Chapter 12: Trends in Medicaid Payments and Users of Covered Services, 1975-91

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Introduction

The Medicaid program was enacted by Congress under title XIX of the Social Security Act and provides medical assistance to certain low-income families with dependent children and low-income persons who are aged, blind, or disabled. Historically, coverage of low-income families has focused on persons who receive cash assistance through the Aid to Families with Dependent Children (AFDC) program (title IV-A of the Social Security Act), but recent legislation has expanded Medicaid eligibility for low-income families. Coverage of the aged and disabled has focused on individuals receiving cash assistance through the Supplemental Security Income (SSI) program (title XVI of the Social Security Act) and certain SSI-related groups. The program also may cover medically needy individuals who do not receive cash assistance but have income, after deducting incurred medical expenses, that falls below certain levels. State Medicaid programs must offer certain basic services, including inpatient and outpatient hospital, physician, nursing facility, and home health services. The statute also provides States the flexibility to cover a wide range of other services, including prescription drugs and dental care.

Although the Federal Government finances between 50 and 83 percent of care provided under the Medicaid program for any given State, individual States administer Medicaid within broad Federal requirements and guidelines. Federal guidelines allow States discretion in establishing income and resource criteria for program eligibility; determining the amount, duration, and scope of covered services; and determining provider reimbursement methodologies. This means that the characteristics of State Medicaid programs vary considerably from State to State (Health Care Financing Administration, 1992a).

Despite State program differences, much is to be gained from the analysis of Medicaid program expenditure and utilization trends. Medicaid can be viewed as a confederation of individual State programs designed to address the health care needs of some of our most vulnerable populations. Changes in the number and type of persons served, the type of services rendered, and the relative cost of serving different eligibility groups inform us of how resources are being distributed to provide health care to low-income persons. It also puts in broader perspective the State-specific challenges in addressing cost and access issues for Medicaid enrollees.

These issues have grown in importance as Medicaid expenditures have risen rapidly. The increase has been most dramatic in recent years. For example, expenditures rose from $47 billion in fiscal year (FY) 1987 to more than $90 billion in FY 1991 (Health Care Financing Administration, 1988, 1992b). These Federal and State outlays for Medicaid, which provided needed health care services to nearly 28 million Americans in FY 1991, are projected to surpass Medicare outlays by FY 1995 (Executive Office of the President, 1991). The State share of these expenditures now represents one of the largest and fastest growing components of most States' budgets. Over the last decade, expenditure growth coupled with constraints on increases in revenue have resulted in budget deficits in many States. Because of Medicaid expansions and other budget pressures, many States are experiencing a severe fiscal crisis (National Association of State Budget Officers, 1991). These pressures have led to Federal and State strategies to contain costs, manage health care delivery, and implement a wide variety of measures designed to increase competition and efficiency, while maintaining quality of care. In addition, these pressures have led many States to seek alternative approaches to shift the burden of financing the program to the Federal Government. Concern about the growth in Medicaid expenditures and calls for program reform have been expressed at many levels (Office of Management and Budget, 1991; Congressional Budget Office, 1992; National Association of State Budget Officers, 1991; Feder, 1992).

Against the backdrop of these issues, this chapter presents an overview of trends in Medicaid program payments from 1975 to 1991 by eligibility group and type of service. It extends the analysis of a previous article (Reilly, Clauser, and Baugh, 1990) on Medicaid longitudinal trends. The chapter examines the reasons for growth in total Medicaid expenditures in terms of increases in the numbers and distribution of persons served (Medicaid users) and service intensity (payments per user) after adjusting for increased prices.

Methodological issues

Results in this chapter are based on the Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services (HCFA Form-2082) submitted to the Health Care Financing Administration (HCFA) by State Medicaid agencies. This analysis used the June 1, 1992, version of this report. States generate these reports from their Medicaid Management Information Systems (MMIS). MMIS are used to determine eligibility, adjudicate, and pay claims and are the primary source of national statistical data on program utilization and payments.

In the HCFA Form-2082 report, each State generates aggregate data on Medicaid recipients and payments broken down by factors such as eligibility group and type of service. States submit HCFA Form-2082 reports to HCFA annually for claims paid during the Federal

fiscal year. One advantage of HCFA Form-2082 data is that they reflect actual payments made to providers for services rendered to Medicaid users rather than provider charges or costs. Recently, HCFA has requested States to begin reporting data on Medicaid enrollees (eligibles) in their HCFA Form-2082 reports. Because the data are available for only limited time periods and selected States, this chapter does not include analysis of Medicaid enrollment trends. Also, because data for Arizona have been included only in the 1991 report, Arizona data are omitted from our analysis. HCFA Form-2082 data are used by HCFA, Congress, State agencies, and researchers for policy analysis, program evaluation, economic projections, and management review. (See, for example, Congressional Research Service, 1988; Ruther and Reilly, 1990; Health Care Financing Administration, 1990; Holahan, 1991).

States also report fiscal Medicaid program expenditure data on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (HCFA Form-64 report) to provide the basis for Federal matching payments to the States. HCFA Form-64 provides a more accurate account of total Medicaid expenditures than HCFA Form-2082 does, because it includes certain aggregate Medicaid payments to States that are not reported on HCFA Form-2082. For example, HCFA Form-2082 reports total Medicaid payments of $77 billion in fiscal year 1991 whereas HCFA Form-64 reports $90 billion (excluding program administration and training). Payment amounts missing from HCFA Form-2082 include Medicare Part A or Part B premiums paid by the States for dually enrolled individuals, premiums paid for Medicaid enrollees in capitation plans, payments for State program administration and training, and lump sum payments to providers (such as Medicaid disproportionate share payments to hospitals). However, HCFA Form-64 does not provide the level of detail by eligibility group, enrollee demographics, and other factors that is reported in HCFA Form-2082. This article examines Medicaid trends using HCFA Form-2082 data from fiscal years 1975 to 1991. Data for fiscal year 1992 were not available for publication at this time. A number of methodological issues are discussed in the following sections.

Payments

In this study, payments are defined as amounts paid by both the State and HCFA during the selected fiscal year for Medicaid-covered services, as reported in HCFA Form-2082. In 1992, HCFA's share of the total payments was about 57 percent, and the States' share was 43 percent. This includes all Medicaid payments for medical vendor services and Medicare deductibles and coinsurance. Significant discontinuities in Medicaid payment growth occurred during 1975-91. For this reason, annual compound rates of growth in Medicaid payments are presented for three primary intervals: 1975-81, 1981-88, and 1988-91. Growth rates are also presented for individual years during the 1988-91 period, because of the dramatic increases that have occurred in these years. We will present payment data in terms of both actual dollars and constant dollars, which were adjusted to remove the effects of price increases. We have elected to deflate Medicaid spending by a measure of medical-specific price inflation called the "personal health care expenditure fixed-weight price index" (PHCE-FWPI) (Levit et al., 1991). We consider the PHCE-FWPI a more appropriate deflator than other methods based on the gross domestic product or the gross national product, because we are attempting to isolate changes in the volume of health care services (i.e., persons served and service intensity) provided to Medicaid users.

Users

The term user is defined to be a program enrollee who used a particular Medicaid-covered service (recipient on HCFA Form-2082) during the fiscal year. Because a Medicaid user may receive a given service more than once in a reporting period, a strength of HCFA Form-2082 data is that they present an unduplicated count of unique individuals (or persons served) for each type of service. For example, if Medicaid paid for two hospital admissions during the year for a single individual, this individual is included only once in the count of users for that type of service. However, reported counts of total users are less than the sum of user counts across all types of services. This is because a single individual may receive more than one type of service during a year (e.g., inpatient hospital, nursing facility, and physician services). In this sense, the sum of user counts across all types of services will "double-count" individual users, whereas total users are "unduplicated." Data are presented on actual numbers in each year. Also, as described above, annual compound rates of growth in Medicaid users are presented for each of the study intervals.

Average payments per user

Average payments per user are simply payment amounts divided by the number of users.[1] Actual payments per user are deflated using the PHCE-FWPI to produce constant dollar payments per user. These constant dollar payments per user are a measure of service intensity. Again, annual compound rates of growth in payments per user are presented for each of the study intervals.

[1]The measure of (average) payment per user should be interpreted carefully, particularly with regard to long-term care services. The measure represents the average amount paid by Medicaid per user in a given year. The measure includes payments for all users of that service, regardless of the number of months they were enrolled in Medicaid during that year or the number of months during the year they received the service. For example, the rate for long-term care services may include payments for 12 months for a user who was institutionalized during the entire year. But, it may also include payments for fewer than 12 months for a user who was institutionalized for only part of the year. Thus, in this example, the measure does not represent the average payment for a full year of institutional services.

Eligibility group

To better understand trends in Medicaid, we will present data on Medicaid payments, users, and average payment per user separately by eligibility group. There are dozens of specific eligibility provisions related to these groups, but they can be summarized generally as follows[2]:

- Low-income aged: This group includes persons 65 years of age or over who either receive cash assistance through the SSI program or who do not actually receive cash assistance but are members of SSI-related groups. In 1992, the Federal SSI income standard was $422 per month for an individual and $633 per month for a couple. (Certain States, referred to as 209(b) States, employ more restrictive criteria for Medicaid eligibility than SSI standards).
- Low-income disabled: This group is composed of blind and disabled persons who receive cash assistance through the SSI program or who are members of SSI-related groups.
- Low-income families with dependent children: Historically this group has consisted of families receiving AFDC cash assistance and various AFDC-related groups who do not actually receive cash assistance. Income standards for AFDC (and thus Medicaid) eligibility vary by State. For example, in 1992, the AFDC payment standards for a family of three ranged from $120 per month in Mississippi to $920 per month in Alaska. Recent Federal legislation has expanded Medicaid eligibility to include members of other low-income families, such as pregnant women and children born after September 30, 1983, solely on the basis of their economic status relative to the Federal poverty level. HCFA Form-2082 identifies two separate groups in low-income families with dependent children: children (defined as individuals under age 18 in such families), and adults (defined as "caretaker relatives" in such families, where caretaker relatives are defined to be adults regardless of their age). In this article we will present results separately for children and adults in low-income families.

It should be noted that improving pregnancy outcomes for low-income pregnant women is of particular interest to policymakers both in Medicaid (Waxman, 1989) and in other sectors (Public Health Service, 1991). However, because HCFA Form-2082 data do not permit a separate analysis of pregnant women, they may be included with other children or adults in low-income families. Four broad eligibility groups described above account for most Medicaid payments and users (over 90 percent throughout the period). A small number of Medicaid users are eligible under other provisions and are identified as "other title XIX recipients" in the HCFA Form-2082 report. This group is not separately examined in this chapter, but is included in counts of total payments and users.

Type of service

This report presents payments, users, and payments per user broken down by the following types of service categories (Health Care Financing Administration, 1989):

- Inpatient hospital services: These are services that are ordinarily furnished in a general hospital for the care and treatment of acute inpatient episodes. This category does not include skilled nursing facility or intermediate care facility services furnished by a hospital with swing-bed approval or services in an institution for tuberculosis or mental disease. The category includes services provided in a psychiatric wing of a general hospital, if the psychiatric wing is not administratively separate from the general hospital.
- Intermediate care facility services for the mentally retarded (ICF/MR): These are services provided in an institution for persons with mental retardation or related conditions.
- Other intermediate care facility services (ICF): These are services provided in a facility for individuals who do not require the level of care provided by a hospital or skilled nursing facility, but whose physical or mental condition requires services that are above the level of room and board and can be provided only through institutional facilities. ICF services do not include services furnished in an institution for tuberculosis or mental disease. They do include services provided in a swing-bed hospital that has an approval to furnish ICF services.[3]
- Skilled nursing facility services (SNF): These are services provided in a facility for individuals who require a level of care below that of an acute inpatient but of sufficient complexity that it can be performed safely and effectively only by skilled nursing or skilled rehabilitative personnel. SNF services do not include services furnished in an institution for tuberculosis or mental disease. They do include SNF care provided in a swing-bed hospital.[3]
- Physicians' services: These services include care provided and billed by a physician, whether furnished in a physicians' office, hospital, SNF, or elsewhere. The category does not include physician services if they are provided and billed by a hospital, clinic, or laboratory; laboratory and X-ray services even when they are provided and billed by a physician; early and periodic screening, diagnosis, and treatment (EPSDT) services provided by a physician; or family planning services provided by a physician.
- Outpatient hospital services: These are preventive, diagnostic, therapeutic, rehabilitative, or palliative

[2]These eligibility groups include both the categorically needy and medically needy. Details on the specific eligibility provisions related to these groups can be obtained from the authors.

[3]Effective October 1, 1990, OBRA 1987 combined SNF and ICF levels of service into a single level—nursing facility services—and required States to recognize only the nursing facility level of care for purposes of Medicaid certification.

services that are furnished to outpatients by a licensed hospital.

- Home health services: These are services provided at the patient's place of residence in compliance with a physician's written plan and include nursing services; home health aide services; medical supplies, equipment, and appliances suitable for use in the home; physical, occupational, and speech therapy; personal care services; and services provided under a home and community-based care waiver.
- Prescription drugs: These are drugs prescribed by a physician and dispensed by a licensed pharmacist for the cure, mitigation, or prevention of disease.

The eight types of services described above account for a large share of total Medicaid payments (almost 90 percent in 1991). A number of other services are covered by Medicaid and are reported on HCFA Form-2082, including: clinic, lab and X-ray, family planning, EPSDT, dental, inpatient mental health, and rural health clinic services. These services are not examined separately, but are included in total payments. The format of HCFA Form-2082 does not permit more refined breakouts of certain types of services for specific populations of interest, such as services for persons with AIDS, substance abusers, or services for pregnant women, because States do not report data for persons with particular health conditions or diagnoses on HCFA Form-2082.

Data comparability

Because MMIS requirements do not mandate standardized coding for eligibility and claims data, it is clear that Medicaid data are often coded differently from State to State. Therefore, comparison of HCFA Form-2082 data across States reveals inconsistencies in how payments and users are coded by eligibility group and type of service.

Also, reporting requirements have changed over time, which has resulted in discontinuities in the time series for payment and user trends. A recent discontinuity occurred for ICF and SNF services as a result of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, Public Law 100-203) provisions. Beginning in October 1990, OBRA 1987 combined the ICF and SNF levels of service into one level of care for the purpose of Medicaid certification. This change in policy recognized that the administrative distinctions between SNF and ICF care did not, in practice, display clear differences in the residents they served (Institute of Medicine, 1986). In 1991, most States began to report payments and recipient counts on the HCFA Form-2082 report either as entirely ICF care or entirely SNF care, reflecting this change in policy. However, some States did not. Because of this change, HCFA Form-2082 data for ICF and SNF services in 1991 are not comparable to data from earlier years. Payment data for ICF and SNF services can be combined to examine trends. However, user data for these services cannot be combined because the result may not be an unduplicated count of users. For example, a Medicaid nursing home resident could have been reclassified from the ICF to the SNF level of care (or vice versa) during the same reporting period. In this instance, this individual would be counted as both a SNF and an ICF user. As a result of these inconsistencies, SNF and ICF services will be combined for analysis of Medicaid payment trends. However, these services will remain separated for analysis of user trends. In addition, tabulated data omit growth rates for these services between 1991 and earlier years.

Findings

The Medicaid program is complicated by the diversity of both mandatory and optional provisions for program eligibility, service coverage, and payment methods. In recent years, there have been many major changes to these provisions. In addition, there have been many other factors that have reshaped the program during the study period. These factors include changing demographic characteristics of low-income Americans, increasing social problems (such as substance abuse, teen pregnancy, and homelessness), growing concern about provider participation and patient access to care, advances in health care technology, innovations in health care delivery, new payment policies, and fiscal pressures at both the Federal and State levels. In this article, we are unable to examine the impact of many of these factors on Medicaid growth. However, we have examined trends in Medicaid users and payments from 1975 to 1991 to determine, to the extent possible, how the Medicaid program has changed and what factors have affected program growth.

This analysis is presented in four major sections. In the first, we will analyze aggregate trends in Medicaid payments, users, and payments per user. Both actual levels and annual compound rates of growth are presented. In the second section, the changing composition of the Medicaid program is examined in terms of share of total program payments provided to each major eligibility group and the mix of covered services used by those eligibility groups. The next section attempts to isolate specific factors that relate to payment growth. Such factors include increases in persons served and the level of service "intensity." The last section is a detailed study of trends in Medicaid payments, users, and payments per user for specific eligibility groups and types of service.

Medicaid program growth

Aggregate Medicaid trends

Total Medicaid payments, shown in Table 12.1, increased from $12.2 billion to $77.0 billion between 1975 and 1991—an increase of more than 500 percent. The average rate of growth was 12.2 percent per year. However, Medicaid program growth was not uniform over the entire period. From 1975 through 1981, program payments grew rapidly at an average annual rate of 14.2 percent (a constant dollar increase of 4.3 percent per year). Payment growth slowed

Table 12.1

Medicaid payments for all eligibility groups[1], by type of service: Fiscal years 1975-91

Year	Total[2]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mental retarded	Other					
					Payments in millions				
1975	$12,242	$3,374	$380	$1,885	$2,434	$1,225	$373	$70	$815
	(100.0)	(27.6)	(3.1)	(15.4)	(19.9)	(10.0)	(3.0)	(0.6)	(6.7)
1976	14,091	3,905	634	2,209	2,476	1,369	555	134	940
	(100.0)	(27.7)	(4.5)	(15.7)	(17.6)	(9.7)	(3.9)	(1.0)	(6.7)
1977	16,239	4,562	917	2,637	2,691	1,505	877	180	1,018
	(100.0)	(28.1)	(5.6)	(16.2)	(16.6)	(9.3)	(5.4)	(1.1)	(6.3)
1978	17,992	4,992	1,192	3,104	3,125	1,554	835	210	1,082
	(100.0)	(27.7)	(6.6)	(17.3)	(17.4)	(8.6)	(4.6)	(1.2)	(6.0)
1979	20,472	5,655	1,488	3,773	3,379	1,635	847	263	1,196
	(100.0)	(27.6)	(7.3)	(18.4)	(16.5)	(8.0)	(4.1)	(1.3)	(5.8)
1980	23,311	6,412	1,989	4,202	3,685	1,875	1,101	332	1,318
	(100.0)	(27.5)	(8.5)	(18.0)	(15.8)	(8.0)	(4.7)	(1.4)	(5.7)
1981	27,204	7,194	2,996	4,507	4,035	2,101	1,409	428	1,535
	(100.0)	(26.4)	(11.0)	(16.6)	(14.8)	(7.7)	(5.2)	(1.6)	(5.6)
1982	29,399	7,670	3,467	4,979	4,427	2,086	1,438	496	1,599
	(100.0)	(26.1)	(11.8)	(16.9)	(15.1)	(7.1)	(4.9)	(1.7)	(5.4)
1983	32,391	8,813	4,079	5,381	4,621	2,175	1,574	597	1,771
	(100.0)	(27.2)	(12.6)	(16.6)	(14.3)	(6.7)	(4.9)	(1.8)	(5.5)
1984	33,891	8,848	4,256	5,823	4,810	2,220	1,646	774	1,968
	(100.0)	(26.1)	(12.6)	(17.2)	(14.2)	(6.6)	(4.9)	(2.3)	(5.8)
1985	37,508	9,453	4,731	6,516	5,071	2,346	1,789	1,120	2,315
	(100.0)	(25.2)	(12.6)	(17.4)	(13.5)	(6.3)	(4.8)	(3.0)	(6.2)
1986	41,005	10,364	5,072	6,773	5,660	2,547	1,980	1,352	2,692
	(100.0)	(25.3)	(12.4)	(16.5)	(13.8)	(6.2)	(4.8)	(3.3)	(6.6)
1987	45,050	11,302	5,591	7,280	5,967	2,776	2,226	1,690	2,988
	(100.0)	(25.1)	(12.4)	(16.2)	(13.2)	(6.2)	(4.9)	(3.8)	(6.6)
1988	48,710	12,076	6,022	7,923	6,354	2,953	2,413	2,015	3,294
	(100.0)	(24.8)	(12.4)	(16.3)	(13.0)	(6.1)	(5.0)	(4.1)	(6.8)
1989	54,500	13,378	6,649	8,871	6,660	3,408	2,837	2,572	3,689
	(100.0)	(24.5)	(12.2)	(16.3)	(12.2)	(6.3)	(5.2)	(4.7)	(6.8)
1990	64,859	16,674	7,354	9,667	8,026	4,018	3,324	3,404	4,420
	(100.0)	(25.7)	(11.3)	(14.9)	(12.4)	(6.2)	(5.1)	(5.2)	(6.8)
1991	76,964	19,851	7,680	2,324	18,375	4,946	4,280	4,101	5,424
	(100.0)	(25.8)	(10.0)	(3.0)	(23.9)	(6.4)	(5.6)	(5.3)	(7.0)
					Annual compound rate of growth (Percent)				
1975-91	12.2	11.7	20.7	1.3	13.5	9.1	16.5	29.0	12.6
1975-81	14.2	13.4	41.1	15.6	8.8	9.4	24.8	35.2	11.1
1981-88	8.7	7.7	10.5	8.4	6.7	5.0	8.0	24.8	11.5
1988-91	16.5	18.0	8.4	NA	NA	18.8	21.0	26.7	18.1
1988-89	11.9	10.8	10.4	12.0	4.8	15.4	17.6	27.6	12.0
1989-90	19.0	24.6	10.6	9.0	20.5	17.9	17.2	32.3	19.8
1990-91	18.7	19.1	4.4	NA	NA	23.1	28.7	20.5	22.7
					Annual compound rate of growth, constant dollars (Percent)[3]				
1975-91	4.3	3.9	12.2	−5.8	5.5	1.5	8.3	20.0	4.7
1975-81	4.6	3.9	29.2	5.9	−0.4	0.2	14.3	23.8	1.8
1981-88	1.9	1.0	3.6	1.7	0.1	−1.5	1.3	17.0	4.6
1988-91	9.6	11.1	2.1	NA	NA	11.8	14.0	19.3	11.2
1988-89	4.9	3.8	3.5	4.9	−1.8	8.2	10.2	19.6	5.0
1989-90	11.8	17.1	3.9	2.4	13.2	10.8	10.1	24.3	12.6
1990-91	12.4	12.8	−1.0	NA	NA	16.6	22.0	14.2	16.3

[1]These totals for "all eligibility groups" include the four eligibility groups presented (low-income aged, low-income disabled, children in low-income families, adults in low-income families) and the "Other title XIX" group, which is not presented separately.
[2]The total includes payments for all types of services reported on HCFA Form-2082, not just the eight types of service listed here.
[3]Payments were adjusted for inflation by using the personal health care expenditure fixed-weight price index developed by the Health Care Financing Administration, Office of the Actuary.

