Chapter 13: Recent Trends in Medicaid Expenditures

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Introduction

Recent increases in Medicaid expenditures have exceeded projections, prompting concern at both the State and Federal levels. State officials worry that Medicaid's rate of growth is crowding out other programs (Burke, 1991; Comptroller General of the United States, 1991; Hutchison, 1990). Federal officials also worry about cost increases. However, they believe that some of the increases in Federal expenditures may be because of creative State financing methods (Executive Office of the President, 1991).

In this chapter we examine trends in Medicaid expenditures from 1987 through 1991. We present data by jurisdiction and type of service, and contrast Medicaid expenditure increases with those for Medicare and the private sector. We also show intrastate differences in these increases. Finally, we identify major changes in the Medicaid program that have contributed to the expansion.

The expenditure data are from the HCFA Form-64, entitled "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program." HCFA Form-64 is the accounting statement which States submit each quarter for the Medicaid program. It summarizes the States' administrative and program expenditures, and provides the basis for calculating the Federal share of those expenditures. It is the most accurate source of information about Medicaid spending.

Expenditure data reported on HCFA Form-64 often differ from those derived from HCFA Form-2082, entitled "Statistical Report on Medicaid Care: Eligibles, Recipients, Payments, and Services." HCFA Form-2082 provides utilization information that is not available from HCFA Form-64. It also categorizes annual State data by eligibility group and service type, information which is derived from State claims data. It generally excludes expenditures that are not part of claims payments, such as capitation payments, administrative costs, or lump sum payments to providers. Most of the Medicaid statistics presented in other articles in this supplement come from HCFA Form-2082. For the reasons outlined, aggregated expenditure figures in those chapters will be less than those presented here. Also, because the two forms define service types differently, direct comparisons of figures may not be possible.

Current Medicaid expenditures

Table 13.1 presents Federal and State payments for medical assistance, and administration and training by State. (The payment data in Table 13.1 differ from those presented in other tables in this chapter because they include accounting adjustments such as offsets from third-party liability collections, and payments for administration and training.) In fiscal year (FY) 1991, total net Medicaid expenditures exceeded $94 billion. New York had the highest amount of payments at $18 billion, followed by California at $9 billion; Massachusetts, Pennsylvania, and Texas each had payments exceeding $4 billion. These five States accounted for more than 40 percent of total Medicaid expenditures.

Medicaid payments by type of service are shown in Table 13.2. Inpatient and institutional long-term care payments each account for about one-third of Medicaid spending. However, this distribution varies considerably by State. In Connecticut, for instance, institutional long-term care accounts for 56 percent of payments, although in Missouri nearly one-half goes to inpatient care.

Expenditure trends

Medicaid expenditures are growing at an accelerated rate. Figure 13.3 shows that Medicaid expenditures nearly doubled from FY 1987 to 1991; they are projected to double again by the end of FY 1995. Just the Federal share of these expenditures will exceed $100 billion, which is greater than the spending for Medicare in FY 1991. Figure 13.4 demonstrates that this is partly because of a rate of growth that has significantly exceeded that for Medicare and the private sector. Medicare and private health insurance spending increased at about the same rate from 1987 to 1991. Although Medicaid matched Medicare's rate of growth from 1987 to 1989, it increased much more rapidly after this point.

Tables 13.5 and 13.6 show how Medicaid expenditure increases have varied by type of service and State. Table 13.5 demonstrates that much of the increase has been attributable to inpatient spending because it has one of the highest rates of increase and also accounts for a large proportion of total spending. However, institutional long-term care remains the largest payment category.

Trends in total expenditures mask considerable variation in trends by jurisdiction. Table 13.6 illustrates that for some States, Medicaid spending growth has been phenomenal, more than doubling in only 4 years. The States with the highest rates of growth are presented in Figure 13.7. The very high rate of growth in Arizona is only partly because of the influences identified in this chapter. Arizona does not have a traditional Medicaid program but instead operates a statewide capitation program as a HCFA demonstration project. In FY 1989, Arizona added long-term care services to its program, accounting for much of the large expenditure increases in FY 1989 and 1990 (McCall et al., 1992).

