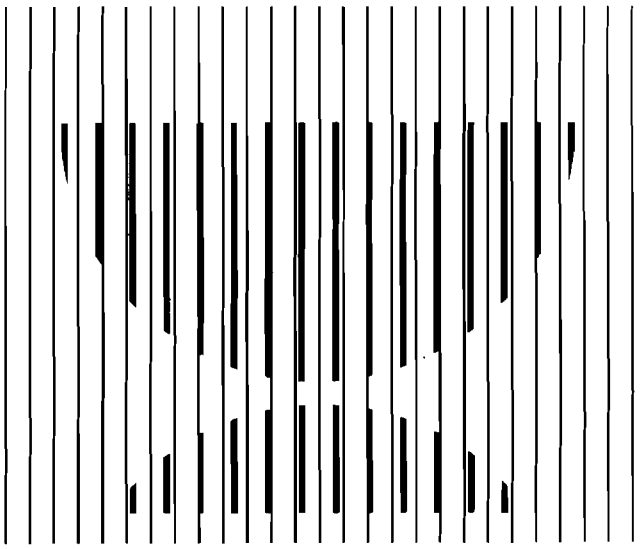
CBO STAFF MEMORANDUM

FACTORS CONTRIBUTING
TO THE GROWTH OF
THE MEDICAID PROGRAM

May 1992



CONGRESSIONAL BUDGET OFFICE
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This Congressional Budget Office (CBO) staff memorandum analyzes recent trends in the Medicaid program and its projected growth through 1996. It discusses some of the policies, legal decisions, and other factors that may be contributing to rising Medicaid expenditures. It was prepared in response to a request from the Senate Committee on Finance.

The memorandum was written by Linda Bilheimer of CBO's Human Resources and Community Development Division under the direction of Nancy Gordon and Kathy Langwell. Tahirih Senne and Julia Jacobsen generated data for the tables, and Kimberly Guise prepared the graphs. Constance Rhind, Verdon Staines, and Carla Pedone made helpful suggestions. Jean Hearne and Patrick Purcell of the Budget Analysis Division developed the Medicaid baseline projections and, along with Scott Harrison, provided valuable assistance.

In addition, John Klemm and David Baugh of the Health Care Financing Administration and Trish Riley of the National Academy for State Health Policy provided useful comments. Roger M. Williams edited the manuscript. Ronald Moore provided administrative assistance for the project and prepared the final version of the manuscript.

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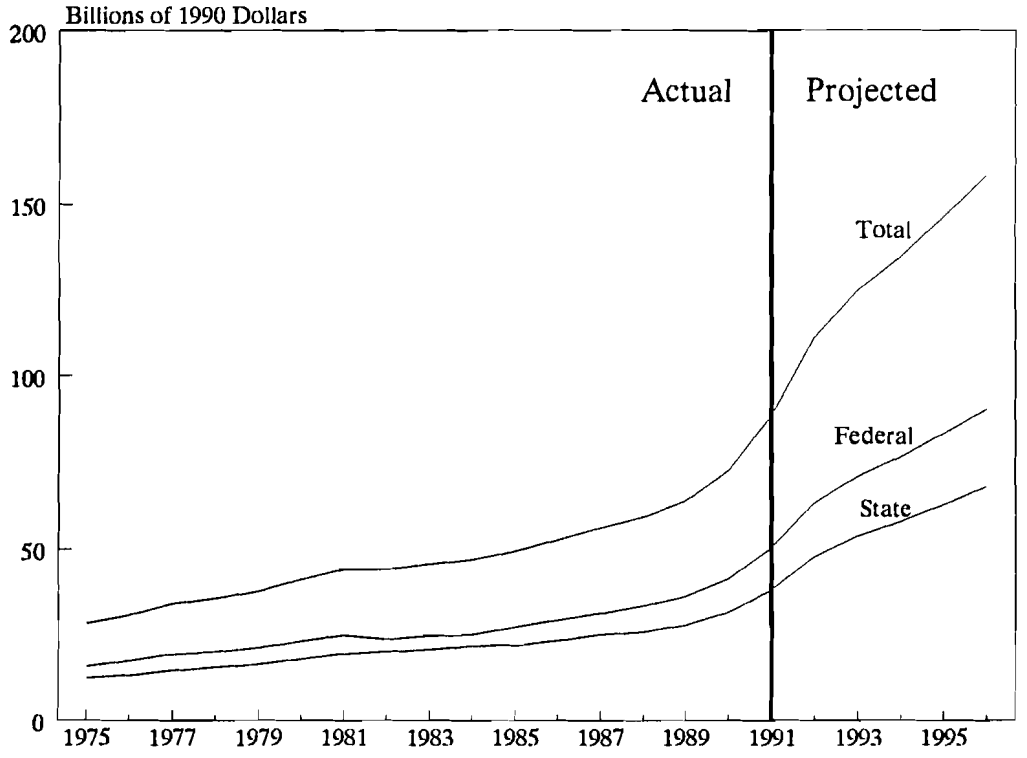
OVERVIEW OF THE MEDICAID PROGRAM

Medicaid is a state-administered program that operates under federal guidelines to provide medical care to certain low-income populations. The program is jointly funded by the federal and state governments with federal financial participation rates that currently range from 50 percent to 80 percent. The states have considerable discretion in establishing the income and resource criteria for program eligibility; determining the amount, duration, and scope of covered services; and determining methods for reimbursing providers.

Medicaid expenditures have grown dramatically in recent years, reaching $92 billion in 1991. Federal spending constituted 57 percent of this amount; state and local spending accounted for the balance. After adjusting for general inflation, real Medicaid expenditures, which grew by 34 percent between 1981 and 1988, increased by 23 percent between 1988 and 1990 and then by a further 22 percent in 1991 alone (see Figure 1).

Rapid increases in Medicaid expenditures are likely to continue in the 1990s, with the program absorbing increasingly large percentages of both federal and state dollars. Assuming that the federal share continues at the current average rate of 57 percent, CBO predicts that real Medicaid expenditures will increase by almost 120 percent between 1990 and 1996. Under current budget policies, that means Medicaid expenditures will

Figure 1.
Real Medicaid Expenditures, 1975–1996



SOURCES: Congressional Budget Office calculations based on data on the costs of Medicaid in Committee on Ways and Means, U. S. House of Representatives, 1991 Green Book (May 1991), pp. 1415–1416; and CBO February 1992 baseline projections.

NOTE: Real payments were calculated using the fixed–weighted deflator for gross national product. A federal financial participation rate of 57 percent is assumed for the 1992 to 1996 period.

constitute 7 percent of all federal spending in 1996 compared with 3 percent in 1990. The states also anticipate that Medicaid, which accounted for 9 percent of state general fund expenditures in 1990, will account for a rising percentage of state budgets in the 1990s.[1]

The current rate of growth of Medicaid expenditures is a major concern for the federal and state governments. Controlling Medicaid costs in the current environment is extraordinarily difficult, however, because the number of people seeking help from the program is increasing dramatically at the same time that other forces are contributing to higher Medicaid expenditures per beneficiary. The purpose of this memorandum is to provide an overview of the Medicaid program and to explore the factors that are contributing to its rising costs.

Eligibility for the Medicaid Program

Historically, eligibility for Medicaid has been tied to categorical eligibility for welfare. The primary population groups the program serves are people in low-income families receiving Aid to Families with Dependent Children (AFDC) and elderly, blind, and disabled people receiving Supplemental

1. National Association of State Budget Officers, *State Expenditure Report, 1991* (Washington, D.C.: NASBO, 1991), and unpublished data.

Security Income (SSI). State AFDC income eligibility standards vary widely, leading to corresponding variations in Medicaid eligibility for low-income families. In July 1991, for example, the Medicaid income eligibility threshold for a family receiving AFDC ranged from 13 percent of the poverty level to 77 percent of the poverty level, with 33 states and the District of Columbia having income eligibility thresholds below 50 percent of the poverty level. In addition, 12 states--known as Section 209(b) states--use standards for determining Medicaid eligibility for SSI beneficiaries that are more restrictive than standards used for SSI.[2]

States may choose to provide Medicaid coverage for the "medically needy," an option adopted by 36 states and the District of Columbia as of July 1991.[3] Medically needy people are those who meet the nonfinancial criteria for categorical eligibility--that is, they are members of a single-parent (or unemployed parent) family with dependent children, or are aged, blind, or disabled--whose income or resources exceed the standards set for cash assistance programs but are below some upper limit set by the state. By federal law, the upper income limit may not exceed 133.3 percent of the AFDC payment standard in the state. People who do not automatically qualify as medically needy may do so after their incurred medical expenses

2. More restrictive standards can be used only if they were part of a state's approved Medicaid plan in January 1972, before the SSI program was implemented.

3. In an effort to contain their Medicaid expenditures, some states may have dropped their medically needy programs since that date.

are deducted from their income or resources--a process known as spending down. Section 209(b) states are required to use the process to determine Medicaid eligibility for the elderly and disabled, regardless of whether the state has a medically needy program.

Medicaid coverage can also be provided to other specific population groups who are considered to be categorically needy but do not receive a cash grant. States may, for example, provide benefits to people in additional AFDC-related categories, including so-called Ribicoff children--those under age 21 (or 20, 19, or 18 at the state's option) who meet AFDC income and resource standards but not the definition of a "dependent child." The majority of states cover all such children up to the specified age limit. The remaining states cover selected categories of Ribicoff children, such as foster children, adopted children whose adoptions were subsidized by public funds, and children in institutions or inpatient psychiatric facilities.

States can also extend Medicaid benefits to additional SSI-related groups. Of particular importance is the option to use a higher income ceiling than the medically needy level--not to exceed 300 percent of the SSI benefit amount--to determine Medicaid eligibility for institutionalized individuals. Although use of this option expands eligibility to people with higher incomes,

it also places an absolute income ceiling on eligibility for Medicaid because income is measured before the payment of medical expenses.

Consequently, if the state does not also have a program for the medically needy, some people with nursing home expenses that exceed their income may still not qualify for Medicaid because their income is above the ceiling. As of January 1991, 35 states used a special ceiling to determine Medicaid eligibility for institutionalized individuals, with 32 of those states using the maximum allowed level ($1,221 per month in January 1991).[4] The remaining states either had medically needy programs that included the institutionalized population or were 209(b) states. Institutionalized individuals in those states could, therefore, become eligible for Medicaid by spending down.[5]

Recent legislative initiatives have broken the tie between categorical welfare eligibility and Medicaid eligibility by expanding Medicaid coverage to pregnant women and children in other low-income families as well as extending eligibility to a broader group of low-income elderly and disabled people. Under current law, states must provide Medicaid coverage to:

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4. For a detailed discussion of eligibility for Medicaid long-term care services, see National Governors' Association, *Medicaid Long Term Care Eligibility as of January 1, 1991* (Washington, D.C.: NGA, 1991).

5. Some states were using both a special income ceiling and the spend-down process to determine Medicaid eligibility for the institutionalized population.

