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MEDICAID

Spending Pressures Spur States Toward Program Restructuring

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to testify on how states have addressed rising Medicaid costs brought on by federal mandates and other factors. Since 1984, the Congress has mandated eligibility expansion to certain low-income groups and allowed coverage of others at state option.[1] From the time these mandates began to take effect, Medicaid costs have more than tripled and the number of beneficiaries increased by over 50 percent, to 39 million. Medicaid's current costs exceed $141 billion, and its growth outpaces that of most major items in the federal budget, including Medicare. Without modification, spending is likely to double in the next 5 to 7 years.

In response to these escalating costs, many states are in the process of restructuring their Medicaid programs by seeking section 1115 waivers from the Health Care Financing Administration (HCFA), which oversees the Medicaid program. Named for section 1115(a) of the Social Security Act, these waivers free states from certain Medicaid restrictions on the use of managed care delivery systems. They also allow states to expand Medicaid-financed coverage to individuals not normally eligible for Medicaid.

My statement today will focus on (1) federal mandates and other factors that have led to Medicaid cost growth, (2) states' use of section 1115 waivers for managed care programs to address rising Medicaid costs, and (3) lessons for adequate program planning and oversight from states' experiences implementing managed care programs. My comments are based on recent GAO work on these issues. (See app. II for a list of related GAO products.)

In brief, several factors, including federal mandates that expand eligibility, medical price inflation, and creative financing schemes, have contributed to rising Medicaid costs. To contain these costs, 22 states have recently sought waivers from federal regulations that inhibit their ability to operate extensive managed care programs. Some of these states have mandated the enrollment of their acute care populations--primarily for low-income women and children--into managed care programs and have expanded coverage to previously ineligible individuals. Arizona, which runs a Medicaid managed care program under a federal waiver obtained over a decade ago, has lowered Medicaid spending by millions of dollars. It also leads the states in its development of information systems for collecting medical encounter data essential for assessing quality of care.

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[1]See app. I for details of these major federal expansions of Medicaid eligibility and services.

MANDATES, OTHER FACTORS INCREASE MEDICAID COSTS

Financed jointly by the federal government and the states, Medicaid provides access to health care for two statutorily defined groups of low-income residents--families, primarily women and children; and the aged, blind, and disabled. In reality, Medicaid is not 1, but rather 56 separate programs that differ dramatically across states.[2] Federal statute mandates who is eligible for coverage and the broad categories of services that must be provided. Each state designs and administers its own program by (1) setting certain income and asset eligibility requirements,[3] (2) selecting which optional groups and services to cover, and (3) determining the scope of mandatory and optional services.

Several factors, including federal mandates, have contributed to Medicaid's recent cost explosion. Between 1984 and 1993, the Congress mandated coverage primarily for low-income pregnant women, children, and Medicare beneficiaries and allowed coverage of others at state option. Since these expansions began to be implemented, enrollment has grown by more than 50 percent, to 39 million beneficiaries. At the same time, the mandates and state decisions to cover optional groups led to greater uniformity across states in the proportion of low-income individuals covered by Medicaid.

Enrollment growth resulting from mandates does not, however, fully explain the rise in Medicaid spending. Such factors as medical price inflation, higher provider reimbursements, utilization growth, and an increase in the number of eligibles due to a national recession also played a role. From 1988 through 1991, enrollment, inflation, and increased use of services each accounted for about one-third of the expenditure growth. The most important cost driver in 1991 and 1992, however, was "creative" financing techniques that states adopted to increase supplemental payments to hospitals serving a large number of Medicaid and other low-income patients, thereby partially offsetting costs not covered by Medicaid, state charity care programs, or private insurance. In 2 years, these disproportionate share hospital (DSH) payments grew from just under $1 billion to over $17 billion and represented about $1 out of every $7 Medicaid spent on medical services.

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[2]All 50 states plus the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands have Medicaid programs.

[3]Federal guidelines tie most eligibility categories to the Aid to Families With Dependent Children (AFDC) and the Supplemental Security Income (SSI) programs.

