



Testimony

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MEDICAID

Recent Spending Experience and the Administration's Proposed Program Reform

Statement of William J. Scanlon, Director
Health Financing and Systems Issues
Health, Education, and Human Services Division



Summary

GAO's statement focuses on two broad issues: (1) key factors that explain the Medicaid 3.3-percent growth rate in fiscal year 1996 and their implications for future spending and (2) the administration's proposal to contain Medicaid cost growth through decreases in disproportionate share hospital (DSH) payments and per capita caps, and to increase state flexibility.

GAO found no single pattern across all states that accounts for the recent dramatic decrease in the growth of Medicaid spending. Rather, a combination of factors—some affecting only certain states and others common to many states—explains the low 1996 growth rate. Leading factors include continued reductions in DSH payments in some states as a result of earlier federal restrictions on the amount of such payments and the leveling off of Medicaid enrollment in other states following planned expansions in prior years. A number of states GAO contacted attributed the lower growth rate to a generally improved economy and state initiatives to limit expenditure growth through programmatic changes, such as managed care programs and long-term care alternatives. While the magnitude of the effect of these programmatic changes is less clear, there is evidence that they helped to restrain program costs. It is likely that the 3.3-percent growth rate is not indicative of the growth rate in the years ahead. Just as a number of factors converged to bring about the drop in the 1996 growth rate, so a variety of factors—such as a downturn in the economy—could result in increased growth rates in subsequent years.

The administration's proposal for Medicaid reform would further control spending by reducing DSH expenditures and imposing a per capita cap, while providing the states greater flexibility in program policy and administration for their managed care and long-term care programs. These initiatives should produce cost savings. However, in controlling program spending, attention should be given to targeting federal funds appropriately and ensuring that added program flexibility is accompanied by effective federal monitoring and oversight.

Medicaid: Recent Spending Experience and the Administration's Proposed Program Reform

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss recent Medicaid spending trends and their potential implications for future outlays. My comments are based on work that we have in progress at the request of the Chairmen of the Senate and House Budget Committees. Their request was prompted by an interest in what contributed to the precipitous drop in the annual growth rate of Medicaid spending from over 20 percent in the early 1990s to 3.3 percent in fiscal year 1996. In addition, you have asked us to comment on aspects of the administration's fiscal year 1998 proposal for the Medicaid program.

My remarks today focus on two broad issues: (1) key factors that explain the 3.3-percent growth rate in fiscal year 1996 and their implications for future Medicaid spending and (2) the administration's proposal to contain Medicaid cost growth through decreases in disproportionate share hospital (DSH) payments and per capita caps, and to increase state flexibility. Our findings are based on our analysis of Medicaid expenditure data published by the Department of Health and Human Services' Health Care Financing Administration and our review of federal outlays as reported by the Department of the Treasury. We also contacted Medicaid officials in 18 states that represent a cross-section of state spending patterns over the past 2 years and that account for almost 70 percent of Medicaid expenditures. Our comments on the administration's proposal are based on a review of budget documents and previous work we have conducted.

In brief, we found no single pattern across all states that accounts for the recent dramatic decrease in the growth of Medicaid spending. Rather, a combination of factors—some affecting only certain states and others common to many states—explains the low 1996 growth rate. Leading factors include continued reductions in DSH payments in some states as a result of earlier federal restrictions on the amount of such payments and the leveling off of Medicaid enrollment in other states following planned expansions in prior years. A number of states we contacted attributed the lower growth rate to a generally improved economy and state initiatives to limit expenditure growth through programmatic changes, such as managed care programs and long-term care alternatives. While the magnitude of the effect of these programmatic changes is less clear, there is evidence that they helped to restrain program costs. However, it is likely that the 3.3-percent growth rate is not indicative of the growth rate in the years ahead. Just as a number of factors converged to bring about the drop

in the 1996 growth rate, so a variety of factors—such as a downturn in the economy—could result in increased growth rates in subsequent years. Finally, the administration's proposal for Medicaid reform would further control spending by reducing DSH expenditures and imposing a per capita cap, while providing the states greater flexibility in program policy and administration for their managed care and long-term care programs. These initiatives should produce cost savings. However, in controlling program spending, attention should be given to targeting federal funds appropriately and ensuring that added program flexibility is accompanied by effective federal monitoring and oversight.