- Pregnant women and children up to age 6, with family income below 133 percent of the poverty level;

- Children aged 18 and under, born after September 30, 1983, with family income below the poverty level; and

- Medicare beneficiaries with income below the poverty level (but only for payment of Medicare premiums and cost sharing).

States also have the option to provide Medicaid coverage to pregnant women and infants under age 1 with family income between 133 percent and 185 percent of poverty. By July 1991, 22 states and the District of Columbia had elected to cover all pregnant women and infants with income up to 185 percent of poverty, and six states were providing Medicaid coverage to pregnant women and infants with income above 133 percent of poverty but with a lower income ceiling than 185 percent of poverty.

Services Covered by Medicaid

Federal law requires states to cover certain services in their Medicaid programs; the coverage of other specified services is optional. Unlike

Medicare, which is primarily an acute care program and pays for only a limited amount of nursing home care, Medicaid is a major payer for both acute and long-term care services. The minimum set of services that must be offered to enrollees who are categorically eligible includes:

- Inpatient and outpatient hospital services;
- Physician services;
- Laboratory and X-ray services;
- Family planning services;
- Nurse midwife services;
- Certified family or pediatric nurse practitioner services;
- Nursing facility (that is, nursing home) services for people over 21 years old;
- Home health care for people entitled to nursing facility services;

- o Ambulatory services provided by federally qualified health centers; and

- o Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for people under 21 years old.

Mandatory services for the medically needy population are less comprehensive. At a minimum, however, states that have medically needy programs must provide ambulatory care for children and prenatal and delivery services for pregnant women.

States may also provide a wide range of optional services. As of October 1990, most states chose to offer at least the following to Medicaid enrollees who were categorically eligible:[6]

- o Podiatry;

- o Optometry;

- o Clinic services;

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6. Because of budget problems, some states may have reduced their coverage of optional services since that date.

- Dental care;
- Transportation;
- Intermediate care facility services for the mentally retarded (ICF-MR);
- Nursing facility services for people under 21 years old;
- Prescription drugs;
- Prosthetic devices; and
- Eyeglasses.

Some states offer enrollees who are categorically eligible several other optional services. Thus, in most states, the Medicaid program provides more comprehensive service coverage than many private health insurance packages--at least for people who are categorically eligible. Coverage of optional services for medically needy people, however, is often less generous than for those who are categorically needy.

Requirements for Medicaid Services

The benefit packages offered by state Medicaid programs must meet four basic federal requirements. These requirements address the amount, duration, and scope of services; comparability of services; "statewideness" (uniformity throughout the state); and freedom of choice.

Although states can place limits on the amount of services they provide, the amount, duration, and scope of any service must be reasonably sufficient to achieve its purpose. With a few specific exceptions, services offered to all categorically needy enrollees must be comparable in terms of amount, duration, and scope. (A similar rule applies to medically needy enrollees.) The benefit package must be uniform throughout the state, and enrollees must be free to choose their providers from among those who are qualified and who agree to provide services to Medicaid beneficiaries.

In certain circumstances, states can obtain waivers of some of these federal requirements.[7] For example, waivers authorized by Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (OBRA-81) have enabled states to provide an array of home- and community-based services--including homemaker and home health aide services, personal care, medical day care,

7. For a detailed discussion of Medicaid waivers, see Congressional Research Service, *Medicaid Source Book: Background Data and Analysis* (November 1988), pp. 149-166.

respite care, habilitation services, and psychosocial rehabilitation services--to low-income elderly and disabled people who are at risk of institutionalization. The waivers allow states to offer--to particular groups of enrollees--additional services for which Medicaid would not otherwise pay and to target optional Medicaid services. (Without a waiver, a state cannot restrict the use of an optional service to a subgroup of the Medicaid population.) In addition, a higher income ceiling--not to exceed 300 percent of the SSI benefit amount--can be used to determine eligibility for home- and community-based services.

In order to obtain a Section 2176 waiver, however, states must be able to show that the projected average per capita costs for people receiving services under the waiver are no greater than they would have been without the waiver. This requirement to be budget neutral has sometimes proved difficult to meet in states that have constrained the growth of nursing homes. (Lacking vacant nursing home beds, it is difficult for a state to argue that people receiving home- and community-based services under the waiver would otherwise be in a nursing home.) In the Omnibus Budget Reconciliation Act of 1987, therefore, the Congress established an alternative home- and community-based waiver program for elderly beneficiaries only--the Section 1915(d) waiver program. States participating in the program are not required to limit the provision of services to elderly people who would otherwise be in

nursing homes. States are required, however, to assume some risk by accepting a cap on total long-term care expenditures for the elderly.

In January 1991, 40 states were providing services under home- and community-based waivers to elderly and disabled beneficiaries. Only Oregon, however, has obtained a Section 1915(d) waiver. That probably reflects an uneasiness among the states about assuming additional risks for long-term care.

Waivers of federal requirements have also enabled states to develop managed care programs for Medicaid enrollees.[8] For example, waivers authorized by Section 2175 of OBRA-81 allow states to restrict the freedom of enrollees to choose their providers and to require participation in case management programs. Section 2175 waivers have also been used to avoid Medicaid's comparability and statewideness requirements, thereby permitting states to limit eligibility for managed care programs to certain target populations and to offer a different array of services to managed care participants. As with Section 2176 waivers, states must show that the programs developed under these waivers are cost-effective.

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8. In addition to contracting with traditional health maintenance organizations, states have developed a variety of other Medicaid managed care programs. They include primary care case management plans and plans that place contracting physicians at financial risk for ambulatory but not inpatient services.

Waivers authorized under Section 1115(a) of the Social Security Act have also been used to design and implement innovative managed care projects. Typically, 1115(a) waiver projects are viewed as demonstrations and last a limited time. Arizona, however, has operated its entire medical assistance program under a demonstration waiver since 1982. Medicaid providers in Arizona are selected through a competitive bid process and reimbursed under a prepaid capitation system.[9] The state received multiple waivers of federal requirements that enabled it to take such steps as assigning all Medicaid enrollees to managed care providers and excluding long-term care and certain other services from coverage.[10] Arizona currently has the only statewide managed care program for medical assistance beneficiaries in the country, but other states and the federal government are keenly interested in the Arizona model.

Reimbursement for Providers

States have had considerable discretion in determining how and how much they will reimburse providers. Consequently, reimbursement methods and levels vary considerably (although Medicaid programs typically pay providers

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9. Capitation is a form of payment that provides a predetermined amount per enrollee served by the provider. The latter agrees contractually to accept this payment without regard to the type or frequency of service actually rendered. In this case, the capitation payment covers Medicaid services.

10. The Arizona program began coverage of long-term care services in 1989.

much less than other payers do). With a few exceptions, providers must accept Medicaid reimbursement as payment in full and may not attempt to collect more from patients.

Recent actions by the Congress and court decisions won by providers have begun to impose more requirements on states' reimbursement policies. The Congress, for example, has established minimum criteria for reimbursing disproportionate share hospitals (those that serve disproportionately large numbers of Medicaid or low-income patients) and has codified a regulatory requirement concerning the adequacy of reimbursement for physicians. In addition, Medicaid payments for hospitals and nursing homes (and, more recently, physicians) are the subject of a growing number of lawsuits.

PROGRAM TRENDS BETWEEN 1980 AND 1990

Federal and state initiatives in the 1980s produced dramatic changes in the Medicaid program. Those changes, which included eligibility expansions, service enhancements, and changes in financing and reimbursement, have almost certainly contributed to the recent rapid growth in Medicaid expenditures. In spite of program expansions, however, low reimbursement

rates and the lack of providers in low-income areas may limit access to medical services for some Medicaid enrollees.

Expansions of Eligibility

At the beginning of the 1980s, eligibility for the Medicaid program was closely tied to categorical eligibility for welfare. The number of people using Medicaid services, which had peaked in 1977 (at 22.8 million) and then dropped in 1978 and 1979, rose again in 1980 and 1981.[11] In spite of the effects of the ensuing recession, however, the number of Medicaid users fell between 1981 and 1983 (from 22.0 million to 21.6 million). Cutbacks in the AFDC program enacted in OBRA-81, combined with new Medicaid options that granted states greater flexibility in determining which groups of children to cover, probably contributed to that program contraction.

Beginning in 1984, the Congress began a series of mandatory and optional expansions of Medicaid eligibility, and they continued throughout the decade. Although low-income pregnant women, infants, and children were the primary focus of those expansions, the target populations also included the elderly and the disabled.

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11. Historical data on Medicaid program participation are based on users (or "recipients") of Medicaid services rather than enrollees. Thus, a person enrolled in the program who uses no services is not counted.

The initial Medicaid expansions for pregnant women, infants, and children, authorized in the Deficit Reduction Act of 1984 (DEFRA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) were restricted to people meeting AFDC income and resource standards. With the options granted to states under the Omnibus Budget Reconciliation Act of 1986 (OBRA-86), however, an important shift in program philosophy occurred: for the first time, the linkage between Medicaid and welfare eligibility was severed, and states were authorized to provide Medicaid coverage to all pregnant women and infants with income below the poverty level. A rapid succession of mandates and options for pregnant women, infants, and children followed. The current mandate to cover all pregnant women and children up to age 6 with income below 133 percent of the poverty level was included in the Omnibus Budget Reconciliation Act of 1989 (OBRA-89). An additional mandate to cover all children under 19 born after September 30, 1983, in families with income below the poverty level was part of the Omnibus Budget Reconciliation Act of 1990 (OBRA-90).

The Congress also took steps to streamline and simplify the Medicaid eligibility process for pregnant women, infants, and children. States are now required to:

- Provide continuous eligibility for pregnant women throughout their pregnancies and the 60-day postpartum period;

- Grant continuous eligibility to newborns for the first year of life if they live with their mothers and the mothers would have been eligible for Medicaid if pregnant; and

- Place Medicaid eligibility workers at service delivery sites, including federally qualified health centers and disproportionate share hospitals. (This process is known as "outstationing.")

Other methods states may use to simplify the eligibility process for pregnant women and children include granting presumptive eligibility for pregnant women pending a full eligibility determination (adopted by 25 states and the District of Columbia as of July 1991); dropping the assets test for pregnant women and children, thereby allowing financial eligibility for Medicaid to be based on income alone (adopted by 47 states and the District of Columbia as of July 1991); shortening Medicaid application forms (adopted by 31 states as of July 1991); expediting the eligibility process for pregnant women (adopted by 14 states as of July 1991); and allowing mail

submission of Medicaid applications with no face-to-face interview required (adopted by 14 states as of July 1991).[12]

In the Family Support Act of 1988, the Congress also made Medicaid eligibility a critical component of welfare reform. People who lose their AFDC eligibility as a result of employment are now guaranteed six months of Medicaid coverage for themselves and their families, with no premium requirements. States must offer a second six months of coverage to those families, provided they satisfy certain earnings reporting requirements. During the second six months, states can limit coverage to acute care benefits, impose premiums on families with income above the poverty level, and offer families alternative coverage choices. (In lieu of providing Medicaid coverage, states have the option of paying premiums, deductibles, and coinsurance for eligible families with access to employment-based insurance coverage.) In addition, states must provide Medicaid coverage to poor two-parent families when the principal breadwinner is unemployed, regardless of whether those families are receiving cash assistance in any particular month.

