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Report to the Secretary of Health and Human Services

November 2012

MEDICAID

States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance

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GAO-13-55

November 2012

MEDICAID

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GAO Highlights

Accountability * Integrity * Reliability

Highlights of GAO-13-55, a report to the Secretary of Health and Human Services

Why GAO Did This Study

Medicaid enrollment has grown significantly in recent years due to the economic downturn. This growth is expected to continue as the Patient Protection and Affordable Care Act potentially extends Medicaid eligibility in 2014 to millions of uninsured individuals. To better understand whether states are providing adequate access to medical care for beneficiaries, this report examines (1) states' experiences processing Medicaid applications, (2) states' changes to beneficiary services and provider payment rates, (3) the challenges states report to ensure sufficient provider participation, and (4) the extent to which Medicaid beneficiaries reported difficulties obtaining medical care. To examine the first three objectives, GAO administered a nationwide web-based survey to Medicaid officials on states' experiences from 2008 through 2011 and obtained a response rate of 98 percent. To examine the last objective, GAO analyzed data from the 2008 and 2009 Medical Expenditure Panel Survey, the most current available at the time of our analysis, to assess Medicaid beneficiaries' reported difficulties obtaining care, and the 2009 National Health Interview Survey to assess their reasons for delaying care. To provide context, we compared their experiences to those of individuals with private insurance or who were uninsured.

View GAO-13-55. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

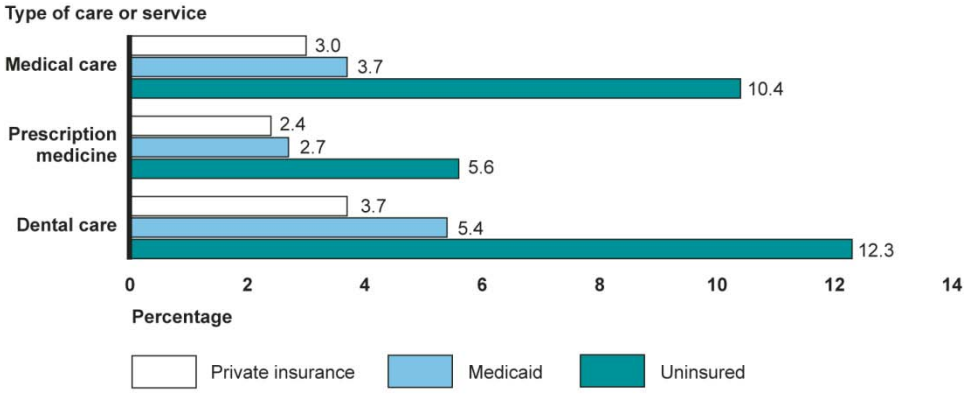
From 2008 to 2011, more than half of states reported maintaining or decreasing their average Medicaid application processing times—the average number of calendar days between the receipt of a new application and the final determination of eligibility. The average processing times reported by 39 states ranged from 11 to 45 calendar days. For the same time period, however, GAO was unable to assess whether states processed applications at a rate that kept pace with the number of new applications received each month, because most states provided incomplete or inconsistent data.

States reported making numerous changes to provider payments, provider taxes, and beneficiary services since 2008. While more states reported provider-rate and supplemental payment increases each year from 2008 through 2011, the number reporting payment reductions and increased provider taxes also grew. More states reported increasing services than limiting them.

Over two-thirds of states reported challenges to ensuring enough Medicaid providers to serve beneficiaries—including dental and specialty care providers. States cited Medicaid payment rates and a general shortage of providers as adding to the challenge. To attract new providers, over half the states reported simplifying administrative requirements or increasing payment rates.

In calendar years 2008 and 2009, less than 4 percent of beneficiaries who had Medicaid coverage for a full year reported difficulty obtaining medical care, which was similar to individuals with full-year private insurance; however, more Medicaid beneficiaries reported difficulty obtaining dental care than those with private insurance. Beneficiaries with less than a full year of Medicaid coverage were almost twice as likely to report difficulties obtaining medical care as those with full-year coverage. Medicaid beneficiaries reported delaying care for reasons such as long wait times and lack of transportation.

Percentage of Individuals Who Reported Difficulties Obtaining Necessary Care or Services, by Full-Year Insurance Status, Calendar Years 2008-2009



Source: GAO analysis of Medical Expenditure Panel Survey data.

The Department of Health and Human Services reviewed a draft of this report and provided technical comments, which GAO incorporated as appropriate.

