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Report to the Chairman, Committee on the Budget, House of Representatives

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MEDICAID

Spending Pressures Drive States Toward Program Reinvention

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GAO

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Health, Education, and
Human Services Division

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April 4, 1995

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

Dear Mr. Chairman:

This report, prepared at your request, reviews federal and state spending trends and states' efforts to restructure their Medicaid programs.

We are sending copies of this report to the Secretary of Health and Human Services; the Administrator, Health Care Financing Administration; the Director, Office of Management and Budget; and other congressional committees. Copies of this report will also be made available to others on request. If you or your staff have any questions, please call me at (202) 512-6806. Major contributors to this report are listed in appendix V.

Sincerely yours,

Janet L. Shikles
Assistant Comptroller General

Executive Summary

Purpose

The $131 billion Medicaid program, a health care lifeline for over 33 million low-income Americans, is at a crossroads. Between 1985 and 1993 Medicaid costs tripled and the number of beneficiaries increased by over 50 percent. Current projections suggest that program costs will double over the next 5 to 7 years. While federal and state budgetary constraints highlight the urgency of containing costs, a number of states are pressuring to expand the program and enroll hundreds of thousands of new beneficiaries. The cost of expanded coverage, they believe, will be offset by the reallocation of certain Medicaid funds and the wholesale movement of beneficiaries into some type of managed care arrangement.

The House Budget Committee is examining Medicaid, among other entitlement programs, looking for opportunities to increase program efficiency and constrain spending growth. In light of this effort, the Chairman of the Committee asked GAO to examine (1) federal and state Medicaid spending, (2) some states' efforts to contain Medicaid costs and expand coverage through waivers of certain federal requirements, and (3) the potential impact of these waivers on federal spending and on Medicaid's program structure overall.

Background

Medicaid is not 1, but 56 separate programs (including the 50 states, District of Columbia, Puerto Rico, and the U.S. territories). Federal mandates call for common eligibility and benefit requirements, but states have discretion in how they implement their programs. As a result, the populations served and benefits provided vary across states. For example, Nevada serves 284 Medicaid beneficiaries for every 1,000 poor or near-poor individuals in the state, whereas Rhode Island serves 913 per 1,000. Similarly, Mississippi spends, on average, less than $2,400 per person on Medicaid services, while New York spends an average of almost $7,300 per person.

State programs also vary in the percentage of program expenditures that are covered by the federal government. The federal percentage is determined by a formula based on a state's per capita income. Low-income states receive higher percentages, though the range is legislatively limited from a minimum of 50 percent to a maximum of 83 percent. The federal government matches what the state spends on Medicaid by this percentage. In fiscal year 1993, 13 states, including New York, received 50 cents for every dollar spent on their respective Medicaid programs, whereas Mississippi, West Virginia, and Utah each received more than 75 cents for every Medicaid dollar spent. Yet because of the differences in

prices and in the benefits and services offered, New York receives $3,600 per beneficiary in federal aid, while Mississippi receives $1,900.

Since the 1970s states have been experimenting with a variety of managed care networks that limit which physicians and hospitals can serve the state's Medicaid beneficiaries. In some cases, the managed care networks are prepaid a fixed amount per enrollee. This financing arrangement is known as capitation and has demonstrated the ability to lower service utilization, which in turn can hold down costs.

More recently, escalating program costs have persuaded some states to move most or all of their Medicaid population into capitated managed care as a way of controlling future cost growth. To do so, states must obtain approval to waive certain federal Medicaid requirements. The waiver authority that gives states the greatest flexibility in implementing statewide managed care programs resides in section 1115 of the Social Security Act. Most waiver states are simultaneously seeking authority to use Medicaid funds to provide health care coverage to a portion of their low-income population that is currently ineligible for Medicaid benefits. States anticipate that savings from capitated managed care systems plus the redirection of other Medicaid or state funds will finance the coverage of these additional people. As part of the process of obtaining a section 1115 waiver, states must propose a financing plan that, over 5 years, is intended not to require greater federal expenditures on their Medicaid program than would have been the case without a waiver.

Results in Brief

Medicaid costs are projected to increase from about $131 billion to $260 billion by the year 2000, according to the Congressional Budget Office. Between 1985 and 1993, federal Medicaid expenditures grew each year, on average, by 16 percent. Although the program's current growth rate has moderated from that experienced in the early 1990s, it is still much higher than the 3.8-percent rate at which the overall federal budget has been growing. The continued phasing in of mandated populations and the increase in the expensive aged and disabled populations figure into estimates of Medicaid's future growth rate.

In the mid-1980s, some states began using creative financing mechanisms to leverage additional federal dollars. States collected donations and taxes from specific hospitals and then returned a portion of the collected funds to the same providers as special Medicaid payments. Because these payments (called DSH payments) were made to hospitals that served a

disproportionate share of Medicaid and low-income patients, they generated matching federal dollars. The states' bookkeeping sleight-of-hand increased federal payments without the states having to dip deeper into their own treasuries. Thus, the states were able to effectively increase the share of Medicaid funded by the federal government. This phenomenon helped fuel annual federal spending increases to over 25 percent—representing billions of dollars—in both 1991 and 1992. Although federal law has limited DSH payment growth since 1993, the gaming of these payments in some states has both increased the level and affected the distribution of current and future federal Medicaid spending.

More recently, states began seeking section 1115 waivers designed to contain the cost of their Medicaid programs through the use of capitated managed care delivery systems and expand coverage to uninsured individuals who would not normally qualify for Medicaid benefits. Certain states' initial estimates of these newly eligible individuals are high: 1.1 million in Florida, 395,000 in Ohio, and 500,000 in Tennessee. In addition to the 7 waivers approved since 1993, 15 states have either applied for waivers or made inquiries about submitting waiver applications. If similar coverage expansions are approved for additional and more densely populated states, the federal government as well as the states could be supporting millions more Medicaid beneficiaries.

GAO's analysis to date of four states with approved waivers shows that Florida, Hawaii, and Oregon may obtain more federal funding than they would have likely received under their original Medicaid programs. For Tennessee, on the other hand, GAO estimates that federal Medicaid spending over the life of the waiver may be less than might have been spent had the waiver not been approved. GAO has not analyzed the potential impact of the other waivers on federal spending.

To date, the administration has portrayed all statewide 1115 demonstration waivers as budget neutral to the federal government. Its approvals of waivers, however, may have state Medicaid programs working at cross purposes with federal deficit reduction goals. While these expansions will extend health care benefits to more low-income individuals, the result could also be a heavier burden on the federal budget.

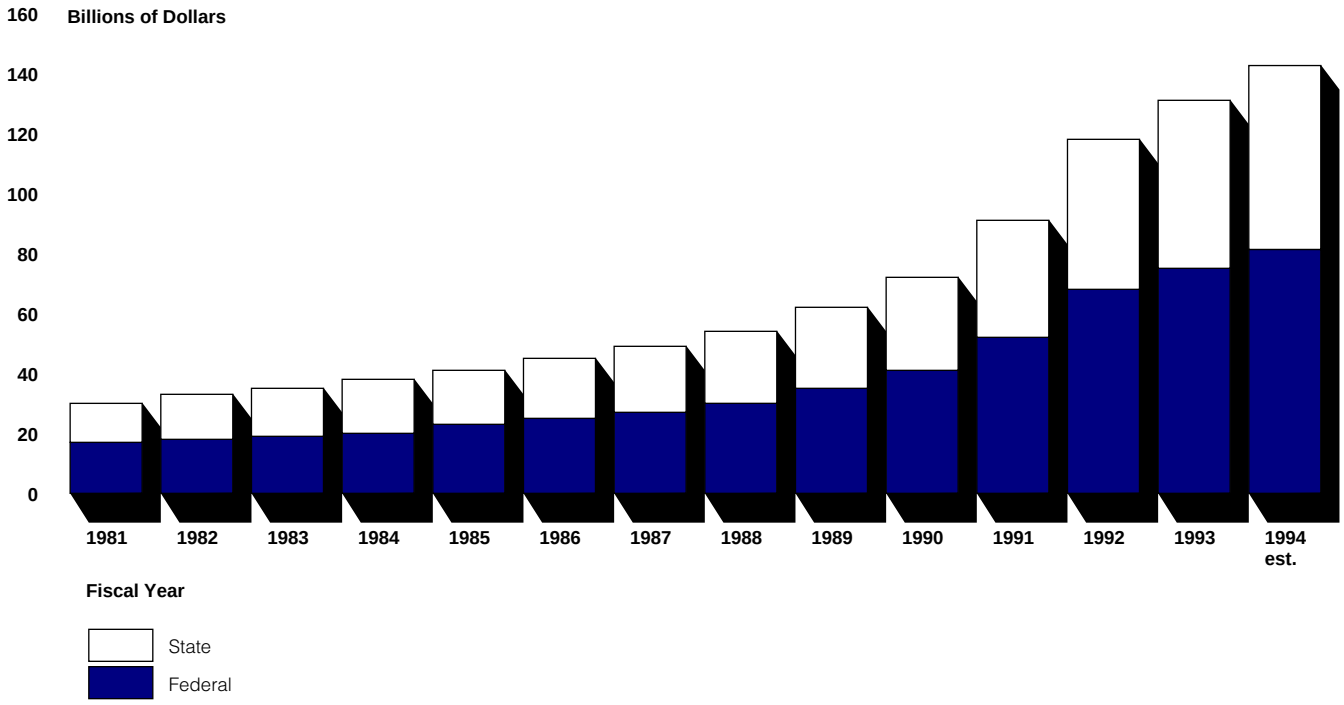
Principal Findings

Medicaid Consumes Growing Share of the Federal Budget

Medicaid currently consumes about 6 percent of all federal outlays (three times the share devoted to Food Stamps and five times the share devoted to Aid to Families with Dependent Children). Moreover, Medicaid's slice of the federal budget is growing faster than most other major budget items. If Medicaid continues indefinitely at its expected pace (10.7 percent), federal spending on the program will double roughly every 5 to 7 years.

Creative financing mechanisms used by states to leverage additional federal dollars contributed significantly to Medicaid's spending growth of over 25 percent in both 1991 and 1992. (Fig. 1 illustrates recent Medicaid spending growth.) Part of these financing mechanisms involved making payments to hospitals that served a disproportionate share of Medicaid and other low-income patients. These payments exploded from slightly less than $1 billion in 1990 to over $17 billion in 1992. However, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 as well as provisions in the Omnibus Budget Reconciliation Act of 1993 now prevent these payments from rising faster than overall Medicaid spending.

Figure 1: Medicaid Spending More Than Tripled Since 1985



Sources: Medicaid Source Book: Background Data and Analysis (A 1993 Update) (A Report Prepared by the Congressional Research Service for the Use of the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives, Jan. 1993), and HCFA.

Other factors have worked to increase Medicaid costs: medical inflation, higher utilization of services, and more beneficiaries. Although many of the new beneficiaries were pregnant women and children made eligible by congressional mandates enacted since 1984, the addition of this group played a less significant role in increasing Medicaid costs because these individuals are relatively inexpensive to serve. The pressure on Medicaid costs is expected to continue. For example, the number of individuals with disabilities receiving Medicaid benefits is growing faster than any other beneficiary group. While only about 15 percent of all Medicaid beneficiaries are disabled, this group accounts for a much larger share of program costs.

Waivers Used to Contain Costs and Expand Program Coverage

Section 1115 waivers are intended to permit experimentation by allowing states to run demonstration projects that further the goals of the Medicaid program. As such, these projects must have an evaluation component and are expected to run for a limited period of time. The only prior use of section 1115 authority comparable to recent statewide waiver applications was the 1982 initiation of a managed care program in Arizona, a state that had not participated previously in Medicaid. On a number of occasions, the Congress and the executive branch have extended the Arizona demonstration authority.

Section 1115 waivers are significant in two regards: they allow states greater flexibility to test cost containment strategies—namely alternative delivery arrangements such as capitated managed care—and they allow states to expand program eligibility beyond traditional Medicaid populations. Since 1993, the Health Care Financing Administration (HCFA), which oversees the Medicaid program, has approved seven statewide demonstration waivers for implementation: Florida, Hawaii, Kentucky, Ohio, Oregon, Rhode Island, and Tennessee. Florida and Ohio are awaiting state legislative approval and have not yet implemented their programs. In Kentucky, state legislators refused to authorize waiver implementation because they doubted that managed care savings would be sufficient to offset the costs associated with coverage of additional groups. Another 12 states have applications pending, and 3 more states have held discussions with HCFA about statewide demonstrations.

States are seeking waivers of managed care restrictions because they believe capitated managed care can cut health care costs. As of June 1994, 15 percent of program beneficiaries were signed up with capitated health plans, the fastest growing type of Medicaid managed care enrollment. However, some of the managed care restrictions being waived were partly a response to quality of care problems that emerged from states' experiments with managed care during the 1970s. When waiving these managed care restrictions through 1115 demonstration authority, HCFA has required states to implement improved quality assurance systems, including the collection of encounter data.

Because only two states have completed their first full year of waiver implementation, it is too early to assess the impact of the shift to managed care on beneficiary access to services and quality of care. However, the experience of Tennessee is instructive regarding the need to proceed cautiously when implementing a capitated managed care program statewide. At the outset, Tennessee start-up problems threatened

beneficiary access to services. The managed care networks were incomplete when beneficiaries were required to choose a plan and even on "opening day," many physicians had not yet determined which networks to join. During the first months of implementation, some providers reported slow or no payments for services. Also, a significant number of beneficiaries have expressed dissatisfaction with Tennessee's managed care program. The most recent beneficiary survey reported that 45 percent of enrollees who had previously received care under Medicaid's fee-for-service program were less than satisfied with TennCare.

Section 1115 Demonstrations Could Increase Federal Spending

The administration asserts that all of the approved statewide 1115 waivers are "budget neutral"—that is, federal spending for the demonstrations will not exceed what would have been spent if the states continued to operate their previous Medicaid programs. However, the administration has shown considerable flexibility in establishing 1115 waiver spending limits. For example, the cost of covering populations that could have been but were not covered—so-called "hypotheticals"—under the predemonstration program, have been considered budget neutral. Such flexibility has made it easier for demonstrations to meet the administration's redefined budget-neutrality test.

In contrast, GAO's initial test of budget neutrality involved a comparison of the approved waiver spending limits to a current services benchmark. This benchmark is defined by applying the administration's national projection of Medicaid spending growth during the life of the waiver to actual spending in the year prior to waiver approval. This comparison indicates that federal spending has the potential to be greater in Florida, Hawaii, and Oregon than it would have been in the absence of waivers, whereas federal spending over the life of Tennessee's waiver may be less than it otherwise would have been. The potential net spending impact associated with the four state waivers we analyzed is likely to be small relative to overall federal Medicaid spending. However, the impact of section 1115 demonstrations could increase substantially if the waivers pending or proposed by several additional states—or even a few large states—are not budget neutral.

Because of the bilateral nature of the negotiations between states and the administration, and because of the discretion granted to the executive branch in approving 1115 waivers, the terms and conditions for each state are unique. As a result, the federal government's financial liability varies with each state, depending on the waiver terms negotiated. Most states

have agreed to limits on federal spending per person, or per capita caps. Two have agreed to a total spending limit, or aggregate cap. Although for some states federal liability is potentially greater than would be the case without the waiver, it is limited in that each waiver agreement ensures a ceiling on federal spending and holds some financial risk for the states.

Observations on Medicaid's Future

Over 33 million low-income women, children, elderly, blind, and disabled Americans depend upon health care made possible by the Medicaid program. However, the program's double-digit spending growth rate imperils efforts to bring the federal deficit under control. Consistent with the Committee's interest in constraining federal spending, states believe they need the flexibility to manage their respective programs. Requiring states to obtain waiver approval in order to aggressively pursue managed care strategies may hamper their cost containment efforts. Yet, because current program restrictions on managed care were designed to reinforce quality assurance, in the absence of these restrictions, continuous oversight of managed care systems is required to protect both Medicaid beneficiaries from inappropriate denials of care and federal dollars from payment abuses. Finally, GAO believes that the potential for increased federal spending under future statewide demonstrations warrants close scrutiny of section 1115 waiver approvals.

Agency Comments

GAO discussed its findings with officials of HCFA's Medicaid Bureau, the Office of Research and Demonstrations, and the Office of State Health Reform. In addition, GAO discussed its approach to measuring budget neutrality with officials at the Office of Management and Budget (OMB). The administration's technical comments have been reflected, as appropriate, in this report.

