s. By 1984, however, concerns were being voiced that these may have been too severe. A study of poor, chronically ill adults terminated from California's Medicaid program, for example, showed that their health soon began to deteriorate. Many, both in the Congress and in the states, feared the potential effects of lost coverage on infant mortality and the health status of low-income children. This trend of diminishing coverage was halted and eventually reversed as a consequence of major expansions of Medicaid eligibility and services legislated between 1984 and 1989.

While generally supporting many of these expansions, states increasingly have become concerned about their cost. As mandates continued to be added every year, 49 of the nation's governors in August 1989 joined in a request to the Congress for a 2-year moratorium on Medicaid legislation. To obtain a clear picture of the current status of state Medicaid programs, the Chairman of the Senate Finance Committee asked us to perform this study. Our objectives were to review state implementation of the expansions to date and the extent to which Medicaid is causing fiscal stress within the states.

Background

Medicaid Program Varies by State

Medicaid is a federally aided, state-administered medical assistance program established under title XIX of the Social Security Act of 1965 (42 U.S.C. 1396-1396s). The federal government currently provides a share of each state's payments for services, between 50 and nearly 80 percent depending on the state's per capita income. (The weighted average federal match is 56 percent.)

The Medicaid program is administered by the Health Care Financing Administration (HCFA), under the Department of Health and Human Services (HHS). Within broad federal guidelines established by HHS, each state designs and administers its own Medicaid program and sets eligibility standards and coverage policies. The nature and scope of a state's Medicaid program are specified in a state plan that, after approval by HHS, provides the basis for federal funds to the state. Participating states are required to provide those eligible with basic benefits, such as

inpatient and outpatient hospital and physician services and periodic screening for children. Additional services, such as dental care and prescription drugs, may be provided under Medicaid if a state so chooses. Thus, Medicaid programs vary considerably from state to state.

Traditionally, eligibility for Medicaid has been linked to actual or potential receipt of cash assistance under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) welfare programs. Thus, eligible persons must meet the requirements of the cash assistance program in terms of age, blindness, disability, or membership in a family with dependent children. State Medicaid programs must, at a minimum, cover all categorically needy persons: those receiving AFDC assistance and most receiving SSI. Qualifying for AFDC is the primary means through which most pregnant women, infants, and children become eligible for Medicaid. Eligibility also requires that income and assets satisfy certain criteria. On average across the states, a family's 1989 income could not exceed 48 percent of the federal poverty level to qualify for AFDC. This poverty line was $10,060 for a family of three.[1]

In addition, states can elect to cover the medically needy under their Medicaid program. The medically needy are persons who meet all the criteria for cash assistance under AFDC or SSI, except that their income and/or assets exceed the standards for such coverage while remaining below a state-established higher limit.[2] Such programs must, at a minimum, cover pregnant women and children. Most participating states, however, also cover additional categories of individuals.

States require extensive documentation of income and assets from families applying for AFDC and/or Medicaid benefits. The application process can be time-consuming and complex. Once an application is received, eligibility must be determined within 45 days. However, states also must periodically redetermine eligibility for both programs. Some do so as often as once a month. In general, an individual found no longer eligible for AFDC subsequently loses Medicaid eligibility.

[1]These AFDC income limits ranged from a low of 14 percent ($1,416 for a family of three) in Alabama to a high of 79 percent ($7,956) in California.

[2]This income limit, however, cannot exceed 133.33 percent of the state's AFDC payment for the same size family.

Severe Cutbacks in the Early 1980s

The Congress and the administration, concerned about rapid increases in Medicaid costs in the 1970s, moved to contain this growth. The Omnibus Budget Reconciliation Act of 1981 (OBRA 1981—P.L.97-35) reduced AFDC eligibility, causing 39-60 percent of working families to lose AFDC eligibility completely.[3] With consequent cuts of an estimated 2 million recipients from Medicaid rolls, the proportion of working poor in the Medicaid population shrank from more than 40 percent in 1979 to about 25 percent in 1983.[4]

Loss of Medicaid coverage can have immediate consequences on the health status of affected individuals. A study of chronically ill, low-income adults terminated from California's Medicaid program documented significant deterioration in health status and access to care 6 months after termination.[5] And once coverage is lost, Medicaid recipients are more likely than other adults to remain without health benefits for an extended period (over 8 months).[6]

Actions Taken to Reverse Impacts on Low-Income Families

By the mid-1980s, there were growing concerns in the states and the Congress that OBRA 1981 cutbacks were too severe. In addressing these concerns, the Congress used an incremental approach. Starting with the Deficit Reduction Act of 1984 (P.L. 98-369), every year has seen at least one piece of federal legislation expanding Medicaid eligibility and/or services. These have incorporated both mandates and options for which federal matching funds would be provided.

Half of the changes in Medicaid eligibility and services between 1984 and 1989 were targeted specifically to pregnant women and/or children. Other federally legislated expansions during this period affected the elderly and the disabled, and a third subset dealt with narrower eligibility groups—for example, newly legalized aliens, the homeless, and ventilator-dependent individuals.

[3]Based on case studies at 5 sites. See An Evaluation of the 1981 AFDC Changes: Final Report (GAO/PEMD-85-4, July 2, 1985).

[4]Johns, Lucy and Gerald S. Adler, "Evaluation of Recent Changes in Medicaid," Health Affairs, Spring 1989, pp.171-181.

[5]Lurie, N. et al., " Termination from Medi-Cal—Does it Affect Health?" New England Journal of Medicine 311(7), 1984, pp.480-84.

[6]Swartz, Katherine and Timothy D. McBride, "Spells Without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," Inquiry, 27, Fall 1990, pp.281-288.

Table 1.1 lists the major federally mandated expansions of Medicaid eligibility and services since 1984. A more comprehensive listing, including optional expansions, is provided in appendix I.

Table 1.1: Major Federal Mandates Affecting Medicaid Eligibility and Services (1984-90)

Law	Population affected	Mandate
DEFRA 1984 (Deficit Reduction Act of 1984) (P.L.98-369)	Infants[a] and children	Requires coverage of all children born after 9/30/83 meeting state AFDC income and resource standards, regardless of family structure.
	Pregnant women	Requires coverage from date of medical verification of pregnancy, providing: (1) they would qualify for AFDC once child was born, or (2) they would qualify for AFDC-UP[b] once child was born, regardless of whether state has AFDC-UP program.
	Infants	Requires automatic coverage for 1 year after birth if mother already is receiving Medicaid and remains eligible, and infant resides with her.
	AFDC families	Requires limited extension of Medicaid coverage if AFDC eligibility is lost due to earnings.
	AFDC families	Extends earned income disregard[c] from 4 to 12 months.
	SSI recipients	Increases qualifying asset limits for applicants for limited time period (1985-89).
COBRA 1985 (Consolidated Omnibus Budget Reconciliation Act of 1985) (P.L.99-272)	Pregnant women	Requires coverage if family income and resources are below state AFDC levels, regardless of family structure.
	Postpartum women	Requires 60-day extension of coverage postpartum if eligibility was pregnancy-related.
	Adoptive and foster children	Requires coverage even if adoption/foster agreement was entered into in another state.
	Children with special needs	Requires coverage regardless of income/resources of adoptive/foster parents.
OBRA 1986 (Omnibus Budget Reconciliation Act of 1986) (P.L.99-509)	Infants and children	Requires continuation of eligibility (for those who otherwise would become ineligible) if they are hospital inpatients when age limit is reached.
	Severely impaired	Establishes new mandatory categorically needy coverage group for qualified individuals under age 65.
	Aliens	Requires provision of emergency services if otherwise eligible (financially and categorically).
	SSI recipients	Makes permanent the previous temporary provision requiring coverage of some former disabled SSI recipients who have returned to work.
Employment Opportunities for Disabled Americans Act 1986 (P.L.99-643)	Disabled	Makes permanent a previous demonstration program for individuals able to engage in substantial gainful activity despite severe medical impairments.
IRCA 1986 (Immigration Reform and Control Act of 1986) (P.L.99-603)	Newly legalized aliens	Requires provision of emergency and pregnancy-related services if otherwise eligible. Also requires full coverage for eligibles under 18.
Anti-Drug Abuse Act 1986 (P.L.99-570)	Homeless	Requires state to provide proof of eligibility for individuals otherwise eligible but having no permanent address.

(continued)

Law	Population affected	Mandate
OBRA 1987 (Omnibus Budget Reconciliation Act of 1987) (P.L.100-203)	Nursing home applicants	Requires states to establish preadmission screening programs for mentally ill and retarded.
MCCA (Medicare Catastrophic Coverage Act of 1988) (P.L.100-360)	Pregnant women and infants	Makes mandatory the OBRA 1986 option of coverage up to 100% of poverty line (phased in by % of poverty line).
	Elderly and disabled	Makes mandatory the OBRA 1986 option of Medicare buy-in[d] up to 100% of poverty line for qualified Medicare beneficiaries(QMBs) (phased in by % of poverty line).
Family Support Act of 1988 (P.L.100-485)	AFDC families	Increases required period of Medicaid coverage if AFDC cash assistance is lost due to earnings.
	AFDC families with unemployed parent (AFDC-UP)	Requires coverage if otherwise qualified.
Implementation beyond 9/30/89		
OBRA 1987 (Omnibus Budget Reconciliation Act of 1987) (P.L.100-203)	Nursing home residents	Requires preadmission screening and annual resident review for mentally ill or retarded.
OBRA 1989 (Omnibus Budget Reconciliation Act of 1989) (P.L.101-239)	Pregnant women and infants	Requires coverage if income is below 133% of poverty line.
	Children	Requires coverage up to age 6, if income is below 133% of poverty line.
	Children	Requires provision of all Medicaid-allowed treatment to correct problems identified during Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings even if treatment is not otherwise covered under state's Medicaid plan.
	Children	Requires interperiodic[e] screenings under EPSDT when medical problem is suspected.
OBRA 1990 (Omnibus Budget Reconciliation Act of 1990) (P.L.101-508)	Children	Requires coverage up to age 18 if income is below 100% of poverty line (phased in by age).
	Pregnant women	Makes mandatory the OBRA 1986 option of continuous eligibility through postpartum period.
	Pregnant women	Extends period of presumptive eligibility before written application must be submitted.
	Pregnant women and children	Requires states to receive and process applications at convenient outreach sites.
	Infants	Requires continuous eligibility if (1) born to Medicaid-eligible mother who would remain eligible if pregnant and (2) remaining in mother's household.
	Elderly and disabled	Extends the MCCA QMB provision to 120% of poverty line (phased in by % of poverty line).

[a]Infants are children up to age 1.

[b]Aid to Families With Dependent Children-Unemployed Parent (AFDC-UP) allows coverage in 2-parent families if principal wage-earner is unemployed.