Recent legislation has also included mandates and options to expand Medicaid eligibility for the elderly and the disabled. States are now required to pay Medicare premiums and cost-sharing amounts for qualified Medicare

12. National Governors' Association, *State Coverage of Pregnant Women and Children: July 1991* (Washington, D.C.: NGA, July 1991).

beneficiaries (QMBs)--those with income below the poverty level and resources less than twice the SSI asset level.[13] Some states have decided not to pay Medicare copayments for QMBs and other dually eligible beneficiaries, however, on the grounds that the 80 percent of reasonable costs that Medicare pays equals or exceeds the amounts that their Medicaid programs would pay for the same service.

States must also pay Medicare Part A premiums for "qualified disabled and working individuals," those with income below 200 percent of the poverty level and resources no greater than twice the SSI asset level. They are disabled people who, by returning to the work force, have lost their former eligibility for Social Security disability income and, hence, for Medicare. (Disabled individuals with income above 150 percent of the poverty level can be required to contribute to the premium payment.)

In a recent mandate authorized in the Medicare Catastrophic Coverage Act of 1988, the Congress took steps to enable nursing home residents to qualify for Medicaid without impoverishing their spouses living in the community. When determining the amount that nursing home residents must contribute to the cost of their care, states must provide a minimum level of

13. States have the option of providing full Medicaid coverage to all elderly and disabled people with incomes below the poverty level. Only six states have exercised the option since its authorization in the Omnibus Budget Reconciliation Act of 1986.

asset and income protection for spouses, thereby expanding Medicaid eligibility for married elderly and disabled people. In particular, states must attribute half of the value of a couple's total countable resources to each spouse, subject (in 1991) to a minimum of $13,296 and a maximum of $66,480 for the spouse remaining in the community. A state has the option of setting the minimum protected asset level anywhere between the minimum and maximum amounts, which are adjusted for changes in the consumer price index. As of January 1991, 29 states and the District of Columbia had set the minimum protected asset level at $13,296, and 16 states were using $66,480.

The spouse remaining in the community is also allowed to retain a monthly income, which, in January 1991, had to be at least 122 percent of the federal poverty level for a couple.[14] The minimum monthly income allowance, which has an indexed cap ($1,662 in January 1991), rose to 133 percent of the poverty level in July 1991 and will rise to 150 percent of the poverty level this July.[15] In January 1991, 22 states had established minimum protected income levels that exceeded the minimum requirement.

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14. If the community spouse has excess shelter expenses, states are required to increase the minimum income allowance.

15. National Governors' Association, *Medicaid Long Term Care Eligibility*.

Service Enhancements

Recent legislation has also included several mandates and options to:

- Enhance prenatal care services for pregnant women;
- Enhance preventive and follow-up treatment services for children through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program;
- Improve the quality of nursing home services; and
- Expand home- and community-based services for the elderly and disabled.

Prenatal Care Enhancements. The Congress has granted states several options to enhance the prenatal care services that Medicaid covers. Services that may now be offered include case management, risk assessment, nutrition and psychosocial counseling, health education, home visiting, and transportation. The majority of states now provide at least some of those enriched benefits.[16]

16. For more detailed information on the enhanced services states are now offering, see National Governors' Association, *State Coverage of Pregnant Women and Children*.

EPSDT Enhancements. In OBRA-89, the Congress enacted major changes to EPSDT--the mandatory program to provide comprehensive health services to individuals under 21 years old who are eligible for Medicaid. Children participating in EPSDT must be screened periodically for health and developmental problems. If potential problems are found, the child must be referred for further diagnostic services and, if necessary, treatment.

In spite of the importance of preventive health services for children, participation in the program has been low. Based on rough estimates, the National Governors' Association concluded that the average state participation rate in 1989 was below 40 percent. The National Academy of Pediatrics estimated that 22 percent of children eligible for Medicaid received EPSDT services in 1989.[17] The purpose of the OBRA-89 changes was to expand the availability of preventive and developmental examinations by allowing more providers to participate, enhance health care services for children for conditions identified through EPSDT screens, and increase participation rates by setting annual enrollment goals for states.

Before OBRA-89, states were required to provide immunizations, dental services, and diagnosis and treatment of vision and hearing problems to children participating in EPSDT. OBRA-89 expanded this mandate. States

17. Ian T. Hill and Janine M. Breyel, *Caring for Kids* (Washington, D.C.: National Governors' Association, 1991), p. 14.

must now pay for any service that is necessary to treat a condition an EPSDT screen identifies--whether or not the state Medicaid plan covers the service--as long as the service is one for which federal matching payments would be allowed. OBRA-89 also required that annual targets for EPSDT enrollment be set for each state; all states are to achieve an 80 percent participation rate by 1995.

Nursing Home Provisions. OBRA-87 substantially changed the standards that nursing homes must meet in order to participate in the Medicare and Medicaid programs, as well as the corresponding monitoring and enforcement procedures. Before the implementation of the OBRA-87 mandates, Medicaid programs paid for long-term care in three classifications of nursing homes: skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and intermediate care facilities for the mentally retarded (ICF-MRs). OBRA-87 eliminated the distinction between SNFs and ICFs, creating a single classification of nursing homes known as nursing facilities (NFs).[18] ICF-MRs, however, were not affected by the legislation. Nursing facilities have to meet requirements very similar to the new requirements for skilled nursing facilities participating in Medicare.

18. Skilled nursing facility services for adults were mandatory; intermediate care facility services were optional. Under the new standards, nursing facility services for adults are mandatory.

Expansion of Home- and Community-Based Services. OBRA-90 created a new Medicaid option to enable states to provide a range of home- and community-based services for disabled elderly people. (States had previously been able to provide a comprehensive package of home- and community-based services by obtaining a waiver.) To be eligible for the new program, elderly Medicaid clients must be limited in at least two of three specific activities of daily living: using the toilet, transferring from a bed or chair, and eating. Also eligible are people with Alzheimer's disease who are unable to perform at least two of five activities of daily living (the above three plus bathing and dressing) or who require substantial supervision. Federal expenditures for this option were capped at $580 million for the 1991-1995 period.

A further Medicaid option authorized by OBRA-90 allows states to provide "community supported living arrangements services" for the developmentally disabled. These services may include personal assistance, training and habilitation, 24-hour emergency assistance, "assistive technology," and "adaptive equipment," but they specifically exclude room and board and employment services. The option will be limited to between four and eight states in the first five years, with expenditures capped at $100 million over that period.

Changes in Financing and Reimbursement Policies

Several changes in federal law and regulations in the 1980s affected the methods used to reimburse hospitals and nursing homes, the reimbursement of disproportionate share hospitals, the use of donations from providers and provider-specific taxes to finance the state's share of Medicaid expenditures, and reimbursement for prescription drugs. These changes have important implications for Medicaid expenditures in the 1990s.

Changes in Methods for Reimbursing Hospitals and Nursing Homes. Before 1980, states were required to reimburse hospitals and nursing homes on a reasonable cost basis, which essentially meant that each facility was paid according to its reported costs. Because of concerns that this approach did not encourage cost containment, the Congress included legislation in the Omnibus Reconciliation Act of 1980 (ORA-80) that allowed states to develop their own reimbursement systems for nursing homes. Known as the Boren Amendment, it required states to pay rates that were "reasonable and adequate" to meet the costs that would be incurred by "efficiently and economically operated" facilities. In 1981, the amendment was expanded to include hospitals, with two additional requirements: that states, in setting their rates, take into account the special needs of disproportionate share

hospitals; and that rates be high enough to ensure that Medicaid enrollees have reasonable access to inpatient hospital services of adequate quality.

The Boren Amendment broke the linkage between Medicare and Medicaid reimbursement rates for hospitals, with striking effects. In 1980, Medicare paid hospitals 95 percent of their costs and Medicaid paid 92 percent. By 1989, Medicare was paying hospitals 92 percent of costs, but Medicaid was paying only 78 percent.[19]

In a further modification of the Boren Amendment, OBRA-87 required states, when setting reimbursement rates for nursing homes, to take into account the costs of complying with the nursing home provisions included in the reconciliation act. OBRA-90 reinforced that requirement, asserting that states must consider the costs of the services required to ensure that nursing home residents attain or maintain the highest practicable level of physical, mental, and psychosocial well-being.

In the 1980s, providers in several states filed lawsuits challenging the reasonableness and adequacy of reimbursement rates for hospitals and nursing homes under the Boren Amendment. In some of the early cases, the courts focused on those aspects of the rates and paid less attention to the process

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19. See Prospective Payment Assessment Commission, *Medicaid Hospital Payment: Congressional Report, C-91-02* (Washington, D.C.: October 1991), p.11.

that states had used to develop them. After an apparent shift in judicial philosophy, the courts placed increasing emphasis on the procedural requirements of the amendment. A corresponding shift occurred in the burden of proof--from plaintiffs (who previously had to show that rates were unreasonable) to states (which had to demonstrate that they had made findings of the costs that efficiently and economically operated facilities would incur). In an important 1989 decision in Colorado, known as the *AMISUB* decision, the United States Court of Appeals for the Tenth Circuit ruled that federal law requires state Medicaid agencies to identify and determine the following: hospitals that are efficiently and economically operated, costs that must be incurred by such hospitals, and the payment rates that are reasonable and adequate to meet the costs of efficiently and economically operated hospitals in that state.[20]

Litigation over the Boren Amendment culminated in 1990 with the U.S. Supreme Court decision in *Wilder* v. *Virginia Hospital Association*--a decision that some believe heralded an era of judicial rate setting.[21] *Wilder* established that providers have an enforceable right to the adoption of Medicaid reimbursement rates that are reasonable and adequate to meet the costs of efficiently and economically operated facilities, and that--under the

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20. *AMISUB [PSL] Inc.* v. *State of Colorado Department of Social Services*, 879 F.2d 789 (CA10 1989).

21. For an extensive discussion of the Boren Amendment and both the *Wilder* and the *AMISUB* decisions, see Jeff E. Harris, "The Boren Amendment," *W-Memo* (American Public Welfare Association, vol. 2, July/August 1990), pp. 9-26.

Boren Amendment--they may sue state officials for declaratory and injunctive relief.[22] Furthermore, the court declared the enforceable right to be both procedural and substantive; that is, states must make findings and assurances about the reasonableness and adequacy of their rates and must implement them accordingly.

Reimbursement of Disproportionate Share Hospitals. As a result of OBRA-81, state Medicaid agencies were required to take into account the special costs disproportionate share hospitals incur when establishing hospital reimbursement rates. Responses to this requirement varied considerably. Some states used reimbursement systems that were based on reasonable costs, thereby assuring that disproportionate share hospitals had their costs taken into account. Other states developed disproportionate share definitions that severely limited the number of hospitals that could qualify for additional payments. Therefore, in OBRA-87 (with amendments in the Medicare Catastrophic Coverage Act of 1988), the Congress set minimum criteria that states must meet in defining disproportionate share institutions and in establishing the rates at which these institutions must be paid.