Administration officials agreed with GAO that their waiver review policies, which they describe as more flexible, differ from those of previous administrations. In particular, the administration's approach to defining budget neutrality is characterized by (1) flexibility in determining appropriate baseline expenditures and (2) assessment of budget neutrality over the life of the waiver rather than year by year. The administration disagrees with GAO's efforts to develop a consistent methodology for assessing budget neutrality by using OMB's national estimate of projected Medicaid spending. Instead, it suggests that a "state-specific approach" that incorporates states' historical experience is necessary to reflect the "dramatic variation" that exists in state Medicaid programs. This report

notes, however, that recent growth in Medicaid expenditures was influenced by a number of state strategies, such as DSH payment schemes and federal eligibility mandates, that are unlikely to be repeated. GAO believes that using unique methods in each state has created the potential for budget-neutrality decisions to be based on the technique most favorable to a particular state. If state-specific reasons exist for future Medicaid growth to differ from the national average, they should be well documented.

The administration disputes GAO's contention that the comprehensive scope of the waiver demonstrations makes it controversial to characterize them as experimental. GAO's view remains that regardless of how innovative the elements of these demonstrations are, the extension of health care coverage to several hundred thousand people will make it difficult to terminate a demonstration that fails to achieve its objectives. (The complete text of the administration's comments is in app. IV.)

Contents

Abbreviations

AFDC	Aid to Families with Dependent Children
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
DEFRA	Deficit Reduction Act of 1984
DSH	disproportionate share hospital
EPSDT	early and periodic screening, diagnostic, and treatment
FMAP	federal medical assistance percentage
FPL	federal poverty level
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IRCA	Immigration Reform and Control Act of 1986
MCCA	Medicare Catastrophic Coverage Act of 1988
NACHC	National Association of Community Health Centers
OBRA 1986	Omnibus Budget Reconciliation Act of 1986
OBRA 1987	Omnibus Budget Reconciliation Act of 1987
OBRA 1989	Omnibus Budget Reconciliation Act of 1989
OBRA 1990	Omnibus Budget Reconciliation Act of 1990
OBRA 1993	Omnibus Budget Reconciliation Act of 1993
OMB	Office of Management and Budget
SSI	Supplemental Security Income

Introduction

In 1993, Medicaid, the government's health financing program for certain low-income populations, cost the federal and state governments $131 billion—almost $100 billion more than just a decade ago.[1] During that same period, the number of Medicaid beneficiaries increased from 22 million to 33 million. Although about three-quarters of the beneficiaries are poor children and their parents, two-thirds of the expenditures are for poor elderly, blind, and disabled individuals. Funding is a shared responsibility between the federal and state governments, with respective federal and state shares determined through a statutory matching formula. Federal law mandates coverage of certain medical services and population groups. It also includes coverage options, allowing states to choose whether to cover additional services or low-income population groups.

Not 1, but 56 Separate Medicaid Programs

Dramatic differences in Medicaid programs across states reflect spending priorities of the states, their ability to pay, and incentives inherent in the federal matching formula.[2] States partly determine the extent of their Medicaid program when they set eligibility requirements for receiving cash assistance (primarily Aid to Families with Dependent Children—AFDC).[3] Under federal law, AFDC recipients are automatically eligible for Medicaid. States also determine program scope by selecting which optional services or groups to include in their programs. With some discretion to modify eligibility and benefit provisions, the proportion of the poor (as defined by the federal poverty level) and near-poor served by Medicaid varies greatly by state.[4] For example, for every 1,000 people with incomes under 150 percent of the federal poverty level, Rhode Island serves 913 beneficiaries, whereas Nevada serves 284. Nationally, in 1994 Medicaid covered medical services for 58 percent of people under age 65 living in poverty.

State Medicaid programs also vary in the levels of benefits provided. For example, some states limit their Medicaid coverage of inpatient days (a required service) to a certain number per person. States also have the

[1]Amounts include both health services and administrative costs.

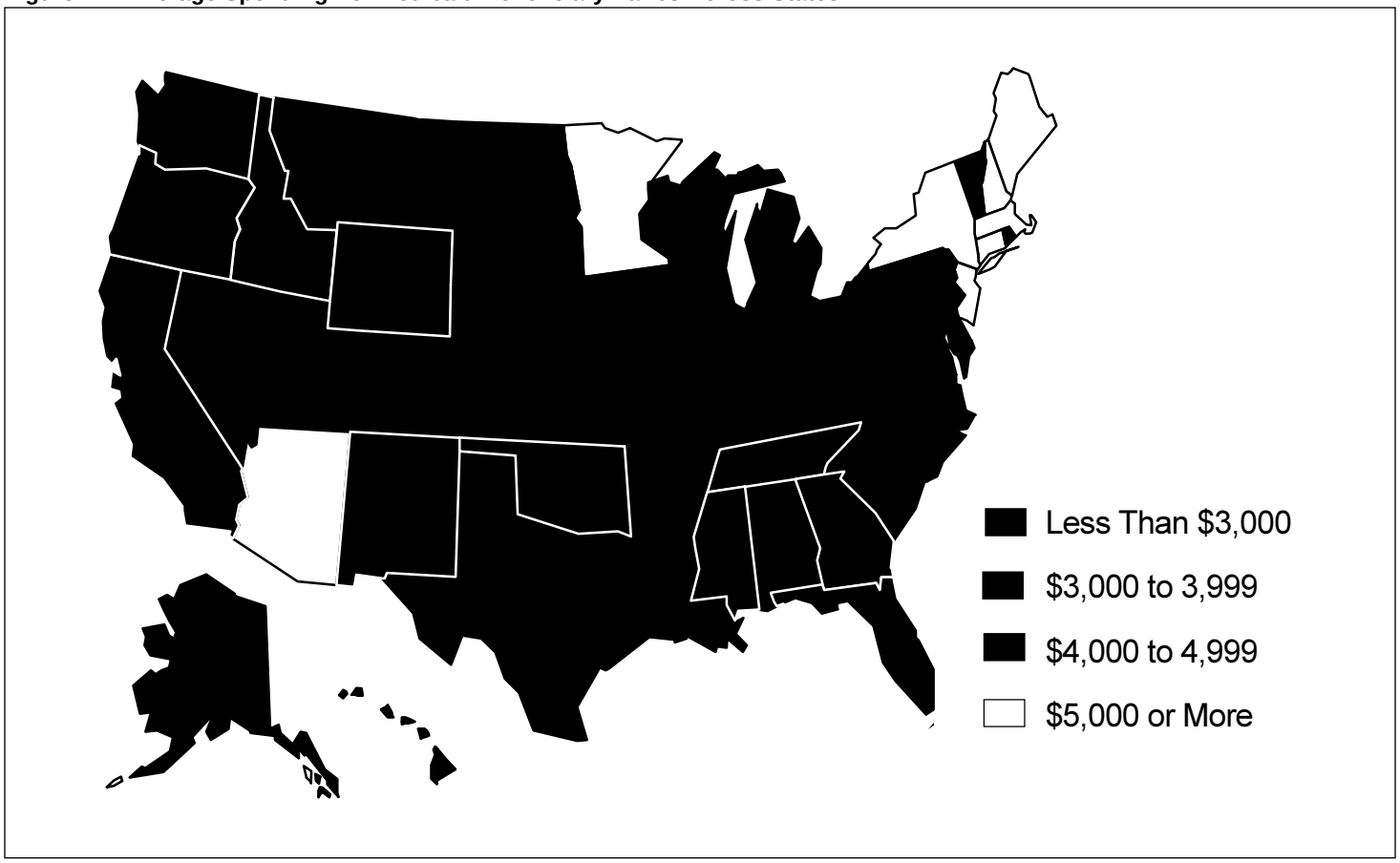
[2]Participation in the Medicaid program by states is voluntary. However, all 50 states plus the District of Columbia and American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands have elected to administer Medicaid programs. We refer to all 56 entities as "states" for this report.

[3]In 1993, the qualifying level for AFDC varied across states from 17 to 93 percent of the federal poverty level, which in 1993 was income of $11,890 for a family of three.

[4]States also have discretion in setting their own standards and methods for reimbursement of Medicaid services.

discretion to drop their coverage of optional services, such as dental or optical care. The average Medicaid benefit (that is, total medical spending divided by total beneficiaries) ranges from $2,372 in Mississippi to $7,286 in New York. (See fig. 1.1 for grouping of states by their average benefit level and table 1.1 for state-by-state data.) States with higher Medicaid benefits tend to cover a greater proportion of poor people, relative to states with lower benefits. Thus, the differences among states in spending per poor person are even greater than the differences among states in spending per beneficiary.

Figure 1.1: Average Spending Per Medicaid Beneficiary Varies Across States



Source: Medicaid Statistics, Program and Financial Statistics, 1993, U.S. Department of Health and Human Services, Health Care Financing Administration.

Table 1.1: Medicaid Expenditures by State, Fiscal Year 1993

State	Federal and state Medicaid spending[a] (thousands)	Federal medical assistance percentage[b]	Medicaid spending per beneficiary	Medicaid spending per person in poverty	Federal Medicaid spending per person in poverty
Alabama	$1,637,242	71.45	$3,139	$2,258	$1,616
Alaska	295,384	50.00	4,539	5,680	3,034
Arizona	1,365,046	65.89	3,379	2,220	1,481
Arkansas	1,031,148	74.41	3,038	2,130	1,587
California	13,538,038	50.00	2,801	2,333	1,168
Colorado	1,091,709	54.42	3,890	3,084	1,687
Connecticut	2,274,592	50.00	6,817	8,212	4,118
Delaware	252,993	50.00	3,670	3,466	1,742
District of Columbia	686,719	50.00	5,710	4,346	2,176
Florida	4,948,988	55.03	2,836	1,974	1,088
Georgia	2,798,657	62.08	2,930	3,045	1,898
Hawaii	380,668	50.00	3,462	4,183	2,098
Idaho	293,674	71.20	2,951	1,958	1,397
Illinois	4,981,454	50.00	3,569	3,113	1,561
Indiana	2,815,525	63.21	4,984	3,999	2,532
Iowa	987,200	62.74	3,413	3,404	2,141
Kansas	889,666	58.18	3,663	2,721	1,587
Kentucky	1,863,697	71.69	3,017	2,443	1,754
Louisiana	3,493,823	73.71	4,651	3,122	2,303
Maine	855,860	61.81	5,070	4,367	2,704
Maryland	1,960,419	50.00	4,409	4,093	2,054
Massachusetts	4,131,904	50.00	5,402	6,446	3,228
Michigan	4,362,644	55.84	3,724	2,958	1,655
Minnesota	2,167,025	54.93	5,093	4,283	2,358
Mississippi	1,196,475	79.01	2,372	1,872	1,480
Missouri	2,251,606	60.26	3,695	2,706	1,635
Montana	323,271	70.92	3,631	2,545	1,822
Nebraska	564,169	61.32	3,426	3,338	2,052
Nevada	423,447	52.28	4,789	3,003	1,578
New Hampshire	417,627	50.00	5,264	3,729	1,874
New Jersey	4,706,049	50.00	5,930	5,434	2,724
New Mexico	571,200	73.85	2,373	2,026	1,510
New York	19,980,838	50.00	7,286	6,703	3,360
North Carolina	2,896,330	65.92	3,224	2,998	1,982
North Dakota	269,675	72.21	4,343	3,852	2,795

(continued)

State	Federal and state Medicaid spending[a] (thousands)	Federal medical assistance percentage[b]	Medicaid spending per beneficiary	Medicaid spending per person in poverty	Federal Medicaid spending per person in poverty
Ohio	5,179,121	60.25	3,474	3,545	2,139
Oklahoma	1,089,730	69.67	2,819	1,646	1,153
Oregon	955,605	62.39	2,938	2,633	1,647
Pennsylvania	5,612,714	55.48	4,589	3,512	1,953
Rhode Island	829,026	53.64	4,337	7,676	4,123
South Carolina	1,682,379	71.28	3,576	2,481	1,772
South Dakota	266,294	70.27	3,826	2,611	1,859
Tennessee	2,675,390	67.57	2,943	2,681	1,812
Texas	7,118,558	64.44	3,084	2,241	1,448
Utah	477,624	75.29	3,224	2,353	1,773
Vermont	255,476	59.88	3,171	4,330	2,605
Virginia	1,791,773	50.00	3,111	2,858	1,435
Washington	2,316,480	55.02	3,657	3,654	2,017
West Virginia	1,200,412	76.29	3,459	3,001	2,290
Wisconsin	2,114,971	60.42	4,489	3,325	2,014
Wyoming	134,793	67.11	2,914	2,106	1,423
Total	**$126,405,107**				
National average		**57.34[c]**	**$3,870**	**$3,223**	**$1,846**

[a]Includes payments made to disproportionate share hospitals (DSH). Excludes federal and state administrative costs.

[b]The FMAP is the federal government's share of each state's payments for services.

[c]Weighted average.

Source: Medicaid Statistics, Program and Financial Statistics, 1993, and Bureau of the Census.

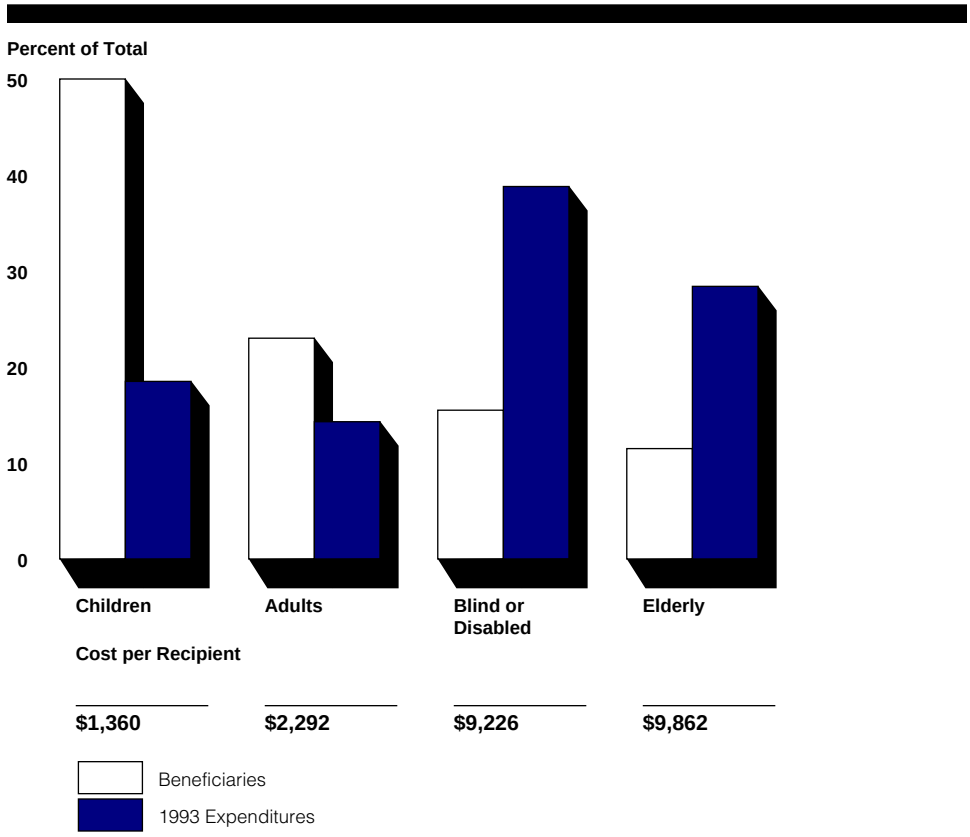
Services for Elderly and Disabled Consume Greatest Share of Funding

By far, the majority of Medicaid funds are paid on behalf of poor elderly, blind, and disabled individuals. Representing only slightly more than a fourth of all Medicaid beneficiaries, these groups incurred about 66 percent ($82.2 billion) of Medicaid's 1993 expenditures, as shown in figure 1.2.[5] The average per person spending for these beneficiaries exceeded $9,200—four times more than was spent on other adults ($2,292) and seven times more than was spent on other children ($1,360). The per

[5]These figures represent national averages—percentages for specific states may be higher or lower.

person spending for all Medicaid beneficiaries averaged nearly $3,900; in contrast, health spending per person for the U.S. population averaged about $3,300.