NOTES: Numbers in parentheses are the percent of total payments. NA is not applicable.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services, HCFA Form-2082.

considerably from 1981 to 1988. Payments grew only at a rate of 8.7 percent per year (a modest constant dollar increase of only 1.9 percent per year). This discontinuity is related to a number of factors that occurred after 1981. First, OBRA 1981, Public Law 97-35, required States to reduce earned income "disregards" for AFDC, which caused many of the "working poor" to lose eligibility. In addition, AFDC income thresholds did not keep pace with inflation in the early 1980s, which made it more difficult for low-income families to qualify for AFDC. During this time, many States implemented new reimbursement methods (e.g. diagnosis-related groups) for inpatient hospital services, cost containment policies for optional services, and moved to limit or restrict access to some services. At the same time, however, some States expanded eligibility to include medically needy individuals and/or Ribicoff children (Holahan, 1987; Rymer and Burwell, 1987; Health Care Financing Administration, 1985).

Larger annual increases in total Medicaid payments were observed after 1988: 11.9 percent in 1989, 19.0 percent in 1990, and 18.7 percent in 1991. In terms of constant dollars, these increases were 4.9, and 11.8 and 12.4 percent, respectively. The rapid growth in Medicaid payments from 1988 to 1991 largely reflects recently enacted Medicaid program expansions. OBRA 1986, Public Law 99-509, gave States the option to cover pregnant women and children with income below the Federal poverty level (FPL). OBRA 1986 also gave States the option to cover all Medicaid services or Medicare copayments and deductibles for aged and disabled persons with incomes below the poverty level. OBRA 1987 extended the OBRA 1986 legislation by giving States the option to cover infants and pregnant women up to 185 percent of FPL and by mandating coverage of additional children in families with incomes below AFDC requirements who were not otherwise eligible. OBRA 1987 also mandated a series of nursing home reforms that include new staffing requirements and a new inspection system to improve quality of care.

The Medicare Catastrophic Coverage Act of 1988 (MCCA)[4] mandated phased-in coverage of infants and pregnant women in families with incomes up to 100 percent of FPL. MCCA also mandated phased-in coverage of Medicare copayments and deductibles for aged and disabled persons (known as "qualified Medicare beneficiaries," QMBs) with incomes up to 100 percent of the poverty level and liberalized treatment (disregards) of income and assets for spouses of users who are institutionalized in nursing homes. OBRA 1989, Public Law 101-239, mandated eligibility for pregnant women and children up to age 6 with income below 133 percent of FPL. Also, OBRA 1989 required Medicaid programs to pay for care provided to enrolled children to treat health problems identified during EPSDT screenings even if treatment is not covered under the State's Medicaid plan.

OBRA 1990, Public Law 101-508, required phased-in coverage of children born after September 30, 1983, up to age 19 if income is below 100 percent of FPL. Also, OBRA 1990 mandated the provision of continuous eligibility for infants (previously optional under OBRA 1986) if the infant was born to a Medicaid eligible mother who would remain eligible if pregnant; and the infant remains in the mother's household. For the aged and disabled, OBRA 1990 phased in coverage of Medicare copayments to 120 percent of poverty level by 1995 for QMBs.

As mentioned earlier, Medicaid programs are funded jointly by States and the Federal Government. Historically, States raised their share of Medicaid matching payments through State general revenue. Beginning in 1986, States began to supplement general revenue with funds donated by health care providers or taxes levied on health care providers to finance the State's share of Medicaid payments. Thus, the funds generated through these mechanisms have allowed States to receive additional Federal matching funds without raising or reallocating State general revenue. (See Merlis, 1991 for a more thorough discussion of these mechanisms.) States have used these funds in a variety of ways to broaden eligibility, expand service coverage, increase payments to providers, or simply maintain current program options. At the Federal level, concerns have been raised about the impact of these mechanisms to increase program expenditures, shift the financial burden of the program to the Federal sector, and jeopardize the financial stability of the program (Office of Inspector General, 1991; Health Policies Alternatives, Inc., 1992; and U.S. Congressional Budget Office, 1992). The increases in program payments observed in recent years could be in part a result of these donation and tax mechanisms.

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 limit Federal matching payments for Medicaid expenditures when the State's share is financed through voluntary donations or provider taxes. Because this legislation was effective as of January 1992, its impact on the Medicaid expenditure series will not be realized until the future.

During the entire 1975-91 period, the number of Medicaid users grew by a modest 1.5 percent (Table 12.2). From 1975 to 1981, there was no growth in the total number of users. A small increase of 0.6 percent occurred between 1981 and 1988. However, the user population began to grow after 1988, and the rate of growth accelerated to average 6.9 percent between 1988 and 1991. This sudden growth can be attributed, in part, to the mandated expansions of Medicaid eligibility that were described above.

Medicaid payments per user (Table 12.3) show a much different pattern than user trends. The overall rate of increase in constant dollar payments per user was 2.8 percent from 1975 to 1991. However, the rate increased by 4.6 percent annually between 1975 and 1981. After 1981, it grew at most by 1.3 percent per year. Constant dollar payments per user actually declined by 0.8 percent between 1990 and 1991. Because of the recent congressional mandates to expand

[4]Even though the basic provisions of the Medicare Catastrophic Coverage Act were repealed by Congress, Medicaid provisions remain in effect.

program eligibility, increased pressure on States to improve patient access by increasing provider payments, and significant revenue shortfalls in many State budgets, some States may be reducing the amount, duration, and scope of services covered in their Medicaid plans.

Changing composition of Medicaid payments

This section presents a comparative analysis of payments for the four eligibility groups: aged, disabled, children, and adults in low-income families. It examines factors that have changed the composition of the program during the study period. As we previously noted, Medicaid expansions in the late 1980s resulted in substantial increases in the numbers of Medicaid users who were adults (pregnant women) or children in low-income families. In Figure 12.4, constant dollar growth rates for Medicaid payments are compared for the four eligibility groups for FYs 1988-91. Growth rates were highest for children in all 3 years. Adults experienced the second highest growth rate. These groups experienced substantially higher growth rates than either aged or disabled users. For three of the four groups, excluding the aged, the largest rates of growth were reported from 1989 to 1990. If sustained, these differential rates of growth could dramatically change the composition of the Medicaid program in the future.

Table 12.2

Medicaid users for all eligibility groups[1], by type of service: Fiscal years 1975-91

Year	Total[2]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Users in thousands				
1975	22,007	3,432	69	682	630	15,198	7,437	343	14,155
	(100.0)	(15.6)	(0.3)	(3.1)	(2.9)	(69.1)	(33.8)	(1.6)	(64.3)
1976	22,815	3,551	89	724	637	15,624	8,482	319	14,883
	(100.0)	(15.6)	(0.4)	(3.2)	(2.8)	(68.5)	(37.2)	(1.4)	(65.2)
1977	22,832	3,768	107	754	641	16,074	8,619	371	15,370
	(100.0)	(16.5)	(0.5)	(3.3)	(2.8)	(70.4)	(37.7)	(1.6)	(67.3)
1978	21,965	3,782	104	740	639	15,668	8,628	376	15,188
	(100.0)	(17.2)	(0.5)	(3.4)	(2.9)	(71.3)	(39.3)	(1.7)	(69.1)
1979	21,520	3,608	114	766	610	15,168	7,710	359	14,283
	(100.0)	(16.8)	(0.5)	(3.6)	(2.8)	(70.5)	(35.8)	(1.7)	(66.4)
1980	21,605	3,680	121	789	606	13,765	9,705	392	13,707
	(100.0)	(17.0)	(0.6)	(3.7)	(2.8)	(63.7)	(44.9)	(1.8)	(63.4)
1981	21,980	3,703	151	762	610	14,403	10,018	402	14,256
	(100.0)	(16.8)	(0.7)	(3.5)	(2.8)	(65.5)	(45.6)	(1.8)	(64.9)
1982	21,603	3,530	149	765	559	13,894	9,853	377	13,547
	(100.0)	(16.3)	(0.7)	(3.5)	(2.6)	(64.3)	(45.6)	(1.7)	(62.7)
1983	21,554	3,696	151	793	574	14,056	10,069	422	13,732
	(100.0)	(17.1)	(0.7)	(3.7)	(2.7)	(65.2)	(46.7)	(2.0)	(63.7)
1984	21,607	3,467	141	796	559	14,195	10,035	438	13,935
	(100.0)	(16.0)	(0.7)	(3.7)	(2.6)	(65.7)	(46.4)	(2.0)	(64.5)
1985	21,814	3,434	147	828	547	14,387	10,072	535	13,921
	(100.0)	(15.7)	(0.7)	(3.8)	(2.5)	(66.0)	(46.2)	(2.5)	(63.8)
1986	22,515	3,544	145	828	571	14,894	10,702	593	14,704
	(100.0)	(15.7)	(0.6)	(3.7)	(2.5)	(66.2)	(47.5)	(2.6)	(65.3)
1987	23,109	3,767	149	849	572	15,373	10,979	609	15,083
	(100.0)	(16.3)	(0.6)	(3.7)	(2.5)	(66.5)	(47.5)	(2.6)	(65.3)
1988	22,907	3,832	145	866	579	15,265	10,533	569	15,323
	(100.0)	(16.7)	(0.6)	(3.8)	(2.5)	(66.6)	(46.0)	(2.5)	(66.9)
1989	23,511	4,170	148	888	564	15,686	11,344	609	15,916
	(100.0)	(17.7)	(0.6)	(3.8)	(2.4)	(66.7)	(48.2)	(2.6)	(67.7)
1990	25,255	4,593	147	860	601	17,078	12,370	719	17,294
	(100.0)	(18.2)	(0.6)	(3.4)	(2.4)	(67.6)	(49.0)	(2.8)	(68.5)
1991	27,967	5,014	145	190	1,300	19,119	14,031	809	19,581
	(100.0)	(17.9)	(0.5)	(0.7)	(4.6)	(68.4)	(50.2)	(2.9)	(70.0)
					Annual compound rate of growth (Percent)				
1975-91	1.5	2.4	4.8	-7.7	4.6	1.4	4.0	5.5	2.0
1975-81	0.0	1.3	13.9	1.9	-0.5	-0.9	5.1	2.7	0.1
1981-88	0.6	0.5	-0.6	1.8	-0.7	0.8	0.7	5.1	1.0
1988-91	6.9	9.4	0.1	NA	NA	7.8	10.0	12.4	8.5
1988-89	2.6	8.8	2.1	2.5	-2.6	2.8	7.7	7.0	3.9
1989-90	7.4	10.1	-0.7	-3.1	6.5	8.9	9.0	18.1	8.7
1990-91	10.7	9.2	-1.0	NA	NA	11.9	13.4	12.5	13.2

[1]These totals for "all eligibility groups" include the four eligibility groups presented (low-income aged, low-income disabled, children in low-income families, adults in low-income families) and the "Other title XIX" group, which is not presented separately.

[2]The total includes payments for all types of services reported on HCFA Form-2082, not just the eight types of services listed here. A person receiving multiple services (e.g., inpatient hospital, physician and outpatient services) is included once in the user count for each type of service and once in the total.

NOTES: Numbers in parentheses are the percent of total users. NA is not applicable.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

Figure 12.5 presents the proportion of total Medicaid users, by eligibility group, for FYs between 1975-91. In 1975, the aged represented 16.4 percent of total users. This percent declined steadily during the study period to a low of 11.9 percent in 1991. In contrast, the disabled accounted for only 11.2 percent of all users in 1975. They grew, in relative terms, to account for 15.3 percent of all users in 1989. Children in low-income families were between 42.3 and 46.0 percent of all users between 1975 and 1991. Much of this growth is the result of the recent eligibility expansions, discussed earlier, which caused the proportion of children to increase from 43.9 percent of all Medicaid users in 1989 to 46.0 percent in 1991. This sudden increase in the proportion of Medicaid children corresponds to a decrease for disabled users over this 2-year period. Adults in low-income families accounted for only 20.6 percent of all users in 1975. During the period of high unemployment during the early 1980s, the numbers of adults grew to represent 25.9 percent of total users in both 1983 and 1984.

Figure 12.6 shows a different result as it compares the proportion of total Medicaid payments by eligibility group for the study period. In this instance, payments for the aged, who represented 37.8 percent of total payments in 1984, declined steadily and represented only 33.1 percent of payments by 1991. Over most of the study period, payments for disabled users grew in relative terms from 25.7 percent to a high of 38.3 percent of total payments. The share for disabled users declined slightly after 1989. Again, this decline may be the result of eligibility expansions for other groups. The payment level for children (17.9 percent of total payments) in 1975 was the highest for any year in the study period. The proportion of total payments for children declined steadily in the late 1970s and remained below 13 percent from 1981 to 1989. Dramatic increases were observed in 1990 and 1991. The pattern for adults was similar to that observed for children.

An examination of Figures 12.5 and 12.6 permits a direct comparison of the relative proportions of total users and payments for each eligibility group. In 1975,

Table 12.3

Medicaid payments per user for all eligibility groups[1], by type of service: Fiscal years 1975-91

Year	Total[2]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Payment per user				
1975	$556	$983	$5,538	$2,764	$3,865	$81	$50	$204	$58
1976	618	1,100	7,135	3,049	3,886	88	65	420	63
1977	711	1,211	8,530	3,499	4,199	94	102	485	66
1978	819	1,320	11,486	4,194	4,893	99	97	558	71
1979	951	1,568	13,022	4,926	5,544	108	110	734	84
1980	1,079	1,742	16,439	5,322	6,079	136	113	846	96
1981	1,238	1,943	19,812	5,913	6,614	146	141	1,065	108
1982	1,361	2,172	23,312	6,511	7,916	150	146	1,313	118
1983	1,503	2,384	27,006	6,783	8,057	155	156	1,416	129
1984	1,569	2,552	30,170	7,314	8,599	156	164	1,768	141
1985	1,719	2,753	32,238	7,868	9,278	163	178	2,092	166
1986	1,821	2,924	35,089	8,182	9,910	171	185	2,278	183
1987	1,949	3,000	37,490	8,571	10,432	181	203	2,777	198
1988	2,126	3,151	41,413	9,153	10,971	193	229	3,542	215
1989	2,318	3,251	44,999	9,994	11,809	217	250	4,225	232
1990	2,568	3,630	50,048	11,236	13,356	235	269	4,733	256
1991	2,752	3,959	52,791	12,222	14,137	259	305	5,070	277
					Annual compound rate of growth (Percent)				
1975-91	10.5	9.1	15.1	9.7	8.4	7.5	12.0	22.2	10.3
1975-81	14.3	12.0	23.7	13.5	9.4	10.3	18.9	31.7	10.9
1981-88	8.0	7.2	11.1	6.4	7.5	4.1	7.2	18.7	10.3
1988-91	9.0	7.9	8.4	NA	NA	10.3	10.0	12.7	8.8
1988-89	9.0	3.2	8.7	9.2	7.6	12.4	9.2	19.3	7.9
1989-90	10.8	11.7	11.2	12.4	13.1	8.4	7.5	12.0	10.2
1990-91	7.2	9.1	5.5	NA	NA	10.0	13.5	7.1	8.4
					Annual compound rate of growth, constant dollars (Percent)[3]				
1975-91	2.8	1.5	7.1	2.1	0.9	0.0	4.2	13.7	2.6
1975-81	4.6	2.6	13.2	3.9	0.1	1.0	8.8	20.6	1.6
1981-88	1.3	0.5	4.2	−0.2	0.8	−2.4	0.5	11.4	3.5
1988-91	2.6	1.6	2.1	NA	NA	3.8	3.6	6.1	2.4
1988-89	2.2	-3.3	1.8	2.3	0.9	5.4	2.3	11.8	1.1
1989-90	6.5	7.4	6.9	8.1	8.7	4.2	3.3	7.7	5.9
1990-91	−0.8	1.0	−2.3	NA	NA	1.8	5.1	−0.8	0.4

[1]These totals for "all eligibility groups" include the four eligibility groups presented (low-income aged, low-income disabled, children in low-income families, adults in low-income families) and the "Other title XIX" group, which is not presented separately.
[2]The total includes payments for all types of services reported on HCFA Form-2082, not just the eight types of services listed here.
[3]Payments were adjusted for inflation by using the personal health care expenditure fixed-weight price index developed by the Health Care Financing Administration, Office of the Actuary.