SOME STATES ADDRESS RISING MEDICAID COSTS THROUGH GREATER USE OF MANAGED CARE

States' efforts to obtain the flexibility to implement managed care reflects the growth of managed care in the private sector. Managed care plans have the potential to provide care at lower cost by controlling the price and use of services. In 1993, about 60 percent of individuals with health benefits sponsored by large employers were enrolled in some type of managed care plan--up dramatically from a decade ago. As of June 1994 (the most current date for which data were readily available), 23 percent of Medicaid beneficiaries--primarily women and children--were enrolled in some form of managed care.

Managed care is not new to states' Medicaid programs. Under a section 1915 (b) waiver, available since 1981, states have been able to restrict beneficiaries' freedom to choose any health care provider, a key provision of the traditional Medicaid program. More than 40 states currently enroll some portion of their Medicaid population in managed care. A number of provisions in the Medicaid statute, however, cannot be waived under section 1915(b) and inhibit the implementation of broader managed care programs, particularly those involving plans that are paid with a fixed, or capitated, fee. Consequently, a number of states are turning to demonstration projects permitted by section 1115 waivers.

Section 1115 waivers address states' needs in two ways: they allow states greater flexibility to test cost-containment strategies, such as the more extensive use of capitated managed care, and they allow states to expand program eligibility beyond traditional Medicaid populations. Since 1993, HCFA has approved for implementation 12 statewide demonstration waivers: Oregon, Hawaii, Kentucky, Tennessee, Rhode Island, Florida, Ohio, Massachusetts, Minnesota, Delaware, Vermont, and Oklahoma.[4] Of the 12 approved, 5 states have statewide demonstrations currently operating: Tennessee, Hawaii, Oregon, Rhode Island, and Minnesota. Another 10 states have applications pending with HCFA. In all but a few of the approved and pending waiver applications, states have proposed expanding coverage to previously ineligible groups, such as single adults and childless couples.

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[4]In 1982, Arizona was granted an 1115 waiver to initiate a statewide managed care program. Previously, the state had not participated in Medicaid.

Section 1115 waivers allow states to contract with managed care organizations[5] that enroll few or no private patients. In other words, the "75-25 rule" has been waived. This rule stipulates that, to serve Medicaid beneficiaries, 25 percent of a health plan's total enrollment must consist of private-paying patients. The principle behind this restriction is that a health plan's ability to attract private enrollees can serve as one assurance of quality.

The waivers also permit states to require beneficiaries to remain enrolled in their health plans for longer periods of time than Medicaid typically requires. Allowing beneficiaries to choose to disenroll at will, as normally permitted by Medicaid, makes managed care organizations' planning for financial stability difficult and therefore the enrollment of Medicaid beneficiaries less attractive.

While HCFA has agreed to waive some of the traditional requirements aimed at ensuring managed care quality, the terms and conditions of section 1115 waivers require states to operate quality assurance systems and to collect medical encounter data. Beneficiary protections are essential because of the financial incentive to underserve in managed care plans that are paid, and are themselves paying providers, on a per capita rather than per service basis.

STATES' EXPERIENCE WITH SECTION 1115 MANAGED CARE PROGRAMS SUGGESTS LESSONS FOR PLANNING AND OVERSIGHT

The experiences of at least three states--Arizona, Tennessee, and Oregon--in implementing their section 1115 demonstration programs show the challenges that states are likely to encounter in changing from the traditional Medicaid fee-for-service program. Under Medicaid's traditional delivery system, program administrators primarily determine beneficiary eligibility and act as third-party payers. Under a managed care system, however, considerable advance planning is important as administrators learn to develop market forces and carefully monitor the care provided.