Background

Medicaid, a federal grant-in-aid program that states administer, finances health care for about 37 million low-income people. With total federal and state expenditures of approximately \$160 billion in 1996, Medicaid constitutes a considerable portion of both state and federal budgets, accounting for roughly 20 percent and 6 percent of total expenditures, respectively.

For more than a decade, the growth rate in Medicaid expenditures nationally has been erratic. Between 1984 and 1987, the annual growth rates remained relatively stable, ranging between roughly 8 and 11 percent. Over the next 4 years, beginning in 1988, annual growth rates increased substantially, reaching 29 percent in 1992—an increase of over \$26 billion for that year. From this peak, Medicaid's growth rates declined between 1993 and 1995 to approximately the levels of the mid-1980s. Then, in fiscal year 1996, the growth rate fell to 3.3 percent.

Key Factors Affecting 1996 Spending Growth and Their Implication for the Future

In analyzing the growth rate for 1996 we found that no single spending growth pattern was evident across the states nor did we find a single factor that explained the decrease in growth. Rather there was a confluence of factors, some of which are unlikely to recur, while others are part of a larger trend. Future spending will potentially be higher if the economy weakens and as the elderly population continues to grow.

No Single Spending Trend Across States

The 3.3-percent growth in 1996 federal Medicaid outlays masks striking variation among the states. Growth rates ranged from a decrease of 16 percent to an increase of 25 percent. Such differences in program spending growth across states has been fairly typical. In addition, there are often some states that experience large changes in growth from one year

to the next because of major changes in program structure or accounting variances that change the fiscal year in which a portion of expenditures is reported. To determine the stability of the growth rates among states, we compared states' growth rates in fiscal year 1995 with those in fiscal year 1996. Our analysis showed that states could be placed in one of five categories, as shown in table 1. (See app. I for specific state growth rates.)

Table 1: Changes in Growth Rate of Federal Medicaid Outlays, Fiscal Years 1995 and 1996

Fiscal year 1996 growth rate compared with fiscal year 1995's	Number of states	Percentage of 1996 federal outlays	States
Decreased substantially	10	16	Colorado, Florida, Hawaii, Louisiana, North Carolina, Oregon, Rhode Island, South Carolina, Tennessee, Wyoming
Decreased moderately	20	48	Alabama, California, Idaho, Illinois, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, Vermont, Washington
Changed minimally	16	32	Arizona, Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, Utah, Virginia, West Virginia, Wisconsin
Increased moderately	3	2	Alaska, Maine, New Mexico
Increased substantially	2	2	Indiana, New Hampshire

Ten states that collectively account for 16 percent of 1996 federal outlays experienced substantial decreases in fiscal year 1996 growth compared with fiscal year 1995's. However, 80 percent of 1996 federal Medicaid outlays were in states that either experienced moderate decreases or minimal changes in their fiscal year 1996 growth. Although five states' fiscal year 1996 growth rates increased, those states did not have much effect on spending growth patterns because their combined share of Medicaid outlays is only 4 percent.

A Convergence of Factors Led to the 3.3-Percent Growth Rate in 1996

A number of factors have led to decreases in the growth rate in Medicaid spending in recent years. Some of these—such as the prior implementation of cost controls and a leveling off in the number of program eligibles following state-initiated expansions—continue to influence the growth rate in a handful of states. Other factors, such as improved economic conditions and changing program policies—for example, alternatives to institutional long-term care—also influenced

many states' growth rates. The convergence of these factors resulted in the historically low 3.3-percent growth rate in fiscal year 1996 Medicaid spending.