NOTE: NA is not applicable.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

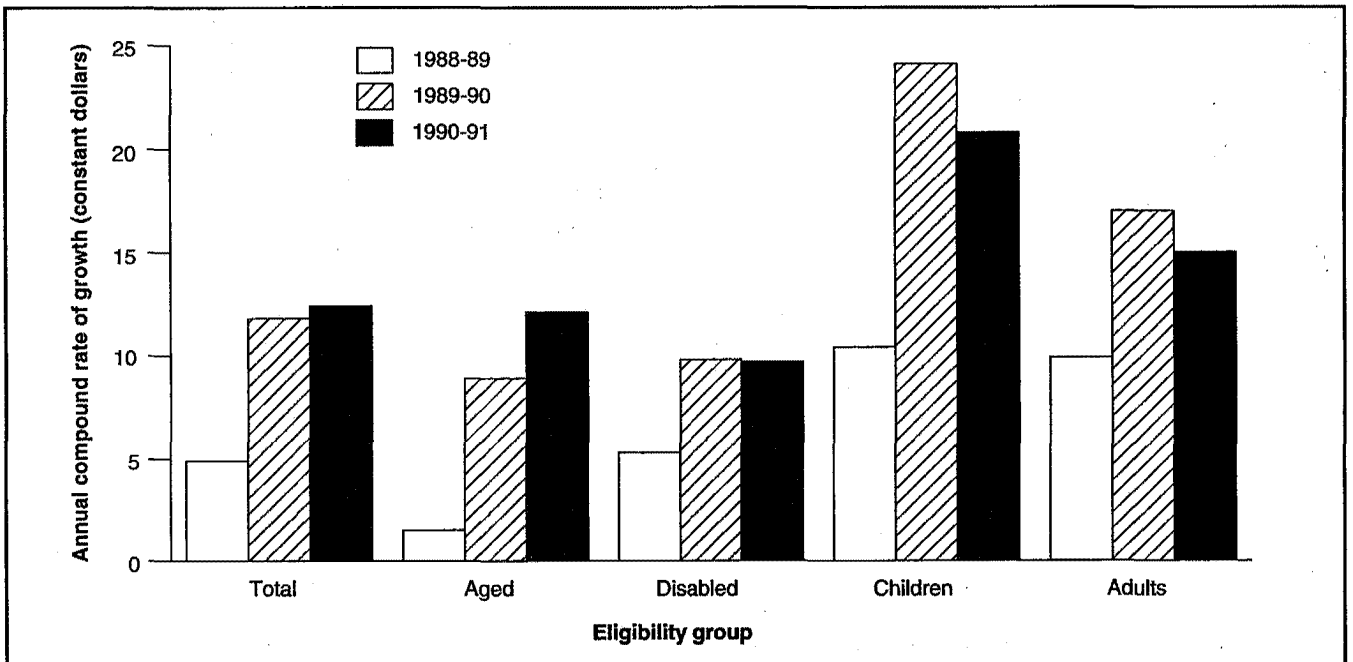
aged and disabled users were only 27.6 percent of the total Medicaid population. Yet, payments for these users represented 61.3 percent of program payments. This disparity persisted in 1991, when the proportion of aged and disabled users accounted for 26.3 percent of all users, but payments for them represented 69.8 percent of all payments. However, the disabled were responsible for the increased disparity in payments. The percent of total payments for the disabled grew steadily, from 25.7 percent in 1975 to 36.7 percent in 1991. Each of the other major groups experienced a decline in their percent of total payments between 1975 and 1991. In 1991, children were the largest group (46.0 percent) as a proportion of total users, but payments for them accounted for only 15.1 percent of total payments.

This disproportionality in payments by eligibility group is directly related to the mix of covered Medicaid services used by each group (Figures 12.7 and 12.8). In 1991, payments per user were $7,617 for the aged and $7,005 for the disabled in comparison to $1,555 for adults and $902 for children. For the aged, recall that many individuals are also covered under Medicare, which pays for much of their inpatient hospital and physician care. Therefore, nursing facility services accounted for more than two-thirds of Medicaid payments for aged users (Figure 12.7). Payments per user for the aged (who received these services) exceeded $12,000. For the disabled, more than 50 percent of payments were for acute inpatient and ICF/MR care (Figure 12.7). Not all disabled users had inpatient hospital or ICF/MR episodes. For the disabled who had ICF/MR care, payments per user were $52,670. Similarly, payments per user were $7,426 for inpatient hospital services. The proportion of total payments for home health services covered by Medicaid increased sharply both for the aged and disabled. Because of the high payments per user for institutional services delivered to aged and disabled users, small numbers of users accounted for relatively large payments.

The relatively modest impact of low-income adults and children on total Medicaid payments reflects the mix of services used by these persons. In 1991, more than 70 percent of payments for both adults and children were for inpatient hospital, physician, and outpatient hospital services (Figure 12.8). Most members of these groups do not use expensive long-term care services. Instead, adults and children who do require expensive care are often classified as "disabled users." Nearly one-half of all payments for adults and children were for inpatient hospital care. However, there was a lower level of service intensity (shorter stays, less intensive treatments, etc.) for these groups than for the aged and disabled. Indeed, for children ($3,653) and adults ($3,012) who received inpatient hospital care, payments for these services were much lower than those observed for aged and disabled users. Between 1975 and 1991, the proportion of total

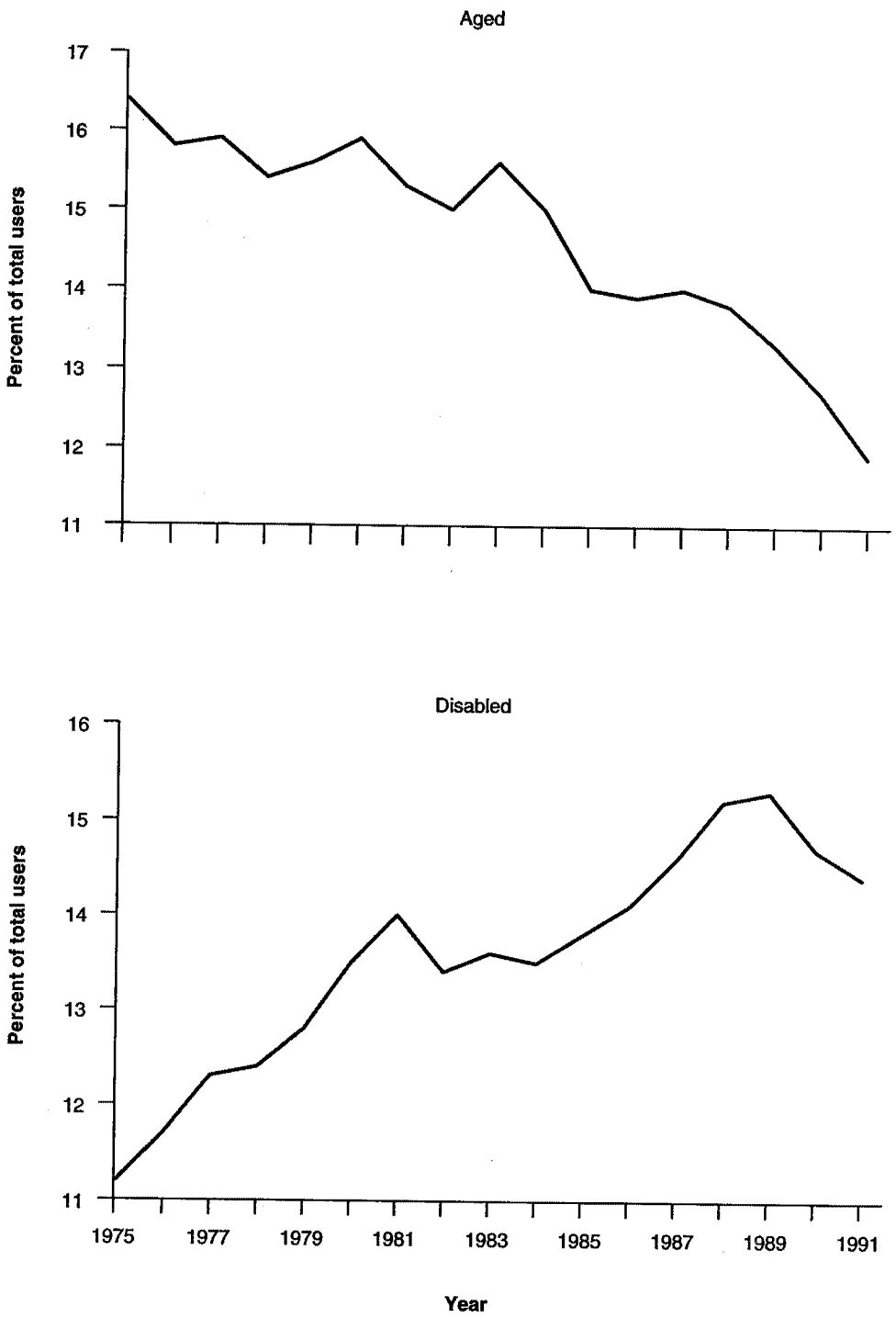
Figure 12.4

Annual compound rate of growth of Medicaid payments, by eligibility group: Fiscal years 1988-91



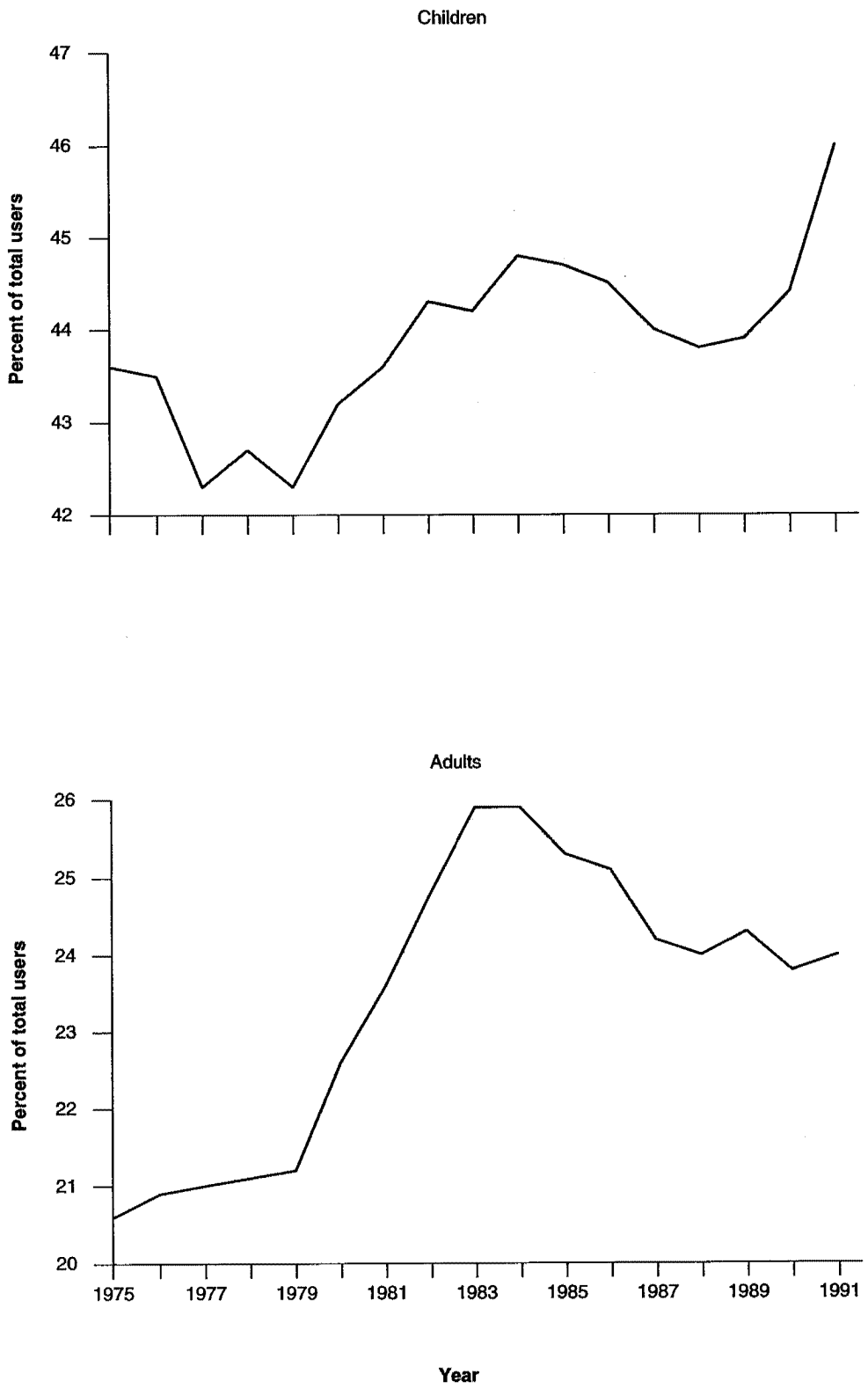
SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 12.5
Percent of total Medicaid users, by eligibility group: Fiscal years 1975-91



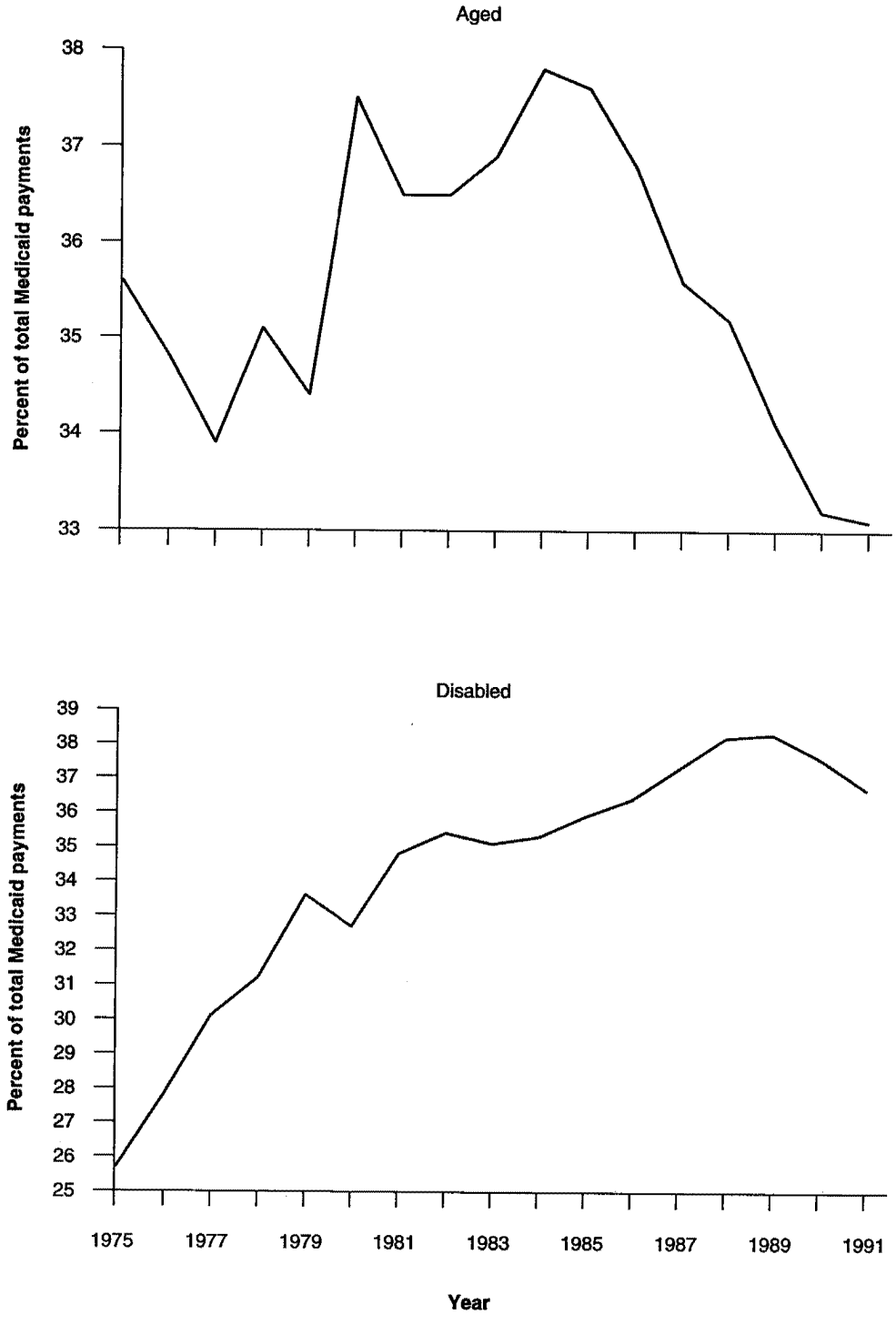
See SOURCE at end of figure.

Figure 12.5—Continued
Percent of total Medicaid users, by eligibility group, Fiscal years 1975-91



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

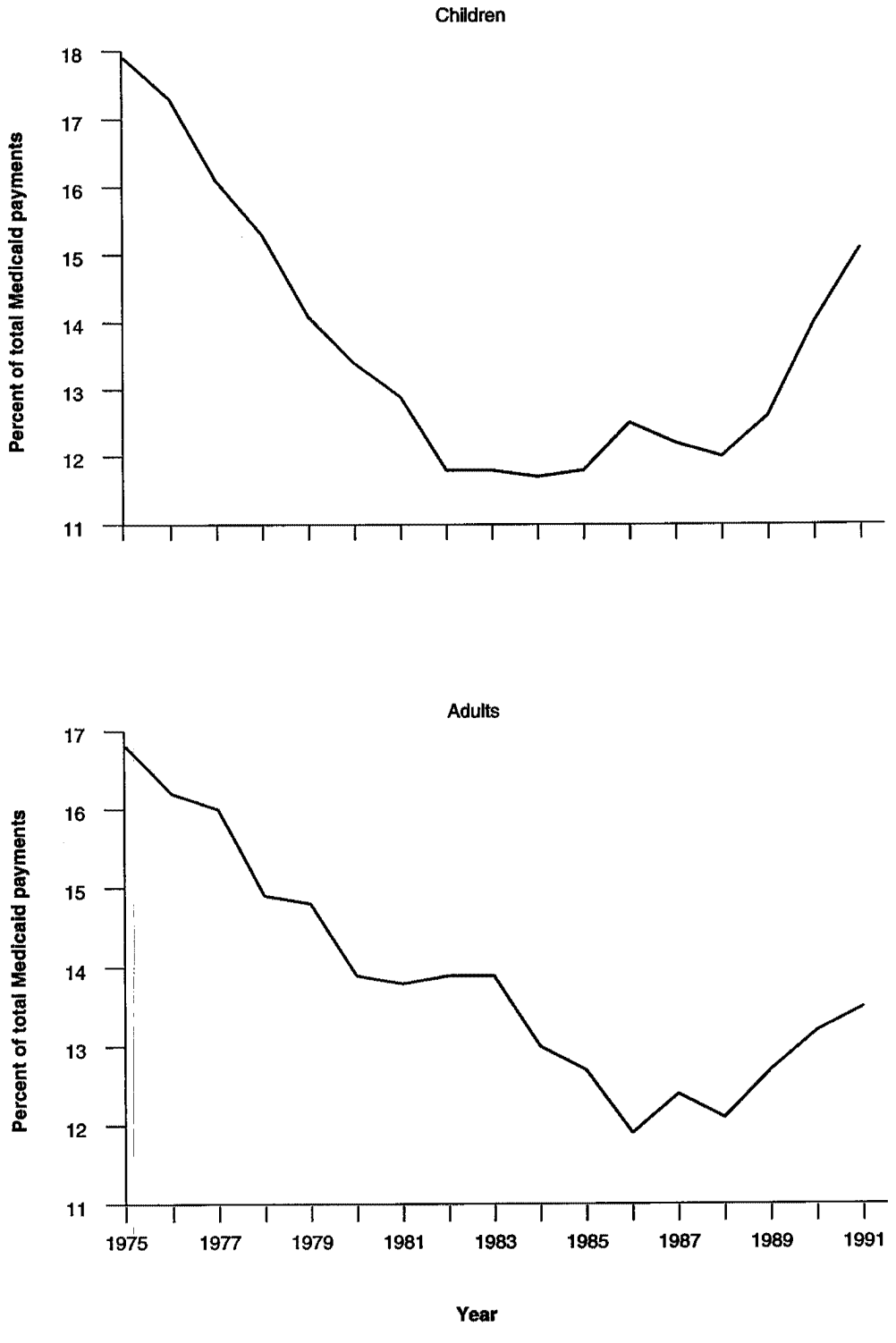
Figure 12.6
Percent of total Medicaid payments, by eligibility groups: Fiscal years 1975-91



See SOURCE at end of figure.