Table 13.1

Medicaid payments, by type of payment and jurisdiction: Fiscal year 1991

Jurisdiction	All payments	Type of payment: Medical assistance — Total computable	Medical assistance — Federal share	Medical assistance — State share	Administration and training — Total computable	Administration and training — Federal share	Administration and training — State share
		Amount in millions					
Total	$94,315.3	$90,504.6	$50,239.5	$40,265.1	$3,810.7	$2,153.6	$1,657.1
Alabama	1,102.4	1,068.2	776.4	291.8	34.2	19.8	14.4
Alaska	190.4	177.6	96.6	81.1	12.8	7.8	5.0
American Samoa	10.5	10.5	1.5	9.1	0.0	0.0	0.0
Arizona	852.3	770.6	481.9	288.7	81.7	44.1	37.6
Arkansas	753.2	726.2	545.6	180.6	27.0	15.4	11.6
California	8,999.4	8,440.0	4,216.6	4,223.4	559.4	302.6	256.8
Colorado	778.1	744.0	401.9	342.0	34.2	20.6	13.6
Connecticut	1,505.8	1,446.9	725.5	721.3	58.9	32.3	26.6
Delaware	194.1	183.7	92.6	91.2	10.4	6.5	3.9
District of Columbia	506.0	484.0	241.0	243.0	22.0	12.7	9.3
Florida	3,381.4	3,246.6	1,767.1	1,479.5	134.8	74.1	60.7
Georgia	2,034.3	1,931.1	1,190.9	740.3	103.2	62.5	40.7
Guam	6.1	5.0	2.0	3.1	1.1	0.6	0.5
Hawaii	273.0	257.7	140.4	117.3	15.3	8.4	6.9
Idaho	223.4	207.8	153.4	54.4	15.6	9.5	6.1
Illinois	2,591.5	2,440.4	1,222.0	1,218.4	151.1	85.5	65.6
Indiana	1,794.0	1,752.2	1,109.8	642.4	41.9	22.0	19.9
Iowa	810.0	777.6	494.2	283.4	32.4	18.2	14.2
Kansas	706.2	679.8	373.2	306.7	26.4	16.5	9.9
Kentucky	1,487.1	1,446.1	1,089.0	357.1	41.0	23.9	17.1
Louisiana	2,035.4	1,994.6	1,485.6	509.0	40.8	23.3	17.5
Maine	599.1	576.4	366.6	209.9	22.7	12.8	9.9
Maryland	1,531.3	1,452.5	702.6	749.9	78.8	44.1	34.7
Massachusetts	4,544.6	4,453.3	2,167.0	2,286.4	91.3	48.9	42.3
Michigan	3,470.2	3,360.3	1,821.8	1,538.4	109.9	84.3	25.6
Minnesota	1,767.4	1,675.2	897.1	778.1	92.2	46.3	45.9
Mississippi	836.4	806.9	643.4	163.5	29.5	17.1	12.4
Missouri	1,698.4	1,650.0	986.3	663.7	48.4	26.4	22.1
Montana	248.1	235.4	170.6	64.8	12.7	7.7	5.0
Nebraska	421.3	400.0	251.2	148.8	21.3	12.8	8.5
Nevada	198.5	185.7	93.4	92.3	12.9	6.9	5.9
New Hampshire	400.4	389.1	195.2	194.0	11.3	6.8	4.5
New Jersey	3,301.8	3,161.6	1,507.3	1,654.3	140.2	79.7	60.5
New Mexico	390.7	374.7	276.4	98.3	16.1	8.7	7.3
New York	17,957.5	17,426.9	7,736.5	9,690.3	530.6	299.3	231.3
North Carolina	2,108.6	2,024.8	1,359.7	665.1	83.8	44.8	39.0
North Dakota	232.0	221.8	155.6	66.1	10.3	5.6	4.6
Northern Marianas	0.9	0.8	0.4	0.4	0.1	0.7	(0.6)
Ohio	3,877.8	3,753.8	2,248.4	1,505.4	124.1	69.5	54.5
Oklahoma	917.8	846.8	592.3	254.5	71.0	39.5	31.5
Oregon	748.4	665.2	424.2	241.0	83.2	46.6	36.6
Pennsylvania	4,401.7	4,238.9	2,376.8	1,862.1	162.8	95.6	67.2
Puerto Rico	158.0	146.1	73.1	73.1	11.9	5.9	5.9
Rhode Island	645.4	633.9	337.8	296.1	11.5	5.9	5.6
South Carolina	1,287.4	1,238.2	900.0	338.2	49.3	27.8	21.5
South Dakota	203.6	198.1	143.9	54.2	5.5	3.2	2.3
Tennessee	1,901.2	1,852.3	1,270.5	581.8	48.9	28.9	20.0
Texas	4,228.9	4,021.9	2,564.9	1,456.9	207.1	114.0	93.1
Utah	372.6	346.8	259.8	87.0	25.7	14.8	11.0
Vermont	211.9	198.0	123.2	74.7	13.9	8.2	5.7
Virgin Islands	5.0	4.2	2.0	2.2	0.9	0.4	0.4
Virginia	1,325.4	1,270.7	639.4	631.3	54.7	31.9	22.9
Washington	1,603.8	1,505.0	819.2	685.8	98.8	54.0	44.8
West Virginia	594.7	576.7	428.7	148.1	18.0	9.4	8.6
Wisconsin	1,790.8	1,729.3	1,033.4	695.9	51.5	35.0	26.5
Wyoming	99.3	93.2	63.9	29.3	6.2	3.9	2.3

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from HCFA Form-64.

Table 13.2

Medicaid payments, by type of service and jurisdiction: Fiscal year 1991

Jurisdiction	Payments by type of service								Percentage distribution by type of service						
			Physicians and practitioners[2]		Long-term care					Physicians and practitioners[2]		Long-term care			
	All services	Inpatient[1]		Other acute[3]	Institutional[4]	Community[5]	Premium payments[6]	Other[7]	Inpatient		Other Acute[3]	Institutional[4]	Community[5]	Premium payments[6]	Other[7]
	In millions of dollars														
Total	$88,378	$28,006	$6,708	$12,642	$28,994	$4,758	$4,577	$2,694	32	8	14	33	5	5	3
Alabama	1,056	390	81	121	300	47	64	53	37	8	11	28	4	6	5
Alaska	182	49	39	32	47	1	2	11	27	21	18	26	1	1	6
American Samoa	11	0	0	0	0	0	0	11	0	0	0	0	0	0	100
Arizona	724	17	3	10	14	0	669	11	2	0	1	2	0	92	2
Arkansas	732	168	75	128	283	32	33	11	23	10	18	39	4	5	2
California	8,085	2,904	987	1,335	1,859	49	710	241	36	12	17	23	1	9	3
Colorado	747	208	63	126	238	68	24	21	28	8	17	32	9	3	3
Connecticut	1,517	217	49	170	854	135	58	33	14	3	11	56	9	4	2
Delaware	185	56	10	25	74	15	2	3	30	6	13	40	8	1	2
District of Columbia	500	198	27	76	159	13	21	6	40	5	15	32	3	4	1
Florida	3,287	941	348	491	946	60	361	140	29	11	15	29	2	11	4
Georgia	1,974	619	274	371	538	68	66	37	31	14	19	27	3	3	2
Guam	5	2	1	2	0	0	0	1	34	14	32	2	1	4	13
Hawaii	254	60	37	39	95	8	7	8	24	14	16	37	3	3	3
Idaho	211	44	23	33	88	10	3	10	21	11	15	42	5	1	5
Illinois	2,511	728	196	285	1,034	67	157	44	29	8	11	41	3	6	2
Indiana	1,775	407	140	316	774	21	83	35	23	8	18	44	1	5	2
Iowa	791	165	91	121	330	12	51	22	21	12	15	42	1	6	3
Kansas	609	191	46	64	246	20	19	23	31	8	11	40	3	3	4
Kentucky	1,508	576	191	282	326	72	29	32	38	13	19	22	5	2	2
Louisiana	1,894	712	185	315	566	12	41	62	38	10	17	30	1	2	3
Maine	589	145	34	73	262	29	26	21	25	6	12	44	5	4	4
Maryland	1,434	474	156	191	422	58	95	39	33	11	13	29	4	7	3
Massachusetts	4,574	1,884	189	480	1,518	248	172	83	41	4	11	33	5	4	2
Michigan	3,359	1,308	259	566	749	158	209	110	39	8	17	22	5	6	3
Minnesota	1,703	254	125	129	867	156	97	75	15	7	8	51	9	6	4
Mississippi	817	235	104	184	248	8	31	8	29	13	23	30	1	4	1
Missouri	1,675	796	68	193	449	59	100	10	47	4	12	27	4	6	1
Montana	235	55	27	41	73	19	9	10	23	12	18	31	8	4	4
Nebraska	401	72	45	60	166	33	16	11	18	11	15	41	8	4	3
Nevada	187	59	27	22	57	7	8	5	32	15	12	31	4	4	3
New Hampshire	390	135	11	42	136	47	7	12	35	3	11	35	12	2	3
New Jersey	3,102	1,125	106	437	1,122	230	33	48	36	3	14	36	7	1	2
New Mexico	370	99	56	60	119	19	7	11	27	15	16	32	5	2	3
New York	15,007	5,051	413	1,981	4,990	1,914	185	474	34	3	13	33	13	1	3
North Carolina	2,070	728	202	305	677	103	41	14	35	10	15	33	5	2	1
North Dakota	227	39	17	25	118	22	2	5	17	7	11	52	10	1	2
Northern Marianas	1	0	0	0	0	0	0	0	57	3	27	0	0	13	0
Ohio	3,804	1,083	275	544	1,615	29	193	64	28	7	14	42	1	5	2

See footnotes at end of table.