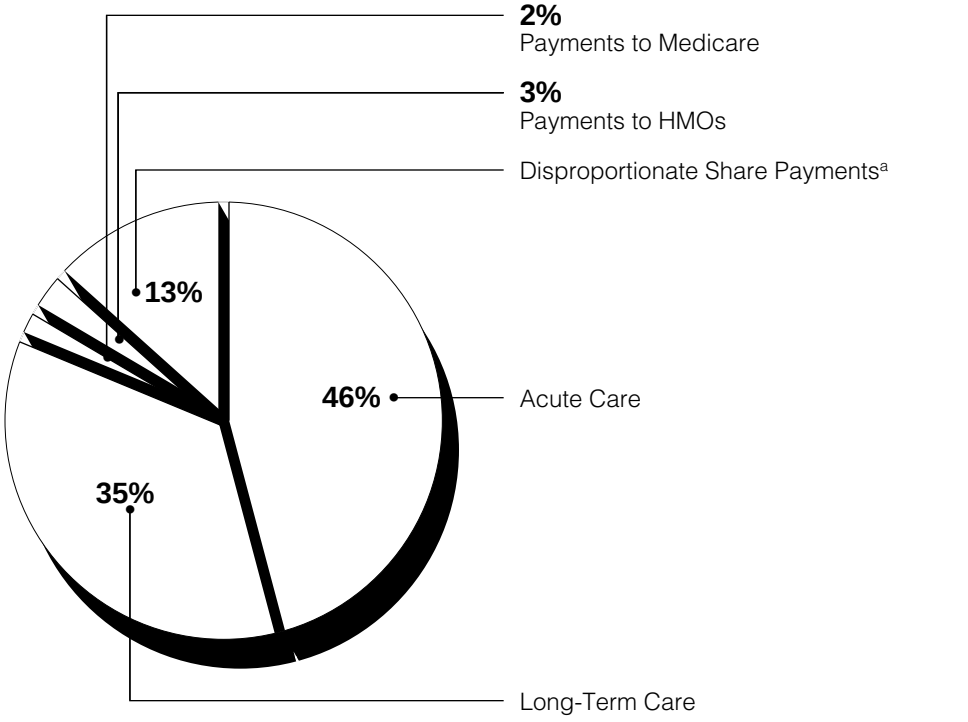
Figure 1.2: Cost of Serving Disabled and Elderly High Compared With That of Serving Other Children and Adults



Source: The Kaiser Commission on the Future of Medicaid.

In 1993, about 35 percent of Medicaid spending was for long-term care, including nursing home care payments. Medicaid pays about 52 cents of every nursing home care dollar. About 46 percent of all Medicaid spending was for acute care. (See fig. 1.3 for a breakdown of Medicaid spending.)

Figure 1.3: Long-Term Care Accounts for One-Third of Medicaid's Spending for Services



[a]Payments to hospitals that serve a disproportionate number of Medicaid and other low-income patients with special needs. There are no federal restrictions on how hospitals use these payments.

Source: The Kaiser Commission on the Future of Medicaid.

Federal Medical Assistance Payments Based on Per Capita Income

The financing of Medicaid is shared by the federal government and the states. The federal share paid to a state is based on the federal medical assistance percentage (FMAP). Determined separately for each state, the FMAP ranges from a minimum of 50 percent to a maximum of 83 percent of total Medicaid costs.

The formula for determining the FMAP is based on a state's per capita income. It is designed to provide a higher federal match to states with low per capita incomes. In fiscal year 1993, Mississippi, West Virginia, and Utah had the highest federal match percentages; each received more than

75 percent of its Medicaid program funding from the federal government. Alternatively for that year, the federal government paid 50 percent of Medicaid costs, the minimum match, in 12 states and the District of Columbia.

In spite of the formula's sliding match rate, federal spending per Medicaid beneficiary tends to be highest in states with high per capita incomes. Because high-income states tend to offer relatively generous benefits, the absolute amount of federal spending per beneficiary is high, even though the match rate is only 50 percent.[6] For example, New York—a high-income state with a 50-percent match—receives $3,600 per beneficiary in federal aid, while Mississippi—a low-income state with approximately an 80-percent match—receives $1,900 per beneficiary in federal aid.[7]

Reporting on this subject in 1983, 1990, and 1993, we noted that the FMAP formula could be improved to meet federal goals.[8] The federal assistance formula is designed to reduce differences among the states in medical care coverage of the poor and distribute fairly among the states the burden of financing program benefits. However, the formula's reliance on a state's per capita income does not adequately address these equity goals. In fiscal year 1991, for example, the District of Columbia and Nevada received the same FMAP, despite the District's greater proportion of people eligible for Medicaid. Our prior work in this area concluded that the formula could better adjust for states' different needs and varying abilities to fund benefits by considering a state's number of persons in poverty and more comprehensive measures of taxing capacity.

Section 1115 Waivers Permit Major Program Changes Without Congressional Debate

In recent years, many states have been experimenting with health financing reforms. Under Medicaid law, states proposing to implement payment and service delivery innovations outside the range allowed by federal rules must seek approval to waive certain federal requirements. Until recently, though, Medicaid experiments have been relatively limited.

[6]The top six states in terms of spending per beneficiary (New York, Connecticut, New Jersey, District of Columbia, Massachusetts, and New Hampshire) have high per capita incomes, relative to the national average, and receive only a 50-percent federal share.

[7]To the extent that the cost of medical services varies with state per capita income, the dollar differences somewhat overstate the differences in real Medicaid services provided by states.

[8]Medicaid: Changing Medicaid Formula Can Improve Distribution of Funds to States (GAO/GGD-83-27, Mar. 9, 1983), Medicaid Formula: Fairness Could Be Improved (GAO/T-HRD-91-5, Dec. 7, 1990), and Medicaid: Improving Funds Distribution (GAO/HRD-93-112FS, Aug. 20, 1993).

However, states have been seeking approval for broader changes under section 1115 waivers, so called because of the statutory provision authorizing them,[9] which offer more open-ended opportunities to make major changes in Medicaid than program waivers.[10] Changes proposed in section 1115 waiver applications are considered demonstration projects. Unlike the routine approvals for program waivers, approvals for demonstration waivers are subject to much greater discretion by the Secretary of the Department of Health and Human Services (HHS). (The Health Care Financing Administration (HCFA) and the Office of Management and Budget (OMB) have also been key players in the waiver approval process.) Section 1115 waivers can exempt states from compliance with normal Medicaid requirements and allow them to receive federal funding for expenditures normally not eligible for such assistance. HHS requires that waiver applications include a formal research or experimental methodology, and historically waivers have not been considered automatically renewable. Section 1115 waivers typically involve limited research projects, but since 1993 several statewide demonstration projects have been approved.

Among other things, recent section 1115 waivers have allowed states to mandate enrollment of all their beneficiaries in Medicaid-participating managed care plans and to prevent disenrollment for specific periods of time, usually 6 to 12 months. States with recently approved waivers have proposed expanding coverage of their indigent citizens by recycling savings anticipated in changing from a fee-for-service to a managed care system and redirecting other Medicaid and state funds. If these states' demonstrations are implemented as planned, the states would be covering some low-income individuals that would not otherwise qualify for Medicaid. We discuss the significance of these waivers to the restructuring of the Medicaid program in chapter 3 and their potential impact on the federal budget in chapter 4.

[9]The waiver authority resides in section 1115(a) of the Social Security Act, 42 U.S.C. 1315(a), which gives the Secretary of HHS broad authority to waive statutory requirements for Medicaid and other programs, such as AFDC, to permit states to run experimental, pilot, or demonstration projects "likely to assist in promoting the [program's] objectives." States may be exempted from compliance with program requirements, or receive federal funding for expenditures normally not eligible for such assistance, or both.

[10]There are various types of waivers under Medicaid, and those typically referred to as "program" waivers (approval to waive certain requirements for a specific population or geographic area) are designed for routine approval, as long as states meet certain qualifications. States may apply for periodic renewals. In 1994 all states, except for Arizona and the District of Columbia, operated one or more innovations under program waivers.

Objectives, Scope, and Methodology

The House Budget Committee asked us to examine (1) the nature of federal and state Medicaid spending in recent years, (2) some states' efforts to contain Medicaid costs and expand coverage through waivers of certain federal requirements, and (3) the potential impact of the waivers on federal spending and on Medicaid's program structure overall.

Collecting Information on Medicaid Spending and Waivers

To address the issue of federal and state Medicaid spending, we analyzed data contained in HCFA statistical reports and also reviewed and synthesized information from research articles and major studies that focused on Medicaid costs. To obtain information on states' efforts to contain Medicaid costs and expand coverage through waivers, we interviewed Medicaid program and other state agency officials, providers, advocacy groups, and state legislators in five of the eight states with approved waivers. We also interviewed HCFA officials responsible for examining waiver proposals and reviewed documentation for the approved and pending projects as well as statistical and other reports on the Medicaid program.

Examining the Potential Impact of Waivers

We determined the potential impact of waivers on federal spending by developing and applying a consistent framework that compares spending limits approved in each waiver with a benchmark incorporating current services budgeting concepts.[11] To eliminate the effect of accelerated program growth from past years—acceleration due in part to high medical inflation, large increases in state disproportionate share hospital (DSH) payments, and mandated expansions in program eligibility—we compared the waiver spending limits with a projection of spending for each state's current Medicaid program over the life of the waiver. To make these projections we used the administration's estimated rate of growth of Medicaid current services outlays for the nation as a whole. These estimated growth rates are based only on expected increases to medical inflation and program population growth—without any change in eligibility requirements.

[11]According to HCFA, each approved waiver is budget neutral, that is, the waiver programs—including the expanded populations—will cost no more to operate than the traditional Medicaid programs would have in each state over the 5 years of the demonstrations. However, in determining the theoretical funding level for continuing the traditional Medicaid program, HCFA and the states made assumptions that we do not believe are consistent with the concept of "budget neutrality," such as including persons who states could make, but are not currently, eligible (frequently referred to as "hypotheticals") in the program baseline and allowing for program growth that more closely approximates historically high levels than the lower projection of future growth.

To make the current services projection for each state's Medicaid program (what we call our budget-neutrality benchmark) we multiplied each state's base-year estimates of Medicaid funding (for the segment of the population to be covered by their waiver) by the administration's estimates of national program growth made when HCFA approved the waiver. We adjusted our baseline, when necessary, to reflect constraints on the growth of DSH payments in each state's Medicaid program. The actual process varied slightly, depending on whether the state's waiver was subject to an aggregate or per capita funding limit.

Once we had determined our administration-based estimate of current services outlays, we compared it with the estimated program funding from the waiver agreements. In states with aggregate caps, we compared our estimates with actual program caps. In states with per capita caps, we compared our estimates with state program funding levels consistent with the enrollment figures found in the waiver applications, recognizing that actual funding ceilings would be higher or lower, depending on actual enrollment.

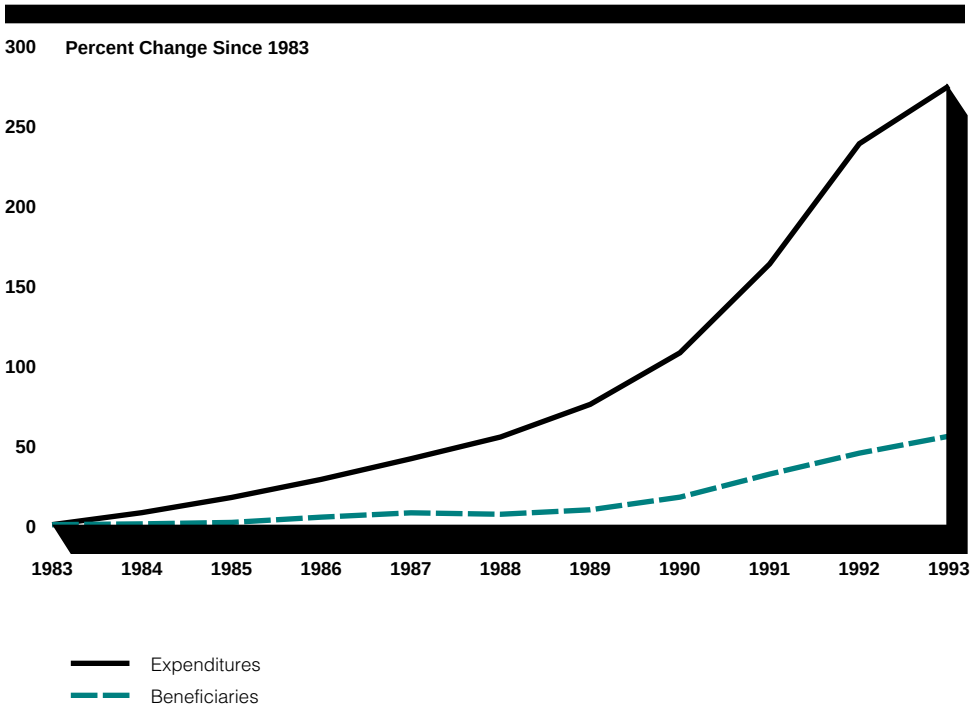
We subtracted our annual, budget-neutrality benchmark figures from the waiver agreement figures and then discounted this amount to determine the present value of potential annual savings or increased funding. The difference—if positive—showed the amount of program funds above our benchmark amount that might be needed to finance the program and—if negative—showed the amount the program might save.

We did our work for this report and other related studies between August 1994 and March 1995 in accordance with generally accepted government auditing standards.

Despite a Recent Slowdown, Medicaid Consumes a Growing Share of the Federal Budget

Medicaid has become one of the fastest growing components of federal and state budgets. In part, this is the result of program expansions. After remaining relatively stable for a decade, the number of Medicaid beneficiaries began to climb rapidly after the mid-1980s.[12] Since that time, the number of beneficiaries served annually has increased by over 11 million, reaching 33.4 million in 1993. However, costs have grown even faster than the number of beneficiaries. (See fig. 2.1.) Between 1985 and 1993, federal Medicaid expenditures grew each year, on average, by 16 percent. During this time, state Medicaid expenditures grew at a slightly slower rate of 15 percent. In 5 years, Medicaid spending is expected to exceed $260 billion annually. (See fig. 2.2.)

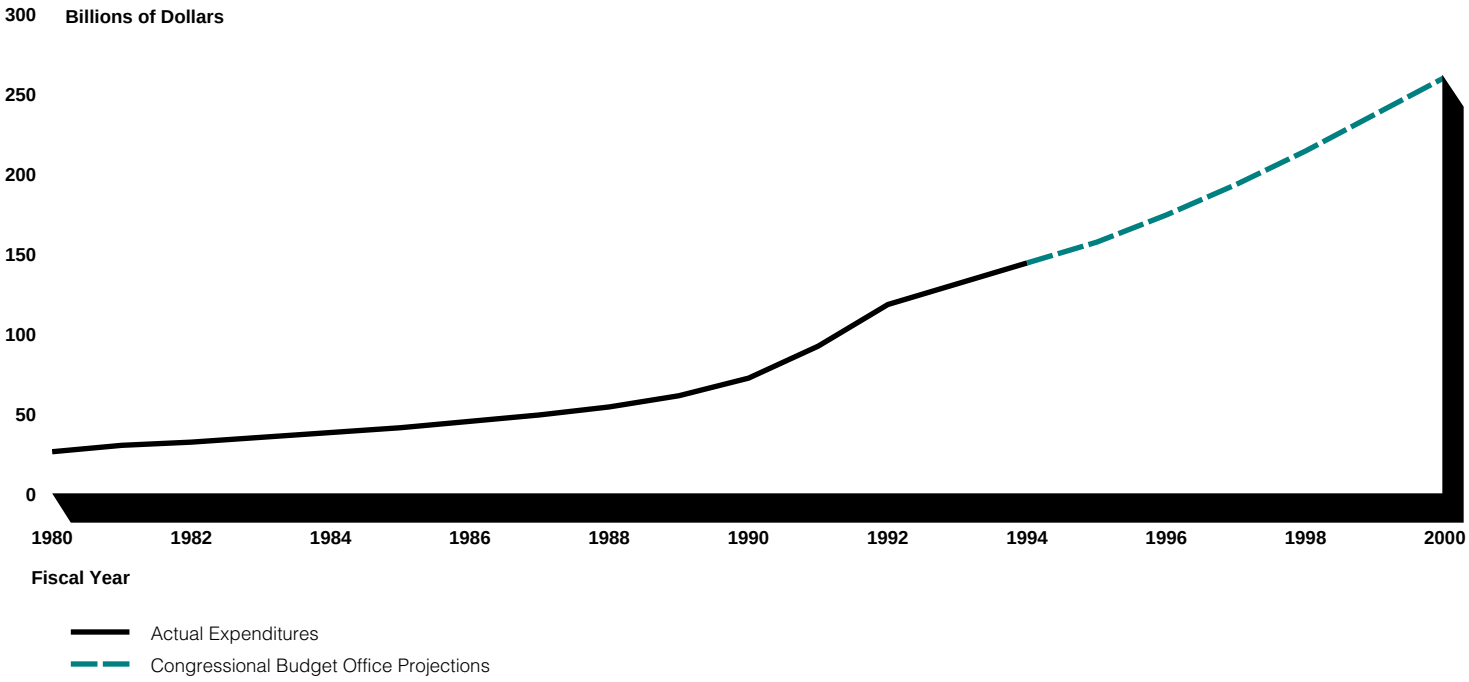
Figure 2.1: Medicaid Spending Outpaced Rise in Beneficiary Numbers From 1983 to 1993



Sources: Medicaid Source Book: Background Data and Analysis (A 1993 Update) (A Report Prepared by the Congressional Research Service for the Use of the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives, Jan. 1993) and Medicaid Statistics, Program and Financial Statistics for 1991-93.

[12]Between 1975 and 1985 the total number of beneficiaries varied by less than 1.5 million, ranging from 21.5 million to 22.8 million.

Figure 2.2: Medicaid Expected to Grow to $260 Billion by Year 2000



Sources: Medicaid Source Book: Background Data and Analysis (A 1993 Update), Medicaid Statistics, Program and Financial Statistics for 1991-93, and Congressional Budget Office estimates.