Several Nonrecurring Factors

The growth rate changes in those states that experienced large decreases in 1996 were largely attributable to three factors not expected to recur: substantial decreases in DSH funding, slowdowns in state-initiated eligibility expansions, and accelerated 1995 payments in reaction to block grant proposals for Medicaid.

In 1991 and 1993, the Congress acted to bring under control DSH payments that had grown from less than \$1 billion to \$17 billion in just 2 years.¹ After new limits were enacted, DSH payments nationally declined in 1993, stabilized in 1994, and began to grow again in 1995. An exception to this pattern, however, was Louisiana—a state that has had one of the largest DSH programs in the nation. It experienced a substantial decrease in its 1996 growth rate as its DSH payments continued to decline. The state's federal outlays decreased by 16 percent in 1996 because of a dramatic drop in DSH payments.

Recent slowdowns in state-initiated eligibility expansions also helped to effect substantial decreases in the growth rates in selected states. Over the past several years, some states implemented statewide managed care demonstration waiver programs to extend health care coverage to uninsured populations not previously eligible for Medicaid. Three states that experienced substantial decreases in their 1996 growth rates—Hawaii, Oregon, and Tennessee—undertook the bulk of their expansions in 1994. The expenditure increases related to these expansions continued into 1995 and began to level off in 1996. Tennessee actually experienced a drop in the number of eligible beneficiaries in 1996, as formerly uninsured individuals covered by the program lost their eligibility because they did not pay the required premiums.

States' acceleration of 1996 payments into 1995 is another explanation sometimes given for the low 1996 growth rate.² In 1995, the Congress—as part of a block grant proposal—was considering legislation to establish

¹DSH payments are intended to partially reimburse hospitals for the cost of providing care not covered by public or private insurance. A number of states, however, began to use the program to increase their federal Medicaid dollars in conjunction with certain creative financing mechanisms. To constrain these payments, DSH payments were limited to a target of 12 percent of Medicaid expenditures, excluding administrative costs.

²Aggregate data show that federal outlays were flat in the first 6 months of 1996 and then grew 6 percent in the last 6 months.

aggregate Medicaid spending limits, which would be calculated using a base year. Officials from a few states told us that, in response to the anticipated block grant, they accelerated their Medicaid payments to increase their expenditures for fiscal year 1995—the year the Congress was considering for use as the base. For example, one state, with federal approval, made a DSH payment at the end of fiscal year 1995 rather than at the beginning of fiscal year 1996. An official from another state, which had a moderate decrease in growth, told us that the state expedited decisions on audits of hospitals and nursing homes to speed payments due these providers.

Strong Economic Conditions

Improved economic conditions, reflected in lower unemployment rates and slower increases in the cost of medical services, also have contributed to a moderation in the growth of Medicaid expenditures. Between 1993 and 1995, most states experienced a drop in their unemployment rates—some by roughly 2 percentage points. As we reported earlier, every percentage-point drop in the unemployment rate is typically associated with a 6-percent drop in Medicaid spending.³ States told us that low unemployment rates had lowered the number of people on welfare and, therefore, in Medicaid.

In addition, growth in medical service prices has steadily been declining since the late 1980s. In 1990, the growth in the price of medical services was 9.0 percent; by 1995, it was cut in half to 4.5 percent. In 1996, it declined further to 3.5 percent. Declines in price inflation have an indirect effect on the Medicaid rates that states set for providers. Officials of several of the states we spoke with reported freezing provider payment rates in recent years, including rates for nursing facilities and hospitals. Such a freeze might not have been possible in periods with higher inflation because institutional providers might challenge state payment rates in court, arguing they had not kept pace with inflation.⁴ With inflation down, states can restrain payment rates with less concern about such challenges.

State Managed Care Programs and Long-Term Care Policies

Several states that we contacted discussed recent program changes that may have had an effect on their Medicaid expenditures. Most prominently mentioned was the states' implementation of Medicaid managed care. However, the overall effect of managed care on Medicaid spending is

³Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, Apr. 4, 1995).