Table 13.2—Continued

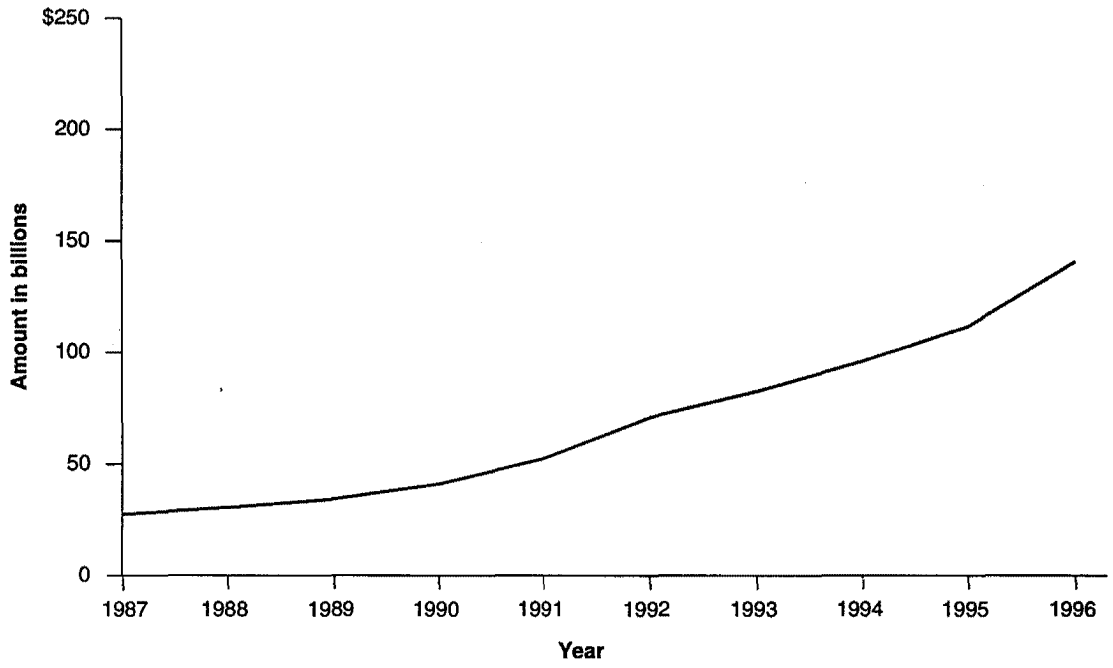
Medicaid payments, by type of service and jurisdiction: Fiscal year 1991

Jurisdiction	Payments by type of service								Percentage distribution by type of service						
					Long-term care							Long-term care			
	All services	Inpatient[1]	Physicians and practitioners[2]	Other acute[3]	Institutional[4]	Community[5]	Premium payments[6]	Other[7]	Inpatient	Physicians and practitioners[2]	Other Acute[3]	Institutional[4]	Community[5]	Premium payments[6]	Other[7]
Oklahoma	857	262	71	112	325	42	29	15	31	8	13	38	5	3	2
Oregon	660	105	58	83	231	87	47	50	16	9	13	35	13	7	8
Pennsylvania	4,073	1,402	164	451	1,540	144	310	63	34	4	11	38	4	8	2
Puerto Rico	146	65	0	81	0	0	0	0	45	0	55	0	0	0	0
Rhode Island	643	293	12	52	233	24	8	21	46	2	8	36	4	1	3
South Carolina	1,286	600	105	166	317	37	27	35	47	8	13	25	3	2	3
South Dakota	203	48	16	27	87	17	5	2	24	8	13	43	8	2	1
Tennessee	1,896	689	231	371	474	23	82	28	36	12	20	25	1	4	1
Texas	4,349	1,108	544	645	1,342	152	116	442	25	13	15	31	3	3	10
Utah	347	108	39	57	91	23	23	6	31	11	16	26	7	7	2
Vermont	197	37	18	36	72	17	3	14	19	9	18	36	9	1	7
Virgin Islands	4	2	0	2	0	0	0	0	38	9	48	0	0	1	5
Virginia	1,259	332	148	218	466	47	25	23	26	12	17	37	4	2	2
Washington	1,518	320	214	287	515	107	30	45	21	14	19	34	7	2	3
West Virginia	614	180	49	115	191	45	23	11	29	8	19	31	7	4	2
Wisconsin	1,731	238	50	243	721	142	216	121	14	3	14	42	8	12	7
Wyoming	93	26	12	18	31	2	3	1	28	13	19	33	2	3	1

[1]Inpatient general and mental hospital services.
[2]Services provided by physicians, dentists, and other practitioners.
[3]Outpatient hospital, laboratory, and X-ray services; services provided by Federally qualified health centers, rural health clinics, and other clinics; prescription drugs, sterilizations, and abortions, and early and periodic screening, diagnosis, and treatment services.
[4]Services in nursing and intermediate care facilities for the mentally retarded.
[5]Home health and home and community-based waiver services, personal care, home and community care for the functionally disabled elderly, and services in community-supported living arrangements.
[6]Medicare premiums, deductibles, coinsurance, group health premiums, and other premiums.
[7]Case management, hospice, and other services.

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from HCFA Form-64.

