Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COST CONTAINMENT FOR MEDICAID DISABILITY PROGRAMS

JUNE GIBBS BROWN
Inspector General

JULY 1997
OEI-05-95-00400

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EXECUTIVE SUMMARY

PURPOSE

To identify trends in the growth of Medicaid disabled beneficiaries and expenditures related to them, and describe State efforts to contain such costs while ensuring quality care.

BACKGROUND

In fiscal year 1995, the Medicaid program served 35 million beneficiaries at a cost of $135 billion to the States and Federal Government. Almost 6 million of these beneficiaries were blind or otherwise disabled, and they accounted for $49 billion in expenditures.

Between 1993 and 1995, Medicaid expenditures increased 33 percent, while the national medical price index increased only 9.6 percent. Concerned about costs, States have increasingly requested waivers from the Health Care Financing Administration to allow them greater flexibility in Medicaid, including implementing managed care and various waiver programs. There are a couple of potential ramifications for Medicaid disability expenditures. First, there is the issue of whether cost savings initiatives adequately address that portion of Medicaid expenditures devoted to disability. At the same time, such proposals and projected funding cuts have led some to question whether beneficiaries with disabilities might experience a loss of coverage or weaker benefit packages.

We analyzed national data about Medicaid expenditures for disabled persons and closely examined how five States with very large Medicaid programs were trying to contain costs while providing quality services for disabled persons.

FINDINGS

RAPID GROWTH OF MEDICAID DISABILITY PROGRAMS: The number of disabled beneficiaries grew 17 percent in 2 years.

In the 2 years from 1993 to 1995, the number of disabled Medicaid beneficiaries grew from 5.0 to 5.85 million. Expenditures for disabled persons increased from $38.6 to $49.2 billion. In 24 States, these expenditures grew 27 percent or more; 8 States experienced growth between 45 and 123 percent.

In 1995, disabled beneficiaries were 17 percent of Medicaid beneficiaries, the second smallest group (following the elderly), but accounted for 37 percent of expenditures, the largest proportion of expenditures. States spent from 23 to 49 percent of all Medicaid dollars for disabled persons alone. The average per capita cost for this

group was $8,422 compared to $1,777 per adult and $1,046 per child in the needy family population.

BROAD STRATEGIES NOT TARGETED AT DISABLED POPULATION: **Sample States target Medicaid cost containment primarily at the less expensive needy family programs rather than the more costly disabled programs.**

None of the sample States are focused strategically on containing Medicaid costs for disabled beneficiaries as a group. They are turning to managed care to contain Medicaid costs, especially through waivers that allow them to develop broad managed care demonstration programs. However, these demonstrations will probably not result in cost savings relative to the disabled population in the foreseeable future. They are too new and targeted primarily at needy families. The cost savings projected are broad, speculative, and in some cases will not appear for the first 2 or 3 years of operation.

FEW INITIATIVES TARGETED AT TOP EXPENDITURES FOR DISABLED PERSONS: **Sample States have few initiatives to reduce costs for hospital inpatient and Intermediate Care Facilities-Mentally Retarded (ICFs-MR) services, which account for the largest proportions of their spending for the disabled.**

We found no initiatives in our five State study for reducing hospital inpatient costs for the disabled. All States have home and community based care waivers for persons with mental retardation or developmental disabilities as part of a shift away from costly institutional placements. However, the waivers affect a small proportion of disabled beneficiaries and these data on cost savings is incomplete and unreliable.

DISABILITY INITIATIVES ARE MODEST: **States also use waivers to serve other relatively small groups of disabled beneficiaries. Their impact on cost containment is not clear.**

In addition to serving people with mental retardation or developmental disabilities, States serve others with disabilities with waivers. However, numbers served are very small and cost data is incomplete.

RECOMMENDATION

The Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation should develop a research agenda aimed at controlling costs while assuring quality of care for disabled Medicaid beneficiaries.

We are aware that there is a lot of Medicaid experimentation being conducted by the States, primarily through waivers and managed care. After examining the literature, participating in conferences and discussing both the waivers and other plans with appropriate State personnel, our findings indicate that the large States in our sample have not yet come to grips with the difficult problem of providing quality care, yet

containing costs, for the Medicaid disability programs. While these findings do not lead to recommendations for quick fixes or even for programmatic changes, we do believe that there is a compelling need to better understand the significant cost forces that these disability programs portend for the broader Medicaid program of the future.

The need then is to develop a research agenda at the Federal, State and local levels that examines the cost and quality of health care for this population. A starting point could be the Health Care Financing Administration's and the Assistant Secretary for Planning and Evaluation's research agenda that focuses on managed care for people with disabilities. Efforts, other than managed care, could include focusing on ICFs-MR, skilled nursing facilities, and in-patient hospitals. Home and community based waivers and other significant initiatives that are important for persons with disabilities should also be studied. We believe that constructing a research agenda for the future now will result in better quality care and cost savings in the next 5 to 10 years.

We recommend that the Health Care Financing Administration (HCFA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) jointly develop such a research agenda.

In response to HCFA's request, we suggest, among others, the following six studies:

- A historical study of the Medicaid treatment received by people with disabilities. This study would focus on the efficacy of current public programs ability to provide the myriad health care, rehabilitative and support services required by the Medicaid disabled population.

- The development and evaluation of the efficacy of integrated care models for financing acute and long-term care for people with disabilities.

- A comparative evaluation of the Medicaid disabled population served by State managed care health care systems and fee-for-service systems.

- A comparative evaluation of access, quality and costs under selected State ICFs-MR programs.

- An evaluation of the appropriateness of various services and care settings for the Medicaid disabled population based on their ability to produce the most efficient and effective outcomes.

- An evaluation of the appropriateness of medical requirements in State Medicaid programs that impact people with disabilities. This study would examine the extent to which these requirements act as barriers to consumer independence and if these requirements could be reduced or eliminated to effect greater consumer control and reduce costs without jeopardizing the health and safety of consumers.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration (HCFA), the Assistant Secretary for Management and Budget (ASMB) and the Assistant Secretary for Planning and Evaluation (ASPE). All concurred with the recommendation and offered suggestions for clarification and technical comments regarding the report. Changes have been made to the report based on these comments as appropriate. The complete text of HCFA's, ASMB's, and ASPE's comments can be found in Appendix B.