[c]Certain expenses associated with work are disregarded from income in calculating AFDC eligibility.

[d]States can cover Medicare cost-sharing charges: premiums, deductibles, and coinsurance.

[e]States establish a screening schedule. "Interperiodic" visits are added to the standard schedule if a problem is suspected.

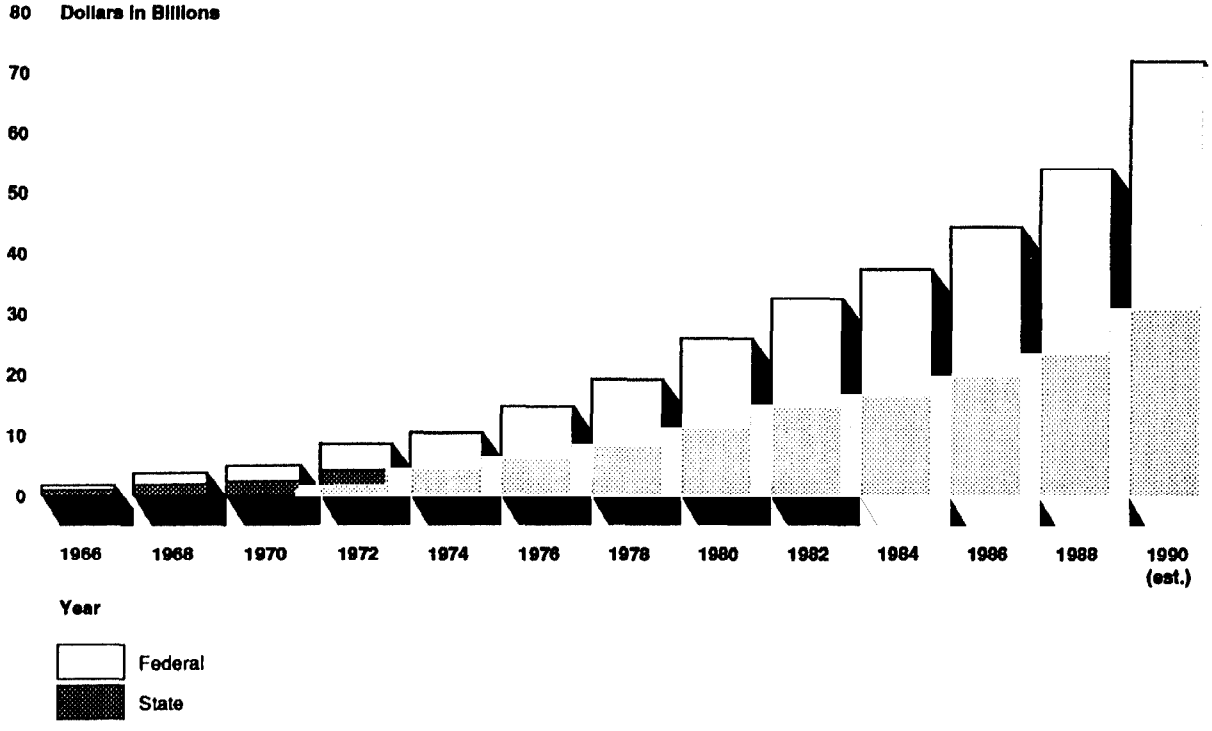
States Express Growing Concern Over Costs of Medicaid Expansions

State officials support the intent of many of these expansions. But as the number of mandates increased, so did state concern over their cost. Almost all state governments are required to balance their budgets. As state revenues are slackening and health care costs are growing faster than general inflation, this stream of federal legislation is viewed as imposing a financial burden.

In August 1989, 49 of the nation's governors signed a letter to the Congress expressing their concern with the impact of recent Medicaid mandates on their budgets. Saying the legislation had undermined states' ability to properly fund education and other important services, they called for a 2-year moratorium on further mandates. In March 1990, the National Conference of State Legislatures also urged the Congress to refrain from imposing additional Medicaid mandates, citing its concern that these would place unreasonable fiscal burdens on states struggling with very tight budgets.

Medicaid expenditures nationwide are growing rapidly, as figure 1.1 shows. During the period of our study, 1984-89, the states' share increased by 60 percent, from $17 billion to $27 billion. For fiscal year 1989, total Medicaid expenditures exceeded $61 billion.

Figure 1.1: Total Medicaid Expenditures (1966-90)



Objectives, Scope, and Methodology

We performed this study at the request of the Chairman of the Senate Finance Committee. Our objectives were to determine the extent to which (1) states have implemented recently authorized Medicaid expansions and (2) Medicaid is contributing to state fiscal problems. The Chairman also asked us to look for any changes in indicators of health status linked to the Medicaid expansions. Due in part to data inadequacies and to external influences other than Medicaid on health status, we were unable to isolate the effect of the Medicaid changes. A discussion of health issues is included as appendix II.

As much of the congressional emphasis has been on pregnant women and children, we focused our analysis primarily on these groups. Our study spanned the period between 1984, when the trend toward Medicaid expansions of eligibility and services began, and 1989, the most

recent year for which quantitative data were available.[7] To determine trends in service delivery and access to care, we obtained from HCFA data on numbers of recipients and Medicaid payments to providers, by state (including the District of Columbia). We excluded Arizona because its Medicaid program is not comparable to those of the other states. To help assess the fiscal status of these states, we obtained other expenditure and revenue data from the Bureau of the Census. The National Center for Health Statistics provided health indicator data.

National organizations provided information regarding state program changes. Our primary sources were the National Governors' Association, the Children's Defense Fund, and the National Association of State Budget Officers.

In Maine and South Carolina, we conducted case studies that involved interviews with state Medicaid, budget, and legislative officials. We also conducted a workshop of state Medicaid directors in Washington D.C. (in conjunction with their annual conference) to obtain a wider spectrum of anecdotal information and comment.

Because Medicaid programs vary greatly among the states, legislated changes are likely to affect them in different ways. To obtain a clearer picture of this diversity, we used several criteria to distinguish states most and least likely to be affected strongly by the recent expansions. These criteria included various measures of

- the generosity of a state's Medicaid program prior to 1984, such as its eligibility requirements and per capita spending;
- the eligibility requirements for the state's AFDC program relative to national poverty standards, and its cash payment standards; and
- the state's economic status.

After ranking the states by a preponderance of these factors, we divided them into quartiles (see table 1.2). We designated as "most limited" the quartile with generally the least comprehensive Medicaid programs and low state fiscal resources. At the other extreme, we designated as "least limited" the quartile of states with more comprehensive programs and greater resources. We analyzed these quartiles separately and compared them with the national average. In terms of this ranking, one of our case

[7]In terms of implementation of eligibility expansions and program changes, we were able to include information current as of January 1990.

study states—South Carolina—falls into the "most limited" category. Maine is in the second quartile, that is, closer to the average.

Table 1.2: Categorization of States by Breadth of Medicaid Program and Fiscal Resources (1984)

Most limited quartile	Least limited quartile
Alabama	Alaska
Arkansas	California
Florida	Connecticut
Idaho	District of Columbia
Kentucky	Hawaii
Mississippi	Massachusetts
Missouri	New Jersey
New Mexico	Rhode Island
South Carolina	Utah
South Dakota	Vermont
Tennessee	Washington
West Virginia	Wisconsin
Middle quartiles	
Colorado	Nebraska
Delaware	Nevada
Georgia	New Hampshire
Illinois	New York
Indiana	North Carolina
Iowa	North Dakota
Kansas	Ohio
Louisiana	Oklahoma
Maine	Oregon
Maryland	Pennsylvania
Michigan	Texas
Minnesota	Virginia
Montana	Wyoming

Note: Arizona is omitted because its Medicaid program is not comparable to those of other states.

None of the data was verified independently. There are acknowledged inconsistencies and ambiguities in the HCFA Medicaid data we used, but these represent the best currently available information on Medicaid payments and recipients that covers all Medicaid jurisdictions through an extended time period. These issues are discussed further and additional details of our methodology are provided in appendix III.

Our work was performed in accordance with generally accepted government accounting standards between December 1989 and November

Between 1984 and 1989, a number of states imposed utilization controls in the form of limits on the amount, duration, and scope of covered services. Fourteen states made such changes in the provision of hospital services between 1984 and 1988. For example, Oklahoma reduced the number of in-patient hospital days covered by Medicaid for adults, and imposed for the first time limits on coverage of in-hospital days for children. Other states eliminated optional services such as hospice care (Nebraska) or dental services (Colorado, Louisiana, and Pennsylvania).

States also have attempted to balance their Medicaid budgets by holding down provider reimbursement. A New York State plan to address its budget shortfall includes delays in Medicaid rate increases. These approaches raise concerns about providers' willingness to serve Medicaid recipients.

Conclusions

For low-income pregnant women and children, congressional initiatives have expanded Medicaid eligibility, reduced disparities between states, and simplified the process of applying for, receiving, and retaining access to Medicaid services. More of these individuals are eligible for Medicaid coverage, more are enrolling, and more are receiving services. Medicaid programs for these groups also have improved through additional services that target their special needs. The effect of these cumulative changes is most evident in states where improvement in Medicaid was most needed.

Moreover, gains for these groups were relatively inexpensive. Although Medicaid expenditures grew rapidly between 1984 and 1989, for most states expansions targeting low-income women and children played a relatively minor role in increasing program outlays.

The prospect for initiatives implemented since 1989 is less optimistic, due to a number of factors. Even for low-income women and children, recently legislated expansions are likely to be more costly than prior changes. Further, these additional expansions come at a time when state revenue growth is declining and expenditures are escalating.

Absent higher tax levies or in conjunction with them, states will need to reduce budgets for other programs or shift funds within Medicaid to finance further cost increases. Recent experience indicates that either approach has the potential of limiting low-income families' access to medical services. To help finance recent Medicaid expansions, for example, some states reduced or eliminated funding for public clinics; some cut back portions of their Medicaid programs by such actions as limiting enrollments or discontinuing optional services. Given the fiscal problems of many states, the use of these alternatives to fund Medicaid expansions may become more widespread.