Figure 12.6 — Continued

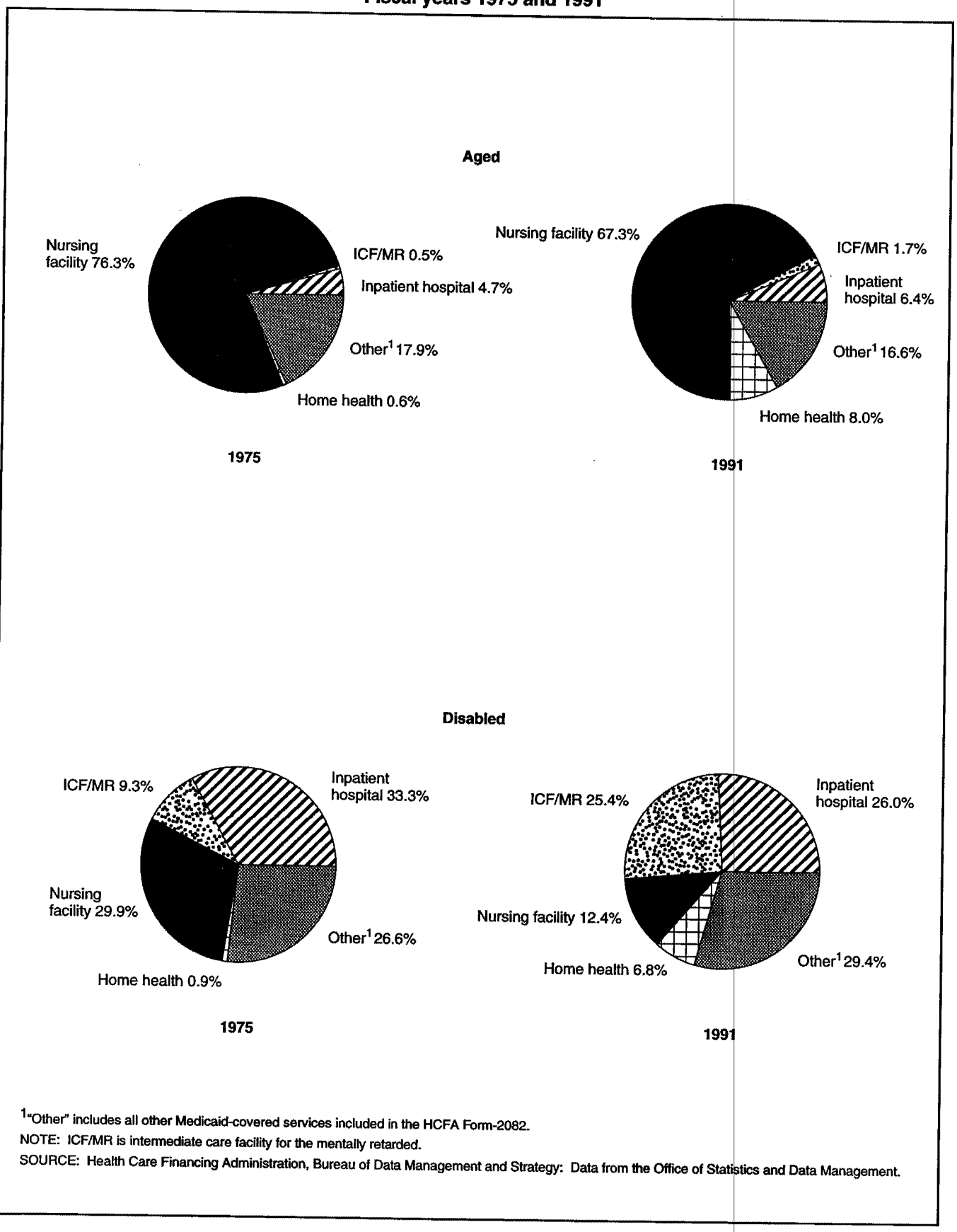
Percent of total Medicaid payments, by eligibility groups: Fiscal years 1975-91



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 12.7

Percent of Medicaid payments for the low-income aged and disabled, by selected type of service: Fiscal years 1975 and 1991



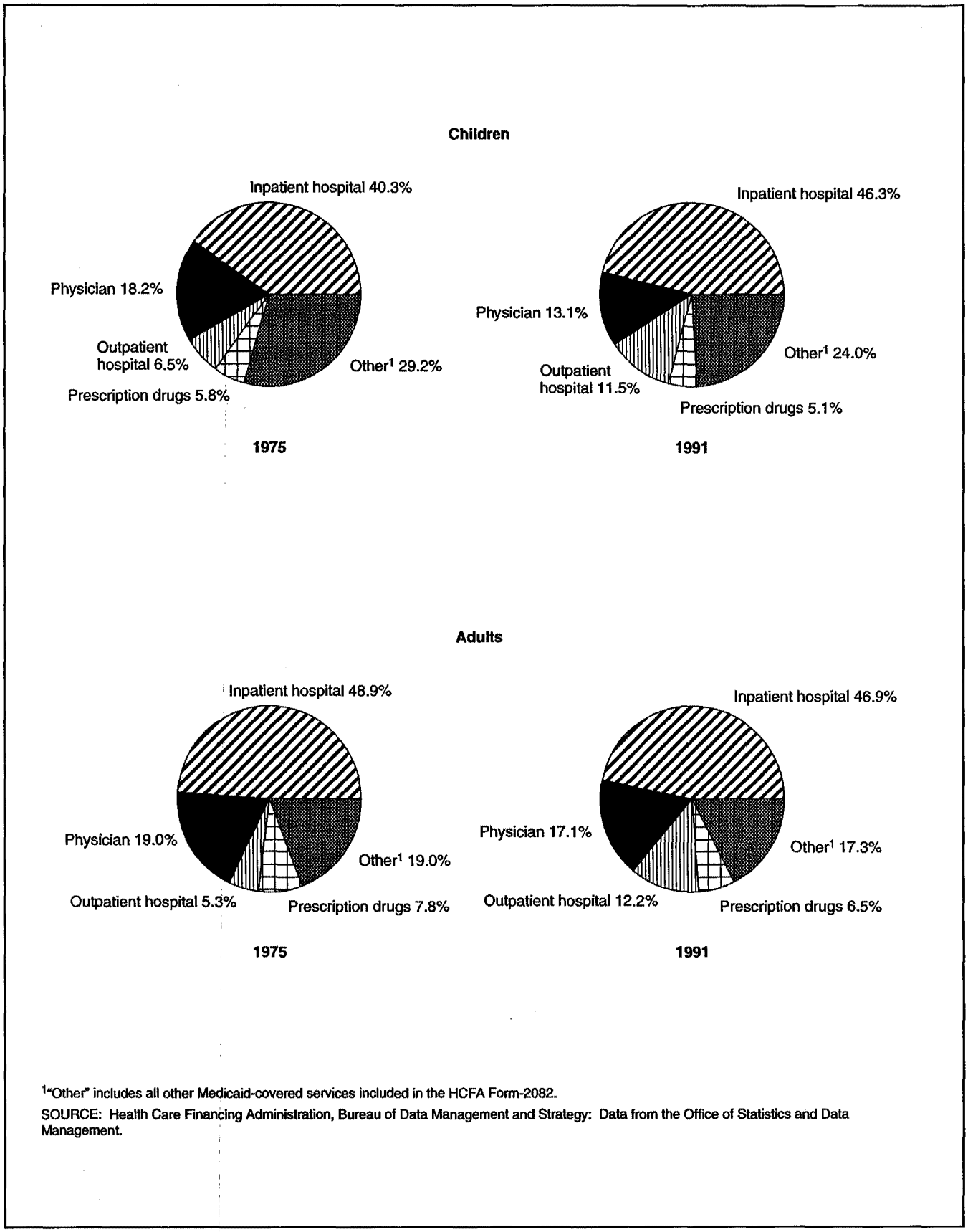
[1] "Other" includes all other Medicaid-covered services included in the HCFA Form-2082.

NOTE: ICF/MR is intermediate care facility for the mentally retarded.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 12.8

Percent of Medicaid payments for low-income children and adults, by selected type of service: Fiscal years 1975 and 1991



[1]"Other" includes all other Medicaid-covered services included in the HCFA Form-2082.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

payments made to outpatient hospitals increased, while the proportion made to physicians decreased.

In summary, payments for children and adults in low-income families contributed significantly to the overall increase in the rate of growth in Medicaid payments in recent years. However, the payments for the aged and disabled still account for the largest share of total Medicaid payments, primarily because of their use of high-cost acute inpatient, ICF/MR, and nursing facility services.

Factors influencing growth in Medicaid payments

This section examines which factors have had the greatest impact on payment growth. Total payments can be represented by the following formula:

Total payments = Users x Payments per user

User counts measure the number of persons served. Because we wish to examine factors influencing growth in Medicaid payments, apart from cost inflation, we have conducted this analysis based on constant dollar payment amounts. Because of this, payments per user are a crude measure of service intensity (e.g., number of service units, intensity of care per unit, etc.). Applying this formula to total Medicaid payments by eligibility group and type of service provides insight into the major reasons for program growth. The results of this analysis are presented for the 1975-81 interval, the 1981-88 interval, and the 1989-91 interval (Table 12.9). The analysis highlights growth for total payments by either of the factors in the formula only when the percent increase exceeds 5 percent.

Table 12.9

Reasons for Medicaid payment growth[1], by eligibility group and type of service: Fiscal years 1975-91

Eligibility group and type of service[3]	1975-1981		1981-1988		1988-1991	
	Persons served	Service intensity	Persons served	Service intensity	Persons served	Service intensity
	Major reason(s) for growth[2]					
Inpatient hospital					X	
ICF/MR	X	X				
Physician					X	
Outpatient hospital	X	X			X	
Home health		X	X	X	X	X
Prescription drugs					X	
Aged						
Inpatient hospital		X				
ICF/MR	X	X			X	
Physician						X
Outpatient hospital		X				X
Home health		X	X			X
Prescription drugs						X
Disabled						
Inpatient hospital	X				X	
ICF/MR	X	X				
Physician					X	
Outpatient hospital	X	X	X		X	
Home health	X	X		X	X	X
Prescription drugs	X		X	X	X	X
Children						
Inpatient hospital					X	
ICF/MR	—	—	—	—	—	—
Physician					X	
Outpatient hospital		X			X	X
Home health				X	X	X
Prescription drugs					X	X
Adults						
Inpatient hospital					X	
ICF/MR	—	—	—	—	—	—
Physician					X	X
Outpatient hospital	X	X			X	
Home health		X			X	
Prescription drugs					X	

[1]The increase is for payment in constant dollars.
[2]If neither reason is indicated, then there was either a decline or growth of less than 5 percent.
[3]Data are not presented for skilled nursing facility or intermediate care facility services.

NOTES: The symbol "—" indicates that numbers were too small to produce a reliable estimate. ICF/MR is intermediate care for the mentally retarded.

SOURCE: Pine, P., Clauser, S., and Baugh, D., Health Care Financing Administration, 1993.

From 1975 to 1981, there was no consistent pattern in constant dollar payment growth across all types of services. Both increases and declines occurred for total payments in both the physician and prescription drug sectors. Payments for outpatient hospital services grew for all eligibility groups. With the exception of children, payments for home health services also grew for all eligibility groups. Increases in both persons served and service intensity contributed to the observed growth.

Total constant dollar payments were remarkably stable for most services between 1981 and 1988. There was a slight decline in payments to physicians during the period for each eligibility group. Home health services were the only sector that exhibited substantial growth in payment during this period. This was true for all eligibility groups but adults.

From 1988 to 1991, an increase in the number of persons served was a factor observed in all payment increases by type of service (except ICF/MR services) and for all eligibility groups (except for the aged). Increases in service intensity also contributed to growth in program payments during this time period, although the impact was not as consistent across both eligibility and type-of-service groups as was the growth in persons served.

Medicaid trends by sector

Growth in Medicaid payments varied by program component. Certain components of the program experienced significant growth, while others were stable or declined. We examine these issues by analyzing trends in Medicaid payments by eligibility group and type of service below.

Eligibility group

Low-income aged

From 1975 to 1981, payments for the low-income aged rose at an annual rate of 14.7 percent, but from 1981 to 1989, the rate of increase slowed to just over 8 percent per year (Table 12.10). From 1989 to 1990, the growth rate increased to 15.9 percent, and it was 18.3 percent between 1990 and 1991. However, the rate of growth in Medicaid payments for the low-income aged from 1988 to 1991 (14.1 percent) was less than the rate of growth across all eligibility groups (16.5 percent).

The number of aged Medicaid users (Table 12.11) actually declined from 1975 to 1989. Modest increases were reported in 1990 (2.2 percent) and 1991 (4.3 percent). The net result was a slight decline of 0.5 percent (approximately 275,000 users) over the entire study period.

Constant dollar payments per user (Table 12.12) grew more rapidly for the aged than for any other eligibility group in this study. The rates were 6.3 percent from 1975 to 1981, 2.3 percent from 1981 to 1988, and 5.4 percent from 1988 to 1991. Conversely, payments per user, for some types of services, were lower for the aged than for other groups because many aged are also enrolled in Medicare. For these dually enrolled persons, Medicaid pays only copayments and deductibles for Medicare-covered services (e.g., see average payments for inpatient hospital, physician, and outpatient services).

Low-income disabled

Payments for the disabled grew more rapidly than those for all enrollees between 1975 and 1989: 20.1 percent from 1975 to 1981, 10.1 percent from 1981 to 1988, and 12.3 percent from 1988 to 1989 (Table 12.13). The respective constant dollar growth rates for these time periods were 10.0 percent, 3.3 percent, and 5.3 percent. Because of this sustained growth, Medicaid payments for the disabled have exceeded those for the aged since 1986 (Figure 12.14). Despite the steady growth of expenditures for this group over the entire study period, expenditures for the disabled grew at lower rates between 1989 and 1991 than expenditures for all enrollees.

Expenditures for home health services grew at an annual rate of 33 percent from 1988 to 1991, while expenditures for prescription drugs grew by almost 20 percent during this period. Like the aged, disabled Medicaid enrollees may also be eligible for Medicare. However, a smaller proportion of disabled than of aged enrollees are also Medicare beneficiaries (Gornick et al., 1985). This may, in part, explain why average Medicaid payments were higher for the disabled than for the aged for a number of services (e.g., inpatient hospital, skilled nursing facility, physician, and outpatient services). Of course, differences in morbidity and service intensity may account for such differences.

The number of disabled Medicaid users grew by an annual rate of 3.1 percent between 1975 and 1991 (Table 12.15), the highest of any of the eligibility groups in this study. Furthermore, it was double the rate of growth in users for the entire Medicaid population (1.5 percent). The rate of growth in the number of disabled users was significantly higher in the 1975-81 and 1988-91 intervals (3.8 and 5.0 percent, respectively) than during the 1981-88 interval (1.8 percent). Because of this sustained rate of growth, the number of disabled users has exceeded the number of aged users since 1986 (Figure 12.16).

Constant dollar payments per user for the disabled (Table 12.17) grew at a rate that was slightly higher than that for all Medicaid users but lower than that for the aged over the entire study period. An actual decline of 1.2 percent was observed between 1990 and 1991.

Children in low-income families

This group accounted for a major proportion of the increase in Medicaid payments between 1988 and 1991. From 1975 to 1981, payments for this group increased at a rate of 8.2 percent per year (Table 12.18). From 1981 to 1988, the annual rate of increase was 7.6 percent. However, payments for these children increased by 17.9 percent, 32.0 percent, and 27.5 percent, respectively, in each of the years 1988 to

Table 12.10

Medicaid payments for the low-income aged, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Payments in millions				
1975	$4,358	$205	$20	$1,431	$1,894	$133	$25	$27	$297
	(100.0)	(4.7)	(0.5)	(32.8)	(43.5)	(3.1)	(0.6)	(0.6)	(6.8)
1976	4,910	244	18	1,693	1,901	147	34	56	364
	(100.0)	(5.0)	(0.4)	(34.5)	(38.7)	(3.0)	(0.7)	(1.1)	(7.4)
1977	5,499	300	18	2,028	2,063	166	44	72	387
	(100.0)	(5.5)	(0.3)	(36.9)	(37.5)	(3.0)	(0.8)	(1.3)	(7.0)
1978	6,308	382	29	2,327	2,428	174	44	85	410
	(100.0)	(6.1)	(0.5)	(36.9)	(38.5)	(2.8)	(0.7)	(1.3)	(6.5)
1979	7,046	454	33	2,805	2,565	184	58	78	449
	(100.0)	(6.4)	(0.5)	(39.8)	(36.4)	(2.6)	(0.8)	(1.1)	(6.4)
1980	8,739	806	199	3,281	3,007	225	67	202	519
	(100.0)	(9.2)	(2.3)	(37.5)	(34.4)	(2.6)	(0.8)	(2.3)	(5.9)
1981	9,926	941	167	3,609	3,350	259	81	267	611
	(100.0)	(9.5)	(1.7)	(36.4)	(33.7)	(2.6)	(0.8)	(2.7)	(6.2)
1982	10,739	1,006	95	3,996	3,678	247	90	310	629
	(100.0)	(9.4)	(0.9)	(37.2)	(34.2)	(2.3)	(0.8)	(2.9)	(5.9)
1983	11,954	1,482	161	4,385	3,848	257	106	378	692
	(100.0)	(12.4)	(1.3)	(36.7)	(32.2)	(2.1)	(0.9)	(3.2)	(5.8)
1984	12,815	1,396	106	4,759	3,890	255	110	451	763
	(100.0)	(10.9)	(0.8)	(37.1)	(30.4)	(2.0)	(0.9)	(3.5)	(6.0)
1985	14,096	1,450	175	5,341	4,068	264	105	639	883
	(100.0)	(10.3)	(1.2)	(37.9)	(28.9)	(1.9)	(0.7)	(4.5)	(6.3)
1986	15,097	1,603	179	5,577	4,480	264	126	766	973
	(100.0)	(10.6)	(1.2)	(36.9)	(29.7)	(1.7)	(0.8)	(5.1)	(6.4)
1987	16,037	1,375	226	5,988	4,699	249	145	982	1,075
	(100.0)	(8.6)	(1.4)	(37.3)	(29.3)	(1.6)	(0.9)	(6.1)	(6.7)
1988	17,135	1,411	216	6,593	5,025	240	161	1,143	1,186
	(100.0)	(8.2)	(1.3)	(38.5)	(29.3)	(1.4)	(0.9)	(6.7)	(6.9)
1989	18,558	1,263	264	7,377	5,182	272	181	1,441	1,282
	(100.0)	(6.8)	(1.4)	(39.8)	(27.9)	(1.5)	(1.0)	(7.8)	(6.9)
1990	21,508	1,315	372	8,097	6,439	286	194	1,733	1,507
	(100.0)	(6.1)	(1.7)	(37.6)	(29.9)	(1.3)	(0.9)	(8.1)	(7.0)
1991	25,444	1,634	430	2,036	15,085	343	255	2,026	1,823
	(100.0)	(6.4)	(1.7)	(8.0)	(59.3)	(1.3)	(1.0)	(8.0)	(7.2)
					Annual compound rate of growth (Percent)				
1975-91	11.7	13.9	21.1	2.2	13.8	6.1	15.6	31.0	12.0
1975-81	14.7	28.9	42.4	16.7	10.0	11.7	21.6	46.5	12.8
1981-88	8.1	6.0	3.7	9.0	6.0	-1.1	10.3	23.1	9.9
1988-91	14.1	5.0	25.8	NA	NA	12.7	16.5	21.0	15.4
1988-89	8.3	-10.5	22.2	11.9	3.1	13.3	12.4	26.1	8.1
1989-90	15.9	4.1	40.7	9.8	24.3	5.3	7.3	20.3	17.5
1990-91	18.3	24.3	15.7	NA	NA	19.9	31.2	16.9	21.0
					Annual compound rate of growth, constant dollars (Percent)[2]				
1975-91	3.9	5.9	12.7	-4.9	5.9	-1.3	7.5	21.8	4.2
1975-81	5.0	18.0	30.4	6.8	0.7	2.3	11.4	34.2	3.3
1981-88	1.4	-0.6	-2.7	2.2	-0.6	-7.2	3.5	15.5	3.1
1988-91	7.4	-1.1	18.4	NA	NA	6.1	9.7	13.9	8.6
1988-89	1.5	-16.1	14.5	4.9	-3.4	6.2	5.4	18.2	1.3
1989-90	8.9	-2.2	32.2	3.1	16.7	-1.1	0.8	13.0	10.4
1990-91	12.1	17.8	9.6	NA	NA	13.6	24.3	10.8	14.6

[1]The total includes payments for all types of services reported on HCFA Form-2082, not just the 8 types of service listed here.
[2]Payments were adjusted for inflation by using the personal health care expenditure fixed-weight price index developed by the Health Care Financing Administration, Office of the Actuary.