Both HCFA and ASMB raised questions involving data, some relating to issues which we ourselves had raised in the report. A more detailed analysis of these concerns is provided in our response to their comments contained in the body of the report.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

To identify trends in the growth of Medicaid disabled beneficiaries and expenditures related to them, and describe State efforts to contain such costs while ensuring quality care.

BACKGROUND

Medicaid (Title XIX of the Social Security Act) is a joint Federal-State means-tested entitlement program, administered by the Health Care Financing Administration (HCFA). The Federal Government provides matching funds to States, which administer the program under Federal guidelines but may make certain policy choices and determine how their program will be structured. State Medicaid programs thus vary with respect to eligibility criteria, service coverage, provider payment arrangements, and program administration.

In fiscal year (FY) 1995, Medicaid served 35 million beneficiaries at a cost of $135 billion. Almost 6 million of these beneficiaries were blind or otherwise disabled, and they accounted for $49 billion in expenditures. They included people receiving Supplemental Security Income (SSI) and people receiving Medicaid but no cash benefits due to excess resources. The disabled Medicaid population can be divided into three very broad groups based on primary disability: those with a physical disability, those with a mental illness, or those with mental retardation. As of December 1994, 43 percent of the under-65 SSI population was physically disabled, 29 percent had a mental illness, and 29 percent had a developmental disability or mental retardation. A small number received SSI based on a substance abuse disorder. Recent changes in Federal guidelines eliminate eligibility based on substance abuse.

The disabled make up the most diverse Medicaid beneficiary group whose needs are equally disparate. Children with spina bifida, the mentally retarded, persons with acquired immunodeficiency syndrome (AIDS), the chronically mentally ill, accident and stroke victims and individuals with such physical disabilities as blindness, muscular dystrophy and rheumatoid arthritis are but a few of the many faces of the Medicaid disabled. Many disabled Medicaid beneficiaries have chronic conditions that require ongoing and costly specialty care, such as end-stage AIDS patients, while others have few or no additional costs beyond those of the general population.[1]

[1] "Medicaid Managed Care: Serving the Disabled Challenges State Programs," United States General Accounting Office, GAO/HHS-96-136, July 1996.

Using a broad array of acute (i.e., inpatient hospital), primary (i.e., clinic visits) and long-term (i.e., nursing home) care services, on average, health care expenditures for the disabled are about 5 percent of their expenditures for long-term care.[2] Nationally, nursing home care expenditures are primarily financed through Medicaid at about 52 percent and the beneficiary, who incurs about 33 percent in out-of-pocket expenses.[3]

"Long-term care" refers to a range of medical, social, personal, supportive and specialized housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or condition. Chronic conditions are the leading cause of illness, disability and death in the United States, affecting about 99 million people in 1995.[4] While chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. With advances in medical technology and the aging of the baby boom generation, individuals living with a chronic condition are projected to grow to 134 million by 2020.[5]

Since 1965, Medicaid has grown from a health financing program for welfare recipients to a major source of health care coverage for low-income families, supplementary insurance for Medicare beneficiaries, and long-term care for the elderly and disabled. From 1989 to 1992, Medicaid spending grew twice as fast as total health care spending, or an average annual increase of 20.5 percent. Between 1993 and 1995, expenditures increased from $101.7 billion to $134.9 billion, or 33 percent, while the national medical price index increased only 9.6 percent during that period. In 1995, the Congressional Budget Office estimated that without changes, total Medicaid spending would increase by more than 10 percent annually over the following five years, reaching $262 billion by 2002.

Concerned about rising costs, States have increasingly requested waivers from HCFA of various Medicaid provisions designed to allow them greater flexibility in their programs. Currently, 49 States have implemented managed care programs for all or segments of their Medicaid populations. As of June 30, 1995, 11.6 million Medicaid beneficiaries were enrolled in managed care plans, representing 32 percent of total beneficiaries. States have also used waivers, particularly home and community based waivers, to serve certain Medicaid populations, including the disabled, in their homes or communities rather than institutions.

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[2] Ashbaugh, John and Smith, Gary, "Beware the Managed Health-Care Companies," Mental Retardation, June 1996.

[3] "Chronic Care in America: A 21st Century Challenge," Prepared by The Institute for Health & Aging, University of California, San Francisco for The Robert Wood Johnson Foundation, Princeton, New Jersey, August 1996.

[4] Ibid.

[5] Ibid.

There has been a lot of activity around these various waivers, including written descriptions of what they are about and some evaluative reports that have explored their effectiveness or impact. However, with their continued rapid growth, innovative nature, and differences among States, the waivers have been difficult to assess in terms of their successes and failures.

Proposals for national Medicaid reform have been made in recent months by the Administration, Congress, and the National Governors' Association. These include creating a Medicaid block grant, with an associated cut in spending, and imposing a 5 percent cap, either on aggregate Medicaid expenditures or on a per capita basis. Such proposals and projected funding cuts have led some to question whether beneficiaries with disabilities might experience a loss of coverage or weaker benefit packages. Of further concern are proposals that would, in effect, repeal certain Federal standards ensuring coverage and services for certain populations.

SCOPE AND METHODOLOGY

This report first analyzes recent growth of the Medicaid disabled population and associated spending, nationally and across States. This analysis is based on figures reported by States to HCFA on Form 2082 for 1993 through 1995.[6] Form 2082 summarizes a State's combined State and Federal Medicaid spending by beneficiary group and service, for a 1 year period.

The report then describes how five States which accounted for a high proportion of Medicaid expenditures in 1995 are approaching cost containment relative to disabled beneficiaries. Four States (California, Illinois, New York, and Texas) ranked in the top five in total 1995 Medicaid expenditures; Massachusetts ranked eighth. These States represent a geographic and demographic mix. In 1995, they collectively accounted for: 41 percent of all Medicaid spending; 34 percent of all disabled beneficiaries; and, 42 percent of expenditures for that population.