Major Federal Expansions of Medicaid Eligibility and Services (1984-90)

Law	Population affected	Expansion	Mandate/ option
DEFRA 1984 (Deficit Reduction Act of 1984) (P.L.98-369)	Infants[a] and children	Requires coverage of all children born after 9/30/83 meeting state AFDC income and resource standards, regardless of family structure.	Mandate
	Pregnant women	Requires coverage from date of medical verification of pregnancy, providing: (1) they would qualify for AFDC once child was born or (2) they would qualify for AFDC-UP[b] once child was born, regardless of whether state has AFDC-UP program.	Mandate
	Infants	Requires automatic coverage for 1 year after birth if mother already is receiving Medicaid and remains eligible, and infant resides with her.	Mandate
	AFDC families	Requires limited extension of Medicaid coverage if AFDC eligibility is lost due to earnings.	Mandate[c]
	AFDC families	Extends earned income disregard[d] from 4 to 12 months.	Mandate
	SSI recipients	Increases qualifying asset limits for applicants for limited time period (1984-1989).	Mandate
COBRA 1985 (Consolidated Omnibus Budget Reconciliation Act of 1985) (P.L.99-272)	Pregnant women	Requires coverage if family income and resources below state AFDC levels, regardless of family structure.	Mandate
	Postpartum women	Requires 60-day extension of coverage postpartum if eligibility was pregnancy-related.	Mandate
	Terminally ill	Allows provision of hospice services.	Option
	Pregnant women	Allows provision of enhanced benefits.	Option
	Infants and children	Allows extension of DEFRA coverage up to age 5 immediately, instead of requiring phase-in by birth date.	Option
	Adoptive and foster children	Requires coverage even if adoption/foster agreement was entered into in another state.	Mandate
	Children with special needs	Requires coverage regardless of income/ resources of adoptive/foster parents.	Mandate
OBRA 1986 (Omnibus Budget Reconciliation Act of 1986) (P.L.99-509)	Aged and disabled	Creates new optional categorically needy group for those with income below 100% of poverty line under certain resource constraints. Option can be exercised for this group only if exercised also for pregnant women and infants.	Option
	Aged and disabled	Allows Medicare buy-in[e] up to 100% of poverty line for qualified Medicare beneficiaries under certain resource constraints.	Option
	Pregnant women and infants	Creates new optional categorically needy group for those with income below 100% of poverty line. Women receive pregnancy-related services only.	Option
	Pregnant women and infants	Allows assets test to be dropped for this newly defined category of applicants.	Option
	Pregnant women	Allows presumptive eligibility for up to 45 days to be determined by qualified provider.	Option

(continued)

Law	Population affected	Expansion	Mandate/ option
OBRA 1986 (cont.)	Pregnant women	Allows guarantee of continuous eligibility through postpartum period.	Option
	Children	Allows coverage up to age 5, if income below 100% of poverty line (phased in).	Option
	Infants and children	Requires continuation of eligibility (for those who otherwise would become ineligible) if they are hospital inpatients when age limit is reached.	Mandate
	Severely impaired	Establishes new mandatory categorically needy coverage group for qualified individuals under age 65.	Mandate
	Ventilator-dependent	Allows coverage of at-home respiratory care services.	Option
	Aliens	Requires provision of emergency services if otherwise eligible (financially and categorically).	Mandate
	SSI recipients	Makes permanent the previous temporary provision requiring coverage of some former disabled SSI recipients who have returned to work.	Mandate
Employment Opportunities for Disabled Americans Act 1986 (P.L.99-643)	Disabled	Makes permanent a previous demonstration program for individuals able to engage in substantial gainful activity despite severe medical impairments.	Mandate
IRCA 1986 (Immigration Reform and Control Act of 1986) (P.L.99-603)	Newly legalized aliens	Requires provision of emergency and pregnancy-related services if otherwise eligible. Also requires full coverage for eligibles under 18.	Mandate
Anti-Drug Abuse Act 1986 (P.L.99-570)	Homeless	Requires state to provide proof of eligibility for individuals otherwise eligible but having no permanent address.	Mandate
OBRA 1987 (Omnibus Budget Reconciliation Act of 1987) (P.L.100-203)	Pregnant women and infants	Allows coverage if income level below 185% of poverty line.	Option
	Children	Allows immediate extension of OBRA 1986 coverage up to 100% of poverty line up to age 5.	Option
	Children	Clarifies that states may provide in-home services for qualified disabled children.	Option
	Children	Allows coverage for children aged 5-7, up to state AFDC level (phased in by age).	Option
	Children	Allows coverage for children below age 9, up to 100% of poverty line (phased in by age).	Option
	Elderly	Allows provision of home and community-based services to those who otherwise would need nursing home care.[f]	Option
	Nursing home applicants	Requires states to establish preadmission screening programs for mentally ill and retarded.	Mandate
MCCA (Medicare Catastrophic Coverage Act of 1988) (P.L.100-360)	Pregnant women and infants	Makes mandatory the OBRA 1986 option of coverage up to 100% of poverty line (phased in by % of poverty line).	Mandate
	Elderly and disabled	Makes mandatory the OBRA 1986 option of Medicare buy-in up to 100% of poverty line for QMBs (phased in by % of poverty line).	Mandate

(continued)

Law	Population affected	Expansion	Mandate/ option
Family Support Act of 1988 (P.L.100-485)	AFDC families	Increases required period of Medicaid coverage if AFDC cash assistance is lost due to earnings.	Mandate[g]
	AFDC families with unemployed parent (AFDC-UP)	Requires coverage if otherwise qualified.	Mandate
Implementation beyond 9/30/89			
OBRA 1987 (Omnibus Budget Reconciliation Act of 1987) (P.L.100-203)	Nursing home residents	Requires preadmission screening and annual resident review for mentally ill or retarded.	Mandate
OBRA 1989 (Omnibus Budget Reconciliation Act of 1989) (P.L.101-239)	Pregnant women and infants	Requires coverage if income is below 133% of poverty line.	Mandate
	Children	Requires coverage up to age 6, if income below 133% of poverty line.	Mandate
	Children	Requires provision of all Medicaid-allowed treatment to correct problems identified during EPSDT screenings even if treatment is not covered otherwise under state's Medicaid plan.	Mandate
	Children	Requires interperiodic[h] screenings under EPSDT when medical problem is suspected.	Prior option now mandated
OBRA 1990 (Omnibus Budget Reconciliation Act of 1990) (P.L.101-508)	Children	Requires coverage up to age 18, if income is below 100% of poverty line (phased in by age).	Mandate
	Pregnant women	Makes mandatory the OBRA 1986 option of continuous eligibility through postpartum period.	Mandate
	Pregnant women	Extends period of presumptive eligibility before written application must be submitted.	Mandate
	Pregnant women and children	Requires states to receive and process applications at convenient outreach sites.	Mandate
	Infants	Requires continuous eligibility if (1) born to Medicaid-eligible mother who would remain eligible if pregnant and (2) remaining in mother's household.	Mandate
	Elderly and disabled	Extends the MCCA QMB provision to 120% of poverty line (phased in by % of poverty line).	Mandate
	Elderly and disabled	Allows limited program permitting states to provide home and community-based services to functionally disabled, and community-supported living arrangements to mentally retarded/ developmentally disabled.	Option

[a]Infants are children up to age 1.

[b]AFDC-UP allows coverage in 2-parent families if principal wage-earner is unemployed.

[c]Mandate is for 9 months. State may opt to provide additional 6-month period of coverage.

[d]Certain expenses associated with work are disregarded from income in calculating AFDC eligibility.

[e]Medicaid covers Medicare cost-sharing charges: premiums, deductibles, and coinsurance.

[f]This is not automatic. HCFA must grant a waiver to any state wishing to provide these services.

[g]Mandate is for 12 months. State may opt to provide additional 6-month period of coverage.

[h]States establish a screening schedule. "Interperiodic" visits are added to the standard schedule if a problem is suspected.

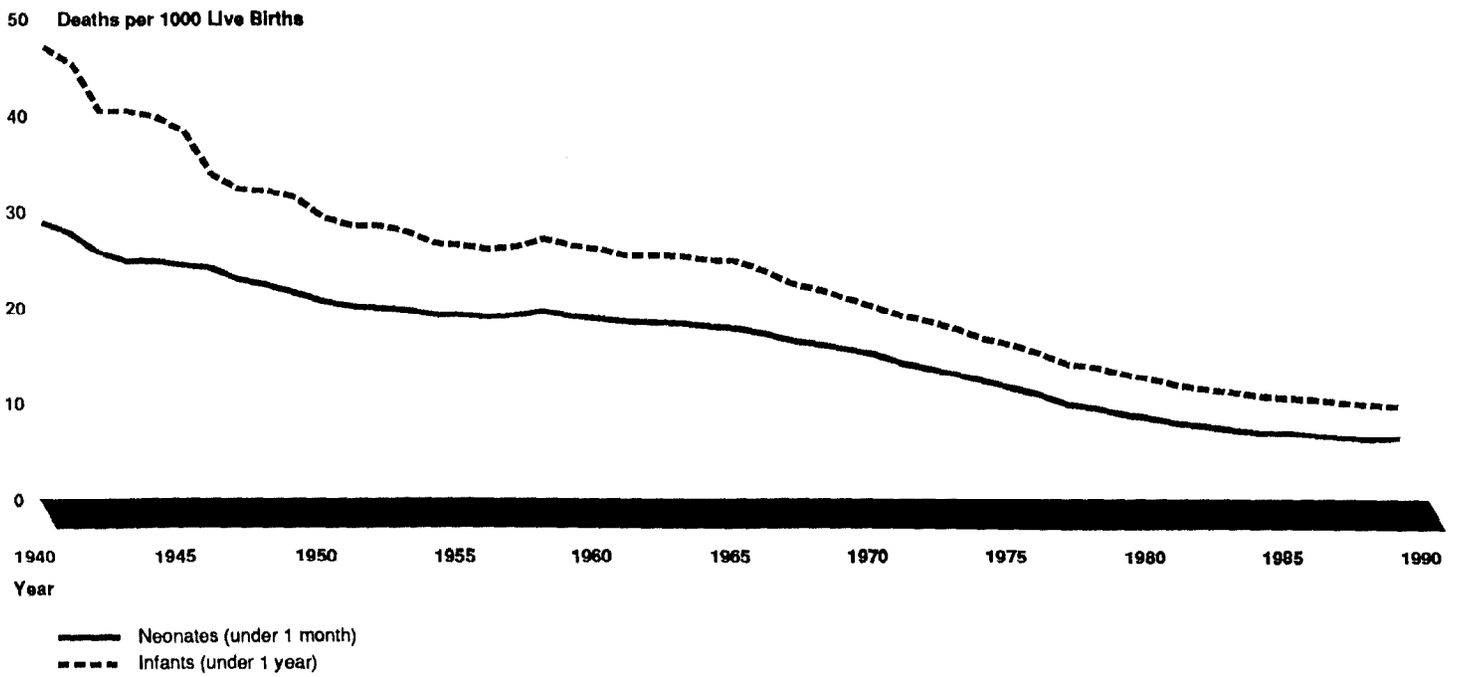
Linkage of Medicaid Expansions to Health Indicators

We were asked to seek any evidence that the recent Medicaid expansions had led to changes in the health status of Medicaid recipients. Available data were insufficient to isolate the effects of Medicaid expansions from other influencing factors. Our study focused primarily on pregnant women and children. Except for a brief setback in the late 1950s, infant mortality has declined nationally since 1940 and neonatal mortality rates have followed a similar pattern. However, there is no apparent change in this trend to correlate with Medicaid expansions. Whether such changes are likely as a consequence solely of improved access to Medicaid is unclear.