Medicaid Coverage Has Expanded Since 1984

The federal government influences total Medicaid spending indirectly by specifying the percentage of state Medicaid expenditures the federal government will pay (higher matching rates encourage greater state spending), and directly by specifying some eligibility and benefit requirements. Between 1984 and 1990, the Congress expanded Medicaid coverage by mandating that states serve certain low-income groups and provide certain services, and allowing optional coverage for other low-income groups and services.[13] (See app. I.)

The mandates extended coverage primarily to additional low-income pregnant women, children, and Medicare beneficiaries. The mandates also extended transitional Medicaid coverage for families leaving AFDC for gainful employment, established a new categorically needy coverage group

[13]The Congress also required states to increase certain aspects of service coverage.

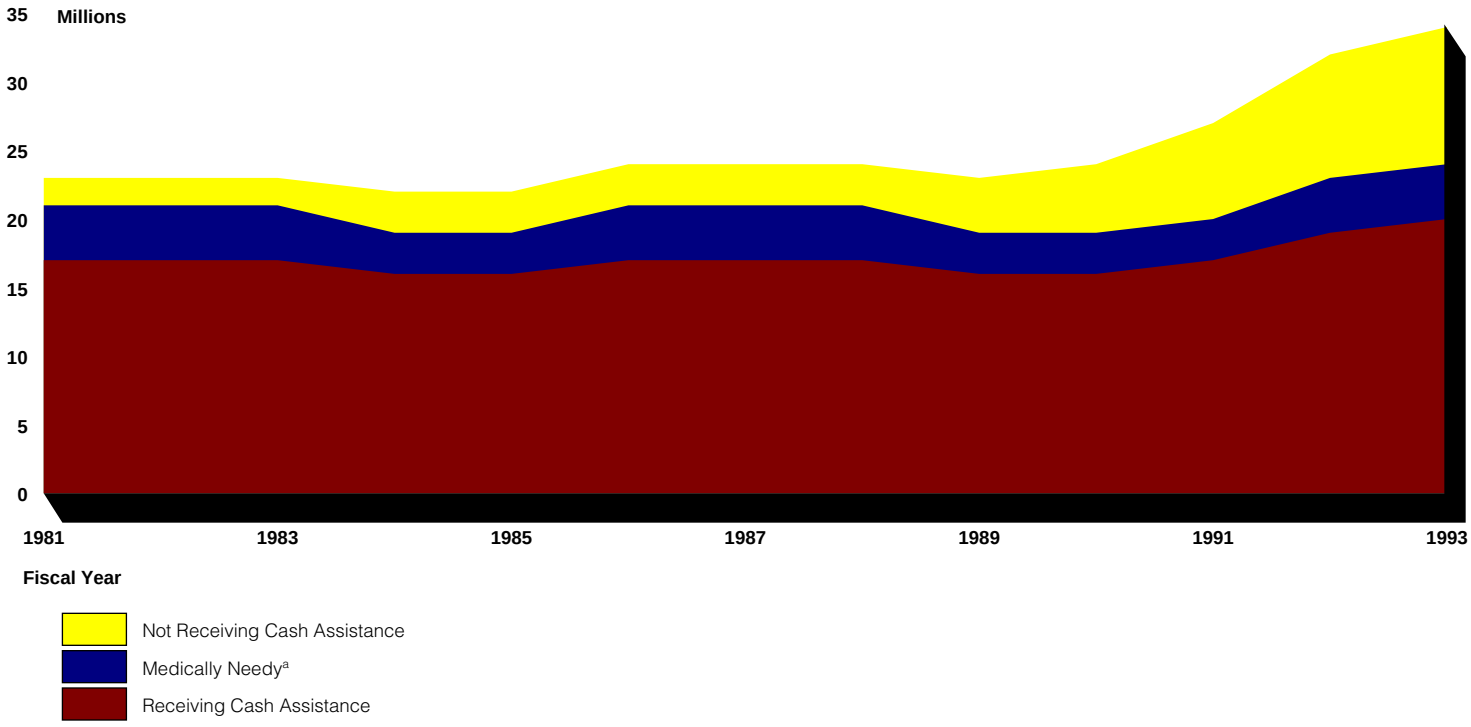
for severely impaired individuals under the age of 65, and added coverage of certain chronically ill or disabled individuals.[14] The Kaiser Commission on the Future of Medicaid noted that between 1990 and 1992, enrollment increased by about 6 million individuals, with about one-third of this increase attributable to pregnant women and children.[15] Since some states provided benefits when coverage of these groups was optional, the mandates tended to equalize benefits among states.

Because both the mandates and options tied coverage to the federal poverty level, which is uniform across states, they greatly increased the number of persons receiving Medicaid who were not eligible for cash assistance. (See fig. 2.3.) This resulted in a decline in the proportion of beneficiaries eligible for Medicaid through a cash-assistance-related category. In 1993, about 60 percent of the beneficiaries were eligible for Medicaid coverage under a cash-assistance-related category, down from 68 percent in 1990.

[14]Access to Medicaid coverage for disabled children has increased since 1990, when the Supreme Court ruled that disability standards for children may be no more narrow than those applied to adults. Sullivan v. Zebley, 493 U.S. 521 (1990). As a result, eligibility criteria for children are based on the child's developmental delay and limitations on the child's ability to engage in age-appropriate activities of daily living. This has increased the number of children classified as disabled. Prior to 1990, the same disability criteria that applied to adults, which emphasize inability to engage in employment, were also applied to children.

[15]Kaiser Commission Update: Medicaid Spending Growth, 1990 to 1992, The Kaiser Commission on the Future of Medicaid, Policy Brief, No. 1 (Washington, D.C.: July 1991).

Figure 2.3: Enrollment Increases Highest for Those Not Receiving Cash Assistance



[a]Individuals who have incomes too high to qualify for cash assistance, but who have incurred medical expenses that depleted their incomes and resources to levels that make them needy. States are permitted, but not required, to cover medically needy individuals.

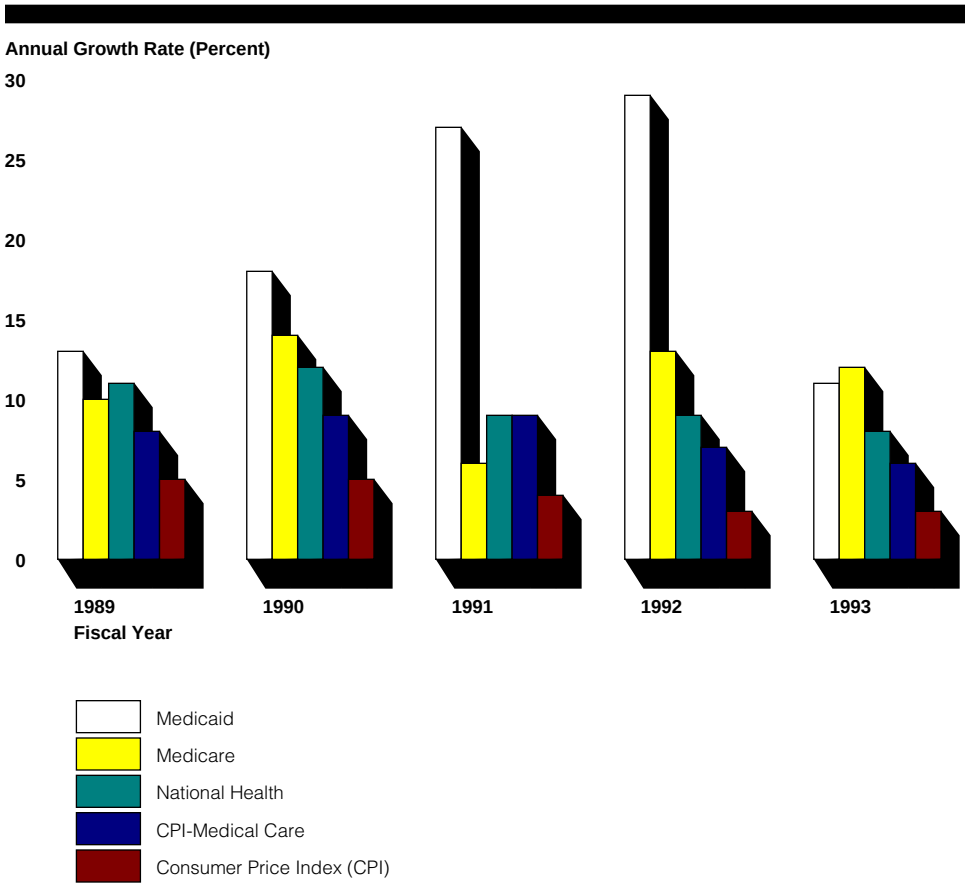
Sources: Medicaid Source Book: Background Data and Analysis (A 1993 Update) and Medicaid Statistics, Program and Financial Statistics for 1991-93.

Medicaid Grew Faster Than Medical Inflation, Other Spending

During most of the 1980s, spending for Medicaid, private health insurance, and Medicare grew at an annual rate of 10 to 11 percent. In 1989, however, Medicaid's spending growth began to rise sharply. In 1991 Medicaid's 27-percent annual growth rate was over three times greater than the growth rate for national health expenditures and over four times greater than the rate for Medicare. (See fig. 2.4.) In 1992 Medicaid's annual growth rate reached a record high of about 29 percent. Even though it fell to 11 percent in 1993, Medicaid's annual growth rate continued to outpace the consumer price index and, except for Medicare, other key indicators

used to measure health care spending. Medicaid consumes slightly more than 14 cents of every personal health care dollar.

Figure 2.4: Dramatic Increases in Medicaid Expenditures Slowed in 1993

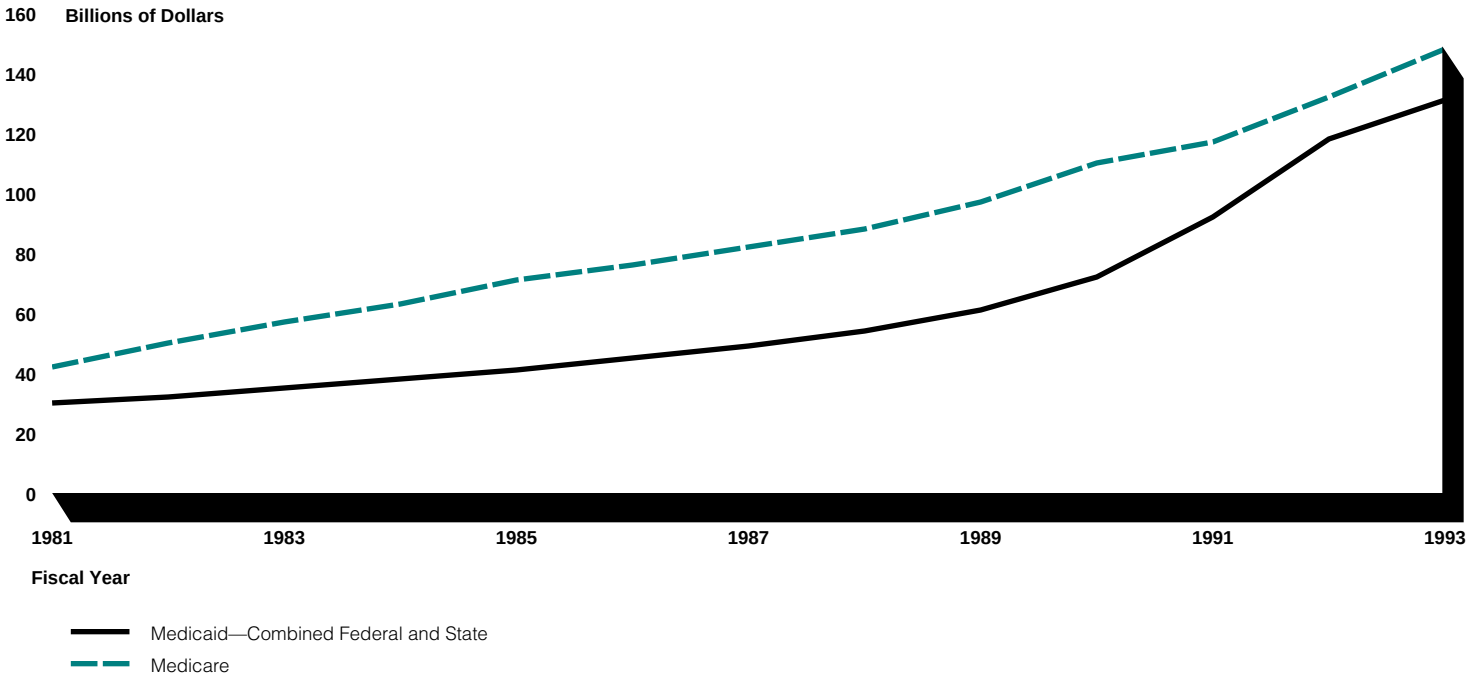


Sources: Data for Medicaid are from Medicaid Source Book: Background Data and Analysis (A 1993 Update). Data for Medicare are from annual reports of the trust funds' trustees, 1989-93. Data for national health expenditures are from Department of Health and Human Services National Health Expenditures for 1993. Data for CPI and Medical Care Index are from Bureau of Labor Statistics.

Figure 2.5 illustrates spending by Medicaid and Medicare since 1981. Historically, Medicaid spending on health care services for the poor has been significantly less than Medicare spending for the nation's elderly. In the 1980s, the gap widened, and by 1990, Medicare spending exceeded

Medicaid's by over $37 billion. By 1992, however, the difference had narrowed to $14 billion.

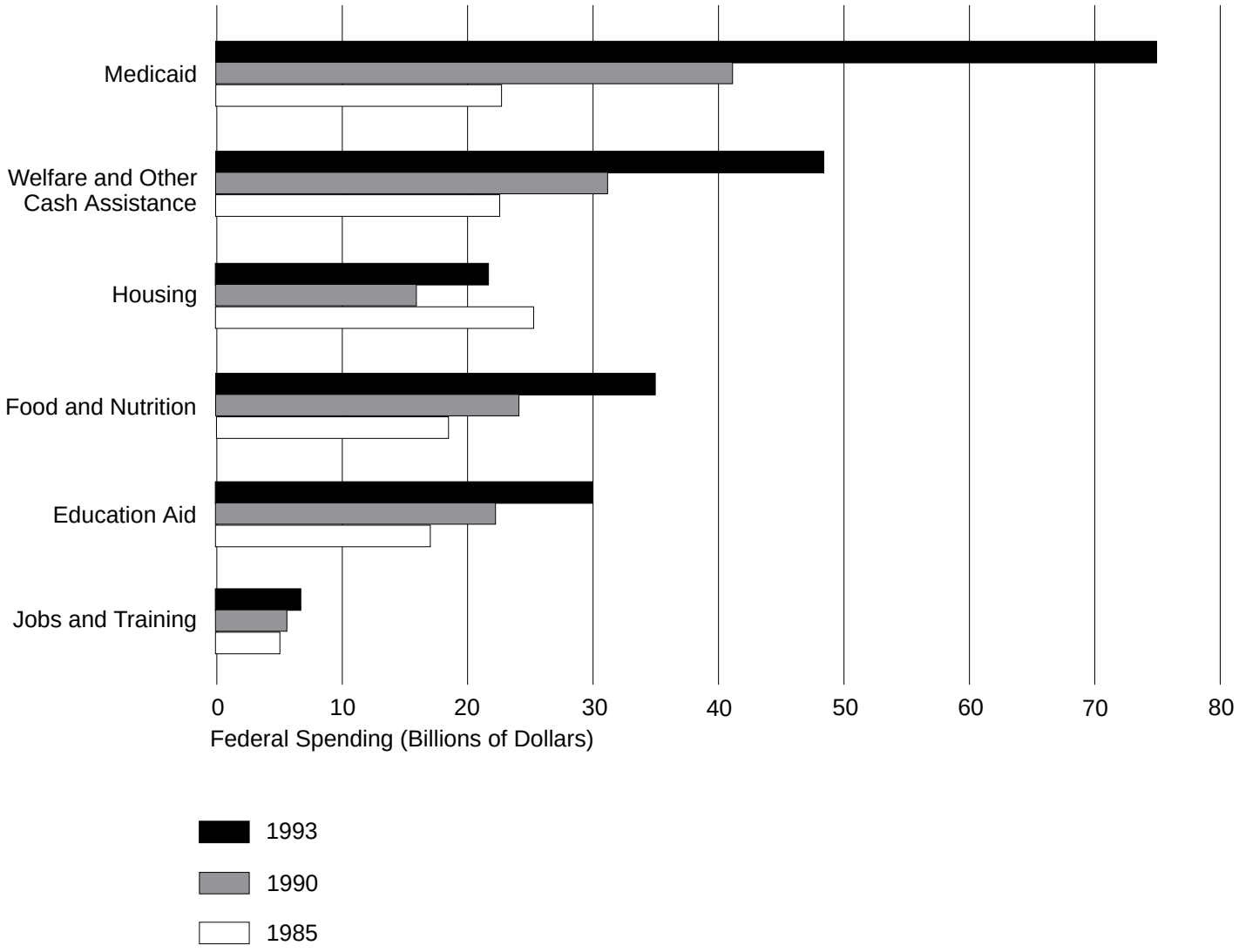
Figure 2.5: Medicaid Spending Approached Spending for Medicare in 1992



Sources: Medicaid data are from Medicaid Source Book: Background Data and Analysis (A 1993 Update). Medicare data are from annual reports of the trust funds' trustees, 1981-93.