The description of State cost containment efforts is based on a literature review[7] and discussions with HCFA regional staff and respondents from Medicaid and other agencies in the sample States. We wanted to learn about cost containment strategies of these States relative to: the disabled population as a whole; the highest categories of expenditures for the disabled; and specific disabled populations or services for them. We sought the best, most complete information available about State activities as of the summer and fall of 1996. However, some information in this report inevitably will be incomplete or out of date by the time the report is issued. The topic is very broad, Medicaid reforms are proceeding very rapidly in these States, and

[6] As of May 1996, fiscal year 1995 data was complete with the exception of New Hampshire.

[7] Articles and reports by national organizations, budget documents from the States, their Medicaid plans, waiver proposals and reports to HCFA, and other program-specific material they sent to us.

sometimes it was impossible to connect with the most knowledgeable respondents due to State agency reorganizations.

We are aware, through our literature review and discussions with various State officials and organizations, that some States have attempted to cut or contain expenditures on behalf of their disabled Medicaid population through such efforts as: more intensive case management, risk adjusted payment systems for managed care plans, preventing unnecessary utilization through gate keeping and substitution of certain services for more costly forms of care. The scope of this study is confined to five States that spend 42 percent of all Medicaid disabled funds and thus does not allow for a detailed discussion of initiatives in other smaller States.

FINDINGS

RAPID GROWTH OF MEDICAID DISABILITY PROGRAMS: The number of disabled beneficiaries grew 17 percent and expenditures grew proportionately.

To examine trends in the number of disabled beneficiaries, expenditures, and services, we analyzed Medicaid data reported by States to the Health Care Financing Administration for fiscal years 1993, 1994, and 1995.

Between FYs 1993 and 1995:

- The number of disabled Medicaid beneficiaries grew 17 percent nationally (from 5.0 to 5.85 million), significantly outpacing growth of 6 percent of total beneficiaries. In 29 States, growth of disabled beneficiaries exceeded 17 percent.

- The proportion of all Medicaid beneficiaries who are disabled grew nationally from 15 percent to 16.6 percent.

- Expenditures for the disabled increased 27 percent (from $38.6 to $49.2 billion) compared to the medical price index of 9.6 percent. Twenty-four States saw increases of this proportion or greater; eight States saw increases from 45 to 123 percent. Only six States saw a decrease.

In 1995:

- Disabled beneficiaries were 17 percent of all Medicaid beneficiaries nationally, the second smallest group (following the elderly), but accounted for 37 percent of expenditures, the largest proportion of expenditures. Figure 1 shows Medicaid beneficiaries by type, and expenditures by type of beneficiary, for FY 1995.

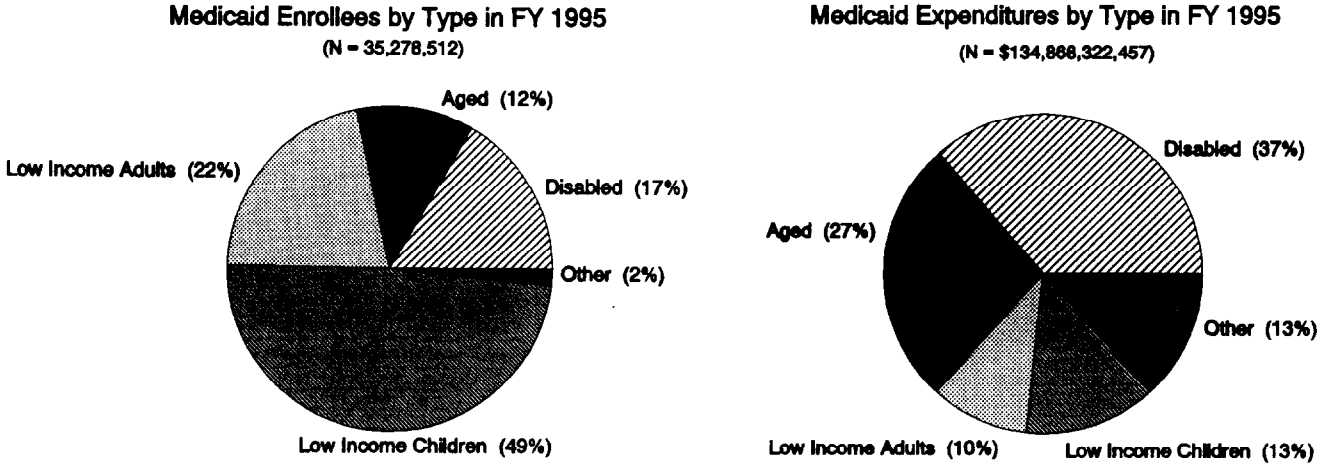

Figure 1

- States spent between 23 percent and 49 percent of all Medicaid dollars on the disabled alone. Thirteen States spent 40 percent or more.

- The average per capita cost was $8,422, with a huge range across the 50 States from about $1,100 in Arizona to almost $19,000 in New York. California's per capita is roughly $6,000, while Illinois is about $10,000. We do not know why such great variation exists, although the existence of large institutional ICFs/MR in some States may be one factor that increases the costs. The national per capita cost is four and a half times more than the $1,777 cost per adult and eight times more than the $1,046 cost per child in the needy family population. Cost per aged recipient was slightly higher at $8,847.

- After adjusting for inflation between 1993 and 1995, overall per capita costs were $8,443 in 1993, $8,114 in 1994, and $8,422 in 1995.

Figure 2 on page 7 shows national and State Medicaid expenditures for disabled persons, as a proportion of total Medicaid expenditures and per capita.

BROAD STRATEGIES NOT TARGETED AT DISABLED POPULATION:

Sample States target Medicaid cost containment primarily at the less expensive needy family programs rather than the more costly disabled programs.

None of the sample States is focused strategically on containing Medicaid costs for disabled beneficiaries as a group. In general, they are turning to managed care to contain Medicaid costs, especially through Section 1115 waivers that allow them to develop broad managed care demonstration programs.[8]

Section 1115 Demonstration Programs

We acknowledge that there are a few States that have included disabled persons in managed care waivers, most notably Oregon and Tennessee. How those States will fare with that population and whether any successes will be able to be replicated in the larger States are very open questions at the current time.