Some Improvement in Infant Mortality Seen

A slow decrease in mortality rates continued during the 1984-89 period both for infants—under 1 year—and newborns (neonates)—under 28 days. For 1989, from preliminary data the National Center for Health Statistics reported a record low rate of 9.7 infant deaths per 1,000 live births, as shown in figure II.1.

Figure II.1: Infant and Neonatal Mortality in the United States (1940-90)



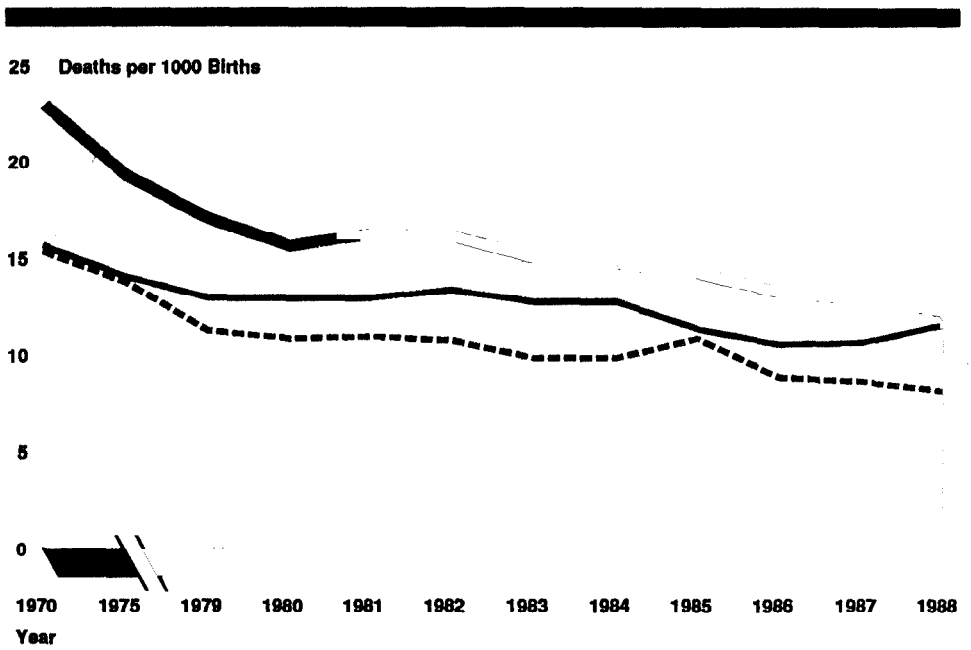
Note: Data for 1988 and 1989 are provisional.
Source: National Center for Health Statistics

In Maine and South Carolina, our case study states, infant mortality similarly declined and fetal mortality also was reduced overall between 1984 and 1988, as indicated in figure II.2. There were fluctuations, however, and the more dramatic improvements generally occurred in the 1970s.

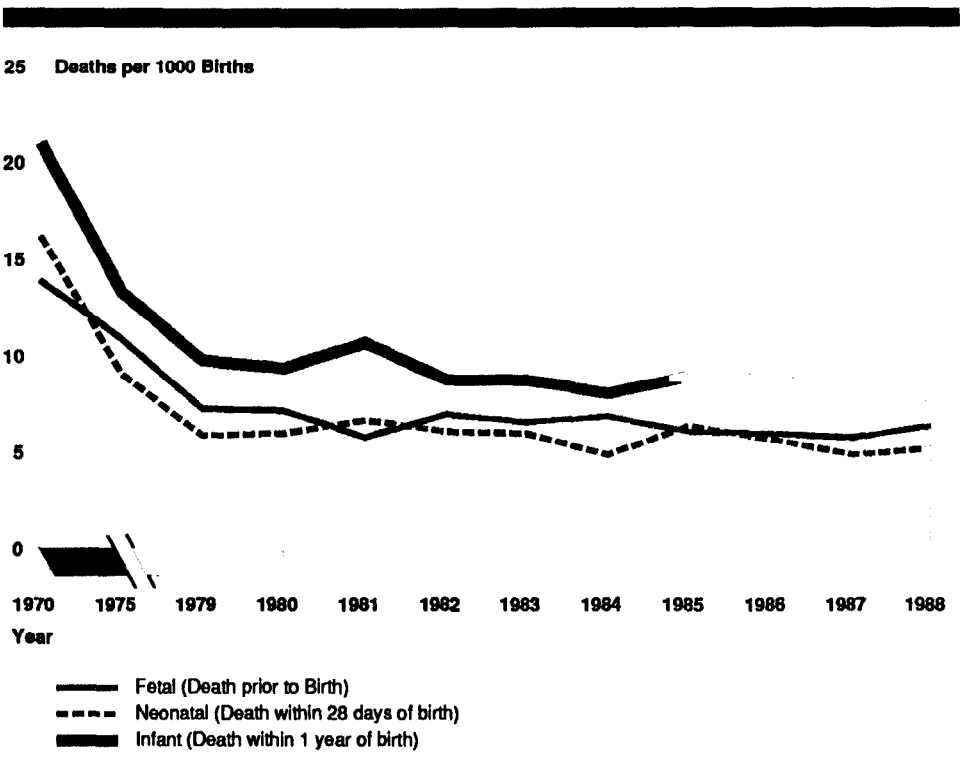
While studies are under way in some states, little information is yet available that would show the effects on infant mortality since 1984 in the Medicaid population only.

Figure II.2: Fetal, Neonatal, and Infant Deaths in South Carolina and Maine (1970-88)

South Carolina



Maine



Access to Medicaid May Not Improve Use of Prenatal Care

On the more general issue of improved use of prenatal care, such evidence as exists is discouraging. From 1986-87 interviews, we reported that, compared with a group of women with private health insurance, Medicaid recipients began prenatal care later and made fewer visits.[1] Only 46 percent of the Medicaid recipients in the study began their prenatal care in the first trimester. This means that over half received insufficient care by Institute of Medicine guidelines, increasing the chance of low birth weight, neonatal mortality, and infant mortality.

A study in Tennessee[2] of the consequences of expanding Medicaid eligibility for married pregnant women showed no concomitant improvements in the use of early prenatal care, birth weight, or neonatal mortality. Maternal groups with the highest rates of adverse pregnancy outcomes had high rates of Medicaid enrollment both before and after the change.[3]

But there is little evidence that Medicaid coverage alone can improve the rates of early prenatal care utilization. While medical coverage is a necessary first step, progress toward improving outcomes may require the accompanying development of programs addressing nonfinancial barriers. These would address factors such as awareness of pregnancy, the need for prenatal care, and its availability, and ready access to provider sites. Experts contend that "health care alone cannot redress entirely the consequences of the poverty, poor education, limited access to fertility services, unaffordable child care, and limited employment opportunities that afflict women with low incomes."[4]

[1]Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care (GAO/HRD-87-137, Sept. 1987).

[2]Piper, Joyce M., et al. "Effects of Medicaid Eligibility Expansion on Prenatal Care and Pregnancy Outcome in Tennessee," Journal of the American Medical Association, Vol.264, No.17, Nov. 7, 1990,pp. 2219-23.

[3]This was prior to the introduction of presumptive eligibility, which indeed could have changed the outcome. A forthcoming report based on a Utah study also offers conflicting evidence, according to the author.

[4]Guyer, Bernard, "Medicaid and Prenatal Care: Necessary But Not Sufficient," Journal of the American Medical Association, Vol.264, No.17, Nov. 7, 1990, pp.2264-65.

Link Between Medicaid and Access to Health Care Unclear

To what extent federal and state actions to expand Medicaid are succeeding in improving access to care is unclear. Any evaluation is difficult, due to various factors. Among these are the complexity and diversity of Medicaid, the incremental nature of the expansions, the variability of state implementation, and accompanying changes in overlapping programs. In addition, uniform, timely, and accurate data are lacking.

From anecdotal evidence, in at least some instances people now eligible for Medicaid by virtue of qualifying under newly created categories were (or would have been) eligible previously under the medically needy program or other state options. For example, Maine's eligibility criteria had changed in 1981 to include children under 18 and in 1984 to include first-time pregnant women. For such states, the Medicaid expansions adopted since 1984, particularly those legislated in the first 2 years, had little effect. In fact, the level of benefits for a pregnant woman could decrease, since membership in the newly created categories qualifies her only for pregnancy-related services. These may be in some respects better, in others less comprehensive than those to which she would otherwise be entitled. Other individuals in these groups also could have been receiving equivalent or related services through public health or other clinics or various state or locally funded programs.

In summary, increased Medicaid eligibility or even the demonstrated increase in delivery of Medicaid services to low-income women and children, while necessary, are insufficient to offer clear evidence of improved access to health care.

Methodology and Data Limitations

This appendix provides a more detailed explanation of some methodological aspects of our study, including (1) the method by which we identified extreme quartiles of states, (2) our selection of appropriate measures of states' fiscal capacity, and (3) the quality of the data used in our analyses.

Categorization of States

For this study, we wished to illustrate the great variation among the states in terms of their sensitivity to the Medicaid expansions addressed by the study and hence the impact of these changes. We ranked the states in order to perform separate analyses throughout the study comparing national averages with those of the top and bottom quartiles. This ranking allowed us to distinguish the quartiles most and least likely to be affected strongly by expansions within the study period.

A combination of six criteria formed the basis for our ranking:

1. Medicaid eligibility levels for a family of four, as a percentage of the federal poverty line;

2. Medicaid expenditures per person in poverty;

3. AFDC need standard for a family of two, as a percentage of the poverty line;

4. AFDC payment standard for a family of three, as a percentage of the poverty line;

5. Poverty rate; and

6. Revenue-raising capacity.

Our selection of criteria was influenced by data availability. For that reason, the last three factors reflect state status at various points within the study period (fiscal years 1984-89) rather than those in effect at its start, as is the case for the first three.

The criteria were based on our perception that states with the most limited Medicaid programs prior to the expansions would have to make the greatest changes. The lower the initial eligibility level and expenditures per capita for Medicaid, the greater the effects of expanding eligibility and services. Also, the close Medicaid/AFDC linkage prior to the recent legislative changes made it likely that states with the lowest AFDC

income thresholds would be burdened more heavily. Accordingly, we reflected such measures in our selection criteria. Each state establishes its need standard separately to reflect the minimum amount of money needed by a family of a given size each month to survive. Need standards generally provide for basic items such as shelter, food, clothing, utilities, and personal care needs. The equal or lower payment standard reflects the maximum contribution the state will make towards meeting those needs. Finally, we incorporated criteria relating to poverty rates within the state (to indicate levels of need relative to national standards) and states' revenue-raising ability (to indicate available resources for responding to that need).