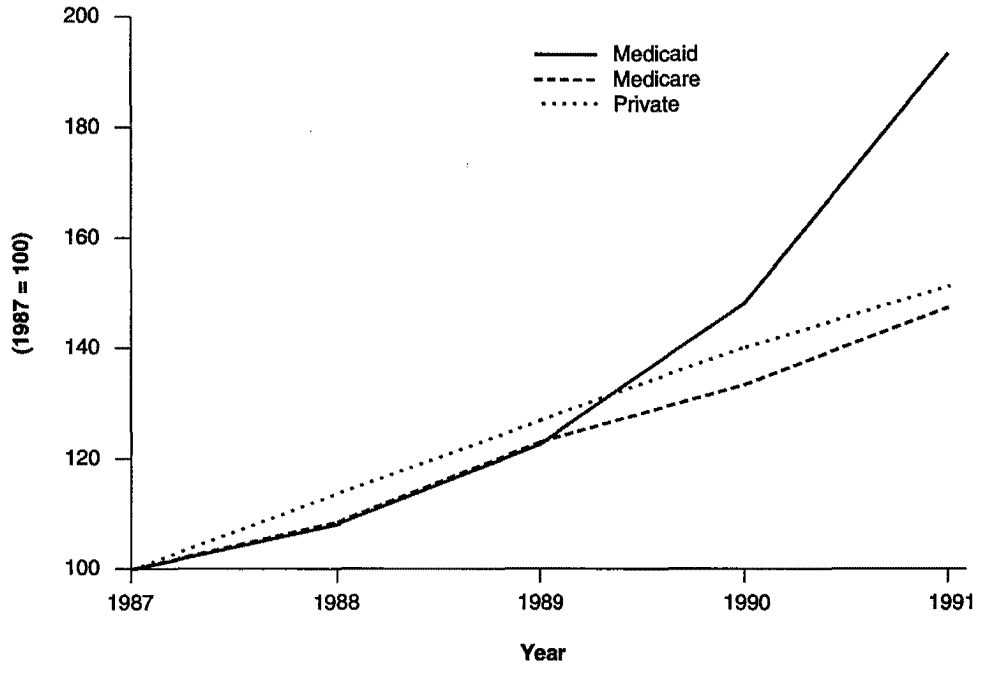
Figure 13.3
Federal Medicaid expenditures: Fiscal years 1987-96



NOTE: The expenditures for fiscal years 1992-96 are projected.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the mid-session review of fiscal year 1993 President's Budget.

Figure 13.4
Growth in Medicaid, Medicare, and private health insurance expenditures: Calendar years 1987-91



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Program factors affecting expenditures

Many factors affect Medicaid expenditures, including general inflation in health care costs and changes in the demographic makeup of the beneficiary population or their consumption patterns. In addition, changes in the economy can increase or decrease the number of people who meet income and asset requirements for program eligibility. Some changes in Medicaid expenditures represent the net effects of program decisions taken by individual States. Although many features of the Medicaid program are mandatory, States have control over others. Within Federal requirements, States establish income and resource eligibility criteria; determine the amount, duration, and scope of covered services; and set provider payment rates.

The remaining set of factors that influence Medicaid expenditures are congressionally mandated program changes. In the 1980s, modifications to Medicaid expanded eligibility and services, and increased payment rates. The degree to which these mandates have contributed to Medicaid expenditure increases cannot be determined. However, a U.S. Department of Health and Human Services (DHHS), Office of Management and Budget task force estimated that Federal legislation and waiver programs accounted for 22 percent of the growth in expenditures from 1980 to 1990; general health care inflation accounted for 59 percent of the growth. State efforts to increase Federal matching funds and other factors accounted for 15 percent, whereas increased enrollment accounted for only 4 percent (Executive Office of the President, 1991).

In the remainder of the chapter we describe the most significant congressionally mandated program changes from 1987 through 1991. We also examine alternative financing arrangements used by States to increase Federal matching funds.

Eligibility expansions

Of the changes to expand Medicaid coverage, the most important have been those targeted to pregnant women, infants, and children. Legislation before 1986 expanded prenatal and delivery services, and extended coverage for infants, and for pregnant women and children in two-parent families. However, this legislation generally accomplished its goals by changing Medicaid eligibility requirements associated with the Aid to Families with Dependent Children (AFDC) program.

Beginning with the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986), expansion of eligibility and services for pregnant women, infants, and children accelerated (Table 13.8). OBRA 1986 and subsequent legislation expanded Medicaid coverage for pregnant women and children based on income, regardless of their eligibility for a State's AFDC program, breaking the previous pattern of tying Medicaid eligibility to the AFDC program (U.S. Congressional Budget Office, 1992; Hill, 1992).

Starting in 1991, States had to provide coverage to pregnant women and children under 6 years of age, with incomes below 133 percent of the poverty level. They also had to provide coverage to children born on or after October 1, 1983, from families with incomes below 100 percent of the poverty standard. This coverage extends to the child's 19th birthday, and therefore will be fully phased in by 2002. For pregnant women, eligibility is now continuous through the end of the month in which the 60-day postpartum period ends. Infants in the first year of life are eligible if they meet two conditions: (1) they live with their mother, and (2) their mother would have been eligible if pregnant. Besides mandatory expansions, many States have implemented optional eligibility provisions that further broaden the coverage of pregnant women and infants.

Table 13.5

Medicaid payments and annual percent increases, by type of service: Fiscal years 1987-91

Type of service	1987	1988	Annual percent increase	1989	Annual percent increase	1990	Annual percent increase	1991	Annual percent increase	Percent increase 1987-91
Total	$46,950	$51,645	10.0	$58,643	13.5	$69,755	18.9	$88,378	26.7	88.2
Inpatient[1]	12,680	13,763	8.5	15,504	12.7	19,247	24.1	28,006	45.5	120.9
Physicians and other practitioners[2]	3,848	4,101	6.6	4,440	8.3	5,368	20.9	6,708	24.9	74.3
Other acute care[3]	6,519	7,427	13.9	8,335	12.2	10,139	21.6	12,642	24.7	93.9
Institutional long-term care[4]	19,067	20,532	7.7	22,296	8.6	25,625	14.9	28,994	13.1	52.1
Community long-term care[5]	2,069	2,449	18.4	3,257	33.0	3,925	20.5	4,758	21.2	130.0
Insurance payments[6]	1,786	2,177	21.9	3,045	39.9	3,498	14.9	4,577	30.9	156.2
Other[7]	981	1,197	22.0	1,766	47.5	1,952	10.6	2,694	38.0	174.5

[1]Inpatient general and mental hospital services.
[2]Services provided by physicians, dentists, and other practitioners.
[3]Outpatient hospital, laboratory, and X-ray services; services provided by Federally qualified health centers, rural health clinics, and other clinics; prescription drugs, sterilizations, and abortions, and early and periodic screening, diagnosis, and treatment services.
[4]Services in nursing and intermediate care facilities for the mentally retarded.
[5]Home health and home and community-based waiver services, personal care, home and community care for the functionally disabled elderly, and services in community-supported living arrangements.
[6]Medicare premiums, deductibles, group health premiums, and other premiums.
[7]Case management, hospice, and other services.

NOTE: Dollar amounts are in millions.

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from HCFA Form-64.