Waiver programs in the sample States include those approved by HCFA and beginning implementation (Illinois and California), others approved by HCFA but not the State legislature, or vice versa (New York, Massachusetts), and one in the planning stage (Texas).

While we have no hard evidence, we have some doubt that these Section 1115 demonstrations will result in cost savings relative to the disabled population, at least in

[8] Section 1115 of the Social Security Act permits a State, with Federal approval, to waive any requirements of the Medicaid program, including eligibility standards, covered benefits, and enrollment in managed care.

FY 1995 MEDICAID SPENDING ON DISABLED: as Percent of Total Spending and Per Capita

Figure 2

State	Total Medicaid Expenditures	% For Disabled	Expenditures For Disabled	Number Of Disabled	Per Capita
AR	$1,379,498,656	48.6%	$670,031,189	87,399	$7,666
IL	$6,392,260,054	43.1%	$2,755,075,554	276,999	$9,946
MI	$3,732,900,505	43.0%	$1,605,831,531	222,852	$7,206
MN	$2,824,292,348	42.2%	$1,191,420,917	75,570	$15,766
NJ	$4,172,526,406	42.0%	$1,750,643,859	144,029	$12,155
RI	$726,159,230	41.8%	$303,470,172	25,252	$12,018
WI	$1,821,910,188	41.5%	$755,993,838	104,745	$7,217
MA	$4,365,454,460	41.3%	$1,801,913,656	160,501	$11,227
DC	$619,436,751	40.7%	$252,419,725	23,901	$10,561
OR	$1,312,376,474	40.6%	$533,272,865	46,157	$11,553
MD	$2,280,219,643	40.6%	$925,638,192	85,638	$10,809
ID	$411,024,089	40.3%	$165,846,131	18,483	$8,973
KY	$2,211,819,116	40.3%	$890,773,040	156,335	$5,698
NY	$24,419,147,016	39.6%	$9,670,729,780	510,573	$18,941
MT	$331,809,600	39.4%	$130,754,598	16,341	$8,002
DE	$378,015,772	39.3%	$148,424,869	12,642	$11,741
SD	$349,435,525	39.1%	$136,770,521	13,486	$10,142
VT	$369,574,420	38.9%	$143,820,187	14,699	$9,784
NE	$568,333,803	38.6%	$219,574,833	23,950	$9,168
ME	$839,127,895	38.2%	$320,252,719	31,971	$10,017
IA	$1,204,742,621	38.1%	$458,942,388	50,057	$9,168
CO	$1,198,058,588	37.9%	$453,972,393	49,466	$9,177
CA	$11,599,939,686	37.8%	$4,381,238,345	742,312	$5,902
AL	$1,604,878,234	37.0%	$594,502,617	131,365	$4,526
ND	$322,586,081	37.0%	$119,306,841	8,720	$13,682
NV	$384,326,755	36.9%	$141,632,027	16,181	$8,753
LA	$3,217,777,569	36.7%	$1,181,094,847	160,134	$7,376
TN	$2,436,373,510	36.3%	$885,266,592	220,698	$4,011
KS	$958,077,472	36.2%	$346,611,769	39,179	$8,847
SC	$1,699,023,049	36.2%	$614,591,905	94,538	$6,501
WV	$1,297,178,135	36.1%	$468,306,793	74,645	$6,274
HI	$259,775,950	36.0%	$93,515,826	13,679	$6,836
MS	$1,488,986,275	35.9%	$533,920,616	125,811	$4,244
WA	$1,632,369,236	34.5%	$563,952,419	104,816	$5,380
PA	$5,142,600,614	34.3%	$1,761,583,845	269,042	$6,548
NM	$895,977,264	34.2%	$306,517,118	39,806	$7,700
UT	$544,296,774	34.1%	$185,679,412	19,010	$9,767
VA	$2,161,936,970	33.7%	$727,915,800	105,733	$6,884
WY	$198,413,171	33.4%	$66,231,438	6,232	$10,628
GA	$3,698,557,191	33.3%	$1,231,103,125	191,421	$6,431
OH	$6,440,601,148	33.0%	$2,123,515,648	232,521	$9,133
CT	$2,353,961,263	32.8%	$772,202,663	49,815	$15,501
IN	$2,165,510,996	32.0%	$693,849,493	67,495	$10,280
FL	$5,831,574,663	30.9%	$1,801,199,574	275,828	$6,530
MO	$2,411,431,591	30.3%	$731,592,528	97,707	$7,488
OK	$1,297,457,076	29.2%	$378,483,007	56,165	$6,739
NC	$3,807,592,334	27.5%	$1,045,427,100	143,974	$7,261
TX	$8,091,194,664	25.3%	$2,046,808,970	270,193	$7,575
AK	$330,834,407	23.1%	$76,327,437	6,668	$11,447
AZ	$292,640,871	23.0%	$67,185,151	61,540	$1,092
VI	$15,052,207	10.7%	$1,603,507	884	$1,814
PR	$379,274,192	4.3%	$16,478,491	69,573	$237
NH	NO REPORT AS OF 5/96				
NATIONAL	$134,868,322,457	36.5%	$49,243,217,861	5,846,731	$8,422

the foreseeable future. First, even the programs being implemented now will not be fully operational for 2 years or more. Second, most of the programs are targeted primarily if not solely at the needy family population. Participation by disabled beneficiaries is often voluntary, and even if mandatory, excludes certain groups (those in institutions, dual-eligibles,[9] those served under special waivers). Third, relatively expensive specialized services used by significant numbers of disabled beneficiaries (mental health services, for example) may be "carved out" to continue on a fee-for-service basis. Finally, while cost savings are projected by the States for these programs, they are broad, speculative, and in some cases not expected to appear for the first 2 or 3 years of operation. Also, cost savings may be one of several goals, taking a backseat to expanding coverage for currently uninsured individuals.

Section 1915(b) Programs

In addition to statewide programs, all five States have, or are planning, smaller managed care programs under 1915(b) ("freedom of choice") waivers, which allow a State to restrict beneficiary choice of provider. However, they target few such managed care programs at disabled beneficiaries and in the few cases where data is available, these programs are serving a small number of disabled beneficiaries.