We chose our outlier quartiles by a "majority vote." That is, if a state fell in the "most limited" quartile in at least three of the rankings, we assigned it to that category overall. Similar logic defined the "least limited" quartile. All other states fell in the middle quartiles, for which no separate analysis is reported.

Measures of Fiscal Status

In our analysis of states' ability and willingness to raise additional revenues to fund Medicaid expansions, we employed two measures of fiscal capacity developed by the U.S. Advisory Commission on Intergovernmental Relations (ACIR) to estimate the relative taxing capacity of states:

- The representative tax system (RTS) calculates the amount of revenue each state would raise if an identical set of tax rates were applied to a comprehensive set of tax bases, including not only income but property, retail sales, mineral production, and the like. Because an identical set of tax rates is used, states differ only in the size of their tax bases.
- The representative revenue system (RRS) is similar, but includes a number of nontax revenue bases—such as user charges, mineral leasing, rents, and royalties—in addition to all the tax bases included in the RTS.

In this study, we used the RTS to determine states' actual 1988 tax collections relative to their potential. This gives an indication of their ability to raise additional revenues without exceeding national average tax rates.

We employed the RRS as the more general basis for state-to-state comparison in seeking a correlation between fiscal capacity and Medicaid quality. For this analysis, we used also a rating of "Medicaid quality"

developed by the Public Citizen Health Research Group.[1] It is generated by a complex scoring model incorporating consideration of eligibility, services, provider availability, quality of care, and reimbursement. The researchers validated their overall state ratings against the judgment of independent experts.

ACIR developed the RTS and RRS measures in 1982 and recommended them for general use by the federal government. We believe these measures constitute a reasonable basis for comparing fiscal capacity across states, despite acknowledged problems due to variations at the substate level and data quality issues. Other measures are available to assess the capacity of states to finance public programs, but none is totally satisfactory for state-by-state comparisons. For example, we have noted in the past the weaknesses of per capita income as a measure of state tax capacity for a variety of reasons.[2] Most significantly, it does not reflect all the income states potentially are able to tax, and thus reflects state policy rather than state capacity.

Data Quality

We used data from two HCFA forms, 2082 and 64, on which states report their Medicaid data. Data from both have serious shortcomings as a basis for this type of analysis, but lacking alternatives these forms were our primary sources of Medicaid data for this study.

- HCFA 2082 data, reported annually to HCFA by the states, summarize medical vendor expenditures and numbers of recipients by type of service and major eligibility category. The form does not distinguish between federal and state expenditure data, nor does it include administrative expenditures.
- HCFA 64 contains final approved figures for both vendor and administrative costs. It reports federal money due to or owed by the states because of their Medicaid programs. Its expenditure data are deemed more reliable than those in the HCFA 2082. HCFA 64 reports total expenditures, including administrative expenses as well as medical vendor payments and both current and actual payments net of adjustments and deferrals. The data, however, are not broken out into the categories needed to

[1] We use the term "Medicaid quality" in this discussion strictly to denote this measure. It is described more fully in the report by Karen Erdman and Sidney M. Wolfe, Poor Health Care for Poor Americans: A Ranking of State Medicaid Programs, Washington D.C., 1987.

[2] Changing Medicaid Formula Can Improve Distribution of Funds to States (GAO/GGD-83-27, Mar. 9, 1983) and Medicaid Formula: Fairness Could Be Improved, Testimony before the Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, House of Representatives, Dec. 7, 1990.

track the effects of legislated expansions. Unlike the HCFA 2082, the HCFA 64 does not include information on recipients, utilization, or expenditures by recipient category. Our data pertaining to the states' share of Medicaid expenditures and to administrative expenses are based on HCFA 64 information.

We used various non-Medicaid financial data as a basis for comparison and to assess state fiscal status. For example, the Bureau of the Census provided information on total state revenues and expenditures, and on education expenditures. This led to problems of data incompatibility. HCFA Medicaid data are reported in terms of federal fiscal years, Census data according to the individual state fiscal years:

- 40 percent of the states report to Census in terms of a fiscal year starting July 1.
- 40 percent use a calendar year basis.
- New York uses an April 1 start date.
- The remaining states use an October 1 start date consistent with the federal fiscal year.

A Bureau of the Census official with whom we discussed the possibility of data conversion to provide a consistent basis said they had decided against this option because egregious reporting problems would result. Consequently, we did not attempt such conversion in this study. We do not believe the validity of our main findings is affected by this anomaly.

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1990. We did not obtain agency comments because the focus of this study was on the effects of federally legislated changes on state programs and on Medicaid populations. Our study did not address issues of program management at either federal or state levels.

States Responsive to Initiatives Targeting Low-Income Women and Children

Congressional initiatives seeking to improve access to Medicaid for low-income women and children appear to have achieved considerable success. States were responsive to these efforts, viewing them as a way of reversing the program cutbacks that occurred in the early 1980s. As a result, state Medicaid programs have become more comprehensive for these groups, in terms of both eligibility and services. Indeed, most states have gone beyond the new legislative mandates, the most substantial improvements occurring in states in which coverage in 1984 was relatively limited. This in effect has reduced disparities among states' Medicaid programs in services to pregnant women and children.

As a result of the changes, delivery of Medicaid services to low-income women and children has increased slightly since 1984. Across the country, more recipients are being served and a slightly greater percentage of Medicaid resources is being spent on this group. Again, the trends are most apparent in states that in 1984 had the most limited programs.

But these gains for pregnant women and children were not a major factor in the rapid growth of Medicaid expenditures. One-third of the states were able to substitute federal for state funds as part of their financing mechanism, as they already were providing similar services to pregnant women and children. Further, these have not been expensive groups to serve relative to other categories—the elderly and disabled—which have been growing faster and use more costly services.

Medicaid Services to Women and Children Cut Back in Early 1980s

The cutbacks of the early 1980s were severe for low-income women and children, who constitute the majority of Medicaid enrollees and recipients. They predominate because of the Medicaid program's link with AFDC—a program serving mostly low-income, single-parent families. At the time, such families generally were ineligible for Medicaid unless they qualified for AFDC cash assistance. States thus were limited in their ability to expand Medicaid coverage to low-income families without also increasing AFDC expenditures, which they were reluctant to do.

Over the 1975-85 decade, the financial criteria states set to establish eligibility for their AFDC programs had become increasingly restrictive. As qualifying income levels declined in real terms by some 30 percent on average, fewer women and children living in poverty could qualify for AFDC and thus for Medicaid.

Further, many low-income children resided in two-parent families. States could provide Medicaid coverage to such children if their family income was below AFDC income thresholds, but this still excluded many children of the working poor. Thus, although poor families and children constituted a growing proportion of the poverty population, the share of Medicaid resources directed to them declined between the mid-1970s and the mid-1980s.[1]

While access to Medicaid was eroding, other federal and state programs for low-income women and children also were affected. Facilities were closed and funding cut back. For example, OBRA 1981 eliminated the requirement that states maintain a comprehensive set of health clinics providing such services as well-baby care, prenatal care, and immunization programs. Also, most states have used Maternal and Child Health block grants to implement programs targeting low-income women and children. Funding for this program too has eroded since the late 1970s, with a 33-percent drop in constant dollars from 1977 to 1984.

In response, states nationwide began seeking ways to serve more adequately the medical needs of this low-income population. The impetus came from national studies demonstrating significant problems with maternal and infant health, along with convincing evidence of dollar savings from early intervention for these groups.[2] In particular, southern states with high infant mortality rates and a high incidence of low-birthweight babies have led the movement to expand medical services to this population.

[1]For example, the number of children living in poverty increased by 44 percent from 1973 to 1983. But Medicaid enrollment did not reflect this because the percentage of poor children receiving AFDC benefits fell from 80 to 50 percent. Also, between 1975 and 1984, the share of Medicaid dollars spent on medical services to families qualifying for AFDC dropped from 39 to 27 percent.

[2]As we noted in Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care (GAO/HRD-87-137, Sept. 1987), several studies have found the cost of providing comprehensive prenatal care to be less than the cost of care associated with poor birth outcome, including neonatal intensive care. The American Academy of Pediatrics reported in 1984 cost estimates of $2-10 saved for every dollar spent on prenatal care.

Federal Legislation Targeted Pregnant Women and Children

Through a combination of mandates and options, in federal legislation enacted yearly since 1984, the Congress significantly increased states' ability to target Medicaid services to low-income pregnant women and children. Between 1984 and 1989, ten pieces of major legislation added services addressing their needs, created new Medicaid eligibility categories for them, and expanded existing AFDC categories by modifying eligibility criteria relative to family structure and employment status. Specifically, legislation amended Medicaid statutes to

- require coverage based on income relative to the federal poverty level rather than to each state's AFDC income level,
- give states the options of going beyond mandated income and age levels and offering additional services, and
- broaden eligibility of individuals who do not receive AFDC payments but are deemed to be AFDC recipients for the purpose of Medicaid coverage.

States thus could expand Medicaid coverage of low-income women and children without also expanding AFDC cash payments. Breaking the Medicaid-AFDC link for this population made it possible to reverse the trend by which Medicaid was serving proportionately fewer people living in poverty.

As a result, states now have two mechanisms for giving low-income women and children access to Medicaid services:

- The traditional route of AFDC eligibility, determined by state income and categorical requirements, and
- Newly-established eligibility categories that use consistent national income standards keyed to the federal poverty line.

This also means that pregnant women and children are affected both by changes in the overall AFDC program and by changes targeting them alone.

States Respond by Expanding Medicaid Eligibility, Services

States responded aggressively to these congressional initiatives. In addition to complying with new mandates,[3] most have implemented several of the optional Medicaid expansions and many also have adopted administrative practices to simplify the process of gaining and maintaining access to Medicaid services. States making the most progress are those whose programs in 1984 were relatively limited in terms of eligibility

[3]Our analysis did not include expansions with delayed implementation dates.

and coverage. It is in these states that the trend of diminishing Medicaid coverage for low-income families is being reversed.

States Complying With Mandates

All states appear to have complied with federal mandates affecting low-income pregnant women and children enacted during the 1984-89 period.[4] By the end of 1989, the major consequences of the targeted mandates were to

- disregard family structure in determining eligibility for pregnant women, thus including first-time pregnancies and those in two-parent families;
- base eligibility for pregnant women and infants on the federal poverty line rather than state AFDC income standards; and
- disregard family structure in requiring coverage for children with family income and resources below state AFDC levels.