Arizona's experience in implementing a managed care program is instructive. Today, Arizona's program includes the development and use of competitive market forces to select health care providers and determine capitation rates. Its effective use of competitive bidding has resulted in millions of dollars of savings to the state

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[5]Managed care here refers to prepaid plans, some of which operate as health maintenance organizations with "gatekeepers" (providers designated to coordinate the care for individual enrollees) and some as preferred provider organizations, which do not use gatekeepers.

and the federal government. Arizona's bidding process also reduced the state's capitated payments to health plans at a time when other states' per capita costs continued to grow. In addition, the state has invested in data collection and analysis capabilities to monitor cost, profitability, and patient encounter data from each health plan.

But these implementation measures have taken time. Arizona has been expanding and refining its approach since 1982 and, as noted in earlier GAO reports, initially experienced a number of difficulties. In particular, early attempts to contract out the program's administration and data information systems failed. Subsequently, the state assumed the responsibility for administering the program and increased its direct oversight. The maturity of Arizona's Medicaid program today--especially with its oversight mechanisms--reflects the substantial preparation and development efforts that the state invested over many years.

In contrast, Tennessee's Medicaid program has encountered a number of difficulties. In an ambitious attempt to expand its Medicaid program to include a large share of its uninsured, the state shifted its entire program from fee-for-service to managed care on January 1, 1994. The difficulties resulted in part from the state's rapid implementation of the shift. Tennessee began operating its statewide managed care program fewer than 9 months after announcing the plan, despite virtually no experience with managed care in its former Medicaid program and a limited private managed care market compared to the rest of the country. As of the program's "opening day," plans for contracting with provider networks were incomplete, and many of the state's physicians had not yet determined which networks, if any, they might join. Some beneficiaries were initially required to choose a plan without knowing which ones would include their physicians. Systems to process bills were not fully developed, and some providers reported slow or no payments for services during the first months of the waiver. The availability of encounter data, which allow officials to monitor access and quality, is not complete after almost 2 years since program implementation.

Oregon began planning its current section 1115 waiver program, also implemented in 1994, several years previously. It has expanded coverage to over 100,000 new eligibles and is one of the first states to integrate its disabled and elderly populations into managed care. Early planning included holding community meetings and consulting with physicians and hospitals in order to build support from those providers who were likely to participate in the managed care program. The state also developed an array of financial and quality safeguards, including limits on providers' financial risk and client satisfaction and disenrollment surveys. The state is in the process of refining an information system that will effectively collect and analyze medical encounter data important for assessing quality of care provided.

CONCLUDING OBSERVATIONS

About 39 million low-income women, children, elderly, blind, and disabled Americans depend on health care made possible by the Medicaid program. However, the program's rapid spending growth imperils efforts to bring the federal deficit under control. Consistent with the interest of the Congress in containing federal spending, states believe they need the flexibility to manage their respective programs. Such flexibility is available today only by seeking federal permission through a section 1115 waiver. If states are granted more direct control to aggressively pursue managed care strategies, the importance of continuous oversight of managed care systems to protect both Medicaid beneficiaries from inappropriate denial of care and federal dollars from payment abuses should not be overlooked. Finally, the experiences of states with Medicaid managed care programs underscores the importance of adequate planning and appropriate quality assurance systems for a Medicaid program's effective transition to managed care.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Subcommittee members may have.

For more information on this testimony, please call Kathy Allen, Assistant Director, on (202) 512-7059. Other major contributors included Richard Jensen and Hannah Fein.

MAJOR FEDERAL EXPANSIONS OF MEDICAID ELIGIBILITY AND SERVICES (1984-93)