⁴The Boren Amendment, section 1902(a)(13)(A) of the Social Security Act, requires that states make payments to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities. Providers in a number of states have used the Boren Amendment to compel states to increase reimbursement rates for institutional services above the rates the states had been paying.

uncertain because of state variations in program scope and objectives. States also mentioned initiatives to use alternative service delivery methods for long-term care. While these initiatives may have helped to bring Medicaid costs down, measuring their effect is difficult.

Although some states have been using managed care to serve portions of their Medicaid population for over 20 years, many of the states' programs have been voluntary and limited to certain geographic areas. In addition, these programs tend to target women and children rather than populations that may need more care and are more expensive to serve—such as people with disabilities and the elderly.⁵ Only a few states have mandated enrollment statewide—fewer still have enrolled more expensive populations—and these programs are relatively new. Arizona, which has the most mature statewide mandatory program, has perhaps best proven the ability to realize cost savings in managed care, cost savings it achieved by devoting significant resources to its competitive bidding process.⁶ However, other states have emphasized objectives besides cost control in moving to managed care. In recently expanding its managed care program, Oregon chose to increase per capita payments to promote improved quality and access and to look to the future for any cost savings. Officials from Minnesota, which has a mature managed care program, and California, which is in the midst of a large expansion, told us that managed care has had no significant effect on the moderate decreases they experienced.⁷ Given the varying objectives, the ability of managed care to help control state Medicaid costs and moderate spending growth over time is unclear.

Some states we contacted are trying to control long-term care costs, which, for fiscal year 1995, accounted for about 37 percent of Medicaid expenditures nationwide. They are limiting the number of nursing home beds and payment rates for nursing facility services while expanding home and community-based services, which can be a less-expensive alternative to institutional care. For example, a New York official told us that the state is attempting to restrain its long-term care costs by changing its rate-setting method for nursing facilities, establishing county expenditure targets to limit growth, and pursuing home- and community-based service

⁵Medicaid Managed Care: Serving the Disabled Challenges State Programs (GAO/HEHS-96-136, July 31, 1996).

⁶Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs (GAO/HEHS-96-2, Oct. 4, 1995).

⁷California considers its managed care program to be budget neutral, having no effect on spending one way or another.

options as alternatives to nursing facilities. Our previous work showed that such strategies can work toward controlling long-term care spending if controls on the volume of nursing home care and home- and community-based services, such as limiting the number of participating beneficiaries and having waiting lists, are in place.⁸

Potential for Higher Expenditure Growth in Future Years

Many of the factors that resulted in the 3.3-percent growth rate in 1996—such as DSH payments, unemployment rates, and program policy changes—will continue to influence the Medicaid growth rate in future years. However, there are indications that some of these components may contribute to higher—not lower—growth rates, while the effect of others is more uncertain.

Without new limits, DSH payments can be expected to add to the growth of the overall program. While Louisiana's adjustments to its DSH payments resulted in a substantial reduction in its 1996 spending, other states' DSH spending began to grow moderately in 1995 as freezes imposed on additional DSH spending no longer applied.⁹ Although DSH payments are not increasing as fast as they were in the early 1990s, these payments did grow 12.4 percent in 1995.

Even though the economy has been in a prolonged expansion, history indicates that the current robust economy will not last indefinitely. The unemployment rate cannot be expected to stay as low as it currently is, especially in states with rates below 4 percent. Furthermore, any increases in medical care price inflation will undoubtedly influence Medicaid reimbursement rates, especially to institutional providers.

While states have experienced some success in dealing with long-term care costs, the continued increase in the number of elderly people will inevitably lead to an increase in program costs. Alternative service delivery systems can moderate that growth but not eliminate it.

Other factors may dampen future spending growth, but by how much is unclear. The recently enacted welfare reform legislation makes people receiving cash assistance no longer automatically eligible for Medicaid. As a result, the number of Medicaid enrollees—and the costs of providing

⁸Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

⁹States whose DSH spending exceeded 12 percent of their total medical assistance spending in 1993 were not allowed to increase DSH spending until it fell below 12 percent of total medical assistance spending.

services—may decrease, since some Medicaid-eligible people may be discouraged from seeking eligibility and enrollment apart from the new welfare process. However, states may need to restructure their eligibility and enrollment systems to ensure that people who are eligible for Medicaid continue to participate in the program. Restructuring their systems will undoubtedly increase states' administrative costs. The net effect of these changes remains to be seen.