Instructions for implementing this requirement, developed by the Secretary of Health and Human Services (HHS), allowed the states to use

22. See 110 S.Ct. 2510 (1990).

alternative methods to define disproportionate share hospitals and to determine the additional payment amounts for these hospitals, provided that the aggregate payment adjustment would be at least as great as under one of the statutory options. Combined with a provision of OBRA-86 that allowed states to pay disproportionate share hospitals more than Medicare would have paid, that authority effectively removed all limitations on payments to disproportionate share hospitals.[23] Some states responded by making large adjustments in those payments.[24]

Proposed regulations published in March 1990 would have eliminated the option to use alternative methods, possibly because those methods were believed to encourage excessive growth in disproportionate share payments in some states. In OBRA-90, however, the Congress allowed the states to continue to use alternative disproportionate share formulas and rapid growth in disproportionate share payments continued.[25] This growth was associated with the increased use of provider taxes and donations to pay part of the

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23. Before OBRA-86, the aggregate Medicaid payments that states made to hospitals could not exceed the amounts that Medicare would have paid. The 1986 legislation waived that requirement for disproportionate share hospitals only.

24. The following examples illustrate the dramatic growth in and wide disparities among disproportionate share payments. Payments in Alabama rose from $300,000 in fiscal year 1989 to $194 million in 1990. Louisiana paid an average of $2.4 million to each of 30 hospitals in 1989; the same number of disproportionate share hospitals in neighboring Mississippi received an average of $70,000 per hospital. (See National Association of Public Hospitals, *Revised State Medicaid Policies for Disproportionate Share Hospitals* (Washington, D.C.: NAPH, August 1991).)

25. Specifically, OBRA-90 allowed states to use an alternative disproportionate-share formula that provides for a minimum specified additional payment amount (or increased percentage payment) that varies according to the type of hospital. The method must apply equally to all hospitals and result in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to Medicaid or low-income patients.

state's share of Medicaid costs. As a result, further regulatory and legislative action ensued in 1991 (see discussion below).

Use of Donations from Providers and Provider-Specific Taxes to Finance the State Share of Medicaid Expenditures. In 1985, the Health Care Financing Administration (HCFA) issued regulations to allow states to use funds donated by both private and public organizations as part of their share of financial participation in Medicaid.[26, 27] Before that, donated funds could be used only for the state's share of training expenditures under Medicaid. The new regulations required that donated funds meet the following criteria:

- Public funds had to be appropriated directly to the Medicaid agency, transferred from other public agencies to the Medicaid agency and placed under its administrative control, or certified by the contributing agency as representing expenditures eligible for federal financial participation. Federal funds from other programs could not be used for the state's share of Medicaid expenditures unless these funds were specifically authorized by federal law to be used to match other federal funds.

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26. For a detailed discussion of the legislative and regulatory history of provider donations and provider-specific taxes, see Mark Merlis, "Medicaid: Provider Donations and Provider-Specific Taxes," *CRS Report for Congress* (Congressional Research Service, October 2, 1991).

27. *Federal Register*, vol. 50 (November 12, 1985), pp. 46657 and 46664.

- Private funds had to be transferred to the Medicaid agency and placed under its administrative control. In addition, such funds could not revert to the donor's facility or use unless the donor was a nonprofit organization and the Medicaid agency decided--of its own volition--to use the donor's facility.

In 1986 and 1987, following this regulatory change, West Virginia and Tennessee began to use funds donated by hospitals to finance part of their state share of Medicaid expenditures.

Although HCFA initially approved those state plans, it subsequently challenged the states' actions in administrative proceedings and indicated its intention to modify the regulations. At the same time, HCFA planned to issue regulations limiting federal financial participation in Medicaid reimbursement for the taxes paid by health care providers. HCFA's policy allowed states to claim federal matching funds when they reimbursed providers for taxes of general applicability--those that affected all businesses--but not for taxes levied exclusively on health care providers or services. The agency viewed both donated funds and provider-specific taxes as mechanisms states could use to generate federal Medicaid matching funds without a corresponding expenditure of state dollars. In either case, funds health care providers paid to the state could be used to claim federal financial

participation. These additional federal dollars could then be returned to the providers, along with their initial financial contribution, through increased reimbursement.

The Congress, however, issued a series of moratoriums on changes to the regulations. The first was included in the Technical and Miscellaneous Revenue Act of 1988, and they continued in OBRA-89 and in OBRA-90. The OBRA-90 legislation extended the moratorium on regulations until December 31, 1991, and it prohibited the Secretary of HHS from denying or limiting federal matching funds for Medicaid expenditures attributable to taxes imposed with respect to the provision of medical services. The Secretary was permitted, however, to deny federal matching funds for Medicaid payments made to reimburse hospitals, NFs, or ICF-MRs for the "costs attributable to" taxes a state imposed solely with respect to such facilities. The interpretation of this legislation has been a source of controversy, and it led to further Congressional action in 1991 (see discussion below).

Reimbursement for Prescription Drugs. Although coverage of prescription drugs is optional under Medicaid, all states provide the service--albeit with some restrictions. Most states reimburse pharmacists for prescription drugs using the estimated acquisition cost (for example, the average wholesale price) and a dispensing fee (or the usual and customary charge, if that is lower).

Because of concerns that the costs of prescription drugs for Medicaid were rising faster than the inflation rate and that Medicaid programs were paying more than other purchasers for such drugs, the Congress enacted legislation under OBRA-90 to control Medicaid costs for outpatient prescription drugs.[28] The legislation requires drug manufacturers to give rebates to Medicaid programs as a condition for federal financial participation in Medicaid payments for their drugs. With some exceptions, states must cover all the drugs of any manufacturer who signs a rebate agreement.

The formula for determining the amount of the rebate, which is calculated on a drug-by-drug basis, depends on the broad classification of the drug. The basic rebate in 1992 for "single-source" drugs (those manufactured under patent) and "innovator multiple-source" drugs (those manufactured by the original patent holder but for which the patent has expired) is the greater of these two: 12.5 percent of the average manufacturer price (AMP) and the difference between the AMP and the "best price" (subject to a maximum of 50 percent of the AMP).[29] After 1992, the basic rebate for these types of drugs will be the greater of 15 percent of the AMP or the difference between

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28. For an extensive review of this legislation, see Bruce N. Kuhlik, "The Medicaid Prescription Drug Rebate and Improved Access to Medicines Requirements of the Omnibus Budget Reconciliation Act of 1990," *Food Drug Cosmetic Law Journal*, vol. 46 (March 1991), pp. 363-390.

29. A manufacturer's "best price" is the lowest price paid by any wholesaler, retailer, or nonprofit or governmental entity, with the exception of prices paid by single-award contracts and supply depots of the federal government. The average manufacturer price is the average price paid to a manufacturer by wholesalers for drugs distributed to the "retail pharmacy class of trade."

that and the best price, with no maximum. Additional rebates will also be required for single-source and innovator multiple-source drugs if their prices rise faster than the general rate of inflation. The required rebate for other drugs is simply 10 percent of the AMP, rising to 11 percent in 1994.

Trends in Medicaid Expenditures

Real Medicaid payments grew at an average annual rate of almost 6 percent between 1975 and 1990, although rates of growth varied considerably during that period (see Tables 1 and 2).[30] The average annual rate of growth of real payments was about 6 percent between 1975 and 1981. That increase was entirely attributable to rising real payments per user.[31] By contrast, although the total number of users varied during the period, it was virtually the same in 1981 as in 1975. The rate of growth slowed to 4 percent between 1981 and 1988, possibly reflecting a variety of cost containment initiatives introduced in ORA-80 and OBRA-81. In addition to reducing the number of potential enrollees in the first half of the 1980s, these actions gave states more

30. Medicaid payments reflect all claims adjudicated or paid during the year but do not include all expenditures. Between 1975 and 1990, total real Medicaid expenditures grew somewhat faster than real payments, at a rate of 6.5 percent a year. In comparison, the annual rate of growth of real national health expenditures was slightly less than 6 percent over the period, and real federal Medicare expenditures grew at 8.5 percent a year. (Medicare and Medicaid expenditures are based on fiscal years, and national health expenditures are based on calendar years.)

31. The analysis presented here is based primarily on data from HCFA Form-2082, Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services. The utilization and payment data in this report are based on users of Medicaid services rather than on enrollees.

TABLE 1. MEDICAID USERS AND REAL PAYMENTS, BY ELIGIBILITY GROUP (Selected fiscal years)

Eligibility Group	1975	1981	1988	1990
Total[a]				
Users (Millions)	22.0	22.0	22.9	25.3
Real payments (Billions of dollars)	27.4	39.4	53.2	64.9
Real payment per user (Dollars)[b]	1,200	1,800	2,300	2,600
Aged				
Users (Millions)	3.6	3.4	3.2	3.2
Real payments (Billions of dollars)	9.8	14.4	18.7	21.5
Real payment per user (Dollars)[b]	2,700	4,300	5,900	6,700
Disabled[c]				
Users (Millions)	2.5	3.1	3.5	3.7
Real payments (Billions of dollars)	7.0	13.7	20.3	24.4
Real payment per user (Dollars)[b]	2,900	4,500	5,800	6,600
Children in Low-Income Families				
Users (Millions)	9.6	9.6	10.0	11.2
Real payments (Billions of dollars)	4.9	5.1	6.4	9.1
Real payment per user (Dollars)[b]	500	500	600	800
Adults in Low-Income Families				
Users (Millions)	4.5	5.2	5.5	6.0
Real payments (Billions of dollars)	4.6	5.5	6.4	8.6
Real payment per user (Dollars)[b]	1,000	1,100	1,200	1,400
Other				
Users (Millions)	1.8	1.4	1.3	1.0
Real payments (Billions of dollars)	1.1	0.8	1.3	1.1
Real payment per user (Dollars)[b]	600	600	1,000	1,100

SOURCE: Congressional Budget Office calculations based on data from HCFA Form-2082 compiled by the Health Care Financing Administration (selected years).

NOTES: Real payments are in constant 1990 dollars, calculated using the fixed-weighted deflator for gross national product. The HCFA Form-2082 Medicaid payment amounts are based on all claims adjudicated or paid during the fiscal year covered by the report. They do not include all Medicaid expenditures. Excluded are Medicare Part A and Part B premiums states paid for the dually enrolled, premiums for capitation plans, payments for state-only enrollees and services, and program administration and training costs.

Because double-counting occurred in some states in the 1980s, the sum of users in all eligibility groups exceeds the (unduplicated) total in 1981 and 1988. See the appendix for a more detailed discussion of reporting inconsistencies.

a. Includes users whose eligibility group is unknown.
b. Rounded to the nearest $100.
c. Includes the blind.