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

Population affected	Expansion	Mandate/option
DEFRA (Deficit Reduction Act of 1984) (P.L. 98-369)		
Infants[a] and children	Requires coverage of all children born after 9/30/83 who meet state AFDC income and resource standards, regardless of family structure.	Mandate
Pregnant women	Requires coverage from date of medical verification of pregnancy, providing the mother would (1) qualify for AFDC once child was born or (2) qualify for AFDC-UP[b] once child was born, regardless of whether state has AFDC-UP program.	Mandate
Infants	Requires automatic coverage for 1 year after birth if mother already is receiving Medicaid and remains eligible and infant resides with her.	Mandate
AFDC families	Requires limited extension of Medicaid coverage if AFDC eligibility is lost as a result of increased earnings.	Mandate[c]
AFDC families	Extends earned income disregard[d] from 4 to 12 months.	Mandate
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) (P.L. 99-272)		
Pregnant women	Requires coverage if family income and resources are below state AFDC levels, regardless of family structure.	Mandate
Postpartum women	Requires 60-day extension of coverage postpartum if eligibility was pregnancy-related.	Mandate
Pregnant women	Allows provision of enhanced benefits.	Option
Infants and children	Allows extension of DEFRA coverage up to age 5 immediately, instead of requiring phase-in by birth date.	Option

(continued)

Population affected	Expansion	Mandate/option
Adoptive and foster children	Requires coverage even if adoption/foster agreement was entered into in another state.	Mandate
OBRA 1986 (Omnibus Budget Reconciliation Act of 1986) (P.L. 99-509)		
Pregnant women and infants	Creates new optional categorically needy group for those with incomes below poverty line. Women receive pregnancy-related services only.	Option
Pregnant women and infants	Allows assets test to be dropped for this newly defined category of applicants.	Option
Pregnant women	Allows presumptive eligibility for up to 45 days to be determined by qualified provider.	Option
Pregnant women	Allows guarantee of continuous eligibility through postpartum period.	Option
Children	Allows coverage up to age 5 if family income is below poverty line (phased in).	Option
Infants and children	Requires continuation of eligibility (for those who otherwise would become ineligible) if individuals are hospital inpatients when age limit is reached.	Mandate
OBRA 1987 (Omnibus Budget Reconciliation Act of 1987) (P.L. 100-203)		
Pregnant women and infants	Allows coverage if family income is below 185% of poverty line.	Option
Children	Allows immediate extension of OBRA 1986 coverage for children up to age 5 in families with incomes up to the poverty line.	Option
Children	Clarifies that states may provide in-home services for qualified disabled children.	Option
Children	Allows coverage for children aged 5-7 up to state AFDC level (phased in by age).	Option

(continued)

Population affected	Expansion	Mandate/option
Children	Allows coverage for children below age 9 in families with incomes up to the poverty line (phased in by age).	Option
MCCA (Medicare Catastrophic Coverage Act of 1988) (P.L. 100-360)		
Pregnant women and infants	Makes mandatory the OBRA 1986 option of coverage up to the poverty line (phased in by % of poverty line).	Mandate
Family Support Act of 1988 (P.L. 100-485)		
AFDC families	Increases required period of Medicaid coverage if AFDC cash assistance is lost as a result of increased earnings.	Mandate[e]
AFDC families with unemployed parent (AFDC-UP)	Requires coverage if otherwise qualified.	Mandate
OBRA 1989 (Omnibus Budget Reconciliation Act of 1989) (P.L. 101-239)		
Pregnant women and infants	Requires coverage if family income is below 133% of poverty line.	Mandate
Children	Requires coverage up to age 6 if family income is below 133% of poverty line.	Mandate
Children	Requires provision of all Medicaid-allowed treatment to correct problems identified during early and periodic screening, diagnostic, and treatment (EPSDT), even if treatment is not covered otherwise under state's Medicaid plan.	Mandate
Children	Requires interperiodic[f] screenings under EPSDT when medical problem is suspected.	Was an option, now mandated
OBRA 1990 (Omnibus Budget Reconciliation Act of 1990) (P.L. 101-508)		
Children	Requires coverage up to age 18 if family income is below the poverty line (phased in by age).	Mandate
Pregnant women	Makes mandatory the OBRA 1986 option of continuous eligibility through postpartum period.	Mandate

(continued)

Population affected	Expansion	Mandate/option
Pregnant women	Extends period of presumptive eligibility before written application must be submitted.	Mandate
Pregnant women and children	Requires states to receive and process applications at convenient outreach sites.	Mandate
Infants	Requires continuous eligibility if (1) born to Medicaid-eligible mother who would remain eligible if pregnant and (2) remaining in mother's household.	Mandate
OBRA 1993 (Omnibus Budget Reconciliation Act of 1993) (P.L. 103-66)		
Mothers and newborns	Expands scope of required nurse-midwife services to include services outside the maternity cycle that midwives are authorized to perform under state law.	Mandate
Children	Requires state Medicaid programs to establish a program to distribute pediatric vaccines furnished by the federal government.	Mandate

[a]Infants are children up to age 1.