The potential for cost savings through managed care also remains unclear, as experience is limited and state objectives in switching to managed care have not always emphasized immediate cost-containment. Yet it is hoped that managed care will, over time, help constrain costs. While Arizona's Medicaid managed care program has been effective, cost savings were due primarily to considerable effort to promote competition among health plans. The challenge is whether the state can sustain this competition in the future.

Administration's Proposal for Medicaid Controls Spending While Increasing Flexibility

To help control Medicaid spending and increase state flexibility, the administration's 1998 budget proposal includes three initiatives: (1) imposing additional controls over DSH payments, (2) implementing a per capita cap policy, and (3) eliminating waiver requirements and the Boren Amendment. Through the implementation of these and other initiatives, the administration's proposal projects a net saving in federal Medicaid spending of \$9 billion over 5 years.

DSH Payments Reduced

As previously mentioned, in 1995 DSH payments began to grow moderately as states began to reach their federal allotments. The Congressional Budget Office's Medicaid baseline estimates the federal share of DSH payments over the next 5 years will increase from \$10.3 billion in 1998 to \$13.6 billion in 2002. The administration's proposal would cap federal spending on DSH at \$10 billion in 1998, \$9 billion in 1999, and \$8 billion in 2000 and thereafter. To achieve the projected savings, the administration's proposal would limit federal DSH payments for 1998 in each state to the state's 1995 level. In subsequent years, the national limit is lowered, and the reduction is distributed across states by taking an equal percentage reduction of all or some of each state's 1995 DSH payments. In states where DSH payments in 1995 exceeded 12 percent of total Medicaid expenditures, the percentage reduction would only apply to the amounts at or under the 12-percent limit. This limit on reductions would affect 16 states that in 1995 had DSH payments in excess of 12 percent of their total Medicaid expenditures.

In the past we reported on states using creative mechanisms to increase their federal Medicaid dollars, specifically through DSH, provider-specific taxes and voluntary contributions, and intergovernmental transfers.¹⁰ Legislation in 1991 and 1993 went a long way toward controlling DSH payments and provider taxes and voluntary contributions. In particular, the 1991 legislation froze DSH payments for “high-DSH” states—those whose DSH expenditures exceeded 12 percent of Medicaid expenditures—because of concerns that these high levels included inappropriate efforts to increase federal matching funds. The administration’s proposal would provide some protection for high-DSH states at the expense of low-DSH states that have kept their share of program spending on DSH below the congressionally specified target level.

Per Capita Caps to Limit Federal Spending

The administration’s proposed per capita cap aims at more certain control over federal Medicaid spending but does not address concerns about the distribution of federal funding resulting from the current matching formula. The administration’s proposal defines a per capita cap policy that would limit federal Medicaid spending on a per beneficiary basis. As Medicaid enrollment increases in a particular state, so would the federal dollars available to the state. The per capita cap would be set using 1996 as the base year—including both medical and administrative expenditures. The proposal would use an index based on nominal gross domestic product (GDP) per capita plus an adjustment factor to account for Medicaid’s high utilization and intensity of services provided. This index and the number of people eligible for Medicaid in a particular year would be applied to the total 1996 expenditures to determine a state’s per capita limit of federal dollars. Savings expected from this proposal will depend on restraining the growth in spending per beneficiary to about 5 percent a year over the 5-year period.