Other mandates mitigating the effects of OBRA 1981 restrictions on the working poor also benefited women and children. Most significantly, these newer laws (1) increased the gross income level for AFDC eligibility, (2) liberalized resource limits and work expense deductions for part-time workers, (3) extended the period of Medicaid coverage when a family member returns to work, and (4) enhanced continuity of care by providing full-year Medicaid coverage for families who qualify for and receive AFDC cash benefits for 6 out of the 12 months.

Optional Expansions Implemented by Most States

In addition to mandated program changes, federal legislation gave states options for expanding eligibility and/or services that still would qualify for matching federal funds. At the end of 1989, six provisions legislated since 1984 that directly focused on pregnant women and children remained optional (that is, were not subsequently mandated). These provisions permitted states to (1) expand their services specifically targeted on pregnant women and children,[5] (2) ease the administrative burden for obtaining Medicaid eligibility, and (3) go beyond the mandated income and age levels used to determine Medicaid eligibility. Nearly all states adopted one or more of these optional expansions or program enhancements, as shown in table 2.1.

[4]Many already were observing these provisions under prior options.

[5]States design their own benefit packages. Examples of covered services include case management, nutritional counseling, home visiting, and transportation.

Table 2.1: Major Optional Program Expansions Affecting Care for Pregnant Women and Children (As of Jan. 1990)

Federal law	Allows	No. of states adopting: Total	By option
COBRA 1985 (P.L. 99-272)	Provision of enhanced benefits specifically for pregnant women	**30**	
OBRA 1986 (P.L. 99-509)	Presumptive eligibility for up to 45 days to be determined by qualified provider upon verification of pregnancy	**25**	
	Guarantee of continuous eligibility for pregnant women through postpartum period	**41**	
	Assets test to be eliminated for pregnant women	**44**	
OBRA 1987 (P.L. 100-203)	States to set maximum income level for coverage of pregnant women and infants up to 185% of poverty line (mandated level is 75%). States set levels variously at	**46**	
	75-100%		2
	100%		23
	125%		1
	130%		1
	150%		4
	185%		15
	States to phase in[a] coverage for children below age 9, up to 100% of poverty line (mandated to age 1). States variously elected to cover children	**41**	
	between ages 1 and 2		8
	below age 3		9
	below age 4		4
	below age 5		6
	below age 6		10
	below age 7		4

[a]This option extended to age 5 initially, with annual increases up to age 8 in fiscal year 1991.

Most states elected to exceed required income limits or cover children older than the mandated age, as the table indicates. For example, as of January 1990:

- The mandated poverty level for coverage of pregnant women and children was exceeded by 46 states, and the national average stood at 127 percent of the poverty line, rather than the mandated 75 percent.
- The mandated age level for children with family incomes above the state AFDC level was exceeded by 41 states, and the average state covered them up to age 3.7 years, instead of the mandated 1 year.

Further, the majority of states elected to simplify the Medicaid eligibility application process and enhance continuity of care for pregnant women as of January 1990, as follows:

- Presumptive eligibility, allowing designated providers of medical services to make an immediate determination that a pregnant woman may qualify for Medicaid, was adopted by 25 states. If she then files a written Medicaid application within 14 days, presumptive eligibility will last for 45 days or the date of final eligibility determination, whichever comes first.[6]
- Elimination of assets tests, which allows more low-income pregnant women to qualify without liquidating their assets, simplifies the lengthy application process, and minimizes the required documentation, was elected by 44 states.[7]
- Continuous eligibility, the administrative solution to another common problem faced by Medicaid-eligible pregnant women, was adopted by 41 states. Fluctuations in family income can interrupt Medicaid eligibility and may affect maternity care. To ensure continuity of treatment and provider payment, states now may guarantee continuous eligibility through 60 days of postpartum care.

In many cases, the states have enhanced the effects of these measures by introducing improvements within their own administrative jurisdiction, by such actions as:

- Introducing or expanding outreach programs and
- Taking applications at sites convenient to recipients, such as clinics and community and migrant health centers.[8]

Greatest Progress Achieved in States With Most Limited Programs

The 1984-89 Medicaid expansions were expected to have sharply differing effects on states, in part because of the significant differences among state Medicaid programs. All else being equal, states that had the least comprehensive Medicaid programs in 1984 in terms of eligibility and services for low-income persons would have to make the most changes to comply with federal mandates. For the purposes of this study, we designated such states "most limited."[9]

[6]Both recipients and providers benefit. A recipient may receive coverage of prenatal care immediately, while full application reviews are conducted. Providers are guaranteed payment during that period regardless of the final outcome of the eligibility determination.

[7]Recent research in southern states indicated that most pregnant women denied Medicaid coverage met the income and assets tests but could not document their financial situation adequately. Removal of the assets test reduces the administrative burden.

[8]This now has been mandated, under OBRA 1990.

[9]As indicated on p. 16, these were Alabama, Arkansas, Florida, Idaho, Kentucky, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Tennessee, and West Virginia.

Indeed, states in this quartile have made substantial improvements in Medicaid pertaining to pregnant women and children. On average, as of January 1990, the states

- exceeded mandated coverage levels for both women and children. In 1989, these states provided coverage to pregnant women with incomes as high as 123 percent of the poverty line, compared with the mandated 75 percent. Children were covered almost to age 4, compared with a mandated 1 year of age.
- had adopted available service options at a rate above the national average. For example, 92 percent of these states had adopted continuous eligibility and dropped the assets test for pregnant women, compared with national averages of 82 and 88 percent respectively. Two-thirds also offered pregnant women enhanced services such as nutritional counseling, home visits, or assistance with transportation to medical visits.
- were more likely than states in other quartiles to implement additional procedures, not linked to federal legislation, to reduce barriers faced by pregnant women in establishing and maintaining access to prenatal care. This included, for example, stationing eligibility workers at convenient sites, such as clinics, and shortening application forms.

Further, states we designated as most limited made the most progress in increasing AFDC income eligibility thresholds so that more persons living in poverty—including low-income women and children—would receive both AFDC and Medicaid coverage. For example, for a family of two—a definition that also includes the first-time pregnant woman—these states increased their thresholds an average 15 percentage points relative to the federal poverty level between 1984 and 1989. In contrast, the average increase nationwide was 7 percent. However, states in this most limited quartile still trail the national average.

Access Increased Nationally and Where Most Needed

Federal expansions of state Medicaid eligibility have led to increases in the numbers of pregnant women and children served by Medicaid since 1984. Nationwide, these gains have been slight. But again, progress is most evident in states that initially had the most restrictive programs.

More Pregnant Women and Children Served

More pregnant women and children are becoming eligible for Medicaid services, and correspondingly the number of recipients is increasing. This is demonstrated by direct examination of these population groups, as well as by trends in AFDC recipients overall.

In 10 states that were "early implementers" of optional expansions for pregnant women, we estimate that between two-thirds and three-quarters of all pregnant women made Medicaid-eligible by these changes enrolled in Medicaid within 2 years after implementation.[10] Nationally, of the new enrollees, 648,000 used Medicaid services in 1989, according to HCFA data.[11] These included 291,000 pregnant women and caretaker relatives, and 357,000 children under age 21. Further, since 1984 the number of AFDC recipients of Medicaid has grown modestly, at an annual rate of about 1 percent. This population would include, among others, all pregnant women and children under both new and prior eligibility criteria.[12] In fiscal year 1989, there were almost 916,000 more AFDC-related recipients than in fiscal year 1984.

Disparities Among States Reduced

In terms of recipients served and resources expended, the legislated expansions have reduced diversity across the states for the targeted population, although major differences remain. Recipient populations in the quartile of states that we deemed most limited grew markedly relative to other states, as table 2.2 shows.

[10]Based on case studies. Whether these women, once enrolled, actually received Medicaid services, was not addressed in the report, Prenatal Care: Early Success in Enrolling Women Made Eligible by Medicaid Expansions (GAO/PEMD-91-10, Feb. 1991).

[11]This constitutes about 3 percent of total FY 1989 Medicaid recipients. However, the number of newly qualified pregnant women, infants, and children reported to HCFA is subject to error. Data may be inconsistent between states because of their individual eligibility structures and interpretation of these newly introduced reporting categories.

[12]Throughout the following analysis, all pregnant women and children receiving Medicaid services, including those eligible only due to the new eligibility criteria, are included in the AFDC recipient population. The use of this aggregate grouping is necessary because this is how the states report such information on the HCFA "2082" statistical report. Only recently has HCFA established separate reporting categories. Not all states use them, and there are inconsistencies even among those that do so.

Table 2.2: Average Annual Percentage Growth Rates for Population, Medicaid Recipients, and Expenditures (1984-89)

Population/ recipients/ expenditures	Most limited quartile	Least limited quartile	National average
Total population	1.2%	1.6%	1.0%
Medicaid recipients	4.8	0.1	2.1
AFDC Medicaid recipients	4.9	−1.3	1.2
Medicaid expenditures	13.0	10.9	10.0
AFDC Medicaid expenditures	17.6	7.5	10.5

These growth rates signify that the quartile that was most in need of improvement consistently served more AFDC as well as total recipients through Medicaid in 1989 than in 1984. The opposite trend is observable in states that in 1984 generally had the most comprehensive Medicaid programs in terms of eligibility and resources expended. For this quartile, AFDC recipients declined in absolute terms as well as relative to an essentially stable total, as shown in table 2.3.

Table 2.3: AFDC Recipients as a Percentage of Total Medicaid Recipients (Fiscal Year 1984-89)

Fiscal year	Most limited quartile	Least limited quartile	National average
1984	62.5%	72.9%	71.6%
1985	62.7	72.2	71.4
1986	63.0	71.6	71.1
1987	63.0	70.3	70.4
1988	64.1	70.2	70.2
1989	65.3	70.4	70.5

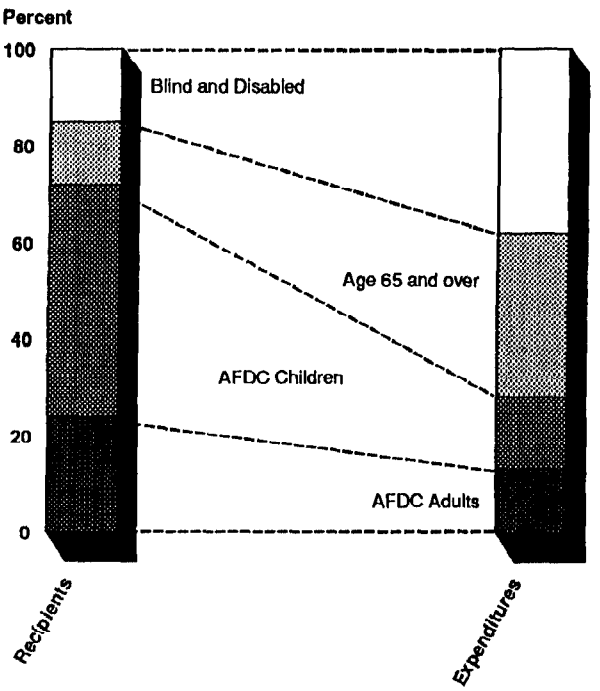
Expanded Services to Women and Children Not Primary to Rise in Medicaid Expenditures

In general, the states do not perceive expansions targeting pregnant women and children as the primary factor in rising Medicaid expenditures. The states recognize the potential benefits of such expansions, viewing prenatal and child care as a worthwhile social goal. In many instances, prenatal care services were already provided, using state and local funds, so savings resulted when the new legislation authorized a federal match. Moreover, the health care needs of these groups are relatively predictable and cost-effective. There is evidence of both short- and long-term savings in health care costs from the provision of prenatal and preventive medical benefits.[13]

[13]An Institute of Medicine study—Preventing Low Birthweight (Washington, D.C., National Academy Press: 1985)—reported $3.38 savings for every $1 expended on prenatal care. Also, each dollar spent on childhood immunizations has been shown to save more than $10.