Medicaid spending has also increased sharply when compared with spending for other federal social programs. (See fig. 2.6.) In 1993, Medicaid consumed 46 percent of all the funds spent on means-tested programs, over three times more than its closest competitor—Food Stamps. By the year 2000, federal spending for Medicaid is expected to reach $149 billion, or about 51 percent of the dollars spent on means-tested programs.

Figure 2.6: Medicaid Increased More Than Other Social Programs From 1985 to 1993



Source: Budget of the United States Government, Historical Tables, Fiscal Year 1996.

Medicaid Spending Grew Faster Than Enrollment

Enrollment growth—over 11 million between 1983 and 1993—does not fully explain the rise in Medicaid spending. For example, the Kaiser Commission estimated that enrollment growth accounted for less than half of the increase in Medicaid costs during the period 1990 to 1992. The

federal mandates of the 1980s that added low-income pregnant women and low-income children to the rolls were a minor factor in increasing costs, accounting for about 6.5 percent of spending growth. Although the mandates added a large number of beneficiaries, the populations added—low-income pregnant women and children—are relatively inexpensive to serve. In contrast, low-income elderly, disabled, and blind beneficiaries were responsible for about 25 percent of the total expenditure growth, even though they accounted for only 18 percent of the enrollment growth from 1990 to 1992.

In addition to enrollment increases, medical price inflation, higher provider reimbursements (that, to some extent, have been fueled by the Boren amendment[16]), utilization growth, and creative financing mechanisms have also contributed to the significant growth in Medicaid expenditures. The importance of each of these factors in explaining cost growth depends upon the specific time period selected. For example, in 1993 the Kaiser Commission reported that enrollment expansions, medical price inflation, and increases in expenditures per beneficiary above inflation each accounted for about one-third of the $37 billion increase in annual Medicaid expenditures from 1988 through 1991.[17]

Disproportionate Share Hospital Payments Responsible for Huge Rise in 1991-92 Spending

Disproportionate share hospital (DSH) payments were the most important cost driver in 1991 and 1992, when Medicaid spending grew by 27 percent and 29 percent, respectively. These are supplemental payments to hospitals that serve large numbers (a disproportionate share) of Medicaid and other low-income patients. The payments are intended to partially reimburse hospitals for the cost of providing care not covered by public or private insurance. In 2 years, DSH payments grew from slightly less than $1 billion in 1990 to $17.4 billion in 1992 and represented about $1 of every $7 Medicaid spent on medical services.

[16]Provider suits brought under the Boren Amendment, 42 U.S.C. 1396a(13), have been a major factor pressuring states to increase payment rates. Enacted in the early 1980s, the Boren Amendment modified federal requirements related to Medicaid payment rates to hospitals and nursing homes. The intent was to provide states with greater flexibility, which some states utilized, for example, to initiate prospective payment systems. Specifically, the Boren Amendment requires states to provide payments "which the state finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable . . . standards and to assure that individuals eligible for medical assistance have reasonable access to inpatient hospital services of adequate quality." Particularly in recent years, states have been dogged by provider lawsuits forcing them to better justify or raise their Medicaid payment rates to hospitals and nursing homes.

[17]The Medicaid Cost Explosion: Causes and Consequences (Baltimore, Maryland: The Kaiser Commission on the Future of Medicaid, Feb. 1993).

DSH payments grew rapidly because they were part of creative financing mechanisms that allowed states to gain additional federal dollars and effectively increase the federal government's share of Medicaid funding. Beginning in the mid-1980s, states were allowed to use revenue raised from "provider-specific" taxes—that is, taxes imposed on hospitals serving Medicaid patients—and "voluntary contributions" (called donations), as part of the state share eligible for federal matching funds. States then returned to providers the funds collected from such taxes and donations along with part of the matching federal payments. In some cases, a portion of the federal matching funds was then redirected to state general revenues and spent on nonhealth-care services. This swapping and redirecting of revenues among providers, the state, and the federal government resulted in increased federal spending, increased funds for providers, and—in some cases—additional revenue for states' treasuries. (See app. II for examples of how states used provider-specific taxes and donations to obtain federal matching dollars without actually spending state funds.)

DSH payments are now capped as a result of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and will not be a significant cost driver in the future. In 1993, DSH payments fell slightly to about $16.7 billion. The 1991 amendments also severely restricted states' ability to use provider-specific taxes and donations (but not intergovernmental transfers) as a source of matching funds, and capped DSH payments at 12 percent of the Medicaid program.[18] States that relied heavily on this financing mechanism are now seeking a new revenue source, cutting their Medicaid programs, or dramatically restructuring their programs under a section 1115 waiver (see ch. 3).

Medicaid's Share of Federal Budget Expected to Grow

Medicaid's tremendous spending growth of the late 1980s and early 1990s is not likely to recur. In 1994, Medicaid spending is expected to have grown about 8 percent. The Congressional Budget Office estimates that program spending will grow by 10.7 percent annually over the next 5 years. As in the past, future growth will be determined by medical inflation, provider reimbursement, utilization, and enrollment increases. Although no new eligibility or benefit mandates are foreseen, some of those already legislated are still being phased in. Mandatory coverage of poor children under the age of 19 will not be fully effective until 2002. Furthermore, the number of disabled individuals covered by Medicaid,

[18]Legislation passed in 1993 placed additional restrictions on DSH payments. (See app. II.)

although relatively small, is rising rapidly (12 percent between 1992 and 1993) and will increase costs.

Some States Use Medicaid Waivers to Increase Managed Care and Expand Coverage

In the past, some states solved their health care financing problems by capitalizing on the use of federal subsidies. Most notably, the DSH payment mechanisms mentioned earlier were used to augment a state's total Medicaid spending to obtain higher federal matching payments: the higher the state's own spending on Medicaid, the higher the federal match. However, since the limits on state DSH payments that were enacted in 1991, continuing budget shortfalls have pressured states to seek alternative financing measures. Now some states are seeking waivers from federal requirements in order to make greater use of alternatives such as prepaid, or HMO-type, managed care.

Under the broad authority of section 1115 of the Social Security Act, HHS has allowed some states to waive certain federal requirements in exchange for the states' expansion of Medicaid coverage and agreement to specific federal funding limits. The waiver authority, as recently granted, permits states to mandate enrollment in managed care health plans; subsidize health care coverage for people with incomes above the federal poverty level; and use funding from other sources, such as public and mental health programs, to finance these efforts.

As of April 1995, 8 states have HHS-approved waivers, 12 have applications pending, and 3 have made inquiries about submitting waiver applications.[19,20] (See table 3.1 and fig. 3.1.) Together, these 23 states have about 50 percent of the Medicaid beneficiaries in the country.

[19]HCFA has approved seven statewide section 1115 waivers since 1993. The eighth state, Arizona, has operated its Medicaid program under a section 1115 waiver since 1982.

[20]Texas, Utah, and Washington have inquired about submitting waiver applications with HCFA.

Table 3.1: Section 1115 Statewide Demonstration Waivers Applied for Since 1991, by Submission Date

State	Submission	Approval	Implementation
Oregon	Aug. 1991[a]	Mar. 1993	Feb. 1994
Kentucky	Mar. 1993	Dec. 1993	[b]
Hawaii	Apr. 1993	July 1993	Aug. 1994
Tennessee	June 1993	Nov. 1993	Jan. 1994
Rhode Island	July 1993	Nov. 1993	Aug. 1994
Florida	Feb. 1994	Sept. 1994	[b]
Ohio	Mar. 1994	Jan. 1995	[b]
South Carolina	Mar. 1994	[c]	
Massachusetts	Apr. 1994		
New Hampshire	June 1994		
Missouri	June 1994		
Delaware	July 1994		
Minnesota	July 1994		
Illinois	Sept. 1994		
Louisiana	Jan. 1995		
Oklahoma	Jan. 1995		
Vermont	Feb. 1995		
New York	Mar. 1995		
Kansas	Mar. 1995		

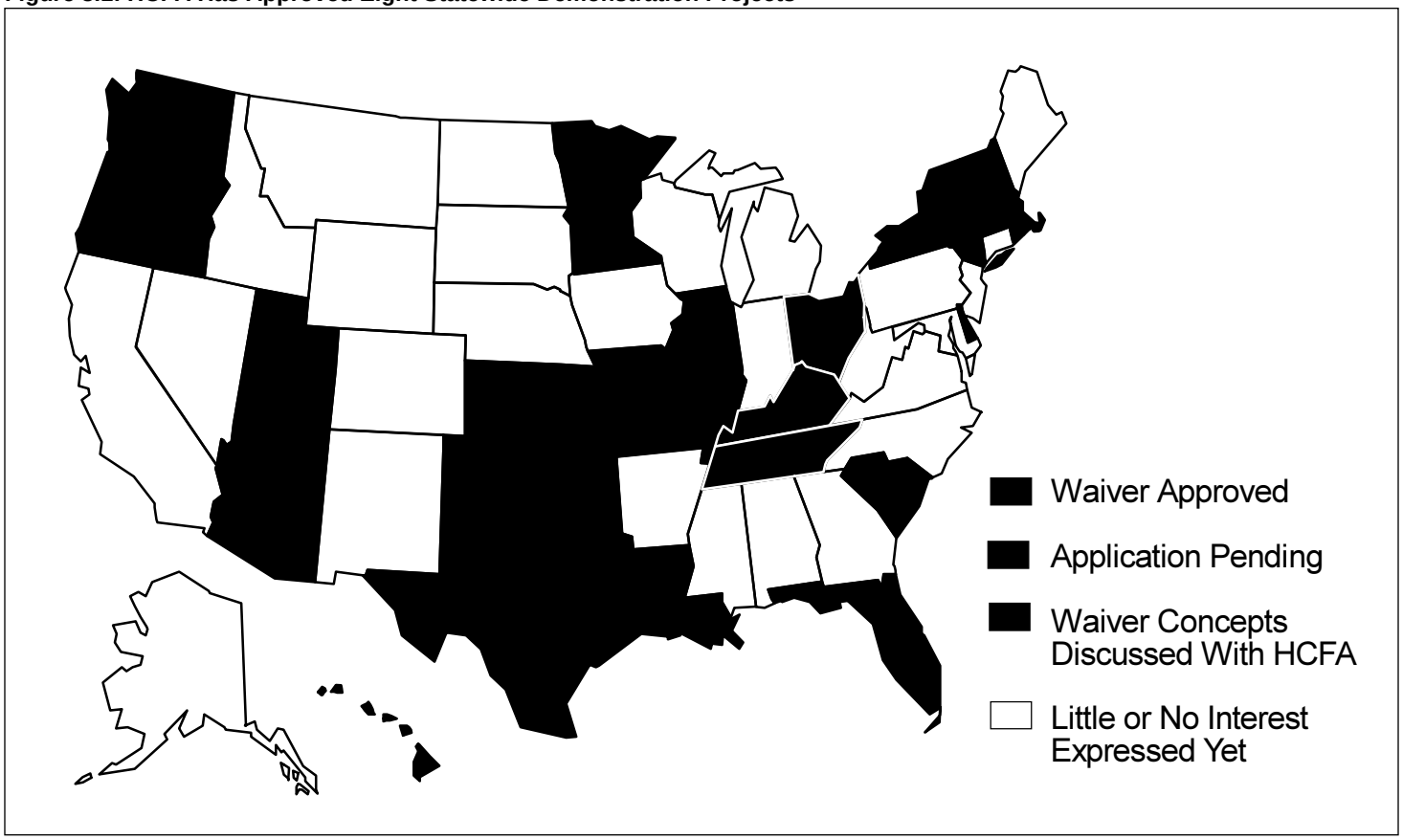
[a]Oregon's initial proposal was denied in August 1992. The state revised and resubmitted the proposal, which was approved in March 1993.

[b]Awaiting state legislature approval.

[c]HCFA has approved South Carolina's waiver proposal framework. However, certain issues must be resolved before the state is allowed to implement its demonstration program.

Source: HCFA.

Figure 3.1: HCFA Has Approved Eight Statewide Demonstration Projects



Source: HCFA.

Waivers Ease Restrictions on Use of Managed Care for Medicaid Population

Waivers Increase Managed Care Options

To constrain rising health care costs, states are increasingly turning to the mandatory enrollment of portions of their Medicaid population into prepaid managed care delivery plans that limit enrollees to certain provider networks as a way to control utilization and costs. Because federal Medicaid law requires that beneficiaries have freedom to choose

among providers willing to accept Medicaid reimbursement, states have had to seek approval to waive this freedom-of-choice requirement. The Secretary of HHS may waive this requirement under two sections of the Social Security Act. Section 1915(b) allows states, among other things, to implement a primary care case management system, to contract with HMOs, and to selectively contract with a limited set of providers. Section 1115 waivers, which are more difficult to obtain, allow states greater flexibility in the use of managed care options, particularly HMO-type delivery. As described in chapter 1, under section 1115 waivers, states can establish criteria to designate prepaid plans that serve only Medicaid enrollees and can prohibit disenrollment from these plans for a certain period of time—two provisions not generally permitted by Medicaid law.

State Experience Indicates Need for Careful Planning When Implementing New Managed Care Networks

States are seeking waivers of managed care requirements because they believe managed care financing and delivery systems can cut health care costs as well as improve access to and quality of care. In our 1993 studies of Medicaid managed care and private sector managed care, we reported that a combination of factors rendered findings of cost savings inconclusive.[21] Because the term managed care refers to a range of financing arrangements—including traditional fee-for-service plans with very few care management features, such as prior approval of hospitalization—our studies of cost savings are quick to distinguish among the various forms of managed care. For the most service-restrictive form of managed care—the "capitated" HMO—reported evidence of lower utilization is straightforward. This promise of lower utilization has made HMO-type plans attractive to the states.[22]

As of June 1994, 15 percent of Medicaid beneficiaries were enrolled in fully capitated health plans. In one year (June 1993 to June 1994), Medicaid full-risk capitation enrollment grew by 91 percent, in part because of the statewide managed care demonstrations obtained through the section 1115 waivers. In the past, the elderly and disabled Medicaid population, which consumes the largest share of state Medicaid budgets (about 66 percent), has rarely been covered by managed care programs. Increasingly, however, states are including or plan to include these populations as well.

[21]Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993) and Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HEHS-94-3, Oct. 19, 1993).

[22]States with approved section 1115 waivers are using a variety of forms of managed care.

When we and others reported in the 1970s on quality of care problems and other abuses in some Medicaid managed care experiments, the Congress placed restrictions on HMO enrollment for Medicaid beneficiaries.[23] In general, these restrictions were designed to ensure that HMOs provide Medicaid beneficiaries a standard of care equal to that provided to private patients. Under section 1115 waivers, HCFA can waive these restrictions to help states enlist HMOs to serve Medicaid beneficiaries. HCFA can waive the "75-25 rule," which specifies that HMOs serving Medicaid beneficiaries must have at least 25 percent of their enrollment consist of private patients (with certain limited exceptions), a rule that—in effect—prohibits Medicaid-only HMOs.[24] HCFA can also waive a federal provision permitting beneficiaries to terminate their enrollment in an HMO at any time; this provision prevents the "lock-in" of beneficiaries that are dissatisfied with a plan.[25] From the beneficiary's perspective, these provisions provide some protection against the possibility of being enrolled by an HMO seeking excessive profit at the expense of quality. From the HMO's perspective, however, the provision allowing beneficiaries to disenroll at will makes planning for financial stability difficult and therefore makes the enrollment of Medicaid patients less attractive.[26]

In February 1995 we testified that, with the Medicare program (which covers medical services for the nation's elderly and certain other groups) HCFA has not aggressively enforced compliance with federal HMO standards.[27] Similar concerns arise about enforcement of standards for plans that enroll Medicaid beneficiaries, particularly because large-scale enrollment in prepaid HMOs is a recent occurrence and state Medicaid departments have limited experience in overseeing such delivery systems. Advocacy groups in some states with waivers have stated that while

[23]Better Controls Needed for Health Maintenance Organizations Under Medicaid in California (Sept. 1974, B-164031(3)), Deficiencies in Determining Payments to Prepaid Health Plans Under California's Medicaid Program (Aug. 1975, MWD-76-15), and Relationships Between Nonprofit Prepaid Health Plans With California Medicaid Contracts and For Profit Entities Affiliated With Them (Nov. 1976, HRD-77-4). For a summary of the status of Medicaid HMO contracting as of early 1981 and the outstanding problems at that time, see Trieger, Sidney, Trudi W. Galblum, and Gerald Riley, HMOs: Issues and Alternatives for Medicare and Medicaid, HCFA Pub. No. 03107 (Baltimore: 1981).