When the Medicaid program was established, a matching formula to determine the share of federal funds was adopted to narrow the differences likely to result among the Medicaid programs of wealthier and poorer states. Because states have discretion regarding the extent and depth of their programs, the federal share of Medicaid expenditures varied with states’ per capita income so that differences in poverty rates and state tax bases would not result in excessive differences in the coverage given to poor people living in different states. However, per capita income has proven to be an imprecise proxy for the incidence of poverty and state tax

¹⁰Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994); Michigan Financing Arrangements (GAO/HEHS-95-146R, May 5, 1995); and State Medicaid Financing Practices (GAO/HEHS-96-76R, Jan. 23, 1996).

capacity. In addition, current law guarantees that no state will have to pay more than half of the total costs of its Medicaid program, meaning states with higher income receive a higher federal share than they otherwise would. This has contributed to disparities among states in coverage of population groups and services as well as in federal funding.

The administration's proposal would not address these disparities. To the extent there is congressional interest in lessening them, we have previously indicated that any distribution formula should include (1) better and more direct measures than per capita income for both the incidence of poverty and states' ability to finance program benefits, (2) adjustors for geographic differences in the cost of health care, and (3) a reduced guaranteed federal minimum match.¹¹

Increased State Flexibility

In regard to state flexibility, the administration has proposed changes in three areas: managed care programs, long-term care programs, and the Boren Amendment. Currently, states must obtain waivers of certain federal statutory requirements in order to implement large-scale managed care programs and to provide home- and community-based services as alternatives to nursing facility care. The administration has proposed eliminating the need for a waiver for such programs. In addition, the Boren Amendment, which places certain requirements on how states can set reimbursement rates for hospitals and nursing facilities, would be repealed.

Medicaid's restrictions on states' use of managed care reflect historical concerns over access and quality. For example, the so-called 75/25 rule that stipulates that, to serve Medicaid beneficiaries, at least 25 percent of a health plan's total enrollment must consist of private paying patients, was intended as a proxy for quality because private patients presumably have a choice of health plans and can vote with their feet. A second provision, allowing Medicaid beneficiaries to terminate enrollment in a health plan at almost any time, aims to provide them with a similar capacity to express dissatisfaction over the provision of care. The administration's proposal would replace these requirements with enhanced quality monitoring systems.

We have studied Medicaid managed care programs for many years and have concluded that some federal requirements may have hampered

¹¹Medicaid: Matching Formula's Performance and Potential Modifications (GAO/T-HEHS-95-226, July 27, 1995).

states' cost-containment efforts. However, the experience of states with Medicaid managed care programs underscores the importance of adequate planning and appropriate quality assurance systems.¹² If states are granted more direct control to aggressively pursue managed care strategies, the importance of continuous oversight of managed care systems to protect both Medicaid beneficiaries from inappropriate denial of care and federal dollars from payment abuses should not be overlooked.

We have also reported on the successful use by states of home- and community-based care services as an alternative to nursing facilities. States we contacted in the course of this work have expanded the use of such services as part of a strategy to help control rapidly increasing Medicaid expenditures for institutional care. States have told us that when implementing these programs, they value the control they have under a waiver but not under the regular program over the amount of home- and community-based services provided. They indicated this control allows them to serve the population in need within budgetary constraints. Despite the limitations in program size, these programs have allowed states to serve more people with the dollars available.

Originally, the Boren Amendment was intended to provide states with greater latitude in setting hospital and nursing facility reimbursement rates while ensuring rates were adequate to provide needed services. Over time, however, states believe court decisions have made the Boren Amendment burdensome to states and affected their ability to set reimbursement rates. The uncertainty created by the language of the Boren Amendment is potentially preventing states from controlling rates of payment to institutional providers in ways that compromise neither access nor quality. While some clarification of the Boren Amendment to address state concerns is needed, its original goals are still valid.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Subcommittee might have at this time. Thank you.

¹²Medicaid: Spending Pressures Spur States Toward Program Restructuring (GAO/T-HEHS-96-75, Jan. 18, 1996); Medicaid: Tennessee's Program Broadens Coverage but Faces Uncertain Future (GAO/HEHS-95-186, Sept. 1, 1995); Medicaid: State Flexibility in Implementing Managed Care Programs Requires Appropriate Oversight (GAO/T-HEHS-95-206, July 12, 1995); Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan (GAO/HEHS-95-87, Apr. 28, 1995); and Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993).