TABLE 2. AVERAGE ANNUAL RATES OF GROWTH IN MEDICAID USERS AND REAL PAYMENTS, BY ELIGIBILITY GROUP (Selected fiscal years, in percent)

Eligibility Group	1975 to 1981	1981 to 1988	1988 to 1990
Total[a]			
Users	0	0.6	5.0
Real payments	6.2	4.4	10.4
Real payment per user	6.3	3.8	5.2
Aged			
Users	-1.2	-0.9	0.7
Real payments	6.7	3.8	7.2
Real payment per user	7.9	4.8	6.5
Disabled[b]			
Users	3.8	1.8	3.3
Real payments	11.7	5.8	9.6
Real payment per user	7.6	3.9	6.2
Children in Low-Income Families			
Users	0	0.7	5.7
Real payments	0.6	3.3	19.4
Real payment per user	0.7	2.6	12.9
Adults in Low-Income Families			
Users	2.3	0.8	4.5
Real payments	2.8	2.4	15.6
Real payment per user	0.5	1.5	10.6
Other			
Users	-4.5	-0.2	-14.2
Real payments	-5.2	7.3	-10.4
Real payment per user	-0.7	7.5	4.4

SOURCE: Congressional Budget Office calculations based on data from HCFA Form-2082 compiled by the Health Care Financing Administration (selected years).

NOTES: Real payments were calculated using the fixed-weighted deflator for gross national product. The HCFA Form-2082 Medicaid payments are based on all claims adjudicated or paid during the fiscal year covered by the report. They do not include all Medicaid expenditures. Excluded are Medicare Part A and Part B premiums states paid for the dually enrolled, premiums for capitation plans, payments for state-only enrollees and services, and program administration and training costs.

Because the data were reported differently in different years, these growth rates should be interpreted carefully. See the appendix for a more detailed discussion.

a. Includes users whose eligibility group is unknown.
b. Includes the blind.

flexibility in designing reimbursement policies for institutions and also cut the federal share of Medicaid expenditures to states.[32] Rising real payments per user again accounted for most of the increase in real payments that occurred in the 1981-1988 period.

Real Medicaid payments began to increase rapidly after 1988, growing at a rate of more than 10 percent a year between 1988 and 1990. In contrast to earlier periods, this dramatic growth reflected large increases in both the number of users and real payments per user.

Although the overall trends in Medicaid payments and users are clear, problems in the available data complicate the process of isolating the trends for the four broad Medicaid eligibility groups (the aged, the disabled, and adults and children in low-income families). Two issues, in particular, arise when examining trends in payments and users for these groups:

- During the 1980s, some states were unable to produce unduplicated counts of Medicaid users in different eligibility

32. Under the provisions of OBRA-81, federal Medicaid payments to states would be reduced by 3 percent in fiscal year 1982, 4 percent in 1983, and 4.5 percent in 1984. States could lower those reductions, however, by 1 percentage point for each of the following: operating a qualified hospital cost review program, having an unemployment rate that was more than 150 percent of the national average, or demonstrating recoveries from fraud and abuse activities (plus third-party recoveries in 1982) equal to 1 percent of federal payments. States also could claim a dollar-for-dollar offset in the federal payment reduction if federal Medicaid expenditures fell below a specified annual target.

groups (although an unduplicated total could be obtained).[33] Thus, a user who during the year was in two different eligibility groups might be counted in both. Alternatively, a user whose medical assistance status changed (from medically needy to categorically needy, for example) might be counted twice in the same eligibility group. The fact that the extent of double-counting varied during the 1980s, however, means that payments and user counts in different eligibility groups are not directly comparable from year to year.

- How some Medicaid users were classified and reported has varied among the states and over time. In part, that reflects changing reporting requirements associated with the Medicaid expansions. "Ribicoff children," for example, were counted in the "Other" eligibility group before 1989 and in the "Children in Low-Income Families" group thereafter.

Unfortunately, the available data do not allow researchers to determine precisely the effects of double-counting and shifting eligibility classifications, but these problems account for some of the apparent inconsistencies in the

33. The total was "unduplicated" in the sense that unique identification numbers were probably counted only once. In some states, however, users who were assigned more than one identification number during the year may have been counted in the total more than once. There is no way to determine the extent of that problem from the aggregate data.

trends among different eligibility groups (see the appendix for a more detailed discussion of these issues). Consequently, the data in Tables 1 and 2 should be treated very cautiously. Given their limitations, these data suggest that the contribution of different eligibility groups to the growth of Medicaid expenditures varied during the 1975-1990 period.

Rising payments for the elderly and the disabled drove the growth in real payments between 1975 and 1981. That reflected increases in real payments per user and a rise in the number of disabled users. Real payments for the disabled continued to rise faster than those for the other eligibility groups during the period of relatively slow growth between 1981 and 1988. By contrast, the dramatic growth in real payments that occurred after 1988 was dominated by large increases in spending for adults and children in low-income families--reflecting rapid growth in both the number of Medicaid users in these groups and in real spending per user.[34] However, payments for the elderly and the disabled also rose more rapidly between 1988 and 1990 than in the earlier part of the decade. Increases in both users and real payments per user contributed in the case of the disabled, whereas growth in real payments per user accounted for almost all of the increase in payments for the elderly.

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34. The change in classification of "Ribicoff children" after 1988 accounts for part of the rise in the number of children reported and for part of the decline in the number of "Other" Medicaid users.

The changing patterns of program growth by eligibility group are reflected in the growth of real payments for different types of services. In the 1975-1981 period, payments for nursing home services--especially ICF-MR--grew rapidly, as did payments for outpatient hospital services and home health care (see Tables 3 and 4). Payments for outpatient hospital services, home health care, and ICF-MR all started from a low base in 1975, however, and that contributed to their high growth rates. By contrast, payments for physician services grew very slowly during that period, and payments for inpatient hospital services and prescription drugs grew at lower rates than overall Medicaid payments.

Payments for both inpatient and outpatient hospital services grew relatively slowly between 1981 and 1988. Payments for home health services continued their dramatic growth, and payments for ICF-MR services and prescription drugs also increased more rapidly than for other major services. Real physician payments continued to grow very slowly, however, and any growth that did occur was accounted for by increases in the number of enrollees using physician services. With the exception of home health care, the numbers of users of most of the major Medicaid services grew only slightly during this period.

TABLE 3. MEDICAID USERS AND REAL PAYMENTS, BY TYPE OF SERVICE (Selected fiscal years)

Type of Service	1975	1981	1988	1990
All Services				
Users (Millions)	22.0	22.0	22.9	25.3
Real payments (Billions of dollars)	27.4	39.4	53.2	64.9
Real payment per user (Dollars)[a]	1,200	1,800	2,300	2,600
Inpatient Hospital				
Users (Millions)	3.4	3.7	3.8	4.6
Real payments (Billions of dollars)	7.6	10.4	13.2	16.7
Real payment per user (Dollars)[a]	2,200	2,800	3,400	3,600
Outpatient Hospital				
Users (Millions)	7.4	10.0	10.5	12.4
Real payments (Billions of dollars)	0.8	2.0	2.6	3.3
Real payment per user (Dollars)[a]	100	200	300	300
Nursing Home (ICF-MR)[b]				
Users (Millions)	0.1	0.2	0.1	0.1
Real payments (Billions of dollars)	0.9	4.3	6.6	7.4
Real payment per user (Dollars)[a]	12,300	28,800	45,400	50,000
Nursing Home (All Other)				
Users (Millions)	1.3	1.4	1.4	1.5
Real payments (Billions of dollars)	9.7	12.4	15.6	17.7
Real payment per user (Dollars)[a]	7,400	9,000	10,800	12,100
Physician				
Users (Millions)	15.2	14.4	15.3	17.1
Real payments (Billions of dollars)	2.7	3.0	3.2	4.0
Real payment per user (Dollars)[a]	200	200	200	200
Prescription Drugs				
Users (Millions)	14.2	14.3	15.3	17.3
Real payments (Billions of dollars)	1.8	2.2	3.6	4.4
Real payment per user (Dollars)[a]	100	200	200	300
Home Health				
Users (Millions)	0.3	0.4	0.6	0.7
Real payments (Billions of dollars)	0.2	0.6	2.2	3.4
Real payment per user (Dollars)[a]	500	1,500	3,900	4,700

(Continued)

TABLE 3. Continued

SOURCE: Congressional Budget Office calculations based on data from HCFA Form-2082 compiled by the Health Care Financing Administration (selected years).

NOTES: Real payments are in constant 1990 dollars, calculated using the fixed-weighted deflator for gross national product. The HCFA Form-2082 Medicaid payments are based on all claims adjudicated or paid during the fiscal year covered by the report. They do not include all Medicaid expenditures. Excluded are Medicare Part A and Part B premiums states paid for the dually enrolled, premiums for capitation plans, payments for state-only enrollees and services, and program administration and training costs.

Because the table shows only selected services, Medicaid payments by type of service do not add to total payments.

a. Rounded to the nearest $100.

b. Intermediate care facilities for the mentally retarded.

TABLE 4. AVERAGE ANNUAL RATES OF GROWTH IN MEDICAID USERS AND REAL PAYMENTS, BY TYPE OF SERVICE (Selected fiscal years, in percent)

Type of Service	1975 to 1981	1981 to 1988	1988 to 1990
All Services			
Users	0	0.6	5.0
Real payments	6.2	4.4	10.4
Real payment per user	6.3	3.8	5.2
Inpatient Hospital			
Users	1.3	0.5	9.5
Real payments	5.5	3.4	12.4
Real payment per user	4.2	2.9	2.7
Outpatient Hospital			
Users	5.1	0.7	8.4
Real payments	16.1	3.7	12.3
Real payment per user	10.4	3.0	3.6
Nursing Home (ICF-MR)[a]			
Users	13.9	-0.6	0.7
Real payments	31.2	6.1	5.7
Real payment per user	15.1	6.7	5.0
Nursing Home (All other)			
Users	0.7	0.7	0.6
Real payments	4.2	3.3	6.5
Real payment per user	3.4	2.6	5.9
Physician			
Users	-0.9	0.8	5.8
Real payments	1.7	0.8	11.6
Real payment per user	2.7	0	5.5
Prescription Drugs			
Users	0.1	1.0	6.2
Real payments	3.3	7.1	10.8
Real payment per user	3.2	6.0	4.3
Home Health			
Users	2.7	5.1	12.4
Real payments	25.8	19.8	24.4
Real payment per user	22.5	14.0	10.6

(Continued)

TABLE 4. Continued

SOURCE: Congressional Budget Office calculations based on data from HCFA Form-2082 compiled by the Health Care Financing Administration (selected years).

NOTES: Real payments were calculated using the fixed-weighted deflator for gross national product. The HCFA Form-2082 Medicaid payments are based on all claims adjudicated or paid during the fiscal year covered by the report. They do not include all Medicaid expenditures. Excluded are Medicare Part A and Part B premiums states paid for the dually enrolled, premiums for capitation plans, payments for state-only enrollees and services, and program administration and training costs.