[24]HCFA regulations allow waiver of the 75-25 rule in some cases without a section 1115 waiver.

[25]States can opt to restrict disenrollments, without a waiver, for up to 6 months for federally qualified HMOs.

[26]The longer the guaranteed enrollment per enrollee, the more stability the HMO experiences in cash flow and the greater the opportunity to adequately plan for meeting the health care needs of its enrollees.

[27]Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

HMO-type managed care may potentially expand beneficiaries' access to providers, quality of care and access problems will go undetected without adequate beneficiary education and vigorous state and federal oversight.[28]

The recent experience of Tennessee's section 1115 demonstration program illustrates the need to proceed cautiously when implementing a capitated HMO program statewide.[29] In response to escalating Medicaid costs, Tennessee sought a section 1115 waiver in 1993. The state proposed "TennCare," a demonstration to enroll in managed care organizations[30] all its Medicaid beneficiaries, in addition to its medically uninsurable citizens and certain other uninsured residents.[31]

In fewer than 2 months after HCFA granted the waiver, Tennessee implemented TennCare. In 1993, the year before the demonstration began, about 2.7 percent of the state's Medicaid population was enrolled in managed care, compared with about 12.4 percent nationally. As of January 1, 1994—TennCare's "opening day"—plans for contracting with provider networks were incomplete, and many of the state's physicians had not yet determined which networks, if any, they might join. Some beneficiaries were initially required to choose a plan without knowing which ones would include their physicians. Systems to process bills were not fully developed, and some providers reported slow or no payments for services during the first months of the waiver. The submission of encounter data to the state, which allow officials to monitor access and quality, was not complete even 1 year after the program began. The most recent beneficiary satisfaction survey taken in 1994 reported that 45 percent of enrollees who had previously received care under Medicaid's fee-for-service program were less than satisfied with TennCare. Individuals who were previously uninsured, however, were not as dissatisfied (8 percent).

[28]HCFA has required states, through its special terms and conditions associated with approved section 1115 waivers, to implement improved quality assurance systems and collect encounter data. HCFA has also contracted for evaluations to examine cost, quality, and access to care.

[29]Medicaid: Experience With State Waivers to Promote Cost Control and Access to Care (GAO/T-HEHS-95-115, Mar. 23, 1995).

[30]These managed care organizations are prepaid plans, some of which operate as HMOs with "gatekeepers" (providers designated to coordinate the care for individual enrollees) and some as preferred provider organizations, which do not use gatekeepers.

[31]These are residents of any income level without access to employer-sponsored or other insurance, although with higher incomes, greater cost-sharing is expected.

Section 1115 Waivers Permit States to Expand Eligibility Beyond Traditional Medicaid Population

States are also using section 1115 waivers to expand Medicaid coverage to more individuals. Most states' demonstrations expand coverage to low-income individuals and families who were previously ineligible for Medicaid (although income and categorical requirements for these new eligibles vary considerably from state to state).[32] In sheer numbers, Tennessee, Florida, and Ohio have the most ambitious expansion programs. Oregon, Kentucky, Hawaii, and Rhode Island plan more modest expansions. (See table 3.2.)

Table 3.2: Estimated Maximum Number of New Eligibles Under Approved Statewide Section 1115 Waivers, by State

State	New eligibles[a]	Eligibility requirements
Florida		Individuals and families with incomes below 250% of the federal poverty level (FPL) are eligible for subsidized private insurance.
	1,100,000	Individuals and families are eligible only if uninsured for 12 months or recently disenrolled from Medicaid.
Hawaii	80,000	Uninsured persons below 300% of FPL.
Kentucky	201,000	Individuals with incomes below FPL.
Ohio	395,000	Individuals and families with incomes below FPL.
Oregon	112,000[b]	Individuals and families with incomes below FPL.
Rhode Island		Pregnant women and children up to age 6 with family incomes between 185% and 250% of FPL.
	11,000	Extension of family planning services for women for 2 years after giving birth.
Tennessee		All uninsured, regardless of employment or income status, including individuals who cannot obtain coverage because of a preexisting condition. (Enrollment capped for newly entitled, not capped for traditional Medicaid recipients.
	500,000[c]	Eligibility restricted to those uninsured prior to a date within the last year.)

[a]Includes expansions to optional groups of Medicaid eligibles.

[b]Actual new enrollment as of March 3, 1995.

[c]In January 1995, Tennessee closed enrollment to the uninsured; demonstration enrollment was 438,000 in February 1995.

Source: State waiver proposals and supporting documentation.

If all states were granted waivers that permitted eligibility expansions, the number of individuals in Medicaid-supported programs could be sizeable. In a recent study,[33] the Urban Institute estimates that expanding coverage

[32]Some states include in their demonstration individuals and families who could have been covered at state option under the regular Medicaid program.

[33]Increasing Insurance Coverage Through Medicaid Waiver Programs (Washington, D.C.: Nov. 1994).

up to 200 percent of the federal poverty level would increase the number of beneficiaries between 18 million and 45 million, depending on the extent to which eligible people apply.[34] A more limited expansion covering individuals with incomes up to the federal poverty level, as approved for Oregon and Kentucky, would increase the number of beneficiaries between 8 million and 14 million.

As Growing Number of States Seek Section 1115 Waivers, Controversy Ensues

Section 1115 waivers are granted for research purposes to test program improvements in keeping with Medicaid goals or examine issues of interest to HCFA. Until Oregon's application was approved in March 1993, only Arizona had been granted authority to run its demonstration statewide.[35] Before that time, most section 1115 demonstrations were relatively small and affected only a small geographic area, target population, or provider group.

Objecting to the section 1115 demonstrations, a legal challenge has been mounted against the waivers. In June 1994, the National Association of Community Health Centers (NACHC) filed suit in federal court (NACHC v. Shalala). NACHC argues, among other things, that the Secretary of HHS acted beyond her statutory powers in approving these statewide section 1115 waivers. The suit challenges the award of waivers granted before the suit was filed and seeks injunctive relief against subsequent approval of similar waivers. Waiver approvals for Hawaii, Kentucky, Oregon, Rhode Island, and Tennessee preceded the suit. Since the suit was filed, Florida and Ohio have also been granted section 1115 waivers.

The issue of expanded coverage may stall the implementation of proposed section 1115 demonstrations in certain states. Florida, Kentucky, and Ohio have waivers approved by HCFA but not by their own state legislatures. Lawmakers in these states are concerned that implementation of the waivers will increase, not decrease, state costs. The Kentucky legislature has required that the state realize savings from managed care before coverage is expanded.

[34]These figures do not represent a net decrease in the number of uninsured, since some of these new eligibles currently have private insurance. Some states with generous program expansions, like Florida, plan to limit the substitution of Medicaid for private insurance by requiring a 12-month waiting period before new eligibles can receive benefits.

[35]Since its inception in 1982, Arizona's entire medical assistance program for AFDC and SSI recipients has been operated as a section 1115 demonstration known as the Arizona Health Care Cost Containment System.

Some Section 1115 Demonstrations Could Increase Federal Expenditures

Some states with approved section 1115 waivers could be eligible for more federal Medicaid funds than they might have received without the waivers. Some states have proposed ambitious coverage expansions, which, through the waivers, would be financed in part by the Medicaid program. While estimating the demonstration projects' potential impact on federal spending is difficult, the administration's approval of the waivers as budget neutral depends on a number of critical assumptions that could be subject to challenge. Furthermore, it is not clear that the administration's rationale for defining budget neutrality in the approved statewide waivers is consistent across all waivers.

We have been evaluating the budget neutrality of approved waivers using a consistent framework that compares approved budgets with a benchmark using current services budgeting concepts. While more extensive analysis is in progress, it appears that one of the four waivers we analyzed may be budget neutral, but three others may not be if fully implemented by the states.[36] In Tennessee, our analysis indicates that federal spending on the Medicaid demonstration program could be lower over the life of the waiver, compared with what might have been spent without the waiver. However, the demonstration programs in Hawaii, Florida, and Oregon may increase federal spending on Medicaid acute care. Because the waiver agreements only specify ceilings on federal spending, the total amount of new federal dollars that could be required by the demonstrations depends upon several factors, including future action by the states. For example, federal spending for Florida will depend, partly, upon how many of the planned maximum 1,100,000 newly eligible individuals that state will actually cover.

The potential net spending impact associated with the four state waivers we analyzed, while it could amount to hundreds of millions of additional federal dollars, is small relative to overall federal Medicaid spending. However, the impact of the section 1115 demonstrations could increase substantially if the waivers pending or proposed by several additional states—or even a few large states—are not budget neutral.

[36]These results are derived by comparing the maximum potential costs of the demonstrations (as outlined in the waiver applications) with a "current services" baseline (the projected amount of federal and state spending necessary to maintain the current level of Medicaid services) calculated separately for each demonstration project. Our ongoing analysis is examining ways to adjust the current services baseline for differences in state experiences. The results of this analysis will be reported at a later date.

Budget Neutrality Redefined

Since the early 1980s, the administration has required that federal spending on a state's section 1115 demonstration project be budget neutral—that is, federal expenditures may not exceed what would have been spent without the waiver. This budget-neutrality policy is still in force. Since 1993, however, the administration has applied the financial test in such a way as to allow states more flexibility in showing that their proposed projects would be budget neutral.

Projecting future spending for the current program is a critical element in determining budget neutrality since this amount represents the baseline against which spending for the demonstration project is compared. The two key steps in developing projections for the current program are estimating (1) base, or initial-year, spending and (2) future annual increases. From a state's perspective, higher base costs or higher annual increases make it easier to claim budget neutrality. That is, a higher baseline makes it possible for planned spending to increase while still meeting the definition of budget neutrality. States have used one or both of the following arguments to secure access to increased federal funds while complying with the current budget-neutrality policy.

- Hypothetical Expansion Argument. Four states—Hawaii, Rhode Island, Kentucky, and Ohio—successfully argued that their baselines should include the cost of extending coverage to optional eligibility groups that could have been, but were not then, served by the state's Medicaid program. These hypothetical expansions primarily covered women and children (but may also include elderly and disabled individuals), whose coverage was optional.[37] Although in Hawaii many of these individuals received limited benefits under one of two state-funded programs, these groups were not served at all in the Medicaid programs. The states argued that since they could have submitted a state plan amendment and thus received federal medical assistance payments for providing health services to these groups, an equivalent amount of federal funding for the Medicaid demonstration project, which would include them, should be considered budget neutral. Including the section 1902(r)(2) population increased Hawaii's baseline by about $58 million over 5 years. Although the Kentucky legislature suspended implementation of the state's waiver, inclusion of the section 1902(r)(2) populations that included the elderly

[37]Under section 1902(r)(2) of the Social Security Act, 42 U.S.C. 1396b(r)(2), states were essentially given the option to cover such individuals by being permitted to employ less restrictive eligibility methodologies. As a matter of policy, HCFA generally limits arguments for hypothetical expansions to those individuals eligible under 1902(r)(2) who will be included in the demonstration.

and disabled with incomes up to the federal poverty level would have added about $524 million to the baseline over 5 years.[38]

- Historical Inflation Argument. The administration allowed some states to project increases in their baseline costs at rates higher than the administration's existing projections of national Medicaid spending growth. These states successfully argued that past years' spending increases exceeded average national spending growth and thus justified a higher or faster growing baseline. For example, in the first year of their waivers, Florida and Tennessee received relatively large increases (about 16 percent) compared with the previous year. Florida also received large annual increases for the remaining years of the waiver.

Because Medicaid costs in the late 1980s and the early 1990s grew for reasons not expected to affect future spending, estimates of future Medicaid expenditures that rely on historical cost growth may be inflated. For example, although the states' use of provider taxes and donations contributed to the rapid rise of DSH payments between 1989 and 1993, recent legislation strictly limits DSH growth. Also, some of the past cost increases were due to the absorption of mandated and optional populations and changes in benefits. Major new mandates have not been added since 1991 and are not likely to be added in the foreseeable future.[39] Furthermore, continued rapid Medicaid cost increases may have been unsustainable because of the great strain they placed on state budgets. Facing rapid cost increases, states would have increased incentive to adopt cost-containment measures. For example, Tennessee officials said the state would have faced massive health care coverage reductions had the waiver not been approved. In another example, after refusing to approve the waiver, the Kentucky legislature reduced physician reimbursements by $50 million.

Another part of the policy change since 1993 is to allow demonstrations to show budget neutrality over the life of the waiver, but not to require it year by year. HCFA agreed that states' demonstration projects may involve temporary start-up costs and permitted increased federal funding to help pay these initial costs, as long as states expected to offset these costs by

[38]Federal Medicaid expenditures could increase substantially if all states provided eligibility for their 1902(r)(2) populations either under a section 1115 demonstration or as part of their regular program. In its November 1994 report, the Urban Institute estimates that annual state and federal spending could increase by between $5.5 billion and $23 billion. The exact amount would depend on how many eligible individuals applied for coverage and how many individuals with private or employer-provided insurance migrated to the publicly subsidized Medicaid program.

[39]As in the past, however, some states may attempt to shift state-funded health and social service programs into Medicaid by extending coverage to optional beneficiaries and thus obtain federal matching payments.

reduced federal funding in later years. Oregon, and perhaps some of the other states with waivers approved since 1993, expect that lower Medicaid cost growth in later years will compensate the federal government for higher expenses in the early years of the demonstrations.

Partial Caps May Limit Federal Liability While Heightening State Risk

Each of the waiver agreements ensures some limits on federal spending and holds some financial risk for the states. Because of the bilateral nature of the negotiations between the states and HHS, and because of the discretion granted to the Secretary of HHS in approving the waivers, the terms and conditions for each state are unique. Thus, the net effect on federal spending resulting from the waiver states' Medicaid programs after the 5-year life of the demonstrations may be different for each state. Under any of the negotiated waivers, however, states are not to receive federal assistance in paying for costs above the agreed-upon limits.

Hawaii, Kentucky, Ohio, Oregon, and Rhode Island have agreed to federal spending limits called per capita caps, which are based on Medicaid spending per person.[40] As shown in table 4.1, these caps allow per person spending to increase by a fixed percentage (plus the percentage change in medical prices in Hawaii and Kentucky). Thus, if the number of eligibles rises or, in Hawaii and Kentucky, if medical prices increase, the states can obtain additional funding. However, if spending rises because of greater utilization of services or a change in the mix of services provided, the states are financially liable.

Under the waiver agreements for Tennessee and Florida, "aggregate caps," or limits on total spending, limit the federal government's financial exposure. In Tennessee, the state and the federal government agreed to set a maximum for federal funding for each year of the waiver. Under these terms, spending for Tennessee's Medicaid program may increase from $2.7 billion in 1993 to $4.1 billion in 1998. Florida and the federal government also set a maximum for annual federal Medicaid funding. Unlike Tennessee's agreement, however, federal spending can exceed the specified amounts if the number of traditional Medicaid beneficiaries exceeds the projected number by more than 3 percent. This means the state's financial risk is limited if the Medicaid rolls swell because of an

[40]In Hawaii, Kentucky, Ohio, and Rhode Island, federal spending limits are based on the number of Medicaid eligibles (including the hypothetical expansions) multiplied by historically based per person fee-for-service costs, adjusted for actual inflation experience. In Oregon, the federal spending limit is based on the number of Medicaid eligibles plus a portion of otherwise ineligible individuals multiplied by actuarially developed per person costs that are agreed to by HCFA and the state.

economic downturn, for example. The two caps also differ in that Tennessee's covers long-term care expenditures, while Florida's does not.

Table 4.1: Type of Expenditure Cap and Annual Adjustment, by State

State	Type of cap	Annual adjustment
Hawaii	Per capita	4% plus medical inflation[a]
Tennessee	Aggregate	5.1% to 8.3%[b]
Florida	Aggregate[c]	14.3% to 15.7%[b]
Kentucky	Per capita	3% plus medical inflation
Ohio	Per capita	6.7% to 9.4%[d]
Oregon	Per capita	8.5%
Rhode Island	Per capita	4% to 8%[b]

[a]Medical inflation is measured by the medical component of the consumer price index.

[b]Varies by year.

[c]Federal funding is increased if the number of Medicaid eligibles grows by more than 3 percent.

[d]Varies by year and category of spending.

Some states may find funding their planned expansions difficult. Hawaii is experiencing financial problems largely because more new eligibles enrolled than expected. Oregon may also face difficulty, due in part to higher than anticipated enrollment of new eligibles and the continuing effects of a tax initiative passed in 1990 that limits state funds available for Medicaid and other programs. Oregon is considering reducing the capitation rate, changing eligibility rules, implementing premiums and copayments, delaying full implementation of mental health services, and reducing benefits, but will need HCFA approval before doing so. Moreover, a state analysis suggests the program will not be budget neutral without the cost savings anticipated from an employer mandate, for which the state must obtain congressional action.[41] Even with the necessary congressional action, however, state political support for the mandate has eroded because of business opposition and changes in the makeup of the state legislature.