NOTES: Numbers in parentheses are the percent of total payments. NA is not applicable.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

1991.[5] Even constant dollar increases in expenditures for Medicaid children were relatively high in these last 3 years, 10.4 percent, 24.1 percent, and 20.8 percent, respectively. These growth rates were significantly higher than those for any other group between 1988 and 1991. However, Medicaid payments for children ($11.6 billion) were much lower than payments for either the aged ($25.4 billion) or the disabled ($28.3 billion) in 1991. While payments for children and adults were roughly comparable between 1975 and 1989 (Figure 12.14), payments for children have grown much more rapidly since 1989.

Recall that recent legislation broadened Medicaid eligibility to include new groups of low-income children. The number of children in low-income families who received Medicaid grew at a rate (1.8 percent) slightly above that of all users (1.5 percent) from 1975 to 1991 (Table 12.19). However, there was little growth until the late 1980s. From 1988 to 1991, user growth accelerated from 2.8 percent in 1989, 8.7 percent in 1990, and 14.6 percent in 1991. The growth rate of Medicaid users was higher for

[5]A number of groups formerly reported as "other title XIX" were included in other eligibility groups beginning in 1989; most of these groups were previously included with other groups of eligible children. However, if one accounts for these coding changes and deducts them from the growth in payments for low income-children, the percentage increase in the latter group is still 16.8 percent in 1989 (this result was consistent across types of services—thus, the effect of the coding change on payments was small).

Table 12.11

Medicaid low-income aged users, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Users in thousands				
1975	3,615	757	3	518	505	2,263	732	115	2,673
	(100.0)	(20.9)	(0.1)	(14.3)	(14.0)	(62.6)	(20.2)	(3.2)	(73.9)
1976	3,612	786	2	567	513	2,275	816	113	2,718
	(100.0)	(21.8)	(0.1)	(15.7)	(14.2)	(63.0)	(22.6)	(3.1)	(75.2)
1977	3,636	824	2	592	520	2,338	828	134	2.678
	(100.0)	(22.7)	(0.1)	(16.3)	(14.3)	(64.3)	(22.8)	(3.7)	(73.7)
1978	3,376	858	3	575	518	2,245	908	106	2,595
	(100.0)	(25.4)	(0.1)	(17.0)	(15.3)	(66.5)	(26.9)	(3.1)	(76.9)
1979	3,364	798	3	597	483	2,222	874	56	2,504
	(100.0)	(23.7)	(0.1)	(17.7)	(14.4)	(66.1)	(26.0)	(1.7)	(74.4)
1980	3,440	831	12	615	480	2,221	903	108	2,524
	(100.0)	(24.2)	(0.3)	(17.9)	(14.0)	(64.6)	(26.3)	(3.1)	(73.4)
1981	3,367	843	9	633	501	2,208	895	102	2,655
	(100.0)	(25.0)	(0.3)	(18.8)	(14.9)	(65.6)	(26.6)	(3.0)	(78.9)
1982	3,240	811	8	644	461	2,148	885	105	2,523
	(100.0)	(25.0)	(0.2)	(19.9)	(14.2)	(66.3)	(27.3)	(3.2)	(77.9)
1983	3,372	881	8	691	495	2,265	1,088	207	2,526
	(100.0)	(26.1)	(0.2)	(20.5)	(14.7)	(67.2)	(32.3)	(6.1)	(74.9)
1984	3,238	785	5	689	475	2,140	1,041	199	2,444
	(100.0)	(24.2)	(0.2)	(21.3)	(14.7)	(66.1)	(32.1)	(6.1)	(75.5)
1985	3,061	729	7	713	458	2,166	804	234	2,400
	(100.0)	(23.8)	(0.2)	(23.3)	(15.0)	(70.8)	(26.3)	(7.6)	(78.4)
1986	3,140	720	6	712	473	2,216	884	254	2,469
	(100.0)	(22.9)	(0.2)	(22.7)	(15.1)	(70.6)	(28.2)	(8.1)	(78.6)
1987	3,224	725	6	730	476	2,239	912	277	2,490
	(100.0)	(22.5)	(0.2)	(22.6)	(14.8)	(69.4)	(28.3)	(8.6)	(77.2)
1988	3,159	728	5	741	507	2,066	918	263	2,504
	(100.0)	(23.0)	(0.2)	(23.5)	(16.0)	(65.4)	(29.1)	(8.3)	(79.3)
1989	3,132	720	5	763	464	1,989	940	264	2,471
	(100.0)	(23.0)	(0.2)	(24.4)	(14.8)	(63.5)	(30.0)	(8.4)	(78.9)
1990	3,202	705	7	736	499	2,056	944	288	2,591
	(100.0)	(22.0)	(0.2)	(23.0)	(15.6)	(64.2)	(29.5)	(9.0)	(80.9)
1991	3,341	759	8	168	1,096	2,185	1,049	300	2,727
	(100.0)	(22.7)	(0.2)	(5.0)	(32.8)	(65.4)	(31.4)	(9.0)	(81.6)
					Annual compound rate of growth (Percent)				
1975-91	−0.5	0.0	6.0	−6.8	5.0	−0.2	2.3	6.2	0.1
1975-81	−1.2	1.8	20.1	3.4	−0.1	−0.4	3.4	−2.0	−0.1
1981-88	−0.9	−2.1	−8.1	2.3	0.2	−0.9	0.4	14.5	−0.8
1988-91	1.9	1.4	15.3	NA	NA	1.9	4.5	4.5	2.9
1988-89	−0.9	−1.1	0.0	3.0	−8.5	−3.7	2.4	0.4	−1.3
1989-90	2.2	−2.1	40.4	−3.6	7.5	3.4	0.4	9.2	4.9
1990-91	4.3	7.7	9.3	NA	NA	6.3	11.1	4.2	5.2

[1]The total includes users for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here. A person receiving multiple services (e.g., inpatient hospital, physician and outpatient services) is included once in the user count for each type of service and once in the total.

NOTES: Numbers in parentheses are the percent of total users. NA is not applicable.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

low-income children than for the disabled between 1989 and 1991.

Payments per user, in constant dollars, declined for Medicaid children from 1975 to 1988 by −0.3 percent per year. A growth rate of 8.9 percent between 1988 and 1991 offset these declines to produce a small increase of 1.4 percent over the entire study period (Table 12.20). As noted previously, OBRA 1989 (Section 6403) required States to pay for care provided to enrolled children to treat health problems identified during EPSDT screenings even if the service is not covered under the State's Medicaid plan. This provision has the potential to expand Medicaid coverage for children to include any Medicaid coverable service judged by the State to be medically necessary. Concerns have been raised by some (Horvath, 1992; Soule, 1992) about the impact of this provision. One concern is about tensions between States and other parties over the determination of medical necessity for particular services. The other concern is about the potential for this mandate to dramatically increase program payments for Medicaid children. The rapid rate of growth observed recently in payments per user for Medicaid children may have resulted from this OBRA 1989 requirement.

Adults in low-income families

Adults in low-income families with dependent children also accounted for a significant part of the increase in the rate of growth in Medicaid payments in 1991. Payments for this group grew at an annual rate of 10.5 percent during 1975-81, 6.6 percent during 1981-88, but 21.0 percent during 1988-91 (Table 12.21). However, real (constant dollar) payments for adults in low-income families grew slowly until after 1988, when observed growth was 13.9 percent per year. When compared with other eligibility groups, data show that payments for this group grew at the slowest constant dollar rate (2.9 percent) from 1975 to 1991. The recent growth in payments for this group reflects growth in both the number of users and payment per user. The number of users in this group grew at an annual rate of

Table 12.12

Medicaid payments per user for the low-income aged, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Payment per user				
1975	$1,205	$271	$6,925	$2,763	$3,754	$59	$35	$238	$111
1976	1,359	310	8,951	2,985	3,702	65	42	493	134
1977	1,512	364	7,482	3,423	3,967	71	53	535	144
1978	1,869	446	9,700	4,048	4,684	78	48	801	158
1979	2,094	569	9,804	4,701	5,309	83	67	1,387	179
1980	2,540	970	16,346	5,334	6,266	101	74	1,873	198
1981	2,948	1,115	19,247	5,703	6,681	118	91	2,624	230
1982	3,315	1,241	11,464	6,204	7,974	115	101	2,944	249
1983	3,545	1,682	20,348	6,344	7,777	114	97	1,829	274
1984	3,957	1,778	23,343	6,909	8,193	119	105	2,263	312
1985	4,605	1,990	26,926	7,491	8,883	122	131	2,731	368
1986	4,808	2,228	32,328	7,829	9,476	119	142	3,015	394
1987	4,975	1,898	39,854	8,208	9,875	111	159	3,551	432
1988	5,425	1,937	45,601	8,896	9,920	116	175	4,344	474
1989	5,926	1,754	51,265	9,666	11,176	137	192	5,452	519
1990	6,717	1,865	52,943	11,005	12,914	139	206	6,013	581
1991	7,617	2,151	56,032	12,103	13,760	157	243	6,749	668
					Annual compound rate of growth (Percent)				
1975-91	12.2	13.8	14.0	9.7	8.5	6.3	12.9	23.3	11.9
1975-81	16.1	26.6	18.6	12.8	10.1	12.2	17.3	49.2	12.9
1981-88	9.1	8.2	13.1	6.6	5.8	−0.2	9.8	7.5	10.9
1988-91	12.0	3.6	7.1	NA	NA	10.7	11.5	15.8	12.1
1988-89	9.2	−9.4	12.4	8.7	12.7	18.1	9.7	25.5	9.5
1989-90	13.3	6.3	3.3	13.8	15.6	1.7	7.1	10.3	12.0
1990-91	13.4	15.4	5.8	NA	NA	12.9	18.0	12.2	15.0
					Annual compound rate of growth, constant dollars (Percent)[2]				
1975-91	4.4	5.9	6.0	2.0	0.9	−1.1	5.0	14.7	4.1
1975-81	6.3	15.9	8.6	3.3	0.8	2.8	7.4	36.6	3.4
1981-88	2.3	1.5	6.1	0.0	-0.7	−6.4	3.0	0.8	4.0
1988-91	5.4	−2.5	0.8	NA	NA	4.2	5.0	9.0	5.6
1988-89	2.4	−15.1	5.4	1.8	5.6	10.7	2.8	17.6	2.6
1989-90	9.0	2.2	−0.7	9.5	11.1	−2.2	3.0	6.0	7.7
1990-91	5.0	6.8	−2.0	NA	NA	4.5	9.3	3.9	6.5

[1]The total includes payments for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here.
[2]Payments were adjusted for inflation by using the personal health care expenditure fixed-weight price index developed by the Health Care Financing Administration, Office of the Actuary.

NOTE: NA is not applicable.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

Table 12.13

Medicaid payments for the low-income disabled, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Payments in millions				
1975	$3,145	$1,049	$294	$443	$498	$243	$81	$27	$201
	(100.0)	(33.4)	(9.3)	(14.1)	(15.8)	(7.7)	(2.6)	(0.9)	(6.4)
1976	3,920	1,247	545	509	543	286	121	55	258
	(100.0)	(31.8)	(13.9)	(13.0)	(13.9)	(7.3)	(3.1)	(1.4)	(6.6)
1977	4,883	1,498	819	598	599	342	193	76	299
	(100.0)	(30.7)	(16.8)	(12.2)	(12.3)	(7.0)	(4.0)	(1.6)	(6.1)
1978	5,620	1,652	1,086	753	673	358	190	87	321
	(100.0)	(29.4)	(19.3)	(13.4)	(12.0)	(6.4)	(3.4)	(1.5)	(5.7)
1979	6,882	1,957	1,402	913	790	396	208	129	372
	(100.0)	(28.4)	(20.4)	(13.3)	(11.5)	(5.8)	(3.0)	(1.9)	(5.4)
1980	7,621	2,207	1,699	868	638	475	275	111	424
	(100.0)	(29.0)	(22.3)	(11.4)	(8.4)	(6.2)	(3.6)	(1.5)	(5.6)
1981	9,455	2,521	2,760	890	672	529	353	140	500
	(100.0)	(26.7)	(29.2)	(9.4)	(7.1)	(5.6)	(3.7)	(1.5)	(5.3)
1982	10,405	2,691	3,296	964	719	512	349	162	531
	(100.0)	(25.9)	(31.7)	(9.3)	(6.9)	(4.9)	(3.4)	(1.6)	(5.1)
1983	11,367	2,943	3,838	988	761	543	369	194	599
	(100.0)	(25.9)	(33.8)	(8.7)	(6.7)	(4.8)	(3.2)	(1.7)	(5.3)
1984	11,977	3,064	4,073	1,057	905	540	429	292	687
	(100.0)	(25.6)	(34.0)	(8.8)	(7.6)	(4.5)	(3.6)	(2.4)	(5.7)
1985	13,452	3,293	4,477	1,170	987	588	484	433	855
	(100.0)	(24.5)	(33.3)	(8.7)	(7.3)	(4.4)	(3.6)	(3.2)	(6.4)
1986	14,913	3,636	4,817	1,181	1,156	637	566	531	1,025
	(100.0)	(24.4)	(32.3)	(7.9)	(7.8)	(4.3)	(3.8)	(3.6)	(6.9)
1987	16,817	4,213	5,282	1,260	1,231	714	679	658	1,174
	(100.0)	(25.1)	(31.4)	(7.5)	(7.3)	(4.2)	(4.0)	(3.9)	(7.0)
1988	18,594	4,588	5,748	1,317	1,298	779	803	815	1,336
	(100.0)	(24.7)	(30.9)	(7.1)	(7.0)	(4.2)	(4.3)	(4.4)	(7.2)
1989	20,885	5,043	6,311	1,442	1,370	892	962	1,052	1,540
	(100.0)	(24.1)	(30.2)	(6.9)	(6.6)	(4.3)	(4.6)	(5.0)	(7.4)
1990	24,404	6,130	6,878	1,534	1,541	1,001	1,039	1,559	1,864
	(100.0)	(25.1)	(28.2)	(6.3)	(6.3)	(4.1)	(4.3)	(6.4)	(7.6)
1991	28,251	7,352	7,181	288	3,212	1,205	1,312	1,917	2,297
	(100.0)	(26.0)	(25.4)	(1.0)	(11.4)	(4.3)	(4.6)	(6.8)	(8.1)
					Annual compound rate of growth (Percent)				
1975-91	14.7	12.9	22.1	-2.7	12.4	10.5	19.0	30.5	16.4
1975-81	20.1	15.7	45.2	12.3	5.1	13.8	27.8	31.6	16.4
1981-88	10.1	8.9	11.0	5.8	9.9	5.7	12.5	28.6	15.1
1988-91	15.0	17.0	7.7	NA	NA	15.6	17.8	33.0	19.8
1988-89	12.3	9.9	9.8	9.5	5.5	14.5	19.8	29.1	15.3
1989-90	16.8	21.5	9.0	6.4	12.5	12.2	8.0	48.2	21.0
1990-91	15.8	19.9	4.4	NA	NA	20.3	26.3	23.0	23.2
					Annual compound rate of growth, constant dollars (Percent)[2]				
1975-91	6.7	5.1	13.6	-9.5	4.5	2.8	10.7	21.4	8.3
1975-81	10.0	6.0	33.0	2.9	-3.7	4.2	17.0	20.5	6.6
1981-88	3.3	2.2	4.2	-0.8	3.1	-0.9	5.5	20.6	7.9
1988-91	8.2	10.2	1.4	NA	NA	8.9	10.9	25.2	12.8
1988-89	5.3	3.0	2.9	2.6	-1.1	7.3	12.3	21.0	8.0
1989-90	9.8	14.2	2.4	0.0	5.7	5.5	1.5	39.3	13.7
1990-91	9.7	13.7	-1.1	NA	NA	14.0	19.6	16.5	16.8

[1]The total includes payments for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here.
[2]Payments were adjusted for inflation by using the personal health care expenditure fixed-weight price index developed by the Health Care Financing Administration, Office of the Actuary.

NOTES: Numbers in parentheses are the percent of total payments. NA is not applicable.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services, HCFA Form-2082.

only 2.3 percent from 1975 to 1981 and 0.8 percent from 1981 to 1988 (Table 12.22). Like the rate of growth in the number of children in low-income families, the rate of growth in the number of adults in low-income families accelerated from 1988 to 1991, increasing to 3.9 percent in 1989, 5.1 percent in 1990, and 11.5 percent in 1991. The growth rate of Medicaid users was higher for adults in low-income families than for the disabled between 1989 and 1991. Payments per user, in constant dollars, declined from 1975 to 1988 but grew by 6.7 percent annually between 1988 and 1991 (Table 12.23).

In spite of the recent growth in this sector, payments for adults in families with dependent children still account for a relatively modest share of total Medicaid payments. In 1991, payments for this group represented only 13.5 percent of all payments.

Type of service

Figures 12.24 and 12.25 show Medicaid payment trends for institutional (inpatient hospital, ICF/MR, and ICF and SNF) and non-institutional (physician, outpatient hospital, home health, and prescription drug) services. It is important to note that while spending for inpatient hospital and ICF and SNF services have grown dramatically, spending growth for ICF/MR has been more modest. In addition, spending for home health services, which was very low until the late 1980's, exceeded spending for outpatient hospital services for the first time in 1990. Also, Medicaid payments for prescription drugs have steadily increased throughout the entire study period. Program growth for selected types of service will be discussed in the following sections.

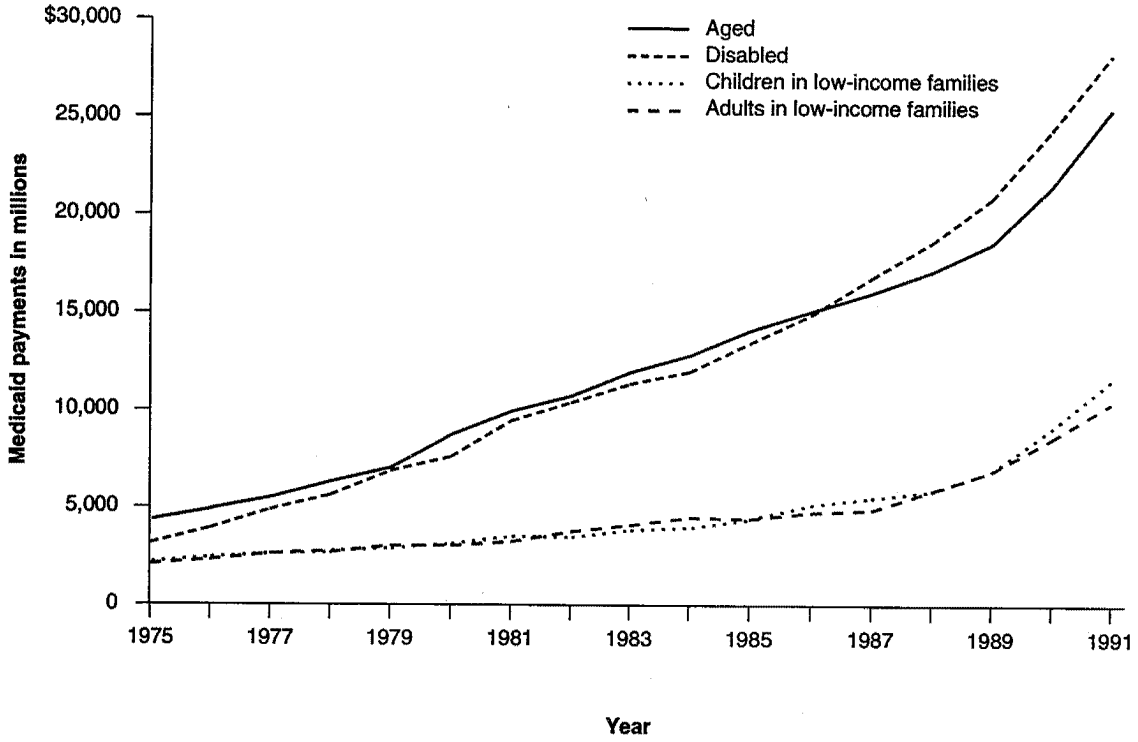
Inpatient hospital

Payments for inpatient hospital services account for a large part of total Medicaid spending. In 1991, payments for these services represented 25.8 percent of all Medicaid payments. Note, however, that the growth in payments for inpatient hospital services has not been uniform through the years. Payments grew at an annual rate of 13.4 percent from 1975 to 1981 but slowed to a growth rate of 7.7 percent from 1981 to 1988. However, payments increased by 18.0 percent between 1988 and 1991.