Growth rates are calculated from unrounded data and therefore may show greater change than that suggested by the rounded data in Table 3.

a. Intermediate care facilities for the mentally retarded.

The dramatic increase in Medicaid expenditures that occurred after 1988 reflects rapid growth in payments for inpatient and outpatient hospital services and physician services, as well as for prescription drugs and home health care. Payments to nursing homes grew at lower rates, although--excluding ICF-MR services--the rate of growth of real nursing home payments was still significantly greater than in the 1981-1988 period. With the exception of nursing home services, large increases in the numbers of users of the major Medicaid services contributed to the high rates of growth of expenditures. As in the previous period, home health care--continuing its extraordinary expansion--experienced the most rapid growth in users. (In fact, 1990 was the first year in which Medicaid payments for home health care ($3.4 billion) exceeded Medicaid payments for outpatient hospital services ($3.3 billion).)

Some of the rapid growth in Medicaid payments for physician and hospital services since 1988 presumably stemmed from the expansions for children and pregnant women. Adults and children in low-income families accounted for about two-thirds of the increase in physician payments and three-quarters of the increase in hospital payments in the 1988-1990 period. The two groups also account for most of the growth in the number of users of those services. That is not surprising because one would expect pregnant women and newborns to use large amounts of medical care.

In addition to the eligibility expansions, however, the growth in the number of Medicaid users in these groups may reflect the effects of the economic downswing. A significant rise in AFDC caseloads began around the end of 1989, and that may have resulted in more people seeking to use the Medicaid program.

It is less clear what other factors contributed to the rapid growth in users of different services and in real payments per user. Increases in real payments for nursing home services, for example, probably reflect some of the effects of the nursing home provisions of OBRA-87, many of which had to be implemented by October 1, 1990. A sizable portion of the substantial increase in payments for home health care is attributable to the growth of the program in the state of New York, which accounted for almost one-half of all Medicaid payments for home health care in 1990 and for more than 40 percent of the total increase in these payments between 1988 and 1990. Because of its sheer size, the New York program dominates the data on home health expenditures. Nonetheless, those expenditures actually grew faster in many other states during the 1988-1990 period, with some states reporting multifold increases.

In spite of the recent rapid growth in expenditures for adults and children in low-income families, the Medicaid program still spends far more for the elderly and the disabled. In 1990, almost 70 percent of Medicaid users

were adults and children in low-income families. Yet, they accounted for only slightly more than one-quarter of Medicaid payments because the average Medicaid payment per user in low-income families was approximately $1,000--less than one-sixth of that for the elderly and disabled.[35] This difference primarily reflects the extensive use of long-term care services by the elderly and the disabled.

Access Problems and Reimbursement for Physicians

Although Medicaid eligibility has been expanding rapidly, its reimbursement rates for physicians as well as institutional providers have lagged behind those of other payers. In some states, Medicaid reimbursement rates for physicians are far below the corresponding rates in the private sector and the rates that Medicare pays. Furthermore, some of the states with the most generous Medicaid programs in terms of eligibility and covered services have the lowest reimbursement rates for providers, so their programs are more limited than they appear. (For example, in 1989, Medicaid reimbursement rates for physicians in New York were among the lowest in the country.) Many states

35. The difference may be greater than these figures suggest, since HCFA Form-2082 data do not include the amounts Medicaid paid for Medicare Part A and Part B premiums to cover dually enrolled people. Premiums for capitation plans and administrative costs are also excluded.

view low reimbursement rates as the primary reason why physicians are unwilling to serve Medicaid patients.[36]

According to the American Medical Association, 75 percent of the nation's physicians participated in Medicaid in 1988; that is, at least 1 percent of their practice revenues came from that source. Participation rates varied geographically, however: 65 percent of physicians in the Northeast participated, compared with 81 percent in the North Central region. Other evidence also suggests that obstetrician/gynecologists have lower participation rates than physicians in other specialties.[37]

The issue of how physicians would respond to higher Medicaid reimbursement rates is the subject of much debate. Although some evidence suggests that higher fees encourage greater physician participation in the Medicaid program, it is not clear that moderate increases in reimbursement rates would improve access to care for many Medicaid enrollees. At present, a large proportion of the physicians who participate in the Medicaid program have small Medicaid practices. Increasing reimbursement rates might only increase the amount paid to the minority of physicians with relatively large

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36. For an extensive discussion of these issues, see Physician Payment Review Commission, *Physician Payment Under Medicaid*, Report No. 91-4 (Washington, D.C.: PPRC, 1991).

37. Ibid., p.24.

Medicaid practices and not substantially increase the number of physicians who treat more than a few Medicaid patients.

Nonetheless, as the Physician Payment Review Commission has pointed out, improving access to care for Medicaid enrollees will be difficult as long as Medicaid reimbursement rates are significantly below those of other payers, even though fee increases alone may not solve the access problem.[38] Few private physicians practice in low-income, inner-city areas, and increasing Medicaid reimbursement rates would probably not attract others there. Making physician services more accessible to concentrated low-income populations might instead require the development of alternative systems of primary care delivery using federally qualified health centers, public health departments, and hospital outpatient departments.

PROJECTED EXPENDITURE GROWTH IN THE 1990s

Total real Medicaid expenditures in 1991--measured in 1990 dollars--were $88 billion, which represented a one-year increase of 22 percent. The Congressional Budget Office projects that real Medicaid expenditures will increase at an average annual rate of 12 percent between 1991 and 1996,

38. Ibid., p. 45.

reaching $158 billion in that year.[39] Of that amount, $90 billion is estimated to be federal expenditures, with the remainder being state and local.[40]

Those CBO projections are somewhat lower than the Administration's estimates, which suggest that real Medicaid expenditures will grow at an average annual rate of 16 percent between 1991 and 1996, reaching $184 billion in 1990 dollars (see Figure 2). The CBO Medicaid baseline is developed using the states' current-year estimates to calibrate current-year spending for the CBO Medicaid projection model. CBO applies inflators--representing the growth of prices, populations, and service intensity--to the current-year estimate to forecast nominal spending throughout the projection period.

In contrast, the Administration based its projections of Medicaid outlays on state forecasts for 1992 and 1993. Because the Administration believes that state forecasts have a systematic downward bias, those estimates were adjusted upward, and estimates of out-year spending were based on the adjusted forecasts. The latter are considerably higher than the corresponding

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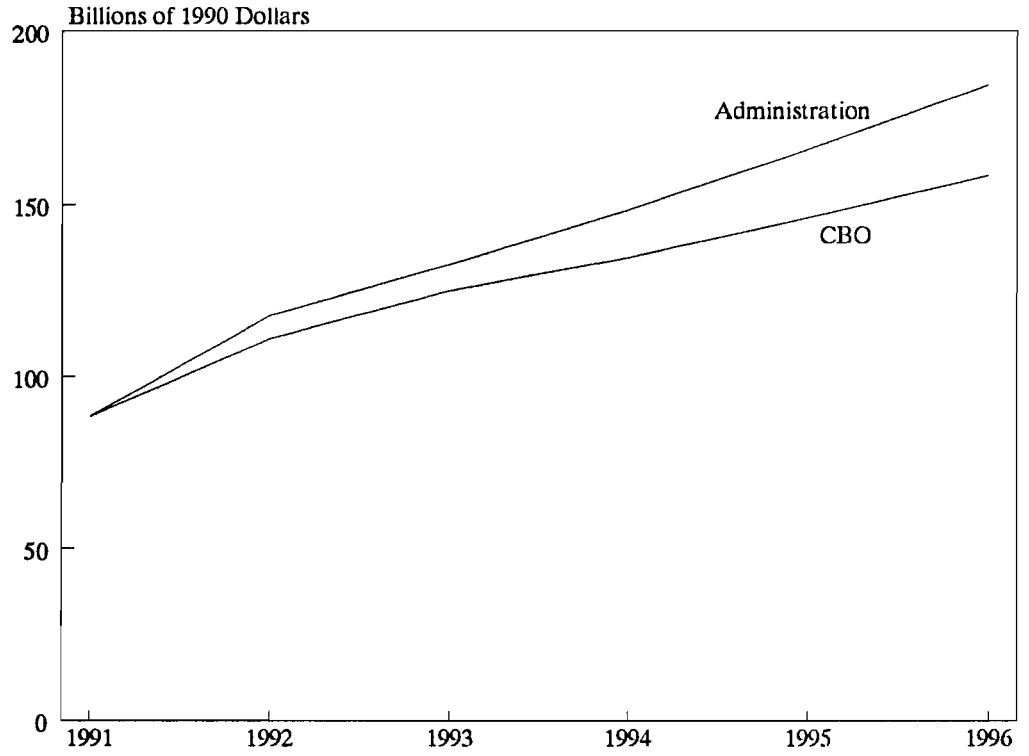
39. By comparison, CBO projects that real federal Medicare expenditures will grow at an average annual rate of about 8 percent between 1991 and 1996. In addition, based on projections made by the Health Care Financing Administration, real national health expenditures will grow at an annual rate of about 6 percent over that period. (Medicare and Medicaid projections are based on fiscal years, and the national health expenditure projections are based on calendar years.)

40. These estimates are based on the assumption that the federal share of Medicaid expenditures remains at approximately 57 percent.

Figure 2.
Real Medicaid Expenditures, 1991–1996



SOURCES: Congressional Budget Office calculations based on data from Budget of the United States Government: Fiscal Year 1993, Supplement (February 1992), Part Five, p. 102; and CBO February 1992 baseline projections.

NOTE: Real payments were calculated using the fixed–weighted deflator for gross national product. Projections of total Medicaid expenditures are derived from the Administration's and CBO's projections of federal Medicaid expenditures, assuming a federal financial participation rate of 57 percent throughout the period.

CBO figures for 1992 and 1993. Taken in conjunction with the Administration's assumption of a higher growth rate after 1994, this accounts for the 16 percent difference in the CBO and Administration estimates for 1996. Even the lower CBO projection, however, represents an enormous rise in Medicaid expenditures for both the federal and the state governments.

The factors contributing to the continuing rise in Medicaid expenditures include a range of economic, social, and demographic forces that lie outside the program. The stagnant economy appears to be causing more people to seek Medicaid assistance and may lead to increased Medicaid expenditures through 1992. The aging of the population is raising the demands on Medicaid budgets, since Medicaid is the major payer for long-term care services. At the same time, Medicaid programs are bearing increasing responsibility for such costly health problems as acquired immune deficiency syndrome (AIDS), drug addiction during pregnancy, and low birthweight--problems concentrated disproportionately in the low-income population.[41] In addition, more people who are eligible for Medicaid services may be drawn to them by increased coordination between Medicaid and other programs serving low-income people: Food Stamps; the Special

41. Although evidence suggests that Medicaid programs are paying for an increasing share of AIDS treatment--at least for inpatient services--less information has been available on Medicaid's role in paying for the treatment of the broader spectrum of disorders related to human immunodeficiency virus (HIV), including drug treatment for asymptomatic people. However, newly released survey data about the experiences of hospitals that are major providers of care to HIV-infected people indicate that Medicaid also pays for a large amount of hospital care for people with HIV-related illnesses other than AIDS. (See Dennis P. Andrulis and others, "Comparisons of Hospital Care for Patients with AIDS and Other HIV-Related Conditions," *Journal of the American Medical Association*, vol. 267 (May 13, 1992), pp. 2482-2486.)