Contents

Abbreviations

CHIP	State Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare & Medicaid Services
DSH	Disproportionate Share Hospital
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
HCERA	Health Care and Education Reconciliation Act
HHS	Department of Health and Human Services
ICF/ID	Intermediate Care Facilities for Persons with Intellectual Disabilities
MEPS	Medical Expenditure Panel Survey
NHIS	National Health Interview Survey
PPACA	Patient Protection and Affordable Care Act
UPL	Upper Payment Limit

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

November 15, 2012

The Honorable Kathleen Sebelius
Secretary of Health and Human Services

Dear Madam Secretary:

Enrollment and expenditures in Medicaid, a federal-state health financing program for certain categories of low-income individuals, have grown significantly in recent years. During the nation's recent economic crisis, Medicaid enrollment grew 14.2 percent from October 2007 through February 2010. During this time, total Medicaid expenditures grew nearly 21 percent, from $332.2 billion in 2007 to $401.5 billion in 2010.[1] Since then, enrollment growth has slowed—averaging around 4 percent nationally—yet the growth in Medicaid spending continues to be a source of concern.[2] Economic downturns can create challenges for states because tax revenues can decrease, while unemployment—and enrollment in Medicaid—can increase. To reduce program spending, states generally may make certain changes to their Medicaid programs, such as altering payments to providers, limiting eligibility, eliminating optional services, or reducing the amount, duration, or scope of services.

While recent laws have provided some fiscal relief to states through the provision of additional federal funding for Medicaid, they have also limited the ability of states to alter their programs. For example, the American Recovery and Reinvestment Act of 2009 (Recovery Act) provided a temporary increase in the rate at which the federal government matched state expenditures, but required states to maintain Medicaid program eligibility in order to receive the additional funding.[3] The Patient Protection

[1]See *2001 Actuarial Report on the Financial Outlook for Medicaid* (Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services, Mar. 16, 2012).

[2]See GAO, *State and Local Governments' Fiscal Outlook, April 2012 Update*, GAO-12-523SP (Washington, D.C.: Apr. 2, 2012).

[3]Pub. L. No. 111-5, § 5001,123 Stat.115, 496-502 (2009). The Recovery Act initially provided states with an estimated $87 billion in increased federal funds for Medicaid from February 2009 through December 2010. In August 2010, Congress extended the increased federal matching rate through June 2011, although at a lower level than what was provided under the Recovery Act. See Pub. L. No. 111-226, §201, 124 Stat. 2389, 2393-4 (2010).

and Affordable Care Act of 2010 (PPACA)[4] requires states to expand their Medicaid programs to cover additional individuals and provides an enhanced federal match for this coverage.[5] PPACA also makes other changes to Medicaid eligibility and payment, such as requiring states to maintain their current levels of eligibility for Medicaid beneficiaries and increasing payment rates for Medicaid primary care services in 2013 and 2014.[6] Potential Medicaid expansions under PPACA are estimated to result in enrollment of about 7 million additional individuals in 2014

[4]Pub. L. No. 111-148, 124 Stat. 119 (2010) (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (HCERA). For purposes of this report, references to PPACA include the amendments made by HCERA.

[5]Effective January 1, 2014, states must expand Medicaid eligibility to non-pregnant individuals under age 65 who have household incomes that do not exceed 133 percent of the federal poverty level for the applicable family size, who are not entitled to or enrolled in Medicare, and who are not already required to be covered under Medicaid. States will receive an increased federal match for newly eligible adults starting at 100 percent in 2014 and gradually decreasing to 90 percent in 2020. 42 U.S.C. §§1396a(a)(10)(A)(i)(VIII), 1396d(y). As initially set forth in PPACA, states that chose not to expand Medicaid coverage faced the potential loss of all federal Medicaid funds, including for the population already covered under the current program. However, the U.S. Supreme Court has ruled that states that choose not to expand Medicaid coverage will forgo only the enhanced federal matching funds associated with such expanded coverage. See *National Federation of Independent Business, et al., vs. Sebelius, Sec. of Health and Human Services, et al.*, 132 S. Ct. 2566, 2012 WL 2427810 (U.S. June 28, 2012).