Contributors

For more information on this testimony, please call Kathryn G. Allen, Assistant Director, on (202) 512-7059. Other major contributors included Lourdes R. Cho, Richard N. Jensen, Deborah A. Signer, and Karen M. Sloan.

Stability of Growth Rate for Federal Medicaid Outlays, Fiscal Years 1995 and 1996

GAO developed a growth stability index that shows the direction and magnitude of change in the growth rates of federal outlays between fiscal years 1995 and 1996. An index of 1.0 indicates no change in the growth rates for the 2 years. An index greater than 1.0 indicates a decrease in the 1995-96 growth rates. For example, Colorado's index of 1.37 ranks it as having the largest decrease.

Table I.1: Growth Stability Index for Federal Medicaid Outlays by State, Fiscal Years 1995 and 1996

	Percentage growth, fiscal year 1995	Percentage growth, fiscal year 1996	Growth stability index	State ranking based on growth stability index
States and District of Columbia	11.00	3.18^a	1.08	
Alabama	10.63	3.71	1.07	26
Alaska	2.54	17.60	0.87	49
Arizona	2.70	4.58	0.98	43
Arkansas	8.76	7.50	1.01	38
California	13.73	2.80	1.11	21
Colorado	30.84	-4.66	1.37	1
Connecticut	10.68	11.51	0.99	40
Delaware	24.47	19.65	1.04	35
District of Columbia	-0.51	-1.37	1.01	39
Florida	22.35	-4.28	1.28	4
Georgia	7.82	2.44	1.05	31
Hawaii	31.87	11.46	1.18	9
Idaho	12.99	5.46	1.07	24
Illinois	16.30	1.85	1.14	12
Indiana	-13.34	24.52	0.70	51
Iowa	11.46	-0.02	1.11	17
Kansas	12.67	-2.05	1.15	11
Kentucky	13.36	2.15	1.11	19
Louisiana	1.19	-15.96	1.20	8
Maine	-0.22	10.21	0.91	48
Maryland	15.56	3.36	1.12	16
Massachusetts	11.22	3.50	1.07	23
Michigan	7.86	1.46	1.06	27
Minnesota	13.48	2.52	1.11	20
Mississippi	16.54	3.34	1.13	15
Missouri	8.70	6.81	1.02	36
Montana	7.05	11.76	0.96	46

(continued)

Appendix I
Stability of Growth Rate for Federal
Medicaid Outlays, Fiscal Years 1995 and
1996

	Percentage growth, fiscal year 1995	Percentage growth, fiscal year 1996	Growth stability index	State ranking based on growth stability index
Nebraska	6.22	9.89	0.97	45
Nevada	20.88	15.52	1.05	32
New Hampshire	-21.73	0.95	0.78	50
New Jersey	10.16	5.54	1.04	33
New Mexico	13.80	21.30	0.94	47
New York	8.13	6.47	1.02	37
North Carolina	26.51	1.27	1.25	5
North Dakota	11.19	0.08	1.11	18
Ohio	10.94	4.43	1.06	28
Oklahoma	9.22	3.42	1.06	30
Oregon	38.37	4.26	1.33	3
Pennsylvania	7.50	1.62	1.06	29
Rhode Island	18.81	-10.97	1.33	2
South Carolina	16.72	0.71	1.16	10
South Dakota	13.18	-0.03	1.13	13
Tennessee	21.67	0.78	1.21	7
Texas	11.80	4.57	1.07	25
Utah	10.14	11.25	0.99	41
Vermont	18.23	7.40	1.10	22
Virginia	5.24	8.41	0.97	44
Washington	15.39	2.02	1.13	14
West Virginia	-3.19	-1.77	0.99	42
Wisconsin	7.55	3.17	1.04	34
Wyoming	20.88	-1.68	1.23	6

^aAggregate growth in federal outlays for Medicaid is 3.3 percent when outlays for territories are included in calculation.

Source: Federal outlays for Medicaid, U.S. Treasury.

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