Growth in this sector was especially pronounced for children and adults in low-income families. From 1981

Figure 12.14

Medicaid payments[1], by eligibility group: Fiscal years 1975-91



[1]Total for each year includes estimated payments for non-reporting States.

NOTE: Data for 1977 and 1978 have been adjusted to distribute small amounts of payments on behalf of persons whose basis of eligibility was unknown.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

to 1988, payments for inpatient services for low-income children grew at annual rate of 7.9 percent, but from 1988 to 1991, these payments increased by 25.5 percent (Table 12.18). Similarly, from 1981 to 1988, payments for adults increased at an average rate of 5.6 percent per year, but from 1988 to 1991, payments in this sector increased by 20.8 percent (Table 12.21). This recent growth rate for children and adults in low-income families reflects increases in payments per user. From 1989 to 1990, the payments per user for children in low-income families who received hospital care increased by 14.4 percent (Table 12.20). Between 1989 and 1990, payments per user for adults increased by 11.9 percent (Table 12.23).

Long-term care facilities

From 1975 to 1991, payments for services in long-term care facilities grew from $4.7 billion to $28.4 billion. Institutional long-term care services have consistently accounted for the largest share of total Medicaid payments. In 1991, 36.9 percent of all Medicaid payments were for services provided by long-term care facilities. Note, however, that long-term care services have constituted a slowly declining percent of total Medicaid payments, dropping from 41.8 percent of total payments in 1987 to 36.9 percent in 1991. The following sections present trends for two types of long-term care services: intermediate care facilities for the

Table 12.15

Medicaid low-income disabled users, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Users in thousands				
1975	2,464	531	57	157	116	1,652	874	99	1,745
	(100.0)	(21.6)	(2.3)	(6.4)	(4.7)	(67.0)	(35.5)	(4.0)	(70.8)
1976	2,669	602	78	154	117	1,816	1,064	112	1,912
	(100.0)	(22.6)	(2.9)	(5.8)	(4.4)	(68.0)	(39.9)	(4.2)	(71.6)
1977	2,802	677	94	156	115	1,980	1,137	127	2,049
	(100.0)	(24.2)	(3.4)	(5.6)	(4.1)	(70.7)	(40.6)	(4.5)	(73.1)
1978	2,718	691	91	160	116	1,956	1,150	97	2,046
	(100.0)	(25.4)	(3.3)	(5.9)	(4.3)	(72.0)	(42.3)	(3.6)	(75.3)
1979	2,753	718	102	165	124	1,985	1,120	87	2,081
	(100.0)	(26.1)	(3.7)	(6.0)	(4.5)	(72.1)	(40.7)	(3.2)	(75.6)
1980	2,911	749	102	171	124	2,032	1,269	170	2,193
	(100.0)	(25.7)	(3.5)	(5.9)	(4.3)	(69.8)	(43.6)	(5.8)	(75.3)
1981	3,079	775	142	152	120	2,076	1,418	169	2,226
	(100.0)	(25.2)	(4.6)	(4.9)	(3.9)	(67.4)	(46.1)	(5.5)	(72.3)
1982	2,891	733	143	144	106	2,030	1,284	168	2,156
	(100.0)	(25.4)	(4.9)	(5.0)	(3.7)	(70.2)	(44.4)	(5.8)	(74.6)
1983	2,921	748	151	138	93	2,057	1,354	144	2,156
	(100.0)	(25.6)	(5.2)	(4.7)	(3.2)	(70.4)	(46.4)	(4.9)	(73.8)
1984	2,913	730	139	134	96	2,056	1,361	161	2,200
	(100.0)	(25.1)	(4.8)	(4.6)	(3.3)	(70.6)	(46.7)	(5.5)	(75.5)
1985	3,017	728	141	135	97	2,161	1,413	188	2,287
	(100.0)	(24.1)	(4.7)	(4.5)	(3.2)	(71.6)	(46.8)	(6.2)	(75.8)
1986	3,182	751	140	129	103	2,298	1,569	205	2,451
	(100.0)	(23.6)	(4.4)	(4.1)	(3.2)	(72.2)	(49.3)	(6.4)	(77.0)
1987	3,381	801	144	132	104	2,458	1,698	221	2,627
	(100.0)	(23.7)	(4.3)	(3.9)	(3.1)	(72.7)	(50.2)	(6.5)	(77.7)
1988	3,487	834	140	129	101	2,521	1,772	216	2,738
	(100.0)	(23.9)	(4.0)	(3.7)	(2.9)	(72.3)	(50.8)	(6.2)	(78.5)
1989	3,590	885	142	128	96	2,596	1,911	236	2,882
	(100.0)	(24.7)	(4.0)	(3.6)	(2.7)	(72.3)	(53.2)	(6.6)	(80.3)
1990	3,718	913	137	120	96	2,735	1,982	297	3,022
	(100.0)	(24.5)	(3.7)	(3.2)	(2.6)	(73.6)	(53.3)	(8.0)	(81.3)
1991	4,033	990	136	22	194	2,971	2,196	341	3,282
	(100.0)	(24.6)	(3.4)	(0.5)	(4.8)	(73.7)	(54.4)	(8.4)	(81.4)
					Annual compound rate of growth (Percent)				
1975-91	3.1	4.0	5.6	-11.6	3.3	3.7	5.9	8.0	4.0
1975-81	3.8	6.5	16.4	-0.5	0.6	3.9	8.4	9.3	4.1
1981-88	1.8	1.1	-0.2	-2.3	-2.4	2.8	3.2	3.6	3.0
1988-91	5.0	5.9	-0.9	NA	NA	5.6	7.4	16.4	6.2
1988-89	3.0	6.1	1.4	-0.8	-5.0	3.0	7.8	9.3	5.3
1989-90	3.6	3.1	-3.6	-6.2	0.5	5.4	3.7	25.8	4.9
1990-91	8.5	8.5	-0.4	NA	NA	8.6	10.8	14.8	8.6

[1]The total includes users for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here. A person receiving multiple services (e.g., inpatient hospital, physician, and outpatient services) is included once in the user count for each type of service and once in the total.

NOTES: Numbers in parentheses are the percent of total users. NA is not applicable.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

mentally retarded and other long-term care facilities that include skilled nursing facilities and other intermediate care facilities.

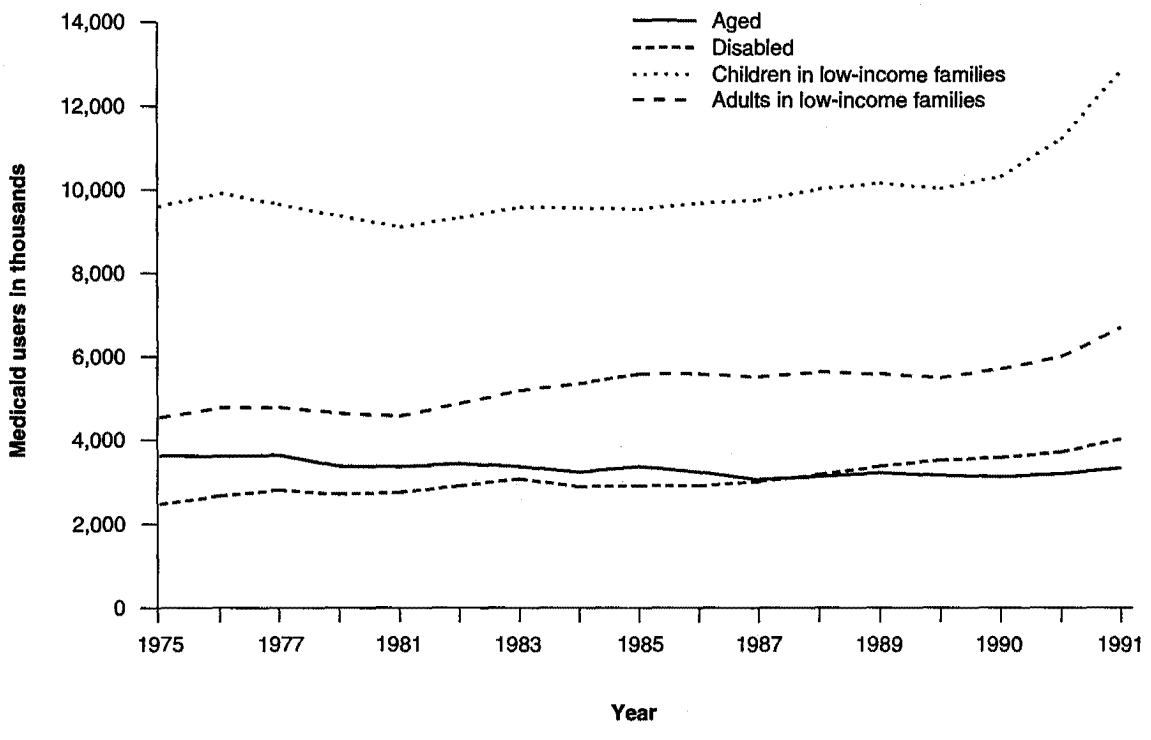
Intermediate care facilities for the mentally retarded

Payments for services in ICF/MRs have traditionally represented one of the largest areas of growth in the Medicaid program. From 1975 to 1991, payments in this sector rose from 3.1 percent to 10.0 percent of total program payments (Table 12.1). Much of this growth occurred in the early years of the program when the financial responsibility for institutional care of the mentally retarded shifted from State-only programs to the joint Federal-State Medicaid program. In the period from 1975 to 1981, the average annual rate of increase in ICF/MR payments was 41.1 percent, but it was only 10.5 percent from 1981 to 1988 and 8.4 percent from 1988 to 1991.

The growth in these payments reflects a large increase in the average payment per ICF/MR user. These payments per user grew from $5,538 in 1975 to $52,791 in 1991 (Table 12.3). Note, however, that the rate of growth in payments per user has slowed in recent years. From 1975 to 1981, the average annual growth was 23.7 percent, but from 1981 to 1988, the average annual growth had slowed to 11.1 percent and was 8.4 percent between 1988 and 1991. This may in part reflect the increasing trend among States of placing ICF/MR users in smaller, community-based facilities where many medical services are provided outside the facility. In this situation, services that would have been rendered in the ICF/MR are rendered (and billed) by other types of providers, such as physicians and outpatient hospital units.

Another factor influencing the decline in the growth rate of ICF/MR payments is the recent decline in users. Most of the ICF/MR users were disabled users (93 percent in 1991). Between 1975 and 1981, the number of ICF/MR users grew by an annual rate of 13.9 percent. Much of this increase was due to ICF/MR certification of previously existing State institutional beds (Lakin, Hill, and Bruininks, 1985). However, from 1981 to 1988, the number of ICF/MR recipients declined slightly, by an average of −0.6 percent per year. With the exception of a slight increase in the growth rate from 1988 to 1989, the number of users in this sector has continued to decline during the period 1989-91. This decline in the number of ICF/MR users during this 10-year period can be attributed to the rapid growth in the placement of many ICF/MR residents

Figure 12.16
Medicaid users, by eligibility group: Fiscal years 1975-91



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

into Medicaid section 1915(c)[6] home and community-based long-term care waiver programs since 1981 (Miller, 1993).

Other long-term care facilities

Historically, the Medicaid program has recognized two levels of other long-term care facility services (ICF and SNF services), and States have reported users and program payments for these distinct levels of service. Program inferences based on trends in payments for ICF and SNF services must be made with caution. The administrative distinctions between SNFs and ICFs do not in practice indicate differences in the residents they serve, and in many cases, the regulatory distinction between SNF and ICF simply reflects differences in nursing staff (Institute of Medicine, 1986). As discussed earlier, Congress recognized these problems and in OBRA 1987 eliminated the ICF and SNF level-of-care distinction and created a single type of service called "nursing facility." Most States responded to the OBRA 1987 changes by reporting payments and users for these services either as entirely ICF services or entirely SNF services. For this reason, ICF and SNF services are combined in this analysis.

Initially, from 1975 to 1981, ICF and SNF payments grew at an annual rate of 12.0 percent. From 1981 to 1988, the rate of growth slowed to 7.6 percent, and between 1988 and 1991 the rate of growth was 13.2 percent. From 1990 to 1991, these payments grew by 17.0 percent. These data suggest that the rate of growth may increase further in later years.

[6]Section 1915(c) of the Social Security Act authorizes HCFA to grant States waivers to provide home and community-based long-term care services to the disabled who would otherwise be placed in institutional settings. States are required to apply for 1915(c) waivers and meet conditions established by HCFA for approving these waiver programs. These conditions include demonstrating the cost-effectiveness estimate of the waiver by the number of institutional days saved as a result of placing the disabled into community-based long-term care programs.

Table 12.17

Medicaid payments per user for the low-income disabled, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Payment per user				
1975	$1,276	$1,977	$5,186	$2,818	$4,295	$147	$92	$276	$115
1976	1,469	2,072	6,940	3,297	4,645	158	114	492	135
1977	1,743	2,214	8,684	3,835	5,188	173	170	600	146
1978	2,068	2,392	11,926	4,717	5,813	183	165	893	157
1979	2,500	2,734	13,719	5,536	6,386	200	186	1,488	179
1980	2,619	2,948	16,653	5,092	5,149	234	217	652	193
1981	3,071	3,254	19,452	5,871	5,602	255	249	828	225
1982	3,600	3,672	23,065	6,709	6,782	252	272	966	246
1983	3,891	3,934	25,501	7,163	8,188	264	273	1,348	278
1984	4,112	4,196	29,353	7,886	9,417	262	315	1,813	312
1985	4,459	4,525	31,726	8,651	10,133	272	343	2,303	374
1986	4,687	4,841	34,462	9,152	11,263	277	361	2,592	418
1987	4,974	5,259	36,753	9,578	11,832	291	400	2,975	447
1988	5,332	5,502	40,910	10,204	12,884	309	453	3,768	488
1989	5,817	5,700	44,466	11,230	14,207	344	503	4,453	534
1990	6,564	6,717	50,242	12,782	15,966	366	524	5,252	617
1991	7,005	7,426	52,670	13,183	16,522	406	597	5,627	700
					Annual compound rate of growth (Percent)				
1975-91	11.2	8.6	15.6	10.1	8.8	6.5	12.4	20.7	11.9
1975-81	15.8	8.7	24.6	13.0	4.5	9.6	18.1	20.1	11.8
1981-88	8.2	7.8	11.2	8.2	12.6	2.8	8.9	24.2	11.7
1988-91	9.5	10.5	8.8	NA	NA	9.5	9.7	14.3	12.8
1988-89	9.1	3.6	8.7	10.1	10.3	11.3	11.0	18.2	9.4
1989-90	12.8	17.8	13.0	13.8	12.4	6.4	4.2	17.9	15.5
1990-91	6.7	10.6	4.8	NA	NA	10.8	14.0	7.1	13.5
					Annual compound rate of growth, constant dollars (Percent)[2]				
1975-91	3.5	1.0	7.5	2.4	1.2	−0.9	4.6	12.3	4.1
1975-81	6.0	−0.5	14.1	3.5	−4.3	0.4	8.1	10.0	2.4
1981-88	1.5	1.1	4.3	1.5	5.7	−3.6	2.2	16.5	4.8
1988-91	3.1	4.0	2.4	NA	NA	3.1	3.2	7.6	6.2
1988-89	2.2	−2.9	1.9	3.1	3.3	4.3	4.1	10.8	2.6
1989-90	8.5	13.3	8.6	9.4	8.0	2.3	0.2	13.4	11.0
1990-91	−1.2	2.4	−2.9	NA	NA	2.6	5.5	−0.8	5.1

[1]The total includes payments for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here.
[2]Payments were adjusted for inflation by using the personal health care expenditure fixed-weight price index developed by the Health Care Financing Administration, Office of the Actuary.

NOTE: NA is not applicable.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

Table 12.18

Medicaid payments for children in low-income families, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility: Mentally retarded	Intermediate care facility: Other	Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
				Payments in millions					
1975	$2,186	$881	$17	$3	$21	$397	$143	$8	$127
	(100.0)	(40.3)	(0.8)	(0.1)	(1.0)	(18.2)	(6.5)	(0.4)	(5.8)
1976	2,431	1,012	11	3	16	442	219	13	126
	(100.0)	(41.6)	(0.5)	(0.1)	(0.7)	(18.2)	(9.0)	(0.5)	(5.2)
1977	2,610	1,149	16	5	11	456	348	17	125
	(100.0)	(44.0)	(0.6)	(0.2)	(0.4)	(17.5)	(13.3)	(0.7)	(4.8)
1978	2,748	1,260	14	4	9	471	332	24	135
	(100.0)	(45.9)	(0.5)	(0.1)	(0.3)	(17.1)	(12.1)	(0.9)	(4.9)
1979	2,884	1,334	22	5	8	474	310	33	140
	(100.0)	(46.3)	(0.8)	(0.2)	(0.3)	(16.4)	(10.7)	(1.1)	(4.9)
1980	3,123	1,476	22	16	8	528	381	8	156
	(100.0)	(47.3)	(0.7)	(0.5)	(0.3)	(16.9)	(12.2)	(0.3)	(5.0)
1981	3,508	1,595	14	2	2	586	493	9	171
	(100.0)	(45.5)	(0.4)	(0.1)	(0.1)	(16.7)	(14.1)	(0.3)	(4.9)
1982	3,473	1,593	9	6	3	573	483	9	170
	(100.0)	(45.9)	(0.3)	(0.2)	(0.1)	(16.5)	(13.9)	(0.3)	(4.9)
1983	3,836	1,771	8	2	2	592	523	10	183
	(100.0)	(46.2)	(0.2)	(0.1)	(0.1)	(15.4)	(13.6)	(0.3)	(4.8)
1984	3,979	1,847	10	1	3	639	536	13	202
	(100.0)	(46.4)	(0.3)	(0.0)	(0.1)	(16.1)	(13.5)	(0.3)	(5.1)
1985	4,414	2,028	12	1	3	651	576	22	217
	(100.0)	(45.9)	(0.3)	(0.0)	(0.1)	(14.7)	(13.0)	(0.5)	(4.9)
1986	5,135	2,412	13	9	8	685	656	24	296
	(100.0)	(47.0)	(0.3)	(0.2)	(0.2)	(13.3)	(12.8)	(0.5)	(5.8)
1987	5,508	2,544	40	9	8	785	657	22	285
	(100.0)	(46.2)	(0.7)	(0.2)	(0.1)	(14.3)	(11.9)	(0.4)	(5.2)
1988	5,848	2,718	11	0	5	833	675	25	298
	(100.0)	(46.5)	(0.2)	(0.0)	(0.1)	(14.2)	(11.5)	(0.4)	(5.1)
1989	6,892	3,270	20	1	5	950	793	38	343
	(100.0)	(47.4)	(0.3)	(0.0)	(0.1)	(13.8)	(11.5)	(0.6)	(5.0)
1990	9,100	4,422	47	2	0	1,187	1,005	55	445
	(100.0)	(48.6)	(0.5)	(0.0)	(0.0)	(13.0)	(11.0)	(0.6)	(4.9)
1991	11,600	5,376	38	2	18	1,518	1,333	93	590
	(100.0)	(46.3)	(0.3)	(0.0)	(0.2)	(13.1)	(11.5)	(0.8)	(5.1)
				Annual compound rate of growth (Percent)					
1975-91	11.0	12.0	—	—	—	8.7	15.0	16.6	10.1
1975-81	8.2	10.4	—	—	—	6.7	22.9	2.0	5.1
1981-88	7.6	7.9	—	—	—	5.2	4.6	15.7	8.3
1988-91	25.6	25.5	—	NA	NA	22.2	25.5	55.1	25.5
1988-89	17.9	20.3	—	—	—	14.0	17.5	52.0	15.1
1989-90	32.0	35.2	—	—	—	24.9	26.8	45.6	29.7
1990-91	27.5	21.6	—	NA	NA	27.9	32.6	68.5	32.5
				Annual compound rate of growth, constant dollars (Percent)[2]					
1975-91	3.2	4.2	—	—	—	1.2	6.9	8.5	2.4
1975-81	−0.9	1.1	—	—	—	−2.3	12.5	−6.6	−3.8
1981-88	0.9	1.2	—	—	—	−1.4	−1.9	8.5	1.6
1988-91	18.3	18.2	—	NA	NA	15.0	18.1	46.0	18.2
1988-89	10.4	12.8	—	—	—	6.9	10.1	42.5	7.9
1989-90	24.1	27.1	—	—	—	17.4	19.1	36.8	21.9
1990-91	20.8	15.2	—	NA	NA	21.2	25.6	59.6	25.6

[1]The total includes payments for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here.
[2]Payments were adjusted for inflation by using the personal health care expenditure fixed-weight price index developed by the Health Care Financing Administration, Office of the Actuary.