Supplemental Food Program for Women, Infants, and Children (WIC); Title V Maternal and Child Health programs; and so forth.

Regardless of those factors, Medicaid expenditures are likely to continue to grow rapidly in the 1990s because of existing mandates under current law and further litigation over Medicaid reimbursement rates. It is less clear how recent legislation concerning federal matching for voluntary donations and provider-specific taxes, as well as the reimbursement of disproportionate share hospitals, will affect the growth of expenditures. The impact of OBRA-90 on Medicaid prescription drug costs is also uncertain.

Mandates Under Current Law

Medicaid eligibility, service coverage, and program participation rates will continue to expand in the 1990s. This reflects both the slow implementation of existing requirements and the mandates under current law with future implementation dates. In assessing the effects of those expansions on Medicaid expenditures, it is important to know to what extent Medicaid funds are substituting for other sources of funding for the care of low-income populations. At present, little information on that subject exists, but the Health Care Financing Administration is now sponsoring a study to track the

flow of funds through the prenatal care system at the community level; that research may help to clarify the issue.

As a result of the mandate to cover all poverty-level children under 19 years old who were born after September 30, 1983, Medicaid eligibility for children will expand through the year 2002. Additional mandates are also being phased in for the Medicare population. Beginning in January 1993, state Medicaid programs will have to pay the Medicare Part B premiums (but not deductibles or copayments) for Medicare beneficiaries with assets below twice the SSI level and income between 100 percent and 110 percent of poverty; the income ceiling rises to 120 percent beginning January 1, 1995.

Because the final regulations have not yet been issued, the potential impact of the OBRA-89 changes to the Early and Periodic Screening, Diagnosis, and Treatment program are unclear. Nonetheless, some states envision large increases in EPSDT expenditures. This outcome is particularly likely in states that had very low EPSDT participation rates before OBRA-90 and in states that do not cover a broad range of services in their Medicaid plans. The areas in which the greatest expenditure growth is anticipated are services for mentally ill children and therapeutic services for developmentally disabled children.[42] Taking the new EPSDT requirements together with the

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42. See Ian T. Hill and Janine M. Breyel, *Caring for Kids* (Washington D.C.:National Governors' Association, 1991), p.56.

mandate to expand eligibility for all poverty-level children under 19, some states could experience exceptionally large increases in Medicaid expenditures for children, especially if other programs serving low-income children--Head Start, for example--encourage and facilitate enrollment in the Medicaid program. At present, however, some states are making slow progress toward meeting the EPSDT enrollment targets. In November 1991, children's advocates in Pennsylvania filed a lawsuit charging that the state has enrolled less than 25 percent of eligible children into the EPSDT program. Advocates claim that similar problems exist in other states.

Expenditures for long-term care services are also likely to increase. It is unclear how much of the effect of the OBRA-87 provisions for nursing homes is already reflected in 1990 nursing home payments. The spousal impoverishment provisions, however, will not be fully implemented until July 1992. Furthermore, concerns have been raised about the growth of Medicaid estate planning activities, which are enabling some people in middle-class families to preserve their assets and become eligible for Medicaid when they need nursing home care. A recent study has suggested that the spousal impoverishment provisions may have triggered the rapid development of this field of estate planning law.[43] States are now required to conduct financial assessments at the point of nursing home admission and to inform married

43. Brian Burwell, "Middle-Class Welfare: Medicaid Estate Planning for Long-term Care Coverage" (paper prepared for Systemetrics/McGraw-Hill, Lexington, Mass., September 1991).

couples of their financial rights and obligations. In consequence, more married people may now be seeking legal advice when facing the nursing home placement of a spouse.

Legislation Concerning Voluntary Donations, Provider-Specific Taxes, and Disproportionate Share Hospitals

Faced with burgeoning Medicaid costs and pressures to increase their reimbursement rates, states have turned increasingly to voluntary donations and provider-specific tax programs to finance their share of Medicaid expenditures. By July 1991, the majority of states had adopted donation or provider-specific tax programs, and HHS was concerned that these initiatives were threatening the financial stability of the Medicaid program. (The Inspector General estimated that provider donation and tax programs would cost the federal government almost $3.8 billion in fiscal year 1991 and that the figure could rise to $12.1 billion by the end of fiscal year 1993.) In October 1991, therefore, HCFA issued interim final regulations to restrict federal matching for state Medicaid expenditures financed through voluntary donations or provider-specific taxes. The regulations were based on HCFA's interpretation of the clause in OBRA-90 that precluded federal matching

funds for Medicaid payments to reimburse institutional providers for "costs attributable to" taxes imposed solely with respect to those providers.[44]

The implementation of the HCFA regulations, by effectively eliminating provider donation and tax programs, would probably have compounded the severe fiscal problems many states faced. In November 1991, the Congress therefore enacted legislation to nullify the HCFA regulations but also to place some restrictions on the use of provider donations and taxes. The act, titled the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, represents a compromise between the Administration, the Congress, and the states. It bars federal matching for most provider donations but allows the states to use some types of provider-specific taxes to finance part of their share of the Medicaid program. Important features of the legislation include the following:

- With the exception of donations for certain administrative costs, federal matching is eliminated for most voluntary donations, effective January 1, 1992. Donations applicable to state fiscal year 1992, received before the effective date under programs in effect or described in state plan amendments submitted to the Secretary by September 30, 1991, remain eligible for federal

44. These regulations were revisions to interim final regulations issued in September 1991.

matching dollars. Donations for providers to pay for outstationing eligibility workers are still allowed, but after October 1992 they may not exceed 10 percent of state administrative costs.

- Federal matching is available for certain "broad-based" provider taxes if no more than 25 percent of the state's share is raised through these means. (Broad-based provider taxes are those that are imposed uniformly on all nonfederal, nonpublic providers in the same class in the state or locality, or on all items or services in the class such providers furnish.) However, states that were already financing more than 25 percent of their Medicaid share through donations and taxes in 1992 can use this higher "state base percentage" as the provider tax ceiling.

- Federal matching is not available for expenditures that provider taxes finance when providers are held harmless for the cost of the tax--that is, when the state arranges to repay the tax to the provider.

- States may continue to receive federal matching for Medicaid expenditures financed by funds transferred from local

governments, even when the latter are also health care providers. (The exception arises when transferred funds are obtained from disallowed donations or taxes.)

Whether these measures will encourage or discourage the continued use of provider taxes is unclear. Furthermore, considerable uncertainty exists about which state programs will be considered to be in compliance with the voluntary contribution and provider tax legislation, and no guidelines have yet been issued. Judging by recent events in Virginia and the District of Columbia, however, states that attempt to restructure their provider tax programs may face strong opposition from provider groups.

The act also has important implications for Medicaid reimbursement for disproportionate share hospitals. Rising disproportionate share payments in recent years have been closely linked to the expansion of voluntary donation and provider tax programs. HCFA issued regulations limiting such payments in October 1991, but the Congress also nullified those regulations.

The November 1991 legislation creates a national cap on payment adjustments to disproportionate share hospitals of 12 percent of Medicaid expenditures. States whose disproportionate share payments are already above this cap can continue to make payments at the higher level but cannot

increase them until they fall below the 12 percent cap. As national Medicaid expenditures rise, states that are below the 12 percent cap will be allowed to increase their disproportionate share payments using a redistribution approach that ensures that the national cap remains at 12 percent. In addition, the act bars HCFA from restricting a state's authority to designate disproportionate share hospitals.

The legislation provides for a transition period to give the states time to bring their Medicaid financing mechanisms into compliance. Since states have different fiscal years, and not all state legislatures meet every year, some disallowed donation and provider tax programs may continue through 1992 and into 1993. Likewise, the disproportionate share cap will not come into effect until October 1992.

Some of the mandates in the legislation are also of limited duration. The 25 percent ceiling on broad-based provider taxes expires in 1995, and some of the restrictions on disproportionate share payments expire by 1996. Specifically, on or after January 1, 1996, states will not be subject to the aggregate limit on payments if they designate as disproportionate share hospitals only those facilities that account for at least 1 percent of all Medicaid days in the state or that have low-income or Medicaid utilization rates exceeding the state mean. (Other criteria may also be specified by the

Secretary of HHS.) This provision will not come into effect, however, until the Congress has enacted legislation to establish limits on payment adjustments to disproportionate share hospitals.

Litigation Over Medicaid Reimbursement Levels

Although lawsuits challenging Medicaid reimbursement rates are not recent phenomena, the *Wilder* decision appears to have led to an upsurge in such litigation.[45] In addition, the courts have cited both the *AMISUB* and the *Wilder* decisions in recent rulings favoring provider plaintiffs. In a July 1991 case that may set precedent, a U.S. district court ruled that hospital reimbursement rates in the state of Washington were inadequate and that the state had not met the procedural requirements of the Boren Amendment. Decisions favoring providers have also been handed down recently in Pennsylvania, New York, Missouri, Kansas, Oregon, Illinois, and Kansas.

Although the effect of Boren Amendment lawsuits on Medicaid expenditures in the 1990s is uncertain, there is a strong likelihood--based on recent settlements--that some states will have to increase hospital and nursing

45. The American Public Welfare Association reported in 1990 that several state nursing home associations were planning to file Boren Amendment lawsuits following the *Wilder* decision. In addition, the Prospective Payment Assessment Commission reported that, as of July 1991, Medicaid hospital payments were the subject of lawsuits in 12 states. Some of those suits may have predated *Wilder*, however.

home reimbursement rates significantly. In Oregon, for example, a settlement reached in 1991 required the state to raise hospital payments by 35 percent. Similarly, hospitals in the state of Washington recently reached a settlement requiring the state to pay an additional $62 million over the next two years.

Litigation concerning the adequacy of physician reimbursement rates is also likely. OBRA-89 required that Medicaid payments to providers be sufficient to ensure access to covered services for Medicaid beneficiaries--to the extent that those services are available to the general population of the area in which they live. The legislation also required states to submit annual plans to HCFA specifying their Medicaid fees for obstetric and pediatric services. HCFA will review the fees to see that they meet the access-to-care requirements. Given the current favorable environment for providers in the courts, physicians may be encouraged to file suit to challenge Medicaid reimbursement rates that remain substantially below those of private payers.

Two federal lawsuits challenging physician reimbursement rates were filed in 1991.[46] The first, in Pennsylvania, addresses the adequacy of Medicaid reimbursement rates for pediatricians; it is part of broader litigation seeking to redesign the entire EPSDT program in the state. The second suit, in Tennessee, involves the adequacy of Medicaid reimbursement for

46. Loretta Morris Williams, "Medicaid Lawsuits: Obstetric, Pediatric Payment," *W-Memo* (American Public Welfare Association, vol. 4, March 1992), pp. 21-26.

obstetricians. Notably, the plaintiffs are Medicaid clients--not physicians--who claim that Medicaid beneficiaries lack adequate access to providers of obstetrical care, with inadequate reimbursement being a contributing factor.