Table 13.6

Medicaid payments, by jurisdiction: Fiscal years 1987-91

Jurisdiction	1987	1988	1989	1990	1991	Percent increase 1987-91
			Amount in millions			
Total	$46,950	$51,645	$58,643	$69,754	$88,378	88.2
Alabama	422	471	543	804	1,056	150.0
Alaska	102	105	132	153	182	79.0
American Samoa	2	4	3	3	11	357.9
Arizona	128	170	368	553	724	465.8
Arkansas	414	435	522	618	732	77.0
California	4,987	5,455	5,947	7,047	8,085	62.1
Colorado	421	463	492	541	747	77.4
Connecticut	769	841	1,052	1,239	1,517	97.1
Delaware	94	103	115	126	185	98.0
District of Columbia	368	387	373	406	500	35.9
Florida	1,246	1,571	1,969	2,535	3,287	163.7
Georgia	957	1,161	1,284	1,566	1,974	106.3
Guam	4	4	4	4	5	35.4
Hawaii	160	161	181	207	254	58.4
Idaho	91	119	132	157	211	130.8
Illinois	1,784	1,928	2,162	2,479	2,511	40.8
Indiana	929	1,053	1,220	1,487	1,775	91.0
Iowa	431	487	542	643	791	83.5
Kansas	291	339	379	493	609	109.4
Kentucky	639	723	841	1,013	1,508	136.0
Louisiana	864	943	1,122	1,402	1,894	119.2
Maine	301	329	373	438	589	96.1
Maryland	809	918	1,015	1,182	1,434	77.3
Massachusetts	1,803	2,036	2,524	3,237	4,574	153.7
Michigan	1,924	2,038	2,218	2,618	3,359	74.6
Minnesota	1,131	1,214	1,306	1,472	1,703	50.7
Mississippi	388	446	513	624	817	110.6
Missouri	659	733	841	948	1,675	154.2
Montana	144	155	172	193	235	63.0
Nebraska	222	245	274	319	401	81.1
Nevada	88	98	108	150	187	111.0
New Hampshire	144	169	195	226	390	171.7
New Jersey	1,579	1,740	1,966	2,374	3,102	96.4
New Mexico	193	231	251	294	370	92.1
New York	8,929	9,603	10,730	12,187	15,007	68.1
North Carolina	851	991	1,211	1,499	2,070	143.2
North Dakota	216	184	180	199	227	5.2
Northern Marianas	1	1	1	1	1	-12.9
Ohio	2,379	2,415	2,759	3,262	3,804	59.9
Oklahoma	543	607	684	723	857	57.8
Oregon	288	377	442	537	660	129.2
Pennsylvania	2,234	2,475	2,727	3,034	4,073	82.3
Puerto Rico	93	130	153	110	146	57.3
Rhode Island	298	337	369	446	643	115.8
South Carolina	445	480	593	857	1,286	189.4
South Dakota	118	128	146	171	203	72.3
Tennessee	902	1,035	1,171	1,439	1,896	110.3
Texas	1,903	2,063	2,375	3,085	4,349	128.5
Utah	194	201	220	276	347	78.7
Vermont	100	109	128	154	197	97.1
Virgin Islands	4	4	1	4	4	3.7
Virginia	695	789	874	1,036	1,259	81.0
Washington	799	910	1,029	1,227	1,518	90.0
West Virginia	273	315	354	410	614	124.4
Wisconsin	1,154	1,170	1,306	1,482	1,731	50.0
Wyoming	45	47	55	67	93	106.2

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from HCFA Form-64.

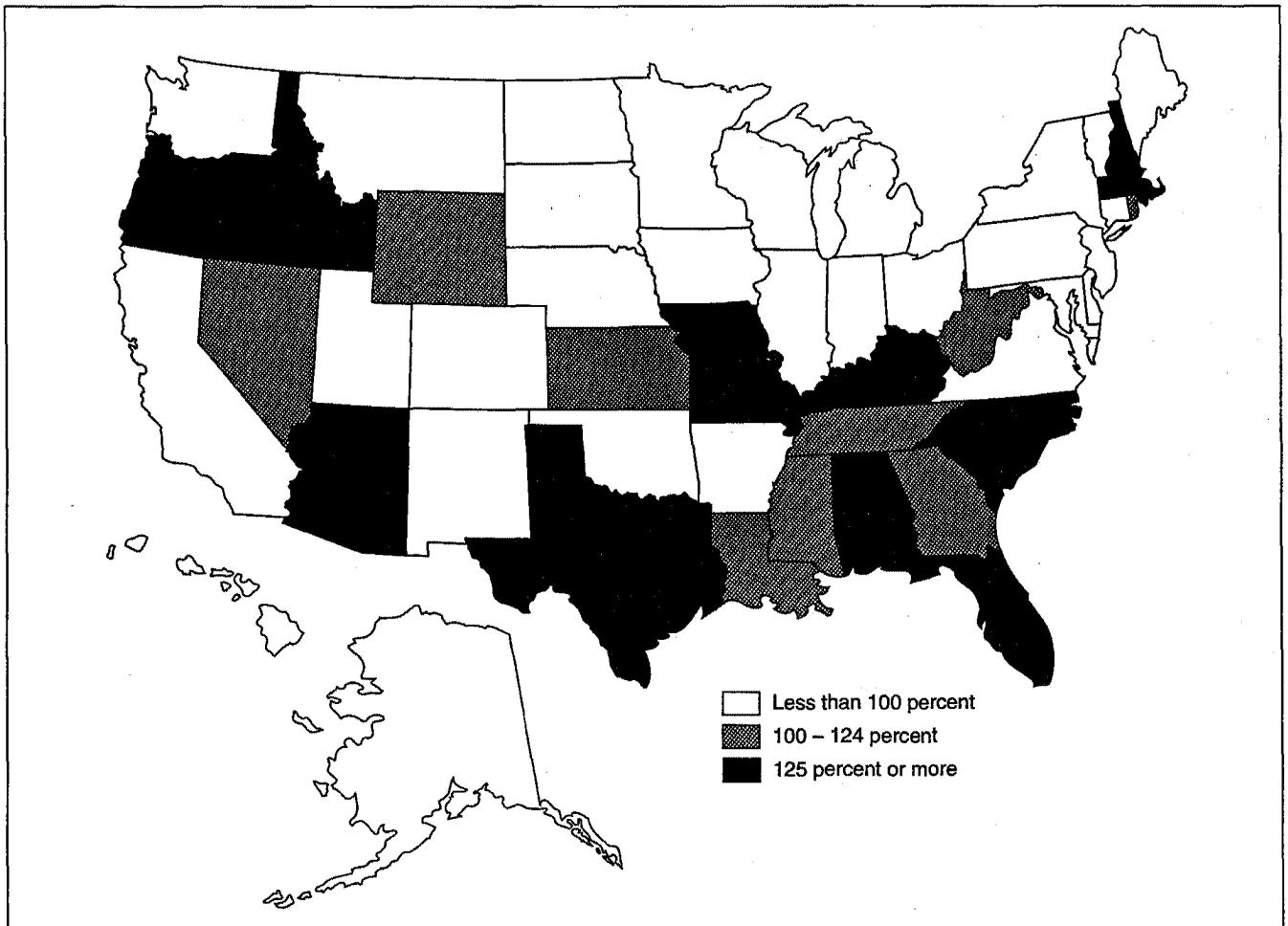
By the end of 1991, 30 States had established upper income limits above 133 percent of poverty: 23 of these used the maximum permissible level of 185 percent of the Federal poverty level (Hill, 1992).