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

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

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

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

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

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

Population affected	Expansion	Mandate/option
DEFRA (Deficit Reduction Act of 1984) (P.L. 98-369)		
SSI recipients	Increases qualifying asset limits for applicants for limited time period (1984-89).	Mandate
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) (P.L. 99-272)		
Children with special needs	Requires coverage regardless of income/resources of adoptive/foster parents.	Mandate
OBRA 1986 (Omnibus Budget Reconciliation Act of 1986) (P.L. 99-509)		
Aged and disabled	Creates new optional categorically needy group for those with incomes below the poverty line under certain resource constraints. Option can be exercised for this group only if exercised also for pregnant women and infants.	Option
Aged and disabled	Allows Medicare buy-in[a] up to the poverty line for qualified Medicare beneficiaries under certain resource constraints.	Option
Severely impaired individuals	Establishes new mandatory categorically needy coverage group for qualified individuals under age 65.	Mandate
Ventilator-dependent individuals	Allows coverage of at-home respiratory care services.	Option
SSI recipients	Makes permanent the previous temporary provision requiring coverage of some former disabled SSI recipients who have returned to work.	Mandate
Employment Opportunities for Disabled Americans Act of 1986 (P.L. 99-643)		
Disabled individuals	Makes permanent a previous demonstration program for individuals able to engage in substantial gainful activity despite severe medical impairments.	Mandate

(continued)

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

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

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

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

Population affected	Expansion	Mandate/option
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) (P.L. 99-272)		
Terminally ill individuals	Allows provision of hospice services.	Option
OBRA 1986 (Omnibus Budget Reconciliation Act of 1986) (P.L. 99-509)		
Aliens	Requires provision of emergency services if otherwise eligible (financially and categorically).	Mandate
IRCA (Immigration Reform and Control Act of 1986) (P.L. 99-603)		
Newly legalized aliens	Requires provision of emergency and pregnancy-related services if otherwise eligible. Also requires full coverage for eligible individuals under 18.	Mandate
Anti-Drug Abuse Act of 1986 (P.L. 99-570)		
Homeless	Requires state to provide proof of eligibility for individuals otherwise eligible but having no permanent address.	Mandate
OBRA 1993 (Omnibus Budget Reconciliation Act of 1993) (P.L. 103-66)		
Medicaid beneficiaries	Makes coverage of personal care services outside the home an optional rather than a mandatory service.	Option
Aliens	Clarifies that Medicaid-covered emergency services for aliens do not include care and services related to organ transplant procedures.	Mandate

RELATED GAO PRODUCTS

Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs (GAO/HEHS-96-44, Nov. 8, 1995).

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

Medicaid: Tennessee's Program Broadens Coverage but Faces Uncertain Future (GAO/HEHS-95-186, Sept. 1, 1995).

Medicaid: State Flexibility in Implementing Managed Care Programs Requires Appropriate Oversight (GAO/T-HEHS-95-206, July 12, 1995).

Medicaid: Statewide Section 1115 Demonstrations' Impact on Eligibility, Service Delivery, and Program Cost (GAO/T-HEHS-95-182, June 21, 1995).

Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan (GAO/HEHS-95-87, Apr. 28, 1995).

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/T-HEHS-95-129, Apr. 4, 1995).

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995).

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

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

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

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

Medicaid: Lessons Learned from Arizona's Prepaid Program (GAO/HRD-87-14, Mar. 6, 1987).

Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985).

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