As the results of our study confirmed, relative to other groups these recipients did not cause major cost increases during the 1984-89 period. Children are the least costly of all Medicaid recipients; their per capita expenditures for medical services in fiscal year 1989 were $699. Even the larger category of AFDC recipients, while costing more per capita in 1989 than in 1984, still constitutes a relatively inexpensive group to serve. For AFDC recipients as a whole, 1989 per capita Medicaid expenditures were $867, compared with an average $2,318 overall. They consume a much smaller percentage of Medicaid expenditures than would be accounted for by their proportion of the Medicaid population (see fig. 2.1).

Figure 2.1: Distribution of Medicaid Recipients and Expenditures (Fiscal Year 1989)



Note: The category "AFDC children" includes individuals under age 21 who meet AFDC income and resource limits but not the AFDC definition of dependent child.

Nationwide, AFDC recipients accounted for less than one-third of the growth in Medicaid expenditures between 1984 and 1989, as shown in

table 2.4.[14] The elderly and disabled population generally is more expensive to serve and has grown at a faster rate. Between 1984 and 1989, this segment grew from 24 to 27 percent of Medicaid recipients and in 1989 accounted for 73 percent of the expenditures.

Table 2.4: Expenditure Growth Attributable to AFDC Recipients
(Fiscal Year 1984-89)

Fiscal year	AFDC increase as percent of total increase in Medicaid provider payments
1984-85	23.8%
1985-86	28.3
1986-87	30.6
1987-88	20.5
1988-89	34.5
1984-89	28.3

Also serving to minimize the cost to the states of expansions for pregnant women and children is the fact that, in many instances, prenatal care and related services already were provided, either under previous Medicaid options or using state and local funds. A 1989 study found that 43 states had implemented 1984-89 expansions targeting pregnant women and children.[15] Of these, 17 financed the expansions in whole or in part by transferring state funds from their public health/maternal and child health budgets to their Medicaid budgets.[16] The states have a clear—and acknowledged—incentive to maximize federal matching funds by means of such transfers, but we have been unable to document the dollar amount involved nationwide.[17]

[14]However, the increase associated with this group was slightly higher than one-third of the total growth for 1988-89.

[15]Fox Health Policy Consultants Inc., State Strategies for Financing Medicaid Expansions to Meet the Needs of Children and Pregnant Women, Aug. 1989

[16]Our case study states differed in this regard. Maine made such a transfer, while South Carolina did not.

[17]States generally employed a combination of funding approaches for these expansions. Thirty-three states used new appropriations, in conjunction with transfers between programs, as part of their funding mechanism.

Medicaid's Contribution to States' Financial Stress Likely to Increase

Between 1984 and 1989, Medicaid outlays generally represented the most rapidly growing segment of state budgets. With overall state expenditures outpacing revenues and their fiscal problems increasing, state governors have come to view Medicaid as a substantial and growing financial burden.

Moreover, states anticipate that more recent expansions may prove significantly more costly than those implemented through 1989. Also, the number of Medicaid recipients and the costs of their care are likely to increase due to a combination of economic, social, and demographic trends.

Key factors influencing Medicaid financing include the willingness and capacity of states both to raise additional funds and to channel them to Medicaid. Given the current fiscal condition of many states, raising such funds through increased revenues may be difficult—at least in the near term. Consequently, there is a risk that future program expansions may be financed at least in part by cutbacks in Medicaid eligibility and/or health services for low-income people not protected by mandates.

State Fiscal Stress Exacerbated by Medicaid

For fiscal year 1990, Medicaid constituted 12 percent of total state expenditures (from all sources), second only to 23 percent for elementary and secondary education. Moreover, total state Medicaid spending[1] is growing faster, at an average annual rate of 10 percent (per fiscal year) between 1984 and 1989 compared with around 8 percent for education (per calendar year). The state share of Medicaid outlays also grew by 10 percent a year.

During this period, as table 3.1 shows, Medicaid expenditures increased at a faster rate than general revenues[2] in all state categories, with considerable variation among individual states.[3]

[1]HCFA Medicaid expenditure data include all Medicaid disbursements made to providers by the state, regardless of the source of funds. That is, they consist of both the state and federal shares unless otherwise indicated. Other state expenditure data are from the Bureau of the Census. Medicaid and Census data are not totally comparable between federal and state fiscal years. See app. III for details.

[2]This includes federal matching funds.

[3]The effects of disparate growth rates are most apparent when data are examined year by year. For example, the ratio of Medicaid growth to revenue growth was 557 percent for West Virginia from 1987 to 1988. That is, for every $1 increase in revenues, Medicaid expenditures increased by almost $6. South Dakota and Mississippi had similar, though less severe, problems from 1986 to 1987.

Table 3.1: Growth in State Medicaid Expenditures and General Revenues
(1984-89)

	Growth rates				
	Most limited quartile	Least limited quartile	National average	Max.	Min.
Medical provider payments	84.6%	68.0%	61.0%	158.4% (FL)	16.7% (MN)
General revenues	52.0	49.6	44.9	86.6 (FL)	−12.1 (AK)

Because of Medicaid's rapid expenditure growth, the program is consuming a larger portion of the states' general revenues. In this, the states varied widely, but a few doubled the percentage of revenues used for Medicaid during the 1984-89 period, as shown in table 3.2.

Table 3.2: Medicaid Expenditures as a Percentage of General Revenues
(Fiscal Year 1984-89)

Fiscal year	Most limited quartile	Least limited quartile	National average	Max. (NY)	Min. (AK)
1984	8.3%	8.8%	10.2%	19.9%	1.3%
1985	8.3	9.1	10.3	20.3	1.2
1986	8.6	9.0	10.4	20.1	1.2
1987	9.0	9.4	10.8	19.8	1.8
1988	9.4	9.8	11.0	19.9	1.9
1989	10.1	9.9	11.4	21.9	2.8

Concerns over the growth in Medicaid expenditures are exacerbated by broader financial problems confronting states. Over the past 6 years, total general expenditures for the average state increased at 8.4 percent, while general revenues increased at 7.7 percent. The greatest discrepancy between growth rates for revenues and expenditures was experienced by the 12 states we deemed least likely to be affected by the Medicaid expansions because of their generally higher taxing capacity and more comprehensive programs existing in 1984.[4] For this group, expenditures exceeded revenues over the past 2 years, drawing down budgetary reserves. In all, expenditures by eight states grew at a rate 2 or more percentage points faster than revenues, half of them in our least limited quartile.

States also experienced fiscal strains from areas other than health care, such as education and corrections. A long-term national trend delegates an increasing share of education expenditures to the states, and at least

[4]As indicated on p.16, these were Alaska, California, Connecticut, District of Columbia, Hawaii, Massachusetts, New Jersey, Rhode Island, Utah, Vermont, Washington, and Wisconsin.

28 states are under court order to expand or improve prison capacity. With an almost universal requirement for states to balance their budgets, these trends inevitably impose significant constraints on state discretionary spending.

Medicaid Spending Increases Influenced by Various Factors, Likely to Worsen

A combination of factors including economic downturns, high rates of medical inflation, and disproportionate growth in the numbers of aged and disabled recipients all contributed to the rapid growth in Medicaid expenditures between 1984 and 1989. Given these circumstances, we were unable to isolate the separate influence of individual mandates and state-elected options on Medicaid outlays to date from the effects of these other factors. States anticipate, however, that federal mandates implemented after the close of fiscal year 1989 are likely to be more costly than earlier expansions and that other factors will continue to drive up Medicaid expenditures.

Factors Increasing Costs Since 1984

Increases in Medicaid outlays over the past 6 years resulted from growth in both numbers of recipients and expenditures per recipient. States vary widely in their estimates of the effects of Medicaid expansions on this expenditure growth, and no definitive data are available. While the Medicaid expansions certainly contributed to this increase, they cannot be isolated as a major factor, given other significant trends that affect program costs.

The economic downturn, first in specific areas and then at the national level, moved more people into poverty, increasing the number likely to become Medicaid-eligible. Demographic changes in the population also have tended to increase the number of Medicaid recipients even without changes in eligibility criteria. Population aging is adding to the number of elderly people dependent on Medicaid for nursing home care—already the single largest component of the Medicaid budget. There has been an absolute rise in the number of young children in all age groups up to 14 years and an increased rate of childbearing, particularly in groups most at risk of poverty.

Further, per recipient costs increased sharply between 1984 and 1987, primarily associated with long-term care. Average annual growth rates in per recipient Medicaid expenditures, in real terms, ranged from around 0.5 percent for AFDC recipients (both adults and children) to 16.9 percent for home health care for the aged and disabled.

The effect of these trends, which continued through 1989, is illustrated by recent projections by the Office of Management and Budget (OMB) of future Medicaid expenditure growth. Even had no expansions been mandated subsequent to 1989, OMB estimates, 1994 state outlays for Medicaid would reach $50 billion per annum, up $24 billion over fiscal year 1989.

Added Factors Increasing Future Costs

States view the escalating effects of phased-in expansions, together with mandates only now being implemented, as more burdensome than the costs of expansions implemented in prior years. These considerations are affecting state attitudes even about additional expansions of eligibility and services for pregnant women and children. One example of the states' concerns is the mandated expansion of Early and Periodic Screening, Diagnosis, and Treatment services to Medicaid-eligible children up to age 21.[5] OBRA 1989 requires states to provide interperiodic screening[6] as appropriate—that is, when a medical problem is suspected—and all medically necessary treatment, regardless of whether the services are covered under the state plan. While unable to estimate EPSDT expenditures with any degree of confidence, the states foresee major, uncontrollable cost increases.[7] The effect of the expansion will be exacerbated by the accompanying requirement that Medicaid coverage be extended to children up to age 6 in families with incomes up to 133 percent of the poverty line.