- Programs in New York, Illinois and Texas target needy families.

- In California, participation of disabled beneficiaries is voluntary, and according to the General Accounting Office (GAO),[10] only about 4 percent of eligible disabled beneficiaries were enrolled in State risk-based managed care programs as of February 1996.

- Texas has four 1915(b) applications pending, but participation by disabled beneficiaries would be voluntary and the waiver applications project budget neutrality rather than savings.

Massachusetts stands out among the sample States in having three large 1915(b) programs, one targets people with mental illness and another, called The Community Medical Alliance, targets those severely disabled or with end-stage AIDS. A Health Maintenance Organization program served about 5 percent of eligible disabled beneficiaries as of February 1996, per GAO. A Primary Care Clinician Program, a fee for service program requiring case management, had over 200,000 enrollees in September 1996, per a State respondent, 53,000 of them disabled. A capitated Mental Health/Substance Abuse Program had 370,000 enrollees as of April 1996; we were unable to learn how many were in the "disabled" category; the program serves fee-for-service and other recipients whether officially categorized as "disabled" or not. These three programs will be strengthened and folded into the planned Section 1115

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[9] Medicare beneficiaries who also receive Medicaid.

[10] Medicaid Managed Care: Serving the Disabled Challenges State Programs, GAO/HEHS-96-136, July 1996.

demonstration, along with a program that provides insurance for working persons with disabilities and parents of children with disabilities.[11]

FEW INITIATIVES TARGETED AT TOP EXPENDITURES FOR DISABLED PERSONS: Sample States have few initiatives to reduce costs for hospital inpatient and Intermediate Care Facilities-Mentally Retarded (ICFs-MR) services, which account for the largest proportions of their spending for the disabled.

Figure 3 shows the eight services that collectively accounted for almost 90 percent of Medicaid expenditures for disabled beneficiaries in 1995.

Spending for inpatient hospital and intermediate care facility-mental retardation (ICFs-MR) services combined has accounted for over 40 percent of national Medicaid expenditures for the disabled since 1993, although the proportion of expenditures they represent dropped from 48 to 43 percent in that time, affected primarily by a dramatic increase of 93 percent in home health expenditures.

MEDICAID EXPENDITURES FOR DISABLED BENEFICIARIES BY TYPE OF SERVICE: FYs 1993 - 1995

SERVICE	EXPENDITURES			PERCENT CHANGE	FY 1995 AS A PERCENT OF TOTAL EXPENDITURES
	FY 1993	FY 1994	FY 1995	FYs 1993 to 1995	
Inpatient Hospital	$10.2b	$11.0b	$11.4b	11.8%	23%
ICFs-MR	$ 8.2b	$ 7.7b	$ 9.7b	18.3%	20%
Home Health	$ 3.0b	$ 4.1b	$ 5.8b	93.3%	12%
Prescribed Drugs	$ 3.6b	$ 4.1b	$ 4.8b	33.3%	10%
SNF	$ 3.9b	$ 4.1b	$ 4.5b	15.4%	9%
Outpatient Hospital	$ 2.0b	$ 2.2b	$ 2.4b	20.0%	5%
Clinic	$ 2.0b	$ 2.1b	$ 2.4b	20.0%	5%
Physician Services	$ 1.8b	$ 1.9b	$ 2.0b	11.1%	4%
Other*	$ 3.9b	$ 5.1b	$ 6.2b	59.0%	12%
TOTAL	$38.6b	$42.3b	$49.2b	27.5%	100%

* Included in the "Other" category are expenditures for: mental hospitals for the aged, SNF/ICF for the aged, psychiatric facilities for age 21 and under, all other ICFs, dental, other practitioners, family planning, laboratory and x-ray, early and periodic screening, rural health clinics, and other miscellaneous services.

Figure 3

[11] In a non-waiver program, Massachusetts also provides in-home services to persons with severe physical disabilities or HIV/AIDS through two special providers. However, the thrust of this program is to enhance access and quality of care rather than cost containment.

In developing cost containment strategies, we assumed that the sample States might target the services costing them the most money. As Figure 4 on the next page shows, in 1995 those services were most often inpatient hospital and ICFs-MR. Home Health represented the highest services in Massachusetts.

We found no initiatives in these States, managed care or otherwise, targeted at hospital inpatient costs for the disabled.[12] Nor do the managed care programs in these States specifically target ICFs-MR costs. However, every State serves some beneficiaries with mental retardation or developmental disabilities through a 1915(c), or home and community based care, waiver. These waivers are part of the States' gradual but strategic shift away from costly placements in institutions such as nursing homes and ICFs-MR. The waivers are serving from 3,600 in Illinois to over 30,000 in California, many more than other 1915(c) waivers in these States but still a small proportion of total disabled beneficiaries there.

States are required to submit a Form 372 to HCFA annually for each 1915(c) waiver reporting the number served and budget figures, including any cost savings. For these mentally retarded/developmentally disabled waivers, the sample States reported per capita cost savings ranging from $3,900 to over $100,000 (projection for 1999). However, we are not convinced that these figures are reliable. For example, some of the Form 372s were submitted 2 or more years late, or not at all and these data provided was sometimes missing or projected rather than actual. For particular waivers (especial model waivers and waivers targeted to individuals with developmental disabilities who were deinstitutionalized as a result of the PASARR programs), the States are not required to complete an entire 372 form. Therefore, even though State respondents believe in the value of the waivers in terms of saving costs (as well as enhancing access and quality of services), we cannot come to any hard and fast conclusions on the question of how much they save, for how many.

On a related note, Massachusetts and New York respondents credited these waivers with enabling them to move or divert thousands from institutional placements. However, it has not been easy to close those institutions completely. The relatively low number of placements in the remaining large ICFs-MR translated into a very high per capita ICFs-MR Medicaid expenditure for 1995: $161,000 in Massachusetts and $160,000 in New York.

In the two sample States where services other than inpatient hospital or ICFs-MR were highest in expenditures, we found no cost containment strategies targeted at them.