[6]42 U.S.C. §§ 1396a(a)(13)(C), (gg),1396u-2(f). States must maintain Medicaid eligibility standards for children from PPACA's enactment, March 23, 2010, until October 1, 2019, and for adults, until the Department of Health and Human Services (HHS) determines an exchange in the state is operational. (PPACA requires states to establish exchanges—marketplaces through which individuals can access private health plans.) Exceptions to this maintenance-of-effort requirement may be granted for certain adults with income above 133 percent of the federal poverty level for states experiencing or projecting a budget deficit. In addition, payment rates for primary care services paid to Medicaid providers either by states or Medicaid managed care plans generally must be increased to Medicare reimbursement levels for those services; such increases relative to a state's December 2009 rates will be federally funded. On November 6, 2012, CMS published a final rule implementing this requirement, in which the agency specifies which services and types of providers qualify for the increased payments and the methods for calculating the federal share for the increased payment amount. Under this rule, CMS also will require states to report data on primary care provider participation before and after the increased payments, which CMS will make publicly available. 77 Fed. Reg. 66,670 (November 6, 2012).

growing to 11 million in 2022.[7] While it is too early to assess the extent to which states will expand Medicaid coverage to this newly eligible population, any growth in Medicaid is likely to place additional pressure on states to manage their programs, maintain or increase their pool of providers, and ensure access to needed health care services for Medicaid beneficiaries.

In October 2010, we reported on changes states were making to sustain their Medicaid programs after certain federal funding increases from the Recovery Act lapsed. Some of these changes could affect beneficiaries' access to care.[8] Over half of the states reported making administrative changes that could affect Medicaid application processing time, such as decreasing the number of staff or staff hours available for processing Medicaid applications and increasing furlough days. Additionally, states reported changes to certain services and payments to providers that could affect beneficiary access. Such changes raise questions about whether Medicaid is meeting the health care needs of the current beneficiaries and whether the expansion of Medicaid may further exacerbate issues of access for beneficiaries. To assess factors that can affect access and beneficiaries' experiences obtaining care, this report examines (1) states' experiences processing Medicaid applications, (2) changes that states have made to beneficiary services and provider payment rates, (3) the challenges states report with regard to ensuring sufficient provider participation, and (4) the extent to which Medicaid beneficiaries' reported difficulties obtaining medical care.

To address the first three objectives, we administered a web-based survey from February 2012 to May 2012 to Medicaid officials in the 50 states, the District of Columbia, and the 5 largest U.S. territories, and

[7]Enrollment numbers reflect new enrollment in both Medicaid and the Children's Health Insurance Program. See Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* (July 2012).

[8]See GAO, *Recovery Act: Increased Medicaid Funds Aided Enrollment Growth, and Most States Reported Taking Steps to Sustain Their Programs*, GAO-11-58 (Washington, D.C.: Oct. 8, 2010). In this report, we described actions states were taking to address program sustainability after funding from the Recovery Act was no longer available.

obtained a response rate of 98 percent.[9] In this survey, we generally asked about states' experiences from 2008 through 2011. For the web-based survey, we relied on the survey response reported by the primary contact for the state's Medicaid program. When we asked states about implementing various efforts, such as application processing improvements, we generally gave a time frame for implementation, and state efforts implemented prior to that time frame are not included in the report. We did not independently verify the accuracy of the data reported by states, but we reviewed all survey responses for internal consistency. In addition, we completed our state survey field work prior to the June 28, 2012, decision by the Supreme Court on certain aspects of PPACA, including the Medicaid expansion provision. Accordingly, state responses were provided to us before they had analyzed any potential effect of the decision on their own state. To address the fourth objective, we analyzed two national surveys, the National Health Interview Survey (NHIS) and the Medical Expenditure Panel Survey (MEPS), to examine the extent to which Medicaid beneficiaries reported difficulties obtaining care. Our MEPS analysis was based on national survey data from 2008 and 2009, the most recent data available at the time of our analysis. Our NHIS analysis was based on the 2009 survey.[10] Both of these national surveys rely on information reported by individuals. To provide context for difficulties obtaining care reported by Medicaid beneficiaries, we examined the extent to which individuals with private insurance or those who are uninsured reported such difficulties. We also conducted the analysis across different age groups, including children, working-age adults,[11] and those 65 and older, but small sample sizes limited the reliability of some analyses, and therefore we did not report them. For the MEPS analysis, children with Medicaid also included those with coverage

[9]Fifty states, the District of Columbia, and 4 U.S. territories (American Samoa, Guam, Puerto Rico and the Commonwealth of the Northern Mariana Islands) responded to the survey. The U.S. Virgin Islands did not complete the survey. For the purposes of this report, we are referring to all 56 jurisdictions that we surveyed as states.

[10]Data from the 2010 NHIS survey were available, but we chose to analyze the 2009 survey so the time period would be compatible with the MEPS analysis.