Providers have also challenged the authority of a state to deny the payment of Medicare cost sharing for beneficiaries who are dually eligible. In a potentially far-reaching decision, the United States Court of Appeals for the Second Circuit ruled in February 1992 that the New York Medicaid program must make Medicare copayments for QMBs and other beneficiaries who are dually eligible for Medicare and Medicaid, regardless of the amounts Medicaid pays for the same services. If the decision is upheld, it could have significant cost implications for many Medicaid programs.

Pricing Policies for Prescription Drugs

The OBRA-90 provisions relating to the prices of prescription drugs were intended to contain outpatient drug costs by tying the Medicaid prices to manufacturers' best prices. In response to the legislation, some manufacturers have apparently cut their discounts to other purchasers, including government entities, in order to raise their best prices (thereby limiting the discounts they

must offer to Medicaid).[47] Although much concern has been voiced about the adverse effects of such actions on other federal programs and public hospitals, it is still too early to determine the net effects of the legislation on drug expenditures under Medicaid.

Conclusion

The role of the Medicaid program in providing health care protection to some of the most vulnerable population groups in this country has been growing steadily since the mid-1980s. It will probably continue to expand in the 1990s as more people become eligible for the program, more services are covered and their quality is enhanced, participation rates rise, and the elderly population in need of long-term care services grows.

Low reimbursement rates for providers, which may have restrained Medicaid costs in the past, have also probably contributed to the problems some Medicaid beneficiaries face in obtaining health care services. Increasingly, therefore, the courts and the Congress are requiring states to

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47. General Accounting Office, *Medicaid: Changes in Drug Prices Paid by VA and DOD Since Enactment of Rebate Provisions* (September 1991); National Association of Public Hospitals, *Newsline: Legislation/Regulation*, vol. 4 (Washington, D.C., NAPH, January 1992); Testimony of Andrew McCulloch on behalf of Harborview Medical Center and the National Association of Public Hospitals," before the Subcommitte on Housing and Consumer Interests, House Select Committee on Aging, Vancouver, Wash., January 16, 1992.

reduce the disparities in payment rates that exist between Medicaid and other third-party payers. Narrowing the Medicaid payment gap, while demands for Medicaid services grow, will be difficult to accomplish without further major increases in Medicaid expenditures.

Budget crises are now forcing some states to cut back their Medicaid programs in those areas in which they still have the flexibility to make reductions. Budget-cutting strategies enacted or under consideration include reducing or eliminating the coverage of such optional services as dental care or prescription drugs, cutting back or eliminating programs for the medically needy, and imposing copayment requirements. Program reductions of that type, which will produce immediate fiscal benefits over the short term, could prove costly in the future. Severe cuts in prescription drug programs, for example, could lead to higher use of inpatient hospital and nursing home services.

In the longer term, states are keen to develop new approaches to the reimbursement and delivery of Medicaid services, both to contain costs and improve access to care. Many states are now experimenting with a variety of managed or coordinated care approaches in their Medicaid programs. By 1991, more than 2.7 million people in 30 states were enrolled in Medicaid managed care plans, and such initiatives are likely to expand in the future.

Some advocates argue that enrolling Medicaid beneficiaries in systems of managed care may not lower overall Medicaid expenditures but may ensure better access to care and more effective use of limited Medicaid dollars than does the current system. Thorough evaluation of alternative Medicaid models of managed care is needed to determine their effects on costs, access to health care, and the quality of care provided.

APPENDIX

TREND ANALYSIS USING DATA FROM HCFA FORM-2082

HCFA Form-2082, otherwise known as the "Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services," is the only national data source for tracking Medicaid payments and utilization by type of service for different subpopulations. The states submit aggregate data annually to HCFA, which produces state-specific reports and data tapes.[1]

Researchers have raised several concerns about using the 2082 data for policy analysis: the accuracy and consistency of some of the data are questionable; program participation is measured in terms of users rather than enrollees (although some states now report both); expenditures and utilization are reported by date of payment rather than date of service;[2] and data on payments exclude some important categories of expenditures, such as Medicare premiums for the dually enrolled, capitation payments, and administrative costs. Nonetheless, even though researchers must use and interpret them with care, the 2082 data are valuable for exploring broad Medicaid trends.

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1. Since 1984, HCFA has been developing an alternative data system known as the Medicaid Statistical Information System (MSIS), which is based on detailed claims and eligibility files. The data this system generates can be used to produce the 2082 reports. If their MSIS data meet an acceptable standard, states participating in MSIS may submit MSIS data tapes to HCFA in lieu of hard-copy 2082 reports. In 1991, 21 of 26 states participating in MSIS were exempted from submitting the hard-copy version.

2. Counts of Medicaid users on the 2082 report therefore reflect the number of people for whom claims were paid during the year rather than the number who actually used Medicaid services.

Double-counting of users and payments is an issue of particular concern for researchers conducting trend analyses with the 2082 data. It may arise in several ways, not all of which are discernible from the data. For example, one may not be able to detect double-counting that occurs when users receive multiple identification numbers. That type of double-counting overstates the reported total number of users as well as the numbers in the different Medicaid subpopulations. The practice is probably diminishing, however, as more states adopt the Social Security number as a unique identifier. Such a reduction would have a dampening effect on the reported growth in Medicaid users.

Double-counting may also occur if changes take place during the year in a Medicaid user's coverage group--a classification determined by the individual's maintenance assistance status and basis of eligibility. The elimination of that type of double-counting in the 1980s produced apparent inconsistencies in the 2082 trend data. In particular, the numbers of users in the coverage groups appeared to be rising more slowly than the total number of users, which was not affected by changes in coverage groups.

The purpose of this appendix is to show how such inconsistencies arise and to facilitate the interpretation of the Medicaid trend data. (For the

remainder of the discussion, double-counting refers only to the second type discussed above--that which is detectable in the 2082 data.)

Coverage Groups

Medicaid users are classified in different coverage groups according to their maintenance assistance status (MAS) and basis of eligibility (BOE). Before 1989, the 2082 reports included four major MAS groups: categorically needy and receiving maintenance assistance, categorically needy and not receiving maintenance assistance, optional categorically needy, and medically needy. In 1989, HCFA dropped the optional categorically needy classification and established two new MAS groups: other coverage groups created by legislation passed before 1988, and coverage groups created by the Medicare Catastrophic Coverage Act of 1988 and later legislation.

In theory, the inclusion of the latter classifications should help researchers track the effects of the eligibility expansions, but some states do not have the capability to break out their data that way. In those states, some of the new coverage groups may be reported in other MAS classifications--such as categorically needy and not receiving maintenance assistance, or medically needy--or they may be reported as having unknown MAS.

The BOE classification indicates a person's categorical relationship to Medicaid. The four major eligibility groups are the elderly, the disabled, and adults and children in low-income families. (Although blind people are listed as a separate eligibility group, they are often included with the disabled.)

The terms "adults in low-income families" and "children in low-income families" actually describe two eligibility groups whose compositions (and titles) have changed somewhat over time, reflecting both the recent eligibility expansions and changes in HCFA's reporting requirements. Before 1989, for example, "Ribicoff children" were included in the "Other Title XIX" eligibility group rather than the children's eligibility group, "AFDC Children Under 21." As a result of new reporting requirements that came into effect in 1989, Ribicoff children should now have a BOE classification of "Children," although it is uncertain whether all states are reporting in this manner. The 1989 switch means that part of the apparent growth in the number of children using Medicaid services actually stems from a reporting change.

Counting Users

Since states submit their 2082 data annually, a question arises about how to classify users whose coverage group changes during the year. For example,

a child whose family received AFDC for part of the year and whose family income was slightly above the poverty level for the remainder of the year might have received some Medicaid services as a categorically needy child and other Medicaid services as a medically needy child. At issue is whether the child should be counted in one or both MAS groups on the 2082 report.

Some researchers argue that Medicaid users (and their corresponding payments) should be counted in each of the MAS/BOE groups in which they received services. Although that approach provides a complete picture of annual Medicaid utilization for each coverage group, it also results in the sum of users across all MAS/BOE groups being greater than the total (unduplicated) number of Medicaid users. An alternative approach, which avoids that problem, counts Medicaid users only once, assigning them to their MAS/BOE category as of a particular date. If that method is used, however, one may have incomplete information about annual utilization within particular coverage groups.

Either of the two basic methods for counting users may be misleading. If all states used the same method, however, the data would at least be internally consistent and comparable from year to year. During the 1980s, however, the states varied in their approaches.

Double-Counting Medicaid Users in the 1980s

Double-counting first became apparent in the 2082 report in 1980. That was the first year in which the reported sum of Medicaid users by eligibility group exceeded the total reported number of users, indicating that some states were assigning users to more than one coverage group.

In 1984, HCFA introduced a new form for reporting the 2082 data that required states to assign each Medicaid user to only one MAS/BOE group. The states did not all adopt the new form immediately, however, and double-counting continued until 1990.[3]

The elimination of double-counting over a period in which Medicaid eligibility was expanding rapidly produced some anomalies and apparent inconsistencies in the trend data. Some states, as they eliminated double-counting, could correctly report the rising total number of Medicaid users with declining numbers in each of the eligibility groups.

By 1988, a significant amount of double-counting was still occurring in 11 states. They accounted for about 18 percent of all Medicaid users, and in

3. Even though all states are now using the 1984 form, reporting of coverage groups remains inconsistent among the states. When reporting users and enrollees who were in more than one MAS/BOE group during the year, states can choose to classify them as of the first or the last day of the fiscal year. The Health Care Financing Administration prefers that states do the latter.

each of them the sum of users among all eligibility groups exceeded the unduplicated count of total users by more than 5 percent. (The range was 6 percent to 57 percent.) The total number of users in the 11 states grew at an average annual rate of 3 percent between 1988 and 1990--although the numbers reported in every eligibility group except the disabled fell during the period, and the reported number of disabled users grew at an average annual rate of less than 1 percent.

The effects of that phenomenon can be seen in Table 2, where the rate of growth of total Medicaid users during the 1988-1990 period appears to be too high when compared with the corresponding growth rates for the eligibility groups. This finding is, in fact, consistent with the elimination of double-counting during the period.

By contrast, the rate of growth of overall payments per user in the 1988-1990 period seems to be too low. Although the elimination of double-counting undoubtedly contributed to that outcome, it is possible--regardless of double-counting--for the overall ratio of payments to users to grow more slowly than the corresponding ratios in any of the eligibility groups. That counterintuitive result can occur because both the numerator and the denominator of the ratio are changing. Indeed, in the current environment, the result should be expected: children and adults in low-income families--the

Medicaid eligibility groups with the lowest payments per user--are the groups growing the fastest. Hence, their low per capita payments bear increasing weight in the overall total.