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[12] Cost containment has been a strong focus in the California Medicaid program for many years, resulting in one of the lowest per capita Medicaid costs in the country. For example, the State has a special commission which negotiates provider reimbursement rates, including hospital rates. It has freedom of choice waivers limiting the providers from which beneficiaries can obtain hospital inpatient, and inpatient psychiatric, services. However, these measures cut across all populations rather than targeting expenditures for the disabled, specifically.

TOP CATEGORIES OF MEDICAID EXPENDITURES FOR DISABLED BY TYPE OF SERVICE: FY 1995						
STATE	TOTAL $ Spent On Disabled	TOP SERVICE $	% TOP TOTAL $	SECOND SERVICE $	% SECOND TOTAL $	% TOTAL SERVICES
California	$4.4b	Inpatient Hospital $1.2b	27%	SNF and Prescribed Drugs $1.2b (combined)	27% (combined)	54%
New York	$9.7b	ICF-MR $2.5b	26%	Inpatient Hospital $2.2b	23%	49%
Illinois	$2.8b	Inpatient Hospital $1.0b	36%	ICF-MR $0.5b	18%	54%
Texas	$2.0b	Inpatient Hospital $0.6b	30%	ICF-MR $0.55b	28%	58%
Massachusetts	$1.8b	Home Health $0.4b	22%	ICF-MR and Inpatient Hospital $0.6b (combined)	33% (combined)	55%
TOTAL THESE STATES	$20.7b	$5.7b	28%	$5.0b	24%	52%
NATIONAL	$49.2b	Inpatient Hospital $11.4b	23%	ICF-MR $9.7b	20%	43%

Figure 4

- California, where prescription drug and skilled nursing facility expenditures share second place, has taken some steps, and proposes others, to reduce costs across the entire Medicaid population but not specifically the disabled. For example, the State limits prescriptions to six per month per Medicaid enrollee, which undoubtedly affects beneficiaries with chronic illnesses or disabilities the most. A special State drug rebate program negotiates with manufacturers for savings of $20 to $30 million over savings from a Federal program.

- In Massachusetts, home health expenditures, the top category of service at 21 percent of all expenditures, are high to a great extent due to the State's deliberate expansion of a 1915(c) ICFs-MR waiver, which accounts for half of all the expenditures in this category. As for the other services under "home health," we found no plan to contain them.

DISABILITY INITIATIVES ARE MODEST: States also use waivers to serve other relatively small groups of disabled beneficiaries. Their impact on cost containment is not clear.

All States in our sample have 1915(c) waivers that serve various disabled populations. Massachusetts has one waiver (the one previously mentioned that serves persons with mental retardation and developmental disabilities). The other States reviewed have four or more. Texas has had preliminary discussions with HCFA about a potential 1915(c) to integrate acute and long-term care services for elderly or disabled people, whose participation would be voluntary.

As previously noted, all five States serve thousands of recipients with mental retardation or developmental disabilities. Illinois has a waiver serving 13,381 persons with physical disabilities. Illinois, New York and California serve persons with AIDS/HIV. Other 1915(c) waivers in these States almost all serve very small numbers of severely disabled persons, including children. New York, for example, has five "Care At Home" waivers for children with various disabilities and service needs, each serving approximately 100-200 children in 1994 or 1995.

While these waivers may well be improving access and quality of care, it is difficult to conclude they are resulting in significant cost savings relative to all expenditures for disabled beneficiaries. Most are serving a small number of people. Second, as mentioned previously, cost data reported for 1915(c) waivers is not always available, timely, or complete.

RECOMMENDATION

The Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation should develop a research agenda aimed at controlling costs while assuring quality of care for disabled Medicaid beneficiaries.

We are aware that there is a lot of Medicaid experimentation being conducted by the States, primarily through waivers and managed care. After examining the literature, participating in conferences and discussing both the waivers and other plans with appropriate State personnel, our findings indicate that the large States in our sample have not yet come to grips with the difficult problem of providing quality care, yet containing costs, for the Medicaid disability programs. While these findings do not lead to recommendations for quick fixes or even for programmatic changes, we do believe that there is a compelling need to better understand the significant cost forces that these disability programs portend for the broader Medicaid program of the future.

The need then is to develop a research agenda at the Federal, State and local levels that examines the cost and quality of health care for this population. A starting point could be the Health Care Financing Administration's and the Assistant Secretary for

Planning and Evaluation's research agenda that focuses on managed care for people with disabilities. Efforts, other than managed care, could include focusing on ICFs-MR, skilled nursing facilities, and in-patient hospitals. Home and community based waivers and other significant initiatives that are important for persons with disabilities should also be studied. We believe that constructing a research agenda for the future now will result in better quality care and cost savings in the next 5 to 10 years.

We recommend that the Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation jointly develop such a research agenda.

In response to HCFA's request, we suggest, among others, the following six studies:

- A historical study of the Medicaid treatment received by people with disabilities. This study would focus on the efficacy of current public programs ability to provide the myriad health care, rehabilitative and support services required by the Medicaid disabled population.

- The development and evaluation of the efficacy of integrated care models for financing acute and long-term care for people with disabilities.

- A comparative evaluation of the Medicaid disabled population served by State managed care health care systems and fee-for-service systems.

- A comparative evaluation of access, quality and costs under selected State ICFs-MR programs.

- An evaluation of the appropriateness of various services and care settings for the Medicaid disabled population based on their ability to produce the most efficient and effective outcomes.

- An evaluation of the appropriateness of medical requirements in State Medicaid programs that impact people with disabilities. This study would examine the extent to which these requirements act as barriers to consumer independence and if these requirements could be reduced or eliminated to effect greater consumer control and reduce costs without jeopardizing the health and safety of consumers.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration (HCFA), the Assistant Secretary for Management and Budget (ASMB) and the Assistant Secretary for Planning and Evaluation (ASPE). All concurred with the recommendation and offered suggestions for clarifications and technical comments regarding the report.

Changes have been made to the report based on these comments as appropriate. The complete text of HCFA's, ASMB's, and ASPE's comments can be found in Appendix B.