[11]In this report, the term "working-age adults" refers to those ages 18-64.

under the State Children's Health Insurance Program (CHIP).[12] We examined differences in reported difficulty obtaining care between beneficiaries reporting fair or poor health and those reporting better health and between those with full-year coverage and less than full-year coverage.[13] For the NHIS and MEPS surveys, we reviewed relevant documentation describing how these data are collected and processed, and examined other research that has used these data to report on potential delays in obtaining health care services to check our results against similar analyses. We determined that the data we used in this report were sufficiently reliable for the purposes of our engagement. (See app. I for additional information on our scope and methodology.)

We conducted this performance audit from December 2011 through November 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicaid finances health care for certain categories of low-income individuals, including pregnant women, children, certain low-income parents, persons with disabilities, and persons who are elderly.[14] In addition, states can expand Medicaid eligibility to other individuals,

[12]CHIP is a federal-state program that generally provides health care coverage to children in low-income families whose incomes exceed the eligibility requirements for Medicaid. States have the choice of three design approaches for their CHIP programs: (1) a Medicaid expansion program, (2) a separate child health program, or (3) a combination program, which has both a Medicaid expansion program and a separate child health program.

[13]Individuals with less than full-year coverage reported having insurance coverage for between 1 to 11 months. Individuals may be covered under Medicaid for only part of the year for a variety of reasons, including changes in income. In this report, we used a 95 percent confidence level and compared upper and lower confidence intervals to determine whether any differences we found were statistically significant. Statistical significance indicates that the difference between observations is unlikely due to chance alone.

[14]Parents are eligible for Medicaid under certain circumstances. For example, states must, at a minimum, cover parents who meet the state's 1996 Aid to Families with Dependent Children eligibility criteria, which vary among states and include both financial and categorical components.

including children and eligible parents with incomes above the current minimum levels. Under broad federal requirements, states administer the day-to-day operations of their Medicaid programs; activities that include determining whether applicants are eligible for Medicaid, setting the scope of covered services, paying providers, and ensuring access to covered services. The Centers for Medicare & Medicaid Services (CMS), a federal agency within the Department of Health and Human Services (HHS), oversees state Medicaid programs at the federal level. States are required to ensure that all individuals who want to apply for Medicaid coverage have the opportunity to do so and must, with reasonable promptness, provide coverage to applicants who are determined eligible.[15] In general, states are required to determine eligibility for individuals who apply for Medicaid within 45 days from the date of application, and within 90 days for those who apply on the basis of disability.[16] In some states, Medicaid applications are reviewed and eligibility is determined at the county level, while other states have centralized their eligibility determination processes.

States' Medicaid programs must cover a set of mandatory services, including those provided by primary and specialty care physicians, as well as services provided in hospitals, clinics, and other settings. States may elect to cover additional optional benefits and services, such as home and community-based services, personal care, and rehabilitative services, under their Medicaid programs. In some cases, not all beneficiaries are eligible for all services. For example, Medicaid requires states to cover necessary dental care for children, but dental coverage for adults is optional.[17] Subject to federal requirements,[18] states may establish the amount, duration, and scope of the mandatory and optional services covered in their Medicaid programs. For example, states may limit the number of visits or the days of care that are provided.

[15]See 42 U.S.C.§ 1396a(a)(8).

[16]See 42 CFR § 435.911. These time standards cover the period from the date an application is submitted to the date the state mails notice of the decision.

[17]As part of the Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, states must provide comprehensive and preventive health care services, including dental services, for individuals who are under 21 years of age who are enrolled in Medicaid. 42 U.S.C. §§ 1936a(a)(43), 1396d(r)(3).

[18]States must provide Medicaid services sufficient in amount, duration, and scope to reasonably achieve their purpose. 42 C.F.R. § 440.230.

States are responsible for setting Medicaid provider payment rates within certain federal requirements. Specifically, federal law requires that state Medicaid payments to providers are consistent with efficiency, economy, and quality of care and are sufficient to enroll enough providers so that services are available to beneficiaries at least to the extent that they are available to the general population in the same geographic area.[19] In addition, states must identify the methodologies for making provider payments in their state plans, and such methodologies must be approved by CMS.