Two other program mandates passed in the late 1980s expanded eligibility for AFDC recipients. The Family Support Act of 1988 extended Medicaid coverage for 6 months to individuals who lose their AFDC eligibility because of employment: States must offer a further 6 months of coverage to such individuals. However, during this period, States may impose premiums and provide fewer benefits, or may pay premiums, deductibles, and copayments in an alternative plan. The Family Support Act also expanded Medicaid eligibility for two-parent households. It mandated AFDC (and therefore Medicaid) coverage for needy families whose principal wage earner was unemployed. Previously, 31 States provided this coverage as an optional program feature.

Although expansions for pregnant women and children have received the most attention, they occurred for the elderly and disabled as well. The Medicare Catastrophic Coverage Act (MCCA) of 1988 mandated coverage which before had been optional for this group. It required States to pay Medicare premiums, coinsurance, and deductibles for qualified Medicare beneficiaries (QMBs) (that is, with incomes below the poverty level and assets at or below twice the SSI resource standard). This coverage was to be phased in by 1992, but OBRA 1990 moved up this deadline to 1991. At the beginning of 1992, the number of QMBs exceeded 1 million (King, Rimkunas, and Nuschler, 1992). MCCA broadened eligibility for the elderly when one member of a couple is institutionalized. Previously, only a small amount of the institutionalized person's income could be set aside for maintenance of the spouse. MCCA mandated that the spouse be able to receive a larger maintenance allowance from the institutionalized member's income. In 1991, the amount had to be sufficient to bring the spouse's income up to 133 percent of the poverty level for a two-person household. MCCA also allowed the spouse to retain more assets. Sixteen States set the protected asset level at $66,480 in 1991, which was the maximum level allowed for that year (U.S. Congressional Budget Office, 1992).

Figure 13.7

Percent increase in Medicaid payments: United States, fiscal years 1987-91



SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from HCFA Form-64.

Table 13.8

Major Medicaid program expansions: 1986-90

Population affected	Expansion	Mandate or option
Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509)		
Aged and disabled	Created new optional categorically needy group for those with income below 100 percent of poverty line under certain resource constraints. Option can be exercised for this group only if exercised also for pregnant women and infants.	Option
Aged and disabled	Allowed Medicare buy-in up to 100 percent of poverty line for qualified Medicare beneficiaries under certain resource constraints.	Option
Pregnant women and infants	Created new optional categorically needy group for those with income below 100 percent of poverty line. Women received pregnancy-related services only.	Option
Pregnant women and infants	Allowed assets test to be dropped for this newly defined category of applicants.	Option
Pregnant women	Allowed presumptive eligibility for up to 45 days to be determined by qualified provider.	Option
Pregnant women	Allowed guarantee of continuous eligibility through postpartum period.	Option
Children	Allowed coverage up to 5 years of age, if income below 100 percent of poverty line (phased in).	Option
Infants and children	Required continuation of eligibility (for those who otherwise would become ineligible) if they are hospital inpatients when age limit is reached.	Mandate
Severely impaired	Established new mandatory categorically needy coverage group for qualified individuals under 65 years of age.	Mandate
Ventilator-dependent	Allowed coverage of at-home respiratory care services.	Option
Aliens	Required provision of emergency services if otherwise eligible (financially and categorically).	Mandate
SSI recipients	Made permanent the previous temporary provision requiring coverage of some former disabled SSI recipients who have returned to work.	Mandate
Employment Opportunities for Disabled Americans Act 1986 (Public Law 99-643)		
Disabled	Made permanent a previous demonstration program for individuals able to engage in substantial gainful activity despite severe medical impairments.	Mandate
Immigration Reform and Control Act of 1986 (Public Law 99-603)		
Newly legalized aliens	Required provision of emergency and pregnancy related services if otherwise eligible and full coverage for eligible under 18 years of age.	Mandate
Anti-Drug Abuse Act of 1986 (Public Law 99-570)		
Homeless	Required state to provide proof of eligibility for individuals otherwise eligible but having no permanent address.	Mandate
Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203)		
Pregnant women and infants	Allowed coverage if income level below 185 percent of poverty line.	Option
Children	Allowed immediate extension of OBRA 1986 coverage up to 100 percent of poverty line up to 5 years of age.	Option
Children	Clarified that states may provide in-home services for qualified disabled children.	Option
Children	Allowed coverage for children aged 5-7, up to State AFDC level (phased in by age).	Option
Children	Allowed coverage for children below 9 years of age up to 100 percent of poverty line (phased in by age).	Option
Elderly	Allowed provision of home and community-based services to those who otherwise would need nursing home care.	Option
Nursing home applicants	Required pre-admission screening programs and annual resident review for mentally ill and retarded.	Mandate
Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360)		
Pregnant women and infants	Made mandatory the OBRA 1986 option of coverage up to 100 percent of poverty line (phased in by percent of poverty line).	Mandate
Elderly and disabled	Made mandatory the OBRA 1986 option of Medicare buy-in up to 100 percent of poverty line for qualified Medicare beneficiaries (phased in by percent of poverty).	Mandate
Elderly and disabled	Set higher minimum levels of protected income and assets for spouses of institutionalized individuals.	Mandate

See SOURCE at end of table.