NOTES: Numbers in parentheses are the percent of total payments. NA is not applicable. The symbol "—" indicates that numbers were too small to produce a reliable estimate.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services, HCFA Form-2082.

In part, the recent growth of ICF and SNF payments may be attributable to the OBRA 1987 provisions, designed to improve the quality of care in long-term care facilities. OBRA 1987 required comprehensive assessments of Medicaid users in nursing homes, mandated nurse aide training programs, and established nursing care standards similar to those in effect for Medicare patients. As a result, States increased payment rates to long-term care facilities to compensate them for their additional costs to meet these requirements. The median rate increase resulting from these statutory changes was $1.16 per patient day (King, Rimkunas, and Nuschler, 1992).

Explaining increases in combined ICF and SNF payments for Medicaid users is complicated by the fact that the aged account for the largest percent of payments for these other long-term care services (77 percent of ICF and SNF payments were for the aged in 1991). Utilization has increased, as expected, because of the growth in the number of disabled users 65 years of age and over. However, ICF and SNF payments per user have not increased. The elderly who qualify for Medicaid coverage in long-term care facilities may be making greater personal contributions to long-term care costs because of their rising income level. If this is true, Medicaid may be paying a smaller share of the total bill. This is not true for disabled users under the age of 65 (e.g., the mentally retarded and developmentally disabled) who are less likely to have personal income,

Table 12.19

Medicaid users who were children in low-income families, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Users in thousands				
1975	9,598	984	4	2	4	6,659	3,619	58	5,552
	(100.0)	(10.3)	(0.0)	(0.0)	(0.0)	(69.4)	(37.7)	(0.6)	(57.8)
1976	9,924	1,005	3	1	3	6,908	4,037	55	5,961
	(100.0)	(10.1)	(0.0)	(0.0)	(0.0)	(69.6)	(40.7)	(0.6)	(60.1)
1977	9,651	1,019	4	2	2	6,864	4,024	62	6,067
	(100.0)	(10.6)	(0.0)	(0.0)	(0.0)	(71.1)	(41.7)	(0.6)	(62.9)
1978	9,376	1,023	3	1	1	6,705	3,992	141	6,016
	(100.0)	(10.9)	(0.0)	(0.0)	(0.0)	(71.5)	(42.6)	(1.5)	(64.2)
1979	9,106	944	5	1	1	6,459	3,528	185	5,655
	(100.0)	(10.4)	(0.1)	(0.0)	(0.0)	(70.9)	(38.7)	(2.0)	(62.1)
1980	9,333	978	5	6	3	6,085	4,238	72	5,590
	(100.0)	(10.5)	(0.1)	(0.1)	(0.0)	(65.2)	(45.4)	(0.8)	(59.9)
1981	9,581	955	1	1	1	6,482	4,282	90	5,810
	(100.0)	(10.0)	(0.0)	(0.0)	(0.0)	(67.7)	(44.7)	(0.9)	(60.6)
1982	9,563	866	1	1	1	6,175	4,171	65	5,432
	(100.0)	(9.1)	(0.0)	(0.0)	(0.0)	(64.6)	(43.6)	(0.7)	(56.8)
1983	9,535	881	1	0	0	6,111	4,159	39	5,488
	(100.0)	(9.2)	(0.0)	(0.0)	(0.0)	(64.1)	(43.6)	(0.4)	(57.6)
1984	9,684	845	1	0	1	6,330	4,178	44	5,667
	(100.0)	(8.7)	(0.0)	(0.0)	(0.0)	(65.4)	(43.1)	(0.5)	(58.5)
1985	9,757	864	1	0	1	6,284	4,269	64	5,592
	(100.0)	(8.9)	(0.0)	(0.0)	(0.0)	(64.4)	(43.8)	(0.7)	(57.3)
1986	10,029	924	0	1	1	6,496	4,445	69	5,949
	(100.0)	(9.2)	(0.0)	(0.0)	(0.0)	(64.8)	(44.3)	(0.7)	(59.3)
1987	10,168	1,005	0	0	0	6,649	4,520	60	6,073
	(100.0)	(9.9)	(0.0)	(0.0)	(0.0)	(65.4)	(44.5)	(0.6)	(59.7)
1988	10,037	1,003	0	0	0	6,628	4,321	51	6,125
	(100.0)	(10.0)	(0.0)	(0.0)	(0.0)	(66.0)	(43.1)	(0.5)	(61.0)
1989	10,318	1,138	1	0	0	6,908	4,662	59	6,454
	(100.0)	(11.0)	(0.0)	(0.0)	(0.0)	(67.0)	(45.2)	(0.6)	(62.6)
1990	11,220	1,345	1	0	1	7,689	5,250	75	7,259
	(100.0)	(12.0)	(0.0)	(0.0)	(0.0)	(68.5)	(46.8)	(0.7)	(64.7)
1991	12,855	1,472	1	0	1	8,911	6,157	103	8,605
	(100.0)	(11.4)	(0.0)	(0.0)	(0.0)	(69.3)	(47.9)	(0.8)	(66.9)
					Annual compound rate of growth (Percent)				
1975-91	1.8	2.5	—	—	—	1.8	3.4	3.6	2.8
1975-81	0.0	-0.5	—	—	—	-0.4	2.8	7.6	0.8
1981-88	0.7	0.7	—	—	—	0.3	0.1	-7.8	0.8
1988-91	8.6	13.6	—	NA	NA	10.4	12.5	26.3	12.0
1988-89	2.8	13.5	—	—	—	4.2	7.9	15.7	5.4
1989-90	8.7	18.2	—	—	—	11.3	12.6	27.4	12.5
1990-91	14.6	9.4	—	NA	NA	15.9	17.3	36.6	18.5

[1]The total includes users for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here. A person receiving multiple services (e.g., inpatient hospital, physician and outpatient services) is included once in the user count for each type of service and once in the total.

NOTES: Numbers in parentheses are the percent of total users. NA is not applicable. The symbol "—" indicates that numbers were too small to produce reliable estimates.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

apart from other public support such as Supplemental Security Income.

Other services

While other services represented a much smaller percent of total payments than inpatient hospital and long-term care facility services, important changes occurred for these services during the study period. The following sections present a brief review of important changes for other selected services:

Physician services—Payments for physician services experienced consistent growth over the study period, but increased sharply from 1988 to 1991. From 1975 to 1981, payments for physician services increased at an annual rate of 9.4 percent, and from 1981 to 1988 the rate of increase slowed to 5.0 percent per year (Table 12.1). However, between 1988 and 1991, payments for physician services increased by 18.8 percent annually. This increase in the rate of growth for the 1988-91 interval reflects a pronounced increase in the average payment per user for physician services. From 1981 to 1988, the average payment per user of physician services was not keeping pace with inflation (a constant dollar change of −2.4 percent). However, between 1988 and 1991, the average payment per user increased slightly by 3.8 percent after adjusting for inflation. These data do not permit us to determine whether this increase in average payment per user reflects an increase in the number or intensity of physician services provided to users or an increase in the reimbursement for physician services. However, OBRA 1989 requires that payments for obstetrical and pediatric services must be sufficient to enlist enough providers so that services are available under each Medicaid State plan, at least to the extent that such care and services are available to the general population in the geographic area. The observed findings may relate directly or indirectly to this provision.

Table 12.20

Medicaid payments per user for children in low-income families, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Payment per user				
1975	$228	$895	—	—	—	$60	$40	$143	$23
1976	245	1,007	—	—	—	64	54	231	21
1977	270	1,128	—	—	—	66	86	281	21
1978	293	1,232	—	—	—	70	83	168	22
1979	317	1,413	—	—	—	73	88	180	25
1980	335	1,509	—	—	—	87	90	105	28
1981	366	1,671	—	—	—	90	115	94	29
1982	363	1,838	—	—	—	93	116	131	31
1983	402	2,009	—	—	—	97	126	251	33
1984	411	2,186	—	—	—	101	128	284	36
1985	452	2,347	—	—	—	104	135	339	39
1986	512	2,611	—	—	—	105	148	345	50
1987	542	2,530	—	—	—	118	145	373	47
1988	583	2,711	—	—	—	126	156	501	49
1989	668	2,874	—	—	—	138	170	639	53
1990	811	3,287	35,196	8,653	19,961	154	191	736	61
1991	902	3,653	43,252	1,862	15,178	170	217	908	69
					Annual compound rate of growth (Percent)				
1975-91	9.0	9.2	—	—	—	6.7	11.1	12.2	7.1
1975-81	8.2	11.0	—	—	—	7.0	19.2	-6.8	3.9
1981-88	6.9	7.2	—	—	—	4.9	4.5	27.0	7.8
1988-91	15.7	10.4	—	NA	NA	10.6	11.5	21.9	11.8
1988-89	14.6	6.0	—	—	—	9.5	9.0	27.5	8.2
1989-90	21.4	14.4	—	—	—	11.9	12.6	15.2	15.7
1990-91	11.3	11.1	—	NA	NA	10.4	13.1	23.3	11.8
					Annual compound rate of growth, constant dollars (Percent)[2]				
1975-91	1.4	1.6	—	—	—	−0.7	3.4	4.4	−0.4
1975-81	−0.9	1.6	—	—	—	−2.0	9.2	−14.6	−4.8
1981-88	0.3	0.5	—	—	—	−1.6	−2.0	19.1	1.1
1988-91	8.9	4.0	—	NA	NA	4.1	5.0	14.8	5.3
1988-89	7.4	−0.6	—	—	—	2.6	2.1	19.5	1.4
1989-90	16.7	10.0	—	—	—	7.6	8.3	10.8	11.2
1990-91	3.0	2.9	—	NA	NA	2.2	4.7	14.2	3.5

[1]The total includes payments for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here.
[2]Payments were adjusted for inflation by using the personal health care expenditure fixed-weight price index developed by the Health Care Financing Administration, Office of the Actuary.

NOTES: NA is not applicable. The symbol "—" indicates that numbers were too small to produce a reliable estimate.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

Table 12.21

Medicaid payments for adults in low-income families, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Payments in millions				
1975	$2,062	$1,009	$0	$5	$4	$392	$109	$6	$160
	(100.0)	(48.9)	(0.0)	(0.2)	(0.2)	(19.0)	(5.3)	(0.3)	(7.8)
1976	2,288	1,153	4	2	6	429	157	9	154
	(100.0)	(50.4)	(0.2)	(0.1)	(0.3)	(18.8)	(6.9)	(0.4)	(6.7)
1977	2,606	1,294	4	2	3	473	257	11	171
	(100.0)	(49.7)	(0.2)	(0.1)	(0.1)	(18.2)	(9.9)	(0.4)	(6.6)
1978	2,673	1,369	1	1	4	484	244	13	181
	(100.0)	(51.2)	(0.0)	(0.0)	(0.1)	(18.1)	(9.1)	(0.5)	(6.8)
1979	3,021	1,591	3	2	3	518	252	21	200
	(100.0)	(52.7)	(0.1)	(0.1)	(0.1)	(17.1)	(8.3)	(0.7)	(6.6)
1980	3,231	1,672	8	18	9	587	314	10	208
	(100.0)	(51.7)	(0.2)	(0.6)	(0.3)	(18.2)	(9.7)	(0.3)	(6.4)
1981	3,763	1,897	2	2	3	674	418	12	243
	(100.0)	(50.4)	(0.1)	(0.1)	(0.1)	(17.9)	(11.1)	(0.3)	(6.5)
1982	4,093	2,117	4	2	3	701	446	13	258
	(100.0)	(51.7)	(0.1)	(0.0)	(0.1)	(17.1)	(10.9)	(0.3)	(6.3)
1983	4,487	2,314	11	2	3	730	495	14	286
	(100.0)	(51.6)	(0.2)	(0.0)	(0.1)	(16.3)	(11.0)	(0.3)	(6.4)
1984	4,420	2,243	8	3	5	727	496	15	303
	(100.0)	(50.7)	(0.2)	(0.1)	(0.1)	(16.4)	(11.2)	(0.3)	(6.9)
1985	4,746	2,330	9	2	5	775	537	22	342
	(100.0)	(49.1)	(0.2)	(0.0)	(0.1)	(16.3)	(11.3)	(0.5)	(7.2)
1986	4,880	2,271	2	3	6	877	534	26	374
	(100.0)	(46.5)	(0.0)	(0.1)	(0.1)	(18.0)	(10.9)	(0.5)	(7.7)
1987	5,592	2,654	2	20	19	926	635	21	427
	(100.0)	(47.5)	(0.0)	(0.4)	(0.3)	(16.6)	(11.4)	(0.4)	(7.6)
1988	5,883	2,771	5	6	17	991	671	21	443
	(100.0)	(47.1)	(0.1)	(0.1)	(0.3)	(16.8)	(11.4)	(0.4)	(7.5)
1989	6,897	3,219	3	40	87	1,186	795	26	494
	(100.0)	(46.7)	(0.0)	(0.6)	(1.3)	(17.2)	(11.5)	(0.4)	(7.2)
1990	8,590	4,209	8	5	18	1,453	977	34	571
	(100.0)	(49.0)	(0.1)	(0.1)	(0.2)	(16.9)	(11.4)	(0.4)	(6.6)
1991	10,421	4,886	5	5	22	1,782	1,268	44	680
	(100.0)	(46.9)	(0.1)	(0.0)	(0.2)	(17.1)	(12.2)	(0.4)	(6.5)
					Annual compound rate of growth (Percent)				
1975-91	10.7	10.4	—	—	—	9.9	16.6	13.2	9.5
1975-81	10.5	11.1	—	—	—	9.5	25.1	12.2	7.2
1981-88	6.6	5.6	—	—	—	5.7	7.0	8.3	9.0
1988-91	21.0	20.8	—	NA	NA	21.6	23.6	27.7	15.4
1988-89	17.2	16.2	—	—	—	19.7	18.5	23.8	11.5
1989-90	24.5	30.8	—	—	—	22.5	22.9	32.1	15.6
1990-91	21.3	16.1	—	NA	NA	22.7	29.8	27.3	19.2
					Annual compound rate of growth, constant dollars (Percent)[2]				
1975-91	2.9	2.7	—	—	—	2.3	8.4	5.3	1.8
1975-81	1.2	1.7	—	—	—	0.2	14.6	2.8	−1.8
1981-88	0.0	−1.0	—	—	—	−0.9	0.4	1.6	2.2
1988-91	13.9	13.7	—	NA	NA	14.5	16.4	20.2	8.6
1988-89	9.9	8.9	—	—	—	12.2	11.0	16.0	4.5
1989-90	17.0	22.9	—	—	—	15.1	15.5	24.1	8.6
1990-91	15.0	10.0	—	NA	NA	16.2	23.0	20.6	12.9

[1]The total includes payments for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here.
[2]Payments were adjusted for inflation by using the personal health care expenditure fixed-weight price index developed by the Health Care Financing Administration, Office of the Actuary.

NOTES: Numbers in parentheses are the percent of total payments. NA is not applicable. The symbol "—" indicates that numbers were too small to produce a reliable estimate.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services, HCFA Form-2082.

Outpatient hospital services—Payments for outpatient hospital services also increased considerably during the study period. From 1975 to 1981, payments for these services increased at an average annual rate of 24.8 percent, but the rate of growth slowed to 8.0 percent per year from 1981 to 1988. Between 1988 and 1991, payments for outpatient services increased by 21.0 percent (Table 12.1). The increase during the 1988-91 period was especially large among children and adults in low-income families.

Home health services—Although home health services represented a relatively small proportion of total payments (5.3 percent in 1991), this sector exhibited the fastest overall rate of growth among the sectors examined in this study. From 1975 to 1991, payments for home health services increased at an average annual rate of 29.0 percent (Table 12.1). There was a slow down in the rate of growth in home health services in later years, but the rate of growth was still substantial. From 1975 to 1981, the annual rate of growth was 35.2 percent; from 1981 to 1988, it was 24.8 percent; and from 1988 to 1991, it was 26.7 percent.

Prescription drugs—The rate of growth in prescription drugs was consistent from 1975 to 1989. The average annual rate of growth in payments for

Table 12.22

Medicaid users who were adults in low-income families, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Users in thousands				
1975	4,529	930	0	3	2	3,368	1,896	50	3,168
	(100.0)	(20.5)	(0.0)	(0.1)	(0.0)	(74.4)	(41.9)	(1.1)	(69.9)
1976	4,773	959	1	1	2	3,437	2,127	31	3,329
	(100.0)	(20.1)	(0.0)	(0.0)	(0.0)	(72.0)	(44.6)	(0.6)	(69.7)
1977	4,785)	993	2	1	2	3,571	2,183	36	3,415
	(100.0)	(20.8)	(0.0)	(0.0)	(0.0)	(74.6)	(45.6)	(0.8)	(71.4)
1978	4,643	975	2	1	2	3,469	2,161	29	3,460
	(100.0)	(21.0)	(0.0)	(0.0)	(0.0)	(74.7)	(46.5)	(0.6)	(74.5)
1979	4,570	970	2	1	1	3,411	1,985	28	3,288
	(100.0)	(21.2)	(0.0)	(0.0)	(0.0)	(74.6)	(43.4)	(0.6)	(71.9)
1980	4,877	1,000	3	5	4	3,206	2,485	41	3,173
	(100.0)	(20.5)	(0.1)	(0.1)	(0.1)	(65.7)	(51.0)	(0.8)	(65.1)
1981	5,187	1,035	1	1	1	3,498	2,657	39	3,501
	(100.0)	(20.0)	(0.0)	(0.0)	(0.0)	(67.4)	(51.2)	(0.8)	(67.5)
1982	5,356	1,035	0	0	1	3,555	2,755	38	3,493
	(100.0)	(19.3)	(0.0)	(0.0)	(0.0)	(66.4)	(51.4)	(0.7)	(65.2)
1983	5,592	1,078	1	1	1	3,684	2,916	34	3,639
	(100.0)	(19.3)	(0.0)	(0.0)	(0.0)	(65.9)	(52.1)	(0.6)	(65.1)
1984	5,600	1,006	0	1	1	3,696	2,894	38	3,663
	(100.0)	(18.0)	(0.0)	(0.0)	(0.0)	(66.0)	(51.7)	(0.7)	(65.4)
1985	5,518	990	0	1	1	3,635	2,933	46	3,562
	(100.0)	(17.9)	(0.0)	(0.0)	(0.0)	(65.9)	(53.2)	(0.8)	(64.6)
1986	5,647	1,016	0	1	1	3,699	3,060	59	3,681
	(100.0)	(18.0)	(0.0)	(0.0)	(0.0)	(65.5)	(54.2)	(1.0)	(65.2)
1987	5,599	1,067	0	2	2	3,704	3,072	46	3,658
	(100.0)	(19.1)	(0.0)	(0.0)	(0.0)	(66.2)	(54.9)	(0.8)	(65.3)
1988	5,503	1,090	0	1	3	3,646	2,894	37	3,617
	(100.0)	(19.8)	(0.0)	(0.0)	(0.1)	(66.3)	(52.6)	(0.7)	(65.7)
1989	5,717	1,247	0	4	7	3,888	3,199	42	3,829
	(100.0)	(21.8)	(0.0)	(0.1)	(0.1)	(68.0)	(56.0)	(0.7)	(67.0)
1990	6,010	1,457	0	0	2	4,168	3,508	48	4,057
	(100.0)	(24.2)	(0.0)	(0.0)	(0.0)	(69.3)	(58.4)	(0.8)	(67.5)
1991	6,703	1,623	0	0	3	4,579	3,979	77	4,603
	(100.0)	(24.2)	(0.0)	(0.0)	(0.0)	(68.3)	(59.4)	(1.1)	(68.7)
					Annual compound rate of growth (Percent)				
1975-91	2.5	3.5	—	—	—	1.9	4.7	2.7	2.4
1975-81	2.3	1.8	—	—	—	0.6	5.8	-4.1	1.7
1981-88	0.8	0.7	—	—	—	0.6	1.2	-0.7	0.5
1988-91	6.8	14.2	—	NA	NA	7.9	11.2	27.6	8.4
1988-89	3.9	14.4	—	—	—	6.6	10.5	13.5	5.9
1989-90	5.1	16.8	—	—	—	7.2	9.7	15.4	6.0
1990-91	11.5	11.4	—	NA	NA	9.9	13.4	58.4	13.4

[1]The total includes users for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here. A person receiving multiple services (e.g., inpatient hospital, physician and outpatient services) is included once in the user count for each type of service and once in the total.