In addition to payments made directly to providers for services to beneficiaries, most states also make supplemental payments that are separate from and in addition to regular Medicaid payments. Supplemental payments include Disproportionate Share Hospital (DSH) payments, which states are required by federal law to make to hospitals that treat large numbers of Medicaid and low-income individuals; DSH payments cannot exceed the unreimbursed cost of furnishing inpatient and outpatient services to Medicaid beneficiaries and the uninsured. Many states also make other optional supplemental payments that are above the standard Medicaid payment rates but within the Upper Payment Limit (UPL).[20] We refer to these payments as non-DSH supplemental payments. In fiscal year 2010, states and the federal government made at least $32 billion in supplemental payments—representing over 8 percent of the Medicaid program's total expenditures—with a federal share of at least $19.8 billion. CMS is responsible for overseeing these payment arrangements, including whether states are appropriately financing their share.[21]

[19]See 42 U.S.C. § 1396a(a)(30)(A). On May 6, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule entitled Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, regarding federal guidelines for approaches for states to demonstrate compliance with some of these requirements. 76 Fed. Reg. 26342 (May 6, 2011). As of October 1, 2012, this rule had not been finalized.

[20]The Upper Payment Limit is the estimated amount that Medicare pays for comparable services.

[21]Over the years, we and others have reported that states were shifting costs inappropriately through several financing methods, notably the use of supplemental payments. A variety of federal legislative, regulatory, and CMS actions have helped curb inappropriate arrangements, but gaps remain. See GAO, *High Risk Series: An Update,* GAO-11-278 (Washington, D.C.: February 2011).

States may also use provider taxes and certain other sources of revenue to finance their Medicaid programs. Provider taxes are taxes, fees, assessments, or other mandatory payments that states may impose on the provision of or payment for certain types of health care items or services, such as inpatient hospital and nursing facility services. States may use revenue from provider taxes for their state share of Medicaid expenditures only if the taxes meet certain criteria.[22] Many states use revenue from a provider tax on a certain type of provider to increase Medicaid payment rates for the same type of provider, and a state could effectively increase a payment rate for a provider without using additional state funds to finance the increase if the revenue from the provider tax and the federal share of the payment rates account for the total increase.[23]

States also may implement certain options to streamline Medicaid eligibility determinations. For example, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established new performance bonuses for states adopting at least five of eight specified policies to simplify Medicaid and CHIP enrollment and retention procedures for children. Possible enrollment and retention simplification measures include adopting 12-month continuous eligibility, eliminating in-person interviews, adopting express lane eligibility, or implementing presumptive eligibility.[24] PPACA also specified additional policies to streamline enrollment and retention in Medicaid and CHIP. For example, PPACA requires states to establish a process by which individuals can

[22]States may receive federal matching funds for provider taxes only if such taxes are broad-based, uniformly imposed, and do not result in any taxpayers being held harmless (i.e., receiving state funds to reduce the net payment to the state to below the amount of the tax). CMS may waive the broad-based and uniform tax requirements if the net effect of the tax is generally redistributive and the tax is not directly related to Medicaid payments. 42 U.S.C. § 1396b(w), 42 C.F.R. §§ 433.68, 72.

[23]See also Congressional Research Service, *Medicaid Provider Taxes,* RS22843 (Mar. 15, 2012).

[24]See Pub. L. No. 111-3, § 104, 123 Stat. 8, 17-23. States are eligible for these performance bonuses for fiscal years 2009 through 2013. Under continuous eligibility, states allow children to remain eligible for Medicaid or CHIP for a full year before any redetermination of eligibility, regardless of changes in household income. Under the express lane eligibility option, states may rely on findings, including income data, from certain other state agencies for Medicaid or CHIP eligibility determination. For presumptive eligibility, states may allow qualified entities, such as, community-based organizations or schools, to screen for eligibility and immediately enroll eligible individuals for a defined period of time.

apply for or renew enrollment in Medicaid using an electronic signature beginning in 2014.[25]

Some States Did Not Report Certain Application Processing Data; Most Reported Decreasing or Maintaining Processing Times

Of the 55 states that responded to our survey, 39 states provided specific data on average application processing times for new Medicaid applications in 2012, and 43 were able to report generally on whether average application processing time increased, decreased, or remained the same since 2008.[26] The average application processing time is the average number of calendar days between the receipt of a new application and the final determination of eligibility. Among the 39 states that reported data, the current application processing ranged from 11 to 45 calendar days, with a median of 25 calendar days.[27] Sixteen states could not report their average processing times, of which about half noted that they do not track these data or that they track them differently than how they were requested in our survey. For example, 4 states noted that they only tracked whether an application met the mandated time frames for the application—not the specific number of days. Another state reported that its data on application processing times were not reliable because of differences in the way the data were reported by counties.