Table 13.8—Continued

Major Medicaid program expansions: 1986-90

Population affected	Expansion	Mandate or option
Family Support Act of 1988 (Public Law 100-485)		
AFDC families	Increased required period of Medicaid coverage if AFDC cash assistance is lost due to earnings.	Mandate
AFDC families with unemployed parent (AFDC-UP)	Required coverage if otherwise qualified.	Mandate
Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239)		
Pregnant women and infants	Required coverage if income is below 133 percent of poverty.	Mandate
Children	Required coverage up to 6 years of age if income below 133 percent of poverty.	Mandate
Children	Required provisions of all Medicaid-allowed treatment to correct problems identified during EPSDT screenings even if treatment is not covered otherwise under State's Medicaid plan.	Mandate
Children	Required interperiodic screenings under EPSDT when medical problem is suspected.	Prior option now mandated
Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508)		
Children	Required coverage up to age 18, if income is below 100 percent of poverty line (phased in by age).	Mandate
Pregnant women	Made mandatory the OBRA 1986 option of continuous eligibility through postpartum period.	Mandate
Pregnant women	Extended period of presumptive eligibility before written application must be submitted.	Mandate
Pregnant women and children	Required states to receive and process applications at convenient outreach sites.	Mandate
Infants	Required continuous eligibility if (1) born to Medicaid-eligible mother who would remain eligible if pregnant and (2) remaining in mother's household.	Mandate
Elderly and disabled	Extended the MCCA qualified Medicare beneficiary provision to 120 percent of poverty line (phased in by percent of poverty).	Mandate
Elderly and disabled	Allowed limited program permitting States to provide home and community-based services to functionally disabled and community-supported living arrangements to mentally retarded and developmentally disabled.	Option

SOURCE: Comptroller General of the United States, 1991.

Service expansions

Legislative changes in the last several years increased both optional and mandatory Medicaid benefits (Table 13.8). One significant expansion focused on services to the elderly and disabled. OBRA 1987 contained a number of provisions designed to improve the quality of nursing home care. The distinction between intermediate and skilled nursing facilities was eliminated, and nursing care standards similar to those for Medicare were instituted. OBRA 1987 also required establishment of nurse aide training programs and comprehensive annual assessments of residents. Pre-admission screening of nursing home applicants with mental illness or mental retardation was also mandated. States were directed to increase rates for nursing homes to compensate for their costs in meeting the requirements. The median rate increase resulting from this mandate was $1.16 per patient day (King, Rimkunas, and Nuschler, 1992).

Another important expansion addressed early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals 21 years of age or under. The EPSDT program is mandatory and screens children for health and developmental problems. OBRA 1989 broadened the program by specifying that screening services include a comprehensive health and developmental assessment. It required States to provide any Medicaid service necessary to treat a condition identified by screening, regardless of whether the service was in the State's plan. It also provided for the establishment of annual participation targets for the EPSDT program.

Changes in payment rates

Medicaid often pays less than other payers. Estimates indicate that Medicaid covered 78 percent of hospital costs in 1989 although Medicare paid 92 percent (Prospective Payment Assessment Commission, 1991). Physician fees in that year averaged 64 percent of Medicare allowed charges (Physician Payment Review Commission, 1991). Because of these differences, some think that Medicaid beneficiaries may not have the same access to services as others. Others believe that Medicaid providers should be better compensated for their services. In response to these concerns, some statutory provisions have mandated changes in payment rates or methodologies.

OBRA 1989 changed provisions for payments to physicians. Regulations had required payments to be sufficient to make Medicaid services available to the

same extent that they were for the general population. OBRA 1989 placed this requirement into statute. It also directed States to submit fee schedules and other data for obstetrical and pediatric services to ensure compliance in these areas. HCFA instructions allowed States to satisfy these requirements in several different ways, only one of which would probably cause fees to be increased. Nevertheless, some States substantially raised fees after 1989 (Holahan, 1991).

Other legislative changes have addressed institutional payment. Beginning in 1980, the Boren Amendment required that hospitals and nursing homes be paid at rates that would adequately compensate efficiently and economically operated facilities. Previously, States had been required to (retrospectively) pay facilities on a reasonable cost basis. Initially, the Boren Amendment allowed States to develop alternative institutional payment methodologies. As a result, most States shifted to prospective hospital payment systems by 1991 (Prospective Payment Assessment Commission, 1991).

The Boren Amendment may have restrained institutional rate increases during the early 1980s. By 1989, States paid hospitals a lower proportion of their costs than they had in the early 1980s (Prospective Payment Assessment Commission, 1991). However, the amendment also provided a standard by which institutions could challenge their payment rates. Increasingly, providers have brought suits claiming that a State's payment methodology did not meet the Boren Amendment standard. In *Wilder vs. Virginia Hospital Association* (1990), the U.S. Supreme Court confirmed the right of providers to bring such suits. As of 1991, 29 States had experienced a Boren Amendment suit. Where these suits have been resolved, they have typically increased payment rates (King, Rimkunas, and Nuschler, 1992). These settlements can increase a State's annual institutional payments by tens of millions of dollars.

Another payment requirement has significantly affected Medicaid expenditures in recent years. OBRA 1981 mandated States to recognize hospitals that served a disproportionate share of low-income patients with special needs. However, only some States subsequently made special provisions for disproportionate share hospitals (DSH) (Prospective Payment Assessment Commission, 1991). OBRA 1987 created minimum standards for hospitals to qualify for DSH payments and for the amount of such payments. By 1989, payments to DSH hospitals covered a higher share of their Medicaid costs than those of other hospitals, a reversal of the situation in 1980. However, payments to all hospitals constituted a lower share of their estimated Medicaid costs in 1989 than in 1980 (Prospective Payment Assessment Commission, 1991).

Although legislative requirements have often increased payment rates, in one area they have decreased them. From FY 1987 to 1990, Medicaid prescription drug expenditures increased by nearly 50 percent. (Drugs constitute almost one-half of the "other acute care" service category in Tables 13.4 and 13.5.) In OBRA 1990, Congress acted to reduce this rate of increase. Beginning in 1991, drug manufacturers were required to give rebates to Medicaid if they wished to have their drugs covered by the program. The formula to determine the amount of the rebate is based on the average manufacturer price and the "best price" of each drug provided to other payers. Reported rebates from this program totaled $111 million in FY 1991.

Finance shifting

A final factor affecting Medicaid expenditures does not result from program expansions but from innovations in State financing arrangements. These innovations can increase total Medicaid expenditures and the Federal share of Medicaid payments. However, they may not represent an actual increase in net State Medicaid spending. One such innovation involves DSH payment methodologies. OBRA 1990 allowed States to develop DSH payment methodologies that varied by hospital type. Accordingly, States could develop more generous methodologies for institutional settings receiving high amounts of State support. Increases in Medicaid DSH payments could then allow net State expenditures for such settings to be reduced by substituting Federally assisted Medicaid support for non-Medicaid State support. The savings could then offset other spending or provide a source of funding for new program initiatives.