We would like to specifically address two issues, one raised by ASMB and the other by HCFA. The ASMB commented that our data on Medicaid disability costs did not agree with the HCFA actuary data. The Medicaid expenditure data to which ASMB refers are figures HCFA's Office of the Actuary derive from two forms, HCFA-64 and HCFA-2082. As a result, these numbers differ somewhat from the numbers contained in Figure 2 of our report. We extracted our data from the HCFA-2082 only, because we needed expenditures by type of service for the disabled and the HCFA-64 did not include this specificity. Our expenditure data do match closely to data reported in HCFA's 1995 Medicaid Statistics publication.

The other issue, raised by HCFA, concerned the HCFA-372 reporting forms. The HCFA disagreed with our determination that the reliability of data contained on the HCFA-372 reporting forms was questionable due to the fact that we found these data to be not always available, timely, or complete. The HCFA states that some States are not required to complete the entire form, particularly model waivers and waivers targeted to individuals with developmental disabilities who were deinstitutionalized as a result of the PASARR programs. Moreover, HCFA states that these data are to reflect actual expenditures (recorded by date of service) for Medicaid services furnished to individuals participating in the waiver program, as well as for individuals at a comparable level of care receiving services in institutions. These data are to be submitted each year, with a lag report submitted a year later, to correct incomplete data that may have resulted from late billings, insurance adjustments, etc. The HCFA says they are aware that some forms have been submitted after the specified deadlines, but, they are not aware of generalized deficiencies in the data.

Having reviewed the HCFA-372 data for our five sampled States, we are not certain that these data are accurately reported. Perhaps HCFA should look further at these data and test for reliability. Our concerns are bolstered by one State respondent who admitted having difficulty in trying to gather comparable costs for institutionalized patients. The respondent stated that many other States were experiencing this same problem because, having removed all of their target group members from the institution, they have no equivalent inpatient cost and thus must "construct" the right side of the formula just for the report. One HCFA official stated that one State in their region seldom submits the HCFA-372 reports. This problem exists because, except for the children's waivers, the home and community based services waivers are scattered organizationally throughout various State offices. No one individual is responsible for gathering the data requested on the form.

APPENDIX A

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BIBLIOGRAPHY

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APPENDIX B

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUN - 7 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Cost Containment for Medicaid Disability," (OEI-05-95-00400)

We reviewed the above-referenced report that identifies trends in the growing number of disabled Medicaid beneficiaries and expenditures related to them.

Our detailed comments on the report recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the Office of Inspector General (OIG) Draft Report: "Cost Containment for Medicaid Disability," (OEI-05-95-00400)

OIG Recommendation

The Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation should develop research agenda aimed at controlling costs while assuring quality of care for disabled Medicaid beneficiaries.

HCFA Response

We concur. HCFA would like the OIG to include ideas for more specific research projects. We have comments on the findings as follows:

Finding 1: Rapid Growth of Medicaid Disability Programs. Between 1993 and 1995, the number of disabled beneficiaries grew 17 percent and related expenditures grew 27 percent. In 1995, Medicaid expenditures for disabled persons were more than double the proportion of the Medicaid disabled population.

HCFA Response

We concur.

Finding 2: Broad Strategies Not Targeted at Disabled Population. Sample states target Medicaid cost containment primarily at the less expensive needy family programs rather than the more costly disabled programs.

HCFA Response

We suggest the conclusion relating to the section 1115 demonstration programs be omitted. The discussion draws a conclusion that the demonstrations will not result in cost savings for the disabled population and postulates a number of reasons for this conclusion. The report, however, does not provide evidence to support this conclusion. Only two of the five sample states implemented a section 1115 demonstration program.

Beneficiaries with disabilities continue to express concerns about the shift to managed care and the potential for loss of access to needed specialized services and continuity of care. Extending managed care coverage to individuals with disabilities poses great potential to improve care but also challenges us to ensure the care delivered in a managed care environment is appropriate, accessible, and sensitive to the needs of individuals with disabilities. Potential benefits of providing Medicaid services to individuals with

disabilities in a managed care environment include: enhanced coordination of care, convenience, emphasis on preventive services and community-based care, and flexibility of benefits.

Currently, the Office of Managed Care, Medicaid Managed Care Team, is providing technical assistance to several states developing section 1915(b) waivers to serve persons with disabilities, and to safeguard options that promote meaningful quality of life, maximum dignity, and respect. In addition, the team hopes to ensure participation in care decisions, independent living in community settings, preservation and support of natural support systems, and cost effectiveness.

Finding 3: Few Initiatives Targeted at Top Expenditures for Disabled. Sample states have few initiatives to reduce costs for hospital inpatient and intermediate care facilities for the mentally retarded (ICFs/MR) services, which account for the largest proportions of spending for the disabled.

HCFA Response

The report states, "Every State except Texas serves some beneficiaries with mental retardation or developmental disabilities through a 1915(c)...waiver." Texas has four different home and community-based services (HCBS) waiver programs targeted specifically to the needs of people with mental retardation or developmental disabilities. These waivers are listed under the following control numbers: 0110.90.R1, 0221.90, 0240, and 0281.

The longest running of these (0110.90.RI) is targeted toward individuals with mental retardation or developmental disabilities, and has been in operation since the mid-1980s. The latest, 0281, has been in operation since March 1, 1995, and is targeted specifically towards individuals age 18 or over with developmental disabilities and concurrent diagnoses of deafness and blindness. We can provide details on these waiver programs should the OIG require this information.

Also, the report states that data on the 372 forms (the annual form states must submit to document the spending, health, and welfare of waiver beneficiaries) are projected, rather than actual, and that some data were missing. For particular waivers (especially model waivers and waivers targeted to individuals with developmental disabilities who were deinstitutionalized as a result of PASARR programs), the states are not required to complete an entire 372 form. Moreover, the data that are supplied are to reflect actual expenditures (recorded by date of service) for Medicaid services furnished to individuals participating in the waiver program, as well as for individuals at a comparable level of

care receiving services in institutions. These data are to be submitted each year, with a lag report submitted a year later, to correct incomplete data that may have resulted from late billings, insurance adjustments, etc. Although we are aware that some 372 forms have been submitted after the specified deadlines, we are not aware of generalized deficiencies in the data.