The impact of higher than anticipated costs on federal funding depends on the specific waiver agreement and HCFA's enforcement. In Florida's case, HCFA would help pay for the increased costs over the life of the waiver, but

[41]To mandate that employers provide health insurance to their employees, states need an exception to provisions of the Employee Retirement Income Security Act. To date, only Hawaii has obtained such an exception, largely because its employer mandate predated the passage of the act.

expects to get paid back for the excess costs at the end of the 5-year project. Ohio's agreement is similar to Florida's, except that it specifies cumulative cost overrun ceilings. If Ohio's cumulative spending exceeds the ceiling, the state must submit a corrective action plan. In Tennessee, the budget-neutrality agreement has a formula to prevent federal expenditures from exceeding the yearly cap by more than a specified percentage. Tennessee has agreed to take steps such as limiting enrollment when this happens.

The total amount of federal funding required for the demonstrations also depends, in part, on how HCFA defines and enforces its methodology for determining the federal expenditure cap in states with per capita limits. For example, even though the Oregon demonstration has been operating for more than a year, HCFA and the state have yet to agree on a specific methodology. The difference between two possible methods for calculating the upper limit on federal spending amounts to more than 5 percent of the state's Medicaid demonstration budget.[42]

[42]Other implementation and enforcement issues may also affect federal spending. For example, most state demonstrations change the method for counting qualifying income from a net to a gross income test. This change makes counting the number of Medicaid-eligible individuals imprecise. As a result, the per capita cap states can only estimate the numbers to determine total federal expenditures for the demonstration. The estimated counts will likely be different from actual counts using the net income test, but whether they will be higher or lower is unknown.

Observations on Medicaid's Future

Millions of Americans—not only poor mothers and children, but also poor elderly, blind, and disabled individuals—depend upon health care made possible by the Medicaid program. Medicaid pays for both acute care and long-term care services. The program underwrites the deliveries of about one-third of the babies born in the United States each year and finances about 50 cents of every dollar paid to nursing homes.

Medicaid is an expensive program. It currently consumes about 6 percent of all federal outlays (3 times the share devoted to Food Stamps and 5 times the share devoted to AFDC). Moreover, Medicaid's slice of the federal budget is growing faster than most other major budget items, including Medicare. If Medicaid continues indefinitely at its forecast growth rate (10.7 percent), federal spending on the program will double roughly every 5 to 7 years.

Success in containing cost growth in Medicaid, as for the health care sector at large, has been elusive. Care for the elderly, blind, and disabled populations—particularly long-term care—is expensive, consuming more than $80 billion of the $130 billion cost of Medicaid in 1993. For acute care services, however, the promise of lower utilization has made the capitated payment features of managed care plans attractive to the states.

Federal restrictions on the use of managed care reflect concerns for quality, because capitated payments allow profits to be earned from underservice. For example, the 75-25 rule seeks to ensure that Medicaid managed care plans are of sufficient quality, as demonstrated by their ability to attract private enrollees. At the same time, states believe that restrictions like this hamper their efforts to implement managed care effectively and that the need to obtain section 1115 waiver approval poses unnecessary obstacles. Requiring states to seek waivers before implementing these health care delivery system reforms may be burdensome, especially if alternatives for addressing quality of care concerns exist. Nonetheless, continuous oversight of managed care systems is required to protect Medicaid beneficiaries from inappropriate denial of care and federal dollars from payment abuses.

Section 1115 waivers, while freeing states to implement managed care cost-containment strategies, could in the long run undermine efforts to contain federal expenditures. Our study of the section 1115 waivers approved to date raises the following concerns:

- The administration is allowing states to apply the federal share of Medicaid savings from managed care to finance coverage of additional populations not included under Medicaid law. To meet the budget-neutrality terms of section 1115 waivers, the administration and states assume that the enrollment of the Medicaid populations in HMOs will save states enough money to cover additional low-income people in the state at no extra cost to the federal government. Even if the proposed demonstrations will not require new federal dollars, the administration's approval of coverage expansions means that anticipated Medicaid cost savings (from more aggressive use of capitated care) will not be used to reduce federal spending. At issue is whether the federal treasury should benefit from these savings. Also of concern is whether eligibility should be made available for new groups only after congressional debate and legislative action.
- The administration's method for determining budget neutrality may allow states access to more federal funding than they would have received without the waiver. Our initial examination of four states' proposed demonstrations suggests that claims of budget neutrality for these states may not be sustainable in all cases. While Tennessee's demonstration project may be budget neutral, the demonstrations in Florida, Hawaii, and Oregon may require increased financial commitment from the federal government. Relative to overall federal Medicaid spending, the amount spent in states with approved section 1115 waivers is small. However, the methods used by the administration to assess the budget neutrality of pending and future waiver proposals may greatly affect federal Medicaid spending in the years to come.
- The Congress may find it difficult to scale back section 1115 demonstrations if they prove more costly than forecast. A demonstration waiver, granted for a limited period of time, may be a shortsighted approach to reducing states' uninsured populations. If at the end of 5 years the demonstrations have cost much more than estimated, the Congress may face the choice of increasing federal funding or relying on the states to reduce benefits or deny coverage to hundreds of thousands of people newly enrolled under the waivers.

For these reasons, we believe that the granting of additional section 1115 waivers merits close scrutiny.

Agency Comments and Our Evaluation

The administration's comments focused on two aspects of this report: waiver review policy changes and our approach to analyzing the budget neutrality of approved statewide section 1115 waivers, with which it disagreed.[43] In brief, our approach begins with a uniform and consistent budget "neutrality" benchmark—OMB's current services projections of future Medicaid growth—for assessing the potential budget impact of waivers. The administration contends that by using OMB's national estimate of projected Medicaid spending growth, we do not accurately capture the variation in state spending patterns. Moreover, it maintains that current services is an inappropriate tool for establishing budget neutrality.

Changes in Waiver Review Policy

The administration's response notes that its approach both to reviewing waivers and to determining budget neutrality represents a departure from previous administrations' policies. Overall, it characterized its new approach as "more flexible."

Although budget neutrality is not specifically defined by regulation or statute, the administration's new approach is characterized by (1) flexibility in determining appropriate baseline expenditures and (2) assessment of budget neutrality over the life of the waiver rather than year by year. Our analysis recognizes these key differences. In fact, we conclude that the administration's new approach represents a redefinition of budget neutrality.

The Administration's Budget-Neutrality Methodology

The administration characterizes its budget-neutrality policy as "state-specific," reflecting the historically "dramatic variation in state Medicaid programs." These variations, the administration notes, have resulted in "radically different levels of expenditures and growth rates across the states." Lacking a state-specific Medicaid baseline, the administration compares its national estimate of growth in Medicaid for the nation as a whole with state historical expenditure growth in determining a budget-neutrality benchmark.

Furthermore, the administration points out that it relies on current federal law in establishing a state-specific neutrality benchmark. It notes that "under current federal law states are able to engage in program expansions and contractions" and that, in establishing a state-specific budget-neutrality baseline, some judgment about states' behavior should be involved.

[43]Our methodology is described in chapter 1.

Our discussion of the administration's approach to budget neutrality recognizes the state-specific nature of its methodology. Thus, in chapter 4, we indicate that the waiver funding agreements for Florida and Tennessee were based on an analysis of large annual growth rates over the past 5 years. We conclude, however, that some of the factors underlying Medicaid's very rapid and recent cost growth will be much less significant in the future and that relying on historical cost growth is inappropriate. For example, a major cause of Medicaid's rapid growth in the past—DSH payments—has been strictly limited by 1991 and 1993 legislation. In addition, major new mandatory coverage expansions are not likely to be undertaken in the foreseeable future.

Demonstration Nature of the Section 1115 Waivers

The administration disputes our contention that the comprehensive scope of the waiver demonstrations makes it controversial to characterize them as experimental. It notes that the waivers allow states to experiment with innovative delivery and payments systems for their Medicaid and low-income populations and that each demonstration has unique components deemed worthy of evaluation. We view the sheer magnitude of some of the waiver projects as what makes it difficult to consider them experimental. Once coverage has been extended to several hundred thousand people, we anticipate significant difficulty in terminating a demonstration if the innovations being tested fail to achieve the intended objectives.

Key Areas of Disagreement

As suggested by the administration, in our initial analysis we have applied a more rigid method for assessing budget neutrality. We take a more uniform base—previous-year spending—and allow it to grow at the rate of increase expected by OMB for the national program. Because we recognize the significant differences in state Medicaid programs' experiences, our preference would have been to use consistently generated state forecasts of expected Medicaid spending. However, neither OMB nor the Congressional Budget Office has developed such forecasts. We believe that using states' historical experiences without adjustments may not be a good guide for the future. In our ongoing work, we are examining state-specific information to determine what adjustments to the national forecasts might be appropriate.

In contrast to our efforts to develop a consistent methodology, the administration's budget-neutrality assessments appear not to be consistent. Thus, in some states, aggregate spending trends over the past 5

years appear to have been the dominant factor used to project budget-neutral spending over the next 5 years. In other states, trends in average costs per person were the major factor used to define budget-neutral trends over the life of the waiver. By using unique methods in each state, the administration has created the potential for budget-neutrality decisions to be based on the technique most favorable to a particular state. We continue to believe that a consistent approach is more appropriate for budget purposes.

If state-specific reasons exist for future Medicaid program growth above (or below) national standards, they should be well documented. However, in reviewing state waiver submissions, no special factors were identified that would justify future growth above a national benchmark.

Finally, the administration suggests that a current law baseline is more appropriate than a current services baseline in assessing budget neutrality. That is, the budget-neutrality assessment should be based on "what states might do" under current law rather than "what states are doing." However, the administration also notes that the President's budget does not distinguish between current services and current law. Although current law gives states the latitude to expand coverage to optional populations, not all states have chosen to do so. We continue to believe that "what states are doing" should be the basis for determining budget neutrality.

The complete text of the administration's comments is in appendix IV.

Major Federal Expansions of Medicaid Eligibility and Services (1984-93)

Table I.1: Federal Medicaid Expansion to AFDC Recipients and Related Populations

Population affected	Expansion	Mandate/option
DEFRA (Deficit Reduction Act of 1984) (P.L. 98-369)		
Infants[a] and children	Requires coverage of all children born after 9/30/83 who meet state AFDC income and resource standards, regardless of family structure.	Mandate
Pregnant women	Requires coverage from date of medical verification of pregnancy, providing the mother would (1) qualify for AFDC once child was born or (2) 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 as a result of increased earnings.	Mandate[c]
AFDC families	Extends earned income disregard[d] from 4 to 12 months.	Mandate
COBRA (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.	Mandate
Postpartum women	Requires 60-day extension of coverage postpartum if eligibility was pregnancy-related.	Mandate
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

(continued)

Population affected	Expansion	Mandate/option
Adoptive and foster children	Requires coverage even if adoption/foster agreement was entered into in another state.	Mandate
OBRA 1986 (Omnibus Budget Reconciliation Act of 1986) (P.L. 99-509)		
Pregnant women and infants	Creates new optional categorically needy group for those with incomes below 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
Pregnant women	Allows guarantee of continuous eligibility through postpartum period.	Option
Children	Allows coverage up to age 5 if family income is below poverty line (phased in).	Option
Infants and children	Requires continuation of eligibility (for those who otherwise would become ineligible) if individuals are hospital inpatients when age limit is reached.	Mandate
OBRA 1987 (Omnibus Budget Reconciliation Act of 1987) (P.L. 100-203)		
Pregnant women and infants	Allows coverage if family income is below 185% of poverty line.	Option
Children	Allows immediate extension of OBRA 1986 coverage for children up to age 5 in families with incomes up to the poverty line.	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

(continued)

Population affected	Expansion	Mandate/option
Children	Allows coverage for children below age 9 in families with incomes up to the poverty line (phased in by age).	Option
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 the poverty line (phased in by % of poverty line).	Mandate
Family Support Act of 1988 (P.L. 100-485)		
AFDC families	Increases required period of Medicaid coverage if AFDC cash assistance is lost as a result of increased earnings.	Mandate[e]
AFDC families with unemployed parent (AFDC-UP)	Requires coverage if otherwise qualified.	Mandate
OBRA 1989 (Omnibus Budget Reconciliation Act of 1989) (P.L. 101-239)		
Pregnant women and infants	Requires coverage if family income is below 133% of poverty line.	Mandate
Children	Requires coverage up to age 6 if family income is below 133% of poverty line.	Mandate
Children	Requires provision of all Medicaid-allowed treatment to correct problems identified during early and periodic screening, diagnostic, and treatment (EPSDT), even if treatment is not covered otherwise under state's Medicaid plan.	Mandate
Children	Requires interperiodic[f] screenings under EPSDT when medical problem is suspected.	Was an option, now mandated
OBRA 1990 (Omnibus Budget Reconciliation Act of 1990) (P.L. 101-508)		
Children	Requires coverage up to age 18 if family income is below the poverty line (phased in by age).	Mandate
Pregnant women	Makes mandatory the OBRA 1986 option of continuous eligibility through postpartum period.	Mandate

(continued)

Population affected	Expansion	Mandate/option
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
OBRA 1993 (Omnibus Budget Reconciliation Act of 1993) (P.L. 103-66)		
Mothers and newborns	Expands scope of required nurse-midwife services to include services outside the maternity cycle that midwives are authorized to perform under state law.	Mandate
Children	Requires state Medicaid programs to establish a program to distribute pediatric vaccines furnished by the federal government.	Mandate

[a]Infants are children up to age 1.

[b]AFDC-UP allows coverage in two-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]Mandate is for 12 months. State may opt to provide additional 6-month period of coverage.

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

Table I.2: Federal Medicaid Expansion to the Population Receiving SSI

Population affected	Expansion	Mandate/option
DEFRA (Deficit Reduction Act of 1984) (P.L. 98-369)		
SSI recipients	Increases qualifying asset limits for applicants for limited time period (1984-89).	Mandate
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) (P.L. 99-272)		
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 incomes below the 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[a] up to the poverty line for qualified Medicare beneficiaries under certain resource constraints.	Option
Severely impaired individuals	Establishes new mandatory categorically needy coverage group for qualified individuals under age 65.	Mandate
Ventilator-dependent individuals	Allows coverage of at-home respiratory care services.	Option
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 of 1986 (P.L. 99-643)		
Disabled individuals	Makes permanent a previous demonstration program for individuals able to engage in substantial gainful activity despite severe medical impairments.	Mandate

(continued)

Population affected	Expansion	Mandate/option
OBRA 1987 (Omnibus Budget Reconciliation Act of 1987) (P.L. 100-203)		
Elderly	Allows provision of home and community-based services to those who otherwise would need nursing home care.[b]	Option
Nursing home applicants	Requires states to establish preadmission screening programs for mentally ill and retarded individuals.	Mandate
Nursing home residents	Requires preadmission screening and annual resident review for mentally ill or retarded individuals.	Mandate
MCCA (Medicare Catastrophic Coverage Act of 1988) (P.L. 100-360)		
Elderly and disabled individuals	Makes mandatory for qualified Medicare beneficiaries the OBRA 1986 option of Medicare buy-in for individuals with incomes up to the poverty line (phased in by % of poverty line).	Mandate
OBRA 1990 (Omnibus Budget Reconciliation Act of 1990) (P.L. 101-508)		
Elderly and disabled individuals	Extends the MCCA qualified Medicare beneficiary provision to individuals with incomes up to 120% of poverty line (phased in by % of poverty line).	Mandate
Elderly and disabled individuals	Allows limited program permitting states to provide home and community-based services to functionally disabled individuals, and community-supported living arrangements to mentally retarded/ developmentally disabled individuals.	Option
OBRA 1993 (Omnibus Budget Reconciliation Act of 1993) (P.L. 103-66)		
SSI recipients	Allows states to offer Medicaid coverage to TB-infected individuals who meet the state's income and resource tests.	Option

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

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

Table I.3: Federal Medicaid Expansion to Other Populations and Service Additions

Population affected	Expansion	Mandate/option
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) (P.L. 99-272)		
Terminally ill individuals	Allows provision of hospice services.	Option
OBRA 1986 (Omnibus Budget Reconciliation Act of 1986) (P.L. 99-509)		
Aliens	Requires provision of emergency services if otherwise eligible (financially and categorically).	Mandate
IRCA (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 eligible individuals under 18.	Mandate
Anti-Drug Abuse Act of 1986 (P.L. 99-570)		
Homeless	Requires state to provide proof of eligibility for individuals otherwise eligible but having no permanent address.	Mandate
OBRA 1993 (Omnibus Budget Reconciliation Act of 1993) (P.L. 103-66)		
Medicaid beneficiaries	Makes coverage of personal care services outside the home an optional rather than a mandatory service.	Option
Aliens	Clarifies that Medicaid-covered emergency services for aliens do not include care and services related to organ transplant procedures.	Mandate

Application of the Disproportionate Share Hospital Program

Overview of Program Operation

The disproportionate share hospital (DSH) program was established in 1981 to enable states to provide additional payments to hospitals with heavy caseloads of Medicaid and other low-income patients. The supplemental payments are intended to help defray costs not covered by Medicaid (because of low reimbursement rates) or private insurance. Subject to certain minimums required by federal law, each state decides on its own criteria for identifying DSHs and its formula for making payments to these hospitals.