The best illustration of the potential benefits to States of this approach concerns psychiatric hospitals. DSH provisions require the greatest assistance to institutions that serve the largest percentage of indigent or Medicaid patients. Typically, State psychiatric hospitals serve the largest proportion of such patients with mental illness. However, because of Medicaid restrictions for institutions for mental diseases, most of these facilities' costs are supported by State expenditures. Without DSH payments, the Federal share of Medicaid payments accounts for only a small percentage of such costs.

The Federal share of DSH payments permits States to reduce their net support of such institutions. Further, DSH payments do not need to be tied to claims nor be related to costs. Therefore, large amounts of Federal support can be provided to institutions that previously received few Medicaid payments and that were largely State-supported. Little data have been gathered about such practices. However, Kansas reported that 95 percent of its DSH payments went for care at its 4 State psychiatric hospitals; the savings helped offset the cost of new mandates (Bergman, 1991). Similar benefits may be produced with other (non-psychiatric) public hospitals. For some of these, DSH payments can significantly exceed deficits that are attributable to uncompensated care (Pallarito, 1991).

Despite concerns with DSH payment methodologies, most attention has been directed to States' use of taxes and donations. Before 1985, States could use donated funds only for the State's share of Medicaid training expenditures. However, regulations issued at that time relaxed this restriction. In 1986 and 1987, West Virginia and Tennessee used donations from hospitals to pay for part of their State's Medicaid obligation. Although

HCFA approved these arrangements, it later sought to deny Federal funds for the spending because of apparent connections between donations and payments. In West Virginia, there appeared to be a clear link between the donations and expedited payments to the donating facilities. The relationship was less clear in Tennessee, but hospital payment enhancements also followed donations from hospitals (Merlis, 1991).

HCFA's concern also extended to tax arrangements. Before West Virginia and Tennessee had instituted their donation arrangements, South Carolina and Florida had begun to tax hospitals. They used the proceeds to support their State Medicaid share (Merlis, 1991). In FY 1991, 23 States reported a provider tax, a voluntary donation program, or both (Table 13.9). The revenues from these programs were estimated to generate $2.4 billion in Federal funds (Miller, 1992).

HCFA believed that such tax and donation programs allowed States to evade their financial obligations, increasing Federal Medicaid expenditures. From this point of view, States could raise payments to providers but recoup all or part of the increase through taxes or donations. Because Federal matching payments would be based on the payment to the provider, however, the share of Medicaid payments supported by other State revenues would decrease. Providers would support such arrangements if the payment increase equaled or exceeded the amount of the tax or donation. States rejected this perspective. Generally, they denied a direct link between Medicaid payments and their tax or donation programs. In their view, donations and taxes are just another source of revenue, even if they are limited to a type of health care provider. As such, they should be as available to the State for financing its Medicaid obligations as any other revenue source.

HCFA nevertheless sought to limit the use of donation programs and provider-specific taxes. However in 1988, Congress prohibited the Secretary of DHHS from issuing regulations in this area. OBRA 1989 and OBRA 1990 extended this prohibition, with the exception that OBRA 1990 allowed the Secretary to limit the use of provider-specific taxes in certain situations.

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 superseded this legislation. These amendments effectively end most donation programs but allow Federal matching funds for some kinds of provider-specific taxes. Such taxes must be applied uniformly to all providers of the same class. Also, the providers may not be held harmless for the costs of the taxes through increased payments or other means.

The legislation specifies that until 1995 provider-specific taxes must constitute no more than 25 percent of the State's Medicaid obligation. States with amounts from donations and taxes that exceed 25 percent may continue at the higher percentage, provided that these revenues meet the new requirements. The amendments also cap DSH payments at 12 percent of Medicaid expenditures nationally. States above the 12 percent level may not increase their DSH payments until they fall to that level. Others may increase them up to that level. The legislation was passed after FY 1991 had ended: FY 1991 expenditures, therefore, include the effects of tax and donation programs that occurred before these restrictions.

Table 13.9

States with provider tax or voluntary donation programs: Fiscal year 1991

State	Provider tax	Voluntary donation program
Total	13	14
Alabama		X
Alaska		
Arizona		
Arkansas		
California		X
Colorado		
Connecticut		
Delaware		
District of Columbia		
Florida	X	X
Georgia		X
Hawaii		
Idaho		
Illinois		
Indiana		
Iowa		
Kansas		
Kentucky	X	
Louisiana		
Maine	X	
Maryland		
Massachusetts	X	X
Michigan		X
Minnesota	X	
Mississippi	X	X
Missouri		X
Montana	X	
Nebraska		
Nevada		
New Hampshire	X	
New Jersey		
New Mexico		X
New York	X	
North Carolina		X
North Dakota		
Ohio	X	
Oklahoma		
Oregon		
Pennsylvania		X
Rhode Island		
South Carolina	X	X
South Dakota		
Tennessee		X
Texas		
Utah		X
Vermont	X	
Virginia		
Washington	X	
West Virginia		
Wisconsin		
Wyoming		

SOURCE: (Miller, 1992).

Summary

Total net Medicaid expenditures exceeded $94 billion in FY 1991, with 5 states accounting for more than 40 percent—New York, California, Massachusetts,

Pennsylvania, and Texas. Nationally, inpatient and institutional long-term care payments each comprise about one-third of Medicaid spending.

Medicaid expenditures have grown rapidly. From 1987 to 1991 they nearly doubled, greatly exceeding the expenditure growth for Medicare and private health insurance. This growth has been unevenly distributed. Expenditures increased by 125 percent or more in 12 States during this period, but an equal number of States had increases below 75 percent. Although expenditures grew the most slowly in institutional long-term care, this still comprises the largest payment category. Spending for inpatient services, community long-term care, insurance payments, and services not otherwise classified had the fastest rate of growth. By 1995, projected Federal expenditures for Medicaid will exceed $100 billion, approximately equal to those for Medicare in 1991.

Health care inflation, State program decisions, and Federal mandates all affect the growth in Medicaid expenditures. Legislative changes have expanded coverage of pregnant women, infants, and children, and also have increased Medicaid payments of Medicare premiums and cost sharing for the elderly and disabled. Other Federal mandates raised nursing home standards and expanded EPSDT services. Legislative requirements and court challenges caused some States to increase provider payment rates.

Some States developed alternative financing arrangements to accommodate the fiscal demands of higher expenditure growth. Requirements for DSH payments allowed States to use Medicaid to offset State support of public hospitals. Provider taxes and donations permitted States to increase Medicaid payments without having to raise other revenues or place an economic burden on providers. These arrangements were significantly curtailed by legislation passed in 1991.

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