The report also questioned the large amount of savings reported on the 372 forms. Since HCBS waivers serve as alternatives to expensive institutional care, it is not surprising the savings reported are large. We are aware of the very high cost of ICFs/MR care, particularly when that care takes place in aging institutions with extremely high fixed costs. Although states have made great strides towards community placement and downsizing of these institutions, their abrupt closing has often been infeasible, since the impact would be not only on the Medicaid population being served, but the economy of entire areas of the state. We are supportive of state efforts to phase out the use of these institutions, and note the HCBS waiver program has been used by states as an effective alternative to the continued use of these very high cost facilities.

Finding 4: Disability Initiatives are Small: States also use waivers to serve other relatively small groups of disabled beneficiaries. Their impact on cost containment is not clear.

HCFA Response:

We suggest the OIG clarify the heading for this finding. We suggest "disability initiatives serve small segments of the disabled population."

In addition, we suggest the conclusion relating to section 1915(c), be deleted. The report concludes the section 1915(c) waivers do not result in significant cost savings relative to all expenditures for disabled beneficiaries. The report contains no evidence to support this statement. In fact, the report states that cost data are "not always available, timely, complete or reliable."

Technical Comments:

We suggest the OIG limit the findings section to findings only. For clarity, we would like to see conclusions in a separate section.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MAR 21 1997

NOTE TO: George Grob
Deputy Inspector General for Evaluations and Inspections

THROUGH: LaVarne Burton
Deputy Assistant Secretary for Policy Initiatives

FROM: Ashley Files
Peter Harbage

RE: Review of IG Report "Cost Containment for Medicaid Disability Programs"

In response to your memorandum of January 29, 1997, please find our comments regarding a draft report from the Office of the Inspector General titled "Cost-Containment for Medicaid Disability Programs," ~~OEI-05-95-00021.~~ 05-95-00400

Please note that the most critical objection occurs on page 7 regarding a chart that displays FY 1995 Medicaid spending on the disabled. According to HCFA actuaries, this information does not correspond to HCFA data on this topic. We strongly recommend that this discrepancy be resolved before the report is made public.

If you have any questions, please feel free to contact Peter Harbage or Ashley Files at 202-690-6553.

Page 1
Although the purpose states that the report will discuss quality control, there is almost no mention of quality control efforts in the report.

Page 2 -- 3rd Paragraph
What was total Medicaid spending adjusted for inflation from 1993 to 1995?

Page 4 -- First Paragraph
It would be helpful if there was a longer discussion of States that have cost containment efforts. The report never makes it clear that there are effective cost containment ideas that States could implement regrading Medicaid Disability. Although managed care is discussed later in the report, it would be helpful to know the other cost containment strategies beyond managed care.

Also, the report states that there is very little activity in terms of cost containment taking place. It would be helpful to know if the five focus States have ever initiated any cost containment efforts with regard to Medicaid disability programs. If States have, why were the initiatives terminated?

Page 5 -- 1st and 3rd Bullet
It would be helpful to have a chart showing each States' trends in Medicaid disability expenditures and the growth in beneficiaries over the three year study period.

Page 5 and Throughout the Report
The report indicates that the number of disabled Medicaid beneficiaries grew from 5 to 5.8 million or 17% from 1993 to 1995. However, the growth rate from 5 to 5.8 is 16% not 17%.
Growth = (5.8 - 5)/5 = .16

Page 6 -- 2nd Bullet
A brief discussion of why there is such wide variation in the per capita expenditures in each State would be helpful.

Page 6 -- 3rd Bullet
The analysis shows that the per capita expenditures on Medicaid disability beneficiaries adjusted for inflation is flat during the three year study period. In fact, it decreased from 1993 to 1994. This may lead some to conclude that cost containment initiatives are not needed, especially given the high expenditure growth rates in other parts of Medicaid. Given the flat per capita growth, there needs to be a discussion of why cost containment is still important. It could be the case that States do not feel cost containment is an issue given this flat growth. It would also be helpful to know the per capita spending stream for all of the States.

Page 6
The report provides the per capita growth adjusted for inflation but not the overall growth of Medicaid disability expenditures adjusted for inflation. What is the overall growth rate adjusted for inflation? Is the overall growth flat as well?

Page 7 -- Chart
According to HCFA actuaries, the chart given on page 7 does not correspond to their data on Medicaid disability expenditures. Before the report is released, we feel that it is critical that this discrepancy be resolved.

Page 9 -- Chart
The "other" category of service grows at 59%, the third highest growth rate given on the chart. It would be helpful to discuss the services provided in this category and why the growth rate is so high.

Page 13 -- 1st Paragraph -- Last Line
Use "cost savings" instead of "cost dividends."

Also--
A chart showing what disability services are provided by each State would be helpful.

It would be interesting to see the per capita growth in cost for the services listed in the chart on page 9.

It would be interesting to see a comparison of growth rates in expenditures for similar disability services covered by private sector insurance companies. Is Medicaid spending on these services growing faster or slower than in the private sector?

TO: June Gibbs Brown
Inspector General

FROM: David F. Garrison JM/for
Principal Deputy Assistant Secretary
for Planning and Evaluation

SUBJECT: OIG Report on Cost Containment for Medicaid Disability Programs--
CONCUR WITH COMMENTS

We greatly appreciate the OIG's efforts to involve OASPE staff during the preparation of this report, and we concur with their recommendation that OASPE and HCFA jointly develop a research agenda.

However, upon reading the report we have a few suggestions:

- You might want to mention that there is no evidence presented in this report that Medicaid expenditures for persons with disabilities are inappropriate. Although cost containment is important, there are other goals in administering state Medicaid programs, especially improving service delivery systems and quality of care for persons with disabilities.

- It would be useful to describe more detailed state program efforts to care for persons with disabilities. For example, much of the effort toward de-institutionalization has taken place to improve quality of care and quality of life. One consequence has been rapid increase in expenditures for home and community-based services. Perhaps New York until recently has had a more generous home and community-based services program than can be justified, but the increase in such services are generally viewed as successes. Similarly, state managed care efforts have several objectives. Cost containment is certainly one of them, but improving access to care, improving enrollees satisfaction, and improving continuity and quality of care are also important objectives.

- Please clarify the first sentence on page 5.