Expansions affecting other recipient groups, such as nursing home residents, also will drive up Medicaid costs. Recent legislation extends beyond changes in eligibility and services—the focus of our study. It incorporates provisions relating to patient assessment, training of nurses' aides, nursing home staffing, and the use of drugs and physical restraints, as well as services to patients. A few states are resisting these reforms, viewing them as too costly.[8] Nursing home residents,

[5]EPSDT services include at a minimum assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; appropriate vision, hearing, and laboratory tests; dental screening from age 3; and treatment for vision, hearing, and dental services found necessary by the screening.

[6]That is, checkups on a more frequent basis than is called for in the standard schedule established by the state.

[7]However, the states do retain three modes of control: the definition of "medically necessary;" reimbursement rates; and the ability to impose a requirement for prior authorization.

[8]California, for example, went to court on the issue. The deputy director of California's Medicaid program said it was unwilling to expend "huge amounts of money" to comply. While the case has been settled, unresolved issues remain.

especially those in intermediate care facilities for the mentally retarded/mentally disabled, are already the most costly Medicaid recipients to serve. Moreover, for many of these expansions, there may be less overlap with existing state programs and thus less possibility to defray these costs by interprogram transfers.

Another legislated expansion is the requirement that states pay Medicare out-of-pocket costs (premiums, deductibles, and copayments) for Medicaid enrollees who are also qualified Medicare beneficiaries. While the initial implementation of this law in January 1989 was reflected in our analysis, the financial effects are worsening incrementally. Each year, more people are covered as the income level qualifying elderly individuals for this benefit increases. At the start of fiscal year 1990, that level stood at 90 percent of the federal poverty line, but it stepped up to 95 percent in 1991 and will rise to 100 percent in 1992.[9]

Medicaid cost increases would continue even absent these expansions of eligibility and services. An OBRA 1989 provision (codifying an earlier requirement) requires that payments to providers be sufficient to ensure that covered services are available to Medicaid beneficiaries, at least to the extent that they are available to the general population in the same geographic area. Recent court cases have required increases in reimbursement rates based on this provision.

Options for Funding New Expansions Limited

In light of the factors discussed above, we conclude that state Medicaid expenditures will continue to increase and states must find additional funds to finance the most recently mandated expansions. Which financing mechanisms states select can affect the extent to which expansions of eligibility or services improve access to health care. The approaches employed in the recent past provide some indication of likely future funding choices.

State options for increasing Medicaid funding are limited: appropriate new funds, reduce budgets for other programs, or shift funds within the Medicaid budget. Key factors in these decisions include not only the capacity but also the willingness to raise additional funds and to use them to expand Medicaid. Where states choose to cut back other programs or other aspects of Medicaid to finance a particular mandate, this may offset the intended gains for the target population.

[9]OBRA 1990 expands this program still further.

Prospects of Increased State Revenues Uncertain

States differ in relative ability and willingness to raise additional revenues to fund Medicaid expansions. States in the least limited quartile—those with more resources and/or more generous Medicaid programs—would find it relatively more difficult to raise additional revenues for further program expansions. Even in states that have excess fiscal capacity, there is no certainty that their legislatures will appropriate resources to expand Medicaid.

To illustrate this, we used a conceptual measure of a state's potential revenue-raising capacity relative to a national average[10] and compared capacity with actual revenues raised. We also compared capacity with a measure of the "quality" of the state's Medicaid program.[11] (See app. III for details of our methodology.)

Most recent (1988) data showed that two-thirds of states in the least limited quartile already tax their residents at rates above the national average. To raise additional revenues, they would have to impose levies at an even higher rate. For the most limited quartile, on the other hand, 1988 revenue collections on average fell short of even the limited amount that could be available.

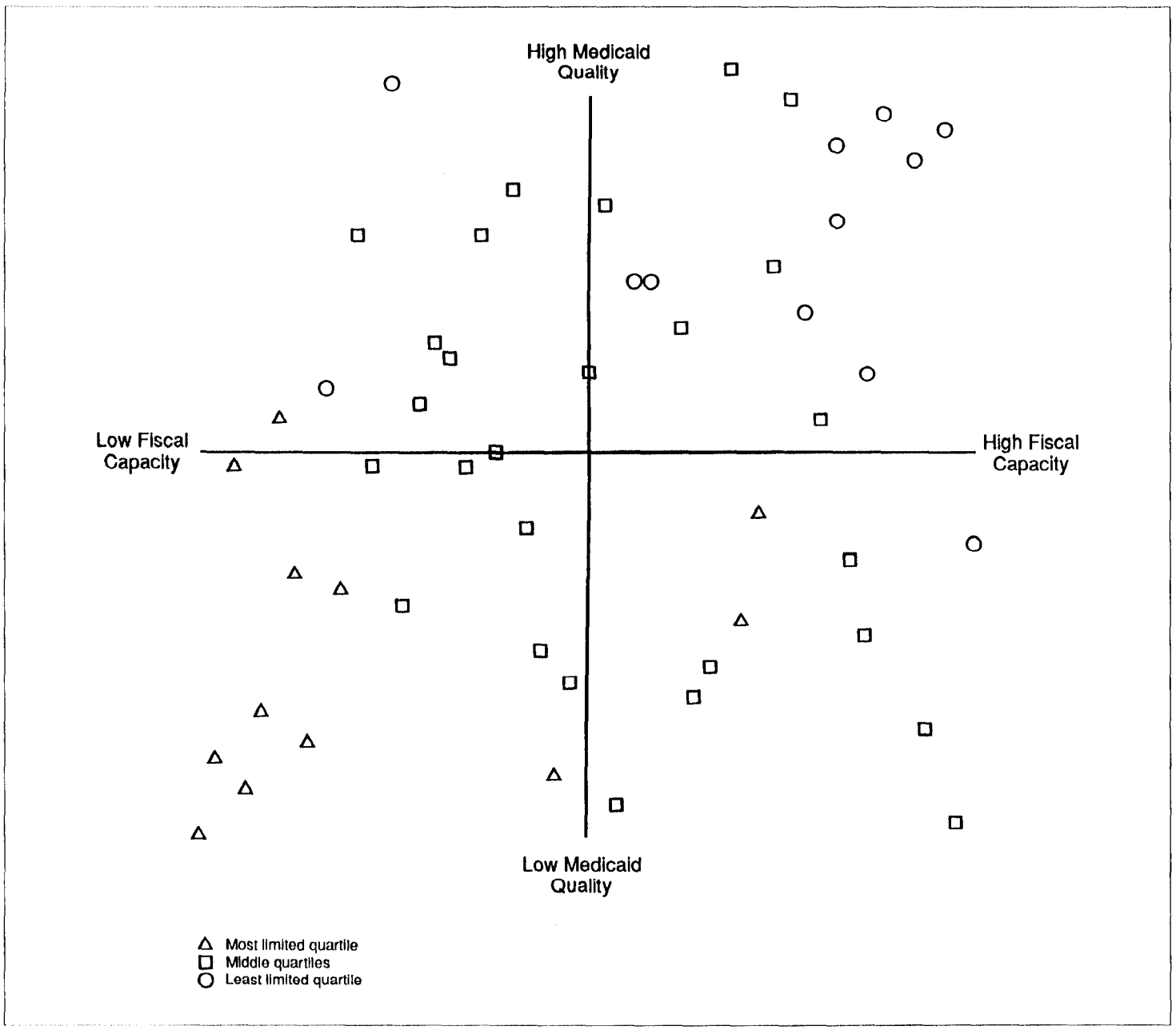
Differences in Medicaid benefits across the states and the manner in which states respond in implementing mandates for new services show no clear correlation with a state's fiscal resources. Each of our defined quartiles contains states with both high and low quality Medicaid programs, as shown in figure 3.1.[12] For example, Wisconsin, Iowa, and Maine, all with relatively low revenue-raising capacity, had programs rated relatively high in terms of overall quality. Other states with higher capacity accomplished less. Nevertheless, fiscal capacity clearly plays a role in Medicaid funding decisions. Three-quarters of the states constituting our most limited quartile lie in the quadrant of limited quality and low capacity.

[10]This measure was developed by the U.S. Advisory Commission on Intergovernmental Relations (ACIR).

[11]We use the term "Medicaid quality" in this discussion strictly to denote the measure developed by the Public Citizen Health Research Group. It is described more fully in the report by Karen Erdman and Sidney M. Wolfe, Poor Health Care for Poor Americans: A Ranking of State Medicaid Programs, Washington D.C., 1987.

[12]These data are from 1982-86, the most recent available when the one-time "quality" ranking was performed.

Figure 3.1: Comparison of States' Medicaid Quality and Fiscal Capacity (1986)



Other Programs May Be Cut to Boost Medicaid

As an alternative or as an adjunct to the raising of new revenues, states may cut other programs to finance Medicaid expansions. The open-ended nature of the federal match encourages the substitution of Medicaid spending for other state/local spending for which the federal match, if any, is less.[13] For example, many states have used Medicaid to provide services that otherwise would be provided under title XX (social services) and title V (maternal and child care) of the Social Security Act. For these programs, federal dollars are fixed annually and marginal spending must be funded entirely with state dollars.

Recently, states have cut indigent care services to provide funds for Medicaid expansions. States closed down services and, in some instances, entire charity hospitals or clinics. While the clinics were reopened after a short time, there are fears that they may be affected again in the future. This approach carries undesirable side effects. While the states thus obtain additional federal matching funds, populations previously served by these facilities may not qualify for Medicaid and so lose this means of access to the health system. Even those who still qualify may suffer diminished access if convenient service points close down. This could be particularly significant in the case of clinics, where 60 percent of U.S. prenatal care subsidized by Medicaid is provided. A Kentucky study concluded that Medicaid recipients who obtained prenatal care through local health department prenatal clinics had lower rates of infant mortality than other women receiving Medicaid.

Shifting Funds Within Medicaid Program May Harm Target Groups

Because states still have administrative control over a significant portion of their Medicaid programs and who qualifies for them, they also have the option of cutting back eligibility, services, or provider reimbursement to finance required expansions.

In the past, many states used eligibility income standards to keep costs down. Reductions in eligibility are more likely to affect AFDC than SSI recipients. For the former group, such reductions can be achieved by inaction—failure to increase eligibility levels commensurate with inflation. This is not generally true for the SSI population, where indexing is governed by federal mandate. Eligibility may be reduced in other ways, also. Arkansas funded recently mandated expansions by discontinuing its medically needy program.

[13]Recent legislation has diminished this incentive. For example, OBRA 1989 required that states not cut back their funding for maternal and child health programs.

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