In the mid-1980s, some states began using recently relaxed rules on raising state Medicaid funds, together with the DSH program, to leverage additional federal dollars. Using this creative financing scheme, these states were able to increase the share of the state Medicaid program funded by the federal government. One common variant of the financing mechanism could be described as follows. A state would receive donations from or levy a tax on specific hospitals. The state would then return the funds to the same hospitals in the form of DSH payments. Because these payments would trigger federal medical assistance payments, the hospitals would receive more in DSH payments than they had provided to the state in donations or taxes. In the end, the hospitals would have received more money because of the scheme, all of it coming from the federal government and none from the state. States could also set the DSH payments so that the new federal funding flowed to the state, and the hospitals received total DSH payments (federal and state combined) just large enough to exactly compensate them for their taxes and donations.

Our August 1994 report detailed how Michigan, Tennessee, and Texas used various financing schemes to increase the federal share of Medicaid expenditures without effectively committing their share of state matching funds.[44]

Financing Mechanisms Used in Michigan

In fiscal year 1993, Michigan used hospital donations to help raise funds for its Medicaid program. Michigan made DSH payments of $458 million, including $256 million in federal matching funds, to 53 hospitals; however, the hospitals returned all but $6 million to the state. As a result, the state received a $250 million net benefit from the federal share of the DSH payments. Michigan stopped this practice because 1991 federal legislation, which took effect for Michigan on January 1, 1993, severely limited provider donations.

[44]Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

In response to these limitations, Michigan's 1994 DSH program included $489 million for those hospitals that provided at least 6 percent of inpatient services to indigent patients in the state. State officials determined that only one hospital would qualify—the state-owned University of Michigan hospital.

On October 2, 1993, Michigan made a DSH payment of $489 million to the University of Michigan hospital. This included $276 million in federal matching funds and $213 million in state funds. Later that day, the hospital returned the entire payment to the state, resulting in a net benefit to the state of $276 million.

Beginning in 1995, the University of Michigan DSH payment will be severely restricted by the Omnibus Budget Reconciliation Act of 1993.[45] State officials have calculated that the state can make a 1995 DSH payment to the University of Michigan hospital of $136.3 million. To make up for the shortfall from the restrictions on the payments to the University of Michigan in 1995, the state has proposed making payments of about $590 million, including federal funds of $335 million, to 92 government-owned hospitals and community health boards. According to the proposal, these governmental entities will then transfer the funds back to the state, thereby allowing the state to continue to benefit from federal Medicaid matching funds.

Under each of the financing mechanisms, providers that received Medicaid payments from the state in turn paid the state almost as much as they received.[46] In effect, in fiscal year 1993 Michigan increased the federal percentage share of total Medicaid spending from 56 percent to 68 percent.

The Urban Institute's DSH Study

In addition to our work on this issue, a December 1994 Urban Institute study reported on how 39 states developed special financing programs.[47]

[45]This legislation limits such payments for 1995 to 200 percent of each qualifying hospital's costs for Medicaid and uninsured patients, less the hospital's total Medicaid reimbursement and payments received from the uninsured. In subsequent years, the act limits DSH payments to the amount of a hospital's uncovered costs.

[46]HCFA advised us that other states are using similar financing arrangements.

[47]Medicaid Disproportionate Share and Other Special Financing Programs: A Fiscal Dilemma for States and the Federal Government, The Urban Institute, (Dec. 1994). The study was sponsored by the Kaiser Commission on the Future of Medicaid. It obtained information from 39 state Medicaid agencies relating to special financing programs and described the types of hospitals that participated in the programs, how much they contributed, and how much they received in DSH and related payments. To obtain detailed information about the use of DSH funds at the state, county, and hospital levels, case studies, using telephone interviews, were conducted in six states.

States collected $5.8 billion through intergovernmental transfers, and taxes and donations from private and county health care providers. This money was augmented with $7.6 billion from federal matching payments, for a total of about $13.4 billion. The states used these revenues to make payments to private, county, and state providers.

The study found that most of the DSH payments, about $8.5 billion, were made to help needy private and county providers. Since these providers contributed $5.8 billion, they realized a gain of $2.7 billion. Hospital officials stated that they used these funds to (1) cover overall hospital operations, including uncompensated care and losses on Medicaid patients; (2) provide AIDS services; (3) pay for capital expenditures, such as opening a new clinic, purchasing an ambulance, or replacing x-ray equipment; (4) secure a commercial bank loan; (5) maintain day-to-day operations because Medicaid payments were often in arrears; and (6) generate income that resulted from placing the funds in interest bearing trusts. These officials emphasized that although the DSH payments helped their hospitals, they were not enough to cover total uncompensated care losses.

State hospitals received $4.8 billion in DSH payments. However, hospital officials indicated that only a small share of the gains were actually retained and available to pay for health care services, such as uncompensated care. Instead, most of the gains were transferred back to state general revenue accounts. Here, they were mixed with other state funds and used to help balance overall state budgets. In some cases, the extra funds were used to support Medicaid, mental health, or general health and welfare spending. Hospital officials believed that to the extent that the DSH programs helped the overall state budget, the programs indirectly helped the hospital's budget. State officials believed that these additional funds prevented larger cuts in the Medicaid program.

GAO Products on Medicaid

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

Uninsured and Children on Medicaid (GAO/HEHS-95-83R, Feb. 14, 1995).

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

Medicaid: Changes in Best Price for Outpatient Drugs Purchased by HMOs and Hospitals (GAO/HEHS-94-194FS, Aug. 5, 1994).

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People (GAO/HEHS-94-176, July 11, 1994).

Medicaid Prenatal Care: States Improve Access and Enhance Services, but Face New Challenges (GAO/HEHS-94-152BR, May 10, 1994).

Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

Medicaid Managed Care: Healthy Moms, Healthy Kids—A New Program for Chicago (GAO/HRD-93-121, Sept. 7, 1993).

Medicaid: Improving Funds Distribution (GAO/HRD-93-112FS, Aug. 20, 1993).

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (GAO/HRD-93-118, Aug. 2, 1993).

Medicaid Estate Planning (GAO/HRD-93-29R, July 20, 1993).

Medicaid: Data Improvements Needed to Help Manage Health Care Program (GAO/IMTEC-93-18, May 13, 1993).

Medicaid: HealthPASS—An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (GAO/HRD-93-67, May 7, 1993).

Medicaid: The Texas Disproportionate Share Program Favors Public Hospitals (GAO/HRD-93-86, Apr. 30, 1993).

Medicaid Formula Alternatives (GAO/HRD-93-18R, Mar. 31, 1993).

Medicaid: Outpatient Drug Costs and Reimbursements for Selected Pharmacies in Illinois and Maryland (GAO/HRD-93-55FS, Mar. 18, 1993).

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993).

Medicaid Formula Alternative (GAO/HRD-93-17R, Mar. 2, 1993).

Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions (GAO/HRD-93-43, Jan. 15, 1993).

Medicaid: Disproportionate Share Policy (GAO/HRD-93-3R, Dec. 22, 1992).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (GAO/HRD-92-89, June 19, 1992).

Medicaid: Ensuring That Noncustodial Parents Provide Health Insurance Can Save Costs (GAO/HRD-92-80, June 17, 1992).

Medicaid Third-Party Liability (GAO/HRD-92-21R, Mar. 3, 1992).

Medicaid: Changes in Drug Prices Paid by VA and DOD Since Enactment of Rebate Provisions (GAO/HRD-91-139, Sept. 18, 1991).

Managed Care: Oregon Program Appears Successful But Expansion Should Be Implemented Cautiously (GAO/T-HRD-91-48, Sept. 16, 1991).

Medicaid Expansions: Coverage Improves But State Fiscal Problems Jeopardize Continued Progress (GAO/HRD-91-78, June 25, 1991).

Substance Abuse Treatment: Medicaid Allows Some Services But Generally Limits Coverage (GAO/HRD-91-92, June 13, 1991).

Medicaid: Alternatives for Improving the Distribution of Funds (GAO/HRD-91-66FS, May 20, 1991).

Medicaid: HCFA Needs Authority to Enforce Third-Party Requirements on States (GAO/HRD-91-60, Apr. 11, 1991).

Medicaid: Legislation Needed to Improve Collections From Private Insurers (GAO/HRD-91-25, Nov. 30, 1990).

Medicaid: Millions of Dollars Not Recovered From Michigan Blue Cross/Blue Shield (GAO/HRD-91-12, Nov. 30, 1990).

Long-Term Care Insurance: Proposals to Link Private Insurance and Medicaid Need Close Scrutiny (GAO/HRD-90-154, Sept. 10, 1990).

Nursing Homes: Admission Problems for Medicaid Recipients and Attempts to Solve Them (GAO/HRD-90-135, Sept. 5, 1990).

Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, Aug. 27, 1990).

Medicaid: States Expand Coverage for Pregnant Women, Infants, and Children (GAO/HRD-89-90, Aug. 16, 1989).

Medicaid: Recoveries From Nursing Home Residents' Estates Could Offset Program Costs (GAO/HRD-89-56, Mar. 7, 1989).

Medicaid: Some Recipients Neglect to Report U.S. Savings Bond Holdings (GAO/HRD-89-43, Jan. 18, 1989).

Medicaid: Changing Medicaid Formula Can Improve Distribution of Funds to States (GAO/GGD-83-27, Mar. 9, 1983).

Comments From the Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

March 31, 1995

The Honorable Charles A. Bowsher
Comptroller General of the
United States
General Accounting Office
Washington, DC 20548

Dear Mr. Bowsher:

Enclosed is the Adminstration's response to the draft GAO report, "MEDICAID: Spending Pressures Drive States Toward Program Reinvention." We appreciate the opportunity to review this draft report and provide our comments on it.

Sincerely,

Bruce C. Vladeck
Administrator

Enclosure

The Administration's Response to Draft GAO Report, "MEDICAID: Spending Pressures Drive States Toward Program Reinvention"

The Administration's budget neutrality methodology

There is no such thing as a State-specific Medicaid baseline. Thus, in reviewing State projections of without-waiver expenditures, the Administration generally compares State historical expenditure growth to the benchmark of baseline growth in the Medicaid program for the nation as a whole. In so doing, the Administration recognizes that there has historically been dramatic variation in State Medicaid programs, e.g., differences in the use of disproportionate share funding, etc. These factors (as well as the geographic variation in practice style) have resulted in radically different levels of expenditures and growth rates across the states.

Further, it is important to recognize that the Administration determines budget neutrality on the basis of current federal law, which is also the basis used in the President's Budget to project baseline Medicaid expenditures. Therefore, in its review of waiver proposals, the Administration acknowledges that under current Federal law States are able to engage in program changes.

Waiver review policy changes under this Administration

The GAO report suggests that this Administration's waiver review policies are different than previous Administration's policies. It is important to note that prior to the Clinton Administration taking office in 1993, only one comprehensive Statewide section 1115 Medicaid waiver had been granted. Recognizing the desire and the need of states to have greater flexibility in reforming their Medicaid systems, upon taking office the Clinton Administration encouraged states to design innovative health delivery systems tailored to each State's unique circumstances, while preserving and enhancing access to quality care. To facilitate these aims, the Clinton Administration developed a more flexible approach to reviews of waiver proposals submitted under section 1115 of the Social Security Act. The Administration announced the principles that would guide its review of such proposals in the Federal Register on September 27, 1994, stating its desire to "facilitate the testing of new policy approaches to social problems" and pledging, among other things, to:

- work with states to develop research and demonstrations in areas consistent with the Department's policy goals;
- consider proposals that test alternatives that diverge from that policy direction;

- consider, as a criterion for approval, a State's ability to implement the research or demonstration project;
- grant waivers to test the same or related policy innovations in multiple States as a mechanism by which the effectiveness of policy changes can be assessed;
- compute budget neutrality over the life of the waiver, since many demonstrations involve making "up-front" investments in order to achieve out-year savings;
- recognizing the difficulty of making appropriate baseline projections of Medicaid expenditures, remain open to development of a new methodology in that regard; and
- in assessing budget neutrality, the Department will not rule out consideration of other budget neutral arrangements proposed by States.

The Administration articulated these principles for reviewing waiver request in part as a response to State concerns about arbitrary spending limits, e.g., the inherent limitations in projections of future spending, the lack of consistently reliable data, and past State experience showing that even the best planning can be overwhelmed by unforeseen effects.

GAO'S use of the national current services baseline to establish budget neutrality

The Administration disagrees with GAO's preliminary analysis of the financing provisions of four Statewide Medicaid demonstrations discussed in the draft report. GAO applies a uniform budget neutrality methodology to each State, without a discussion of the advantages and disadvantages of that approach. GAO compares the baseline costs and growth rates of the approved projects to a "current services" baseline, and finds that three of the four States may not be budget neutral. We believe that each demonstration is budget neutral and take issue with GAO's assumption that their rigid methodology is appropriate for all States. Recognizing that States and their Medicaid programs vary significantly, as discussed above, we have used a more flexible approach to ensure that each project is budget neutral.

There are several conceptual and technical problems with the GAO's approach to using the national current services baseline to establish budget neutrality in all states:

. The GAO uses as a standard for Federal budget neutrality a current services baseline, which they define to include expenditures needed to finance the program assuming laws and policies that are in place at the State level today. Nevertheless, the GAO applies this current services standard to a current law baseline (the President's Budget does not differentiate between the two, essentially applying a current law approach to estimates of current services baseline expenditures). The GAO does not construct a true current services baseline for their analysis.

Conceptually, current services is the wrong baseline to adjudicate budget neutrality. In granting waivers, the federal government determines budget neutrality on the basis of current federal law -- the basis also used to project baseline Federal expenditures. Under current federal law states are able to engage in program expansions and contractions. Thus, establishing a state-specific budget neutrality baseline at a minimum must involve some judgement regarding states' behavior under current law. (See further discussion of hypotheticals below).

The report spends considerable time (Summary, page 2) relating the dramatic variation in state Medicaid programs, i.e., difference in the mix of eligible populations, the mix of services offered, provider payment rates, and the use of disproportionate share funding. All of these factors (as well as the geographic variation in practice styles) have resulted in radically different levels of expenditures and growth rates across the states. However, this variation is ignored in selecting their budget neutrality approach.

The report (Summary, page 3) asserts that the determination of the without-waiver baseline is in considerable "dispute." Yet in asserting its methodology, GAO offers no discussion of pros and cons of its approach or alternative methods. The GAO should at least attempt an analysis of budget neutrality using state-specific data.

Waivers involve subsets of the Medicaid population and services. GAO applies the President's Budget Current Services Medicaid baseline to establish its budget neutrality baseline. It is unclear how GAO measured the services used by "populations covered by the waiver."

For the four waiver states for which GAO provided its estimates of year-by-year with and without baselines, based on the President's Budget baseline for FY 1996, we note that across the four waivers, the federal government actually realizes small savings (0.1% relative to total Federal Medicaid outlays for the FY 1994 to FY 1998 period).[1]

The inclusion of 1902(r)(2) expansion populations in State demonstration baselines

The report criticizes the Administration's decision to allow states to include in their demonstration baselines the cost of extending coverage to optional groups under section 1902(r)(2) of the Social Security Act. We believe this decision is consistent with a current law approach and reflects the priorities of the Administration and Congress to extend coverage to pregnant women and children. We would also emphasize that, to be counted in the "without waiver" baseline costs, the expanded populations must also be covered under the demonstration.

[1]The four states are Tennessee, Florida, Oregon, and Hawaii.

Entitlement growth played minor role in Medicaid's high growth

We concur with GAO's finding that entitlement growth was not the major cause of the 17% cost growth experience in the Medicaid program between 1985 and 1993. However, we believe it is misleading to compare this growth rate with growth in the federal budget of 3.8% over the same time period, as on page 4 of the summary.

Waivers used to do more than contain costs and expand program coverage

GAO's report suggests that the objectives of section 1115 are limited to containing costs and expanding coverage. While these objectives are important -- and we believe they are achieved in section 1115 waivers discussed in this report -- the Administration believes this focus is too narrow.

First, in addition to containing costs and expanding coverage, section 1115 demonstrations allow states to experiment with innovative delivery and payment systems for their Medicaid or low-income populations.

Second, we do not agree with the statement that "whether the comprehensive scope of the demonstrations can be characterized as experimental is controversial." HCFA considers each of the statewide demonstrations as having unique components that are worth testing under a demonstration and has awarded two contracts to evaluate the innovative features of each implemented program.

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