NOTES: Numbers in parentheses are the percent of total users. NA is not applicable. The symbol "—" indicates that numbers were too small to produce reliable estimates.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

prescription drugs was 11.1 percent from 1975 to 1981, 11.5 percent from 1982 to 1988, and 12.0 percent from 1988 to 1989 (Table 12.1). However, in 1990 and 1991, the annual rate of growth rose sharply to 19.8 and 22.7 percent, respectively.

Because of the ever-increasing costs of prescription drugs, Congress enacted as part of OBRA 1990 significant changes in how the Medicaid program pays for outpatient prescription drugs (U.S. General Accounting Office, 1992; Health Care Financing Administration, 1992c). This legislation created the Medicaid Drug Rebate Program. This program requires manufacturers of Medicaid-covered outpatient drugs to enter into a rebate agreement with the Secretary of the Department of Health and Human Services in order to obtain Federal payment under the Medicaid program. The effects of this legislation on Medicaid payments will occur in future years.

Because the aged and disabled account for a large share of the total payments for prescription drugs (76 percent in 1991), their payment patterns dominate the overall trend. Payments per user were much higher in 1991 for the aged ($668) (Table 12.12) and disabled ($700) (Table 12.17) than for children ($69) (Table 12.20) or adults ($148) (Table 12.23).

Discussion and conclusions

We have discussed trends in Medicaid payments from 1975 to 1991. We attempted to identify the sectors that account for growth in Medicaid payments by examining who are served and the types of service they receive. We also attempted to explore the dynamics of change in Medicaid payments within sectors by examining the changes in the number of people receiving services and the average payment per user of service during three distinctly different time intervals during the study period. A number of findings from this analysis are worth highlighting:

Table 12.23

Medicaid payments per user for adults in low-income families, by type of service: Fiscal years 1975-91

Year	Total[1]	Inpatient hospital	Intermediate care facility		Skilled nursing facility	Physician	Outpatient hospital	Home health	Prescription drugs
			Mentally retarded	Other					
					Payment per user				
1975	$455	$1,085	—	—	—	$116	$57	$121	$51
1976	479	1,202	—	—	—	125	74	284	46
1977	545	1,302	—	—	—	132	118	316	50
1978	576	1,404	—	—	—	140	113	457	52
1979	661	1,640	—	—	—	152	127	765	61
1980	663	1,673	—	—	—	183	126	252	66
1981	725	1,833	—	—	—	193	157	303	69
1982	764	2,046	—	—	—	197	162	352	74
1983	802	2,146	—	—	—	198	170	402	78
1984	789	2,229	—	—	—	197	172	411	83
1985	860	2,354	—	—	—	213	183	483	96
1986	864	2,237	—	—	—	237	175	433	102
1987	999	2,487	—	—	—	250	207	459	117
1988	1,069	2,542	—	—	—	272	232	570	122
1989	1,206	2,582	—	—	—	305	249	622	129
1990	1,429	2,889	40,931	5,225	9,126	349	279	709	141
1991	1,555	3,012	42,884	4,488	8,558	389	319	569	148
					Annual compound rate of growth (Percent)				
1975-91	8.0	6.6	—	—	—	7.9	11.4	10.2	6.9
1975-81	8.1	9.1	—	—	—	8.9	18.4	16.5	5.2
1981-88	5.7	4.8	—	—	—	5.0	5.7	9.4	8.5
1988-91	13.3	5.8	—	NA	NA	12.7	11.2	0.0	6.6
1988-89	12.8	1.6	—	—	—	12.1	7.3	9.1	5.7
1989-90	18.5	11.9	—	—	—	14.3	11.9	14.0	9.1
1990-91	8.8	4.2	—	NA	NA	11.6	14.4	-19.7	5.0
					Annual compound rate of growth, constant dollars (Percent)[2]				
1975-91	0.4	-0.8	—	—	—	0.3	3.6	2.5	-0.6
1975-81	-1.0	-0.1	—	—	—	-0.3	8.4	6.7	-3.7
1981-88	-0.8	-1.7	—	—	—	-1.5	-0.8	2.7	1.8
1988-91	6.7	-0.4	—	NA	NA	6.1	4.7	-5.9	0.4
1988-89	5.7	-4.8	—	—	—	5.1	0.6	2.3	-0.9
1989-90	13.9	7.6	—	—	—	9.9	7.6	9.6	4.9
1990-91	0.7	-3.5	—	NA	NA	3.4	5.9	-25.6	-2.7

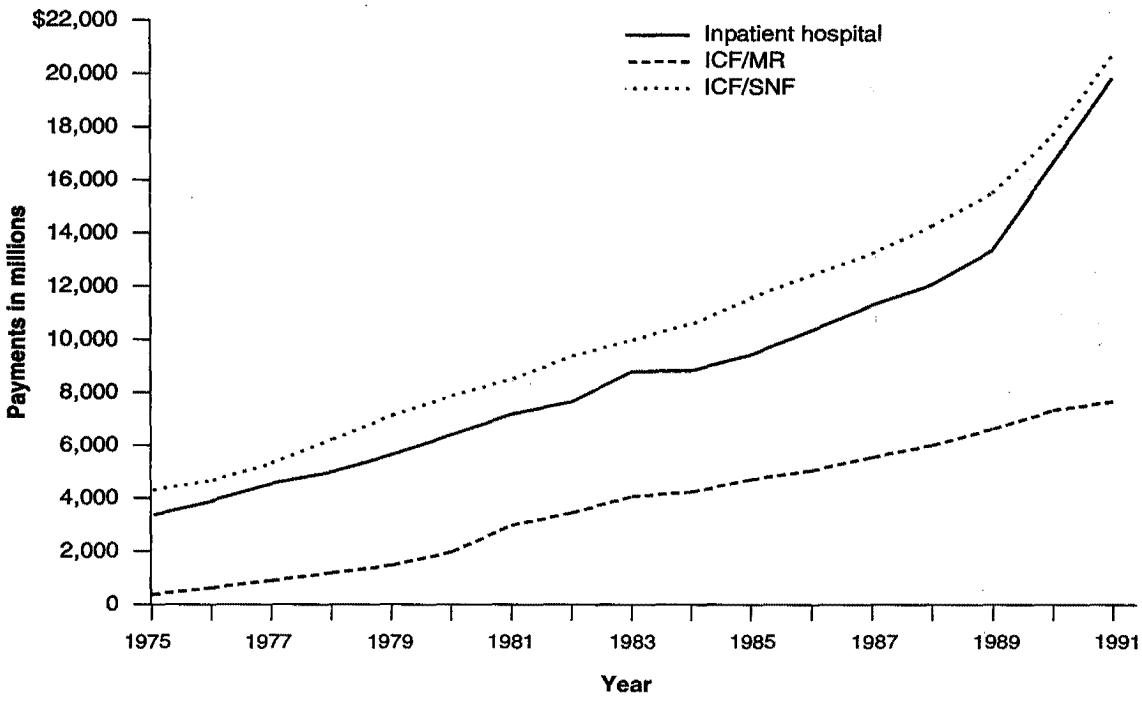
[1]The total includes payments for all types of services reported on HCFA Form-2082, not just the 8 types of services listed here.
[2]Payments were adjusted for inflation by using the personal health care expenditure fixed-weight price index developed by the Health Care Financing Administration, Office of the Actuary.

NOTES: NA is not applicable. The symbol "—" indicates that numbers were too small to produce a reliable estimate.

SOURCE: Health Care Financing Administration: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, HCFA Form-2082.

Figure 12.24

Medicaid payments[1], by type of institutional service: Fiscal years 1975-91



[1]Total for each year includes estimated payments for non-reporting States.

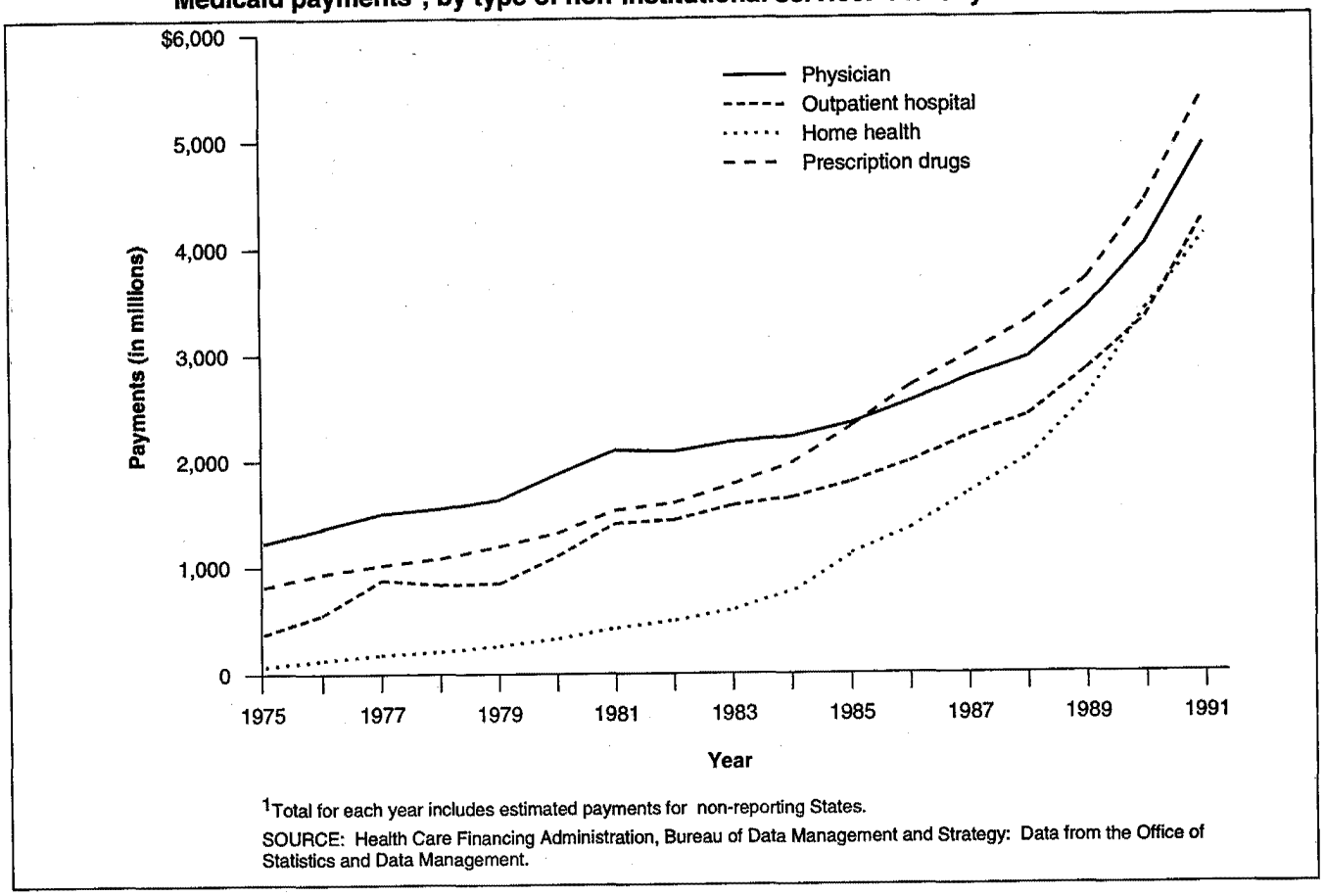
NOTE: ICF/MR is intermediate care facility for the mentally retarded; ICF is intermediate care facility; and SNF is skilled nursing facility.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

- Medicaid payments grew significantly between 1975 and 1991, but the rate of growth was uneven. Total payments grew rapidly from 1975 to 1981. After adjusting for price inflation, increases in both persons served and service intensity contributed to that growth. From 1981 to 1988, the rate of program growth slowed considerably. The analysis suggests that many of the recent program expansions began to take effect after 1988. From 1988 to 1991, constant dollar Medicaid payments began to increase sharply. The major factor contributing to growth was a rapid rise in the number of persons served.
- During the entire study period, the aged and disabled accounted for the largest share of Medicaid payments. Payments for the aged and disabled contributed significantly to program growth between 1975 and 1981. Their use of long-term care services and outpatient hospital services was a major factor in the growth of the Medicaid program during this period. Between 1981 and 1988, overall growth slowed considerably except that the disabled continued to increase their share of total Medicaid payments. However, between 1988 and 1991, payments for children and adults in low-income families contributed significantly to overall growth, with rapid increases in the use of inpatient and outpatient hospital services the major factors in the growth of expenditures for these eligibility groups.
- The percent distribution of Medicaid users by eligibility group has changed considerably during the study period. In 1975, the aged represented 16.4 percent of users. This percent declined steadily and reached a low of 11.9 percent by 1991. In contrast, the disabled accounted for only 11.2 percent of users in 1975 and grew to account for 15.3 percent of all users in 1989. The percent of users for children in low-income families grew from 42.3 and 46.0 percent, respectively, between 1975 and 1991, with much of this increase occurring since 1989 because of eligibility expansions for children. Adults in low-income families accounted for 20.6 percent of all users and grew dramatically in the early 1980s to represent 25.9 percent of total users.
- Between 1975 and 1991, payments for institutional services (inpatient hospital services and long-term care institutions) consistently account for the largest share of Medicaid payments during the entire study period. However, the rate of growth by type of institutional service was uneven. Payments for long-term care increased rapidly between 1975 and 1981, although the pattern of growth varied somewhat by type of long-term care facility. During this period,

Figure 12.25

Medicaid payments[1], by type of non-institutional service: Fiscal years 1975-91



[1]Total for each year includes estimated payments for non-reporting States.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

payments for ICF/MR services increased very rapidly, but the rate of increase declined sharply thereafter. Combined payments for ICF and SNF services also increased sharply during 1975-81, though not at a rate comparable to that for ICF/MR services. The rate of increase also slowed somewhat for ICF-SNF services from 1981 to 1988. However, recent data suggest that there may be a new discontinuity in the series—combined ICF and SNF payments increased sharply in 1990-91.

- Inpatient hospital services accounted for a large share of Medicaid spending from 1975 to 1991, although rates of growth for this service were typically lower than those for total payments over the study period. There was an upturn in the rate of growth in spending for inpatient services from 1988 to 1991, particularly for children and adults in low-income families.
- Since 1981, payments for non-institutional services (e.g., home health services, outpatient hospital services, physician services, and prescription drugs) were the fastest growing components of Medicaid. The most noteworthy increases in payments were observed for home health services, which increased an average of 29 percent per year for the entire study period. As mentioned earlier, much of this growth may be attributed to the expansion of Medicaid home and community-based care waiver programs for the elderly, disabled, and children, which cannot be separately identified in HCFA Form-2082. Payments for outpatient hospital services and prescription drugs also increased during the study period, with the most rapid increases occurring from 1988 to 1991.

Limitations of the research presented here should be noted. First, we have focused only on national trends in Medicaid. As noted previously, there is significant State-to-State variation in the structure of the Medicaid program, so patterns observed on the national level may not hold for individual States. Future research needs to examine and compare trends in Medicaid payments and utilization for individual Medicaid jurisdictions. In addition, data limitations prevent analysis of enrollment, service utilization, and reimbursement rate trends; a more detailed examination of particular Medicaid populations of interest (e.g., pregnant women); and a more thorough analysis of the factors contributing to program growth. Future research efforts should focus on each of these topics if we are to have a better understanding of Medicaid growth.

Second, at the time of this writing, HCFA Form-2082 data were only available through FY 1991. The full effect of recent legislated Medicaid expansions may not appear in program data until 1992 or later. Such expansions undoubtedly will produce additional

increases in Medicaid spending. Future research will need to monitor the effects of these expansions.

Concern was raised by Congress about access to physician services in OBRA 1989 (Section 1926). Some authors have concluded that increases in physician fees should improve physician participation and patient access (Schwartz, Colby, and Reisinger, 1991; Long, Settle, and Stuart, 1986; Cohen, 1989). More recently, others have reported that increased physician participation and access have not accompanied fee increases (Fox, 1992; Fanning, 1993). In future research, it will be important to determine the extent of Medicaid fee increases and their impact on access across the States.

Concern has been raised by several States about recent growth in institutional long-term care expenditures. In addition to the increase in Medicaid payments required to comply with the OBRA 1987 nursing home quality assurance reform changes described earlier in this chapter, some States are also concerned that the demand for Medicaid institutional long-term care may be increasing as well. Among the alleged causes of increased nursing home use are the rapid rise in the growth rate of the disabled population 75 years of age and over; enhanced spousal impoverishment protections in the Medicare Catastrophic Coverage Act of 1988, which make it easier to maintain a spouse of an institutionalized person in the community; and changes in elderly estate planning practices that may enable individuals to shelter assets for the purpose of obtaining Medicaid eligibility for nursing home care (Burwell, 1991). The extent to which these factors are occurring and their influence on rising Medicaid payments for institutional long-term care services merits further study.

Other program effects following 1988 also warrant further attention. For example, while recent eligibility expansions explain the growth in the number of children and adults in low-income families receiving services under Medicaid, payments per user in these two eligibility groups grew from 1988 to 1991. Does this growth in service intensity for adults reflect utilization for newly enrolled pregnant women? Does the growth for children reflect increased use of EPSDT screening services and followup care? Are other factors such as changing morbidity and utilization patterns contributing to this growth? We also need to understand the reasons for the recent increases in average payments for home health, outpatient services, and prescription drugs.

In conclusion, this analysis of HCFA Form-2082 data has provided important insights into trends in Medicaid payments and utilization between 1975 and 1991. We have been able to identify many of the important program changes during this period and some factors that influence these changes. In spite of the inherent limitations with the HCFA Form-2082 data (e.g., lack of information on enrollment, detailed service utilization, and reimbursement rates), the analysis pointed to several additional areas of promising research that will inform policy on how program changes have affected program growth. However, better Medicaid data are needed to enable us to examine many of the questions that we have not been able to answer here. Rising Federal and State Medicaid payments will continue to put fiscal pressure on both Federal and State governments for program reform. Understanding basic Medicaid trends in payments and utilization will be useful in informing policymakers of the implications of various reform options.

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