We also asked more generally whether states' application processing times changed since 2008. Of the 55 states that responded, 30 reported decreasing (19 states) or maintaining (11 states) their average processing times for new Medicaid applications, 13 states reported increased processing times, and 12 states reported not knowing whether their processing times had changed.

[25]42 U.S.C. §1396w-3. As a condition of receiving federal Medicaid funds, states must establish an Internet website through which individuals can apply for or renew Medicaid enrollment and may consent to enrollment or reenrollment through an electronic signature. This enrollment website must be linked to the exchange and CHIP websites, ensuring that individuals will be considered for eligibility for those programs if they are determined ineligible for Medicaid.

[26]The survey included a question that asked states to report average application processing time in calendar days. A separate question asked states generally whether application processing time had changed—increased, decreased, or remained the same—since 2008, but did not ask states to report on the magnitude of the change.

[27]Data presented here were for 95 percent of the sample of states reporting a current average processing time. Data were excluded for one state that reported an average processing time of 9 calendar days and for one U.S. territory that reported 120 calendar days.

Among the 19 states that reported decreased average processing times for new applications, 15 states attributed the decreases to efforts to streamline application procedures.[28] These 15 states most frequently cited the use of electronic applications and the elimination of face-to-face interviews as streamlining procedures that facilitated decreases in application processing times. (See fig. 1.) Some of these 15 states also cited a decrease in documentation requirements, use of express lane eligibility, revised or shortened applications, or use of presumptive eligibility for helping decrease application processing times. Specifically:

- Six states reported that the use of express lane eligibility—the reliance on findings from certain other state agencies or state income-tax data to determine eligibility for Medicaid—helped decrease application processing time.[29]

- Five states reported that their decreased processing times were related to the use of presumptive eligibility procedures, in which authorized entities, including community-based organizations and schools, can screen and immediately enroll eligible individuals into Medicaid for a defined period of time.

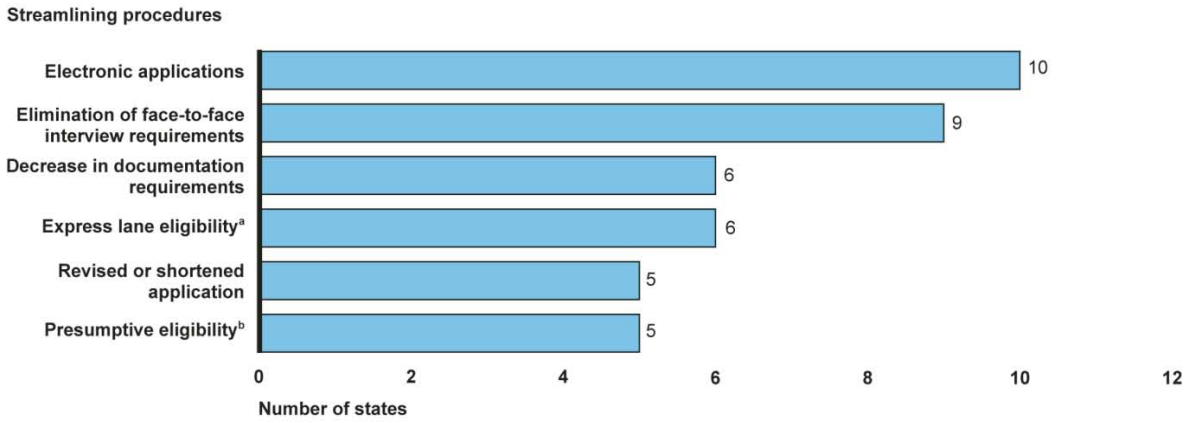
- A few states also attributed decreases in application processing times to other factors not directly related to streamlining application procedures, including additional staff or staff hours (3 states), more intake facilities (2 states) or a reduction in the volume of new applications received (1 state).

(See app. II for further information on states' efforts to use electronic application processing and streamlining the renewal application process.)

[28]Survey results do not indicate the number of states that use a particular application procedure—only the extent to which a state considered this a factor that affected its application processing time. States could cite more than one type of effort to streamline application procedures.

[29]These agencies may include those administering programs including Supplemental Nutrition Assistance, National School Lunch Program, Temporary Assistance for Needy Families, and Head Start.

Figure 1: Number of States Attributing Decreased Application Processing Times, since 2008, to Certain Streamlining Procedures



Source: GAO analysis of state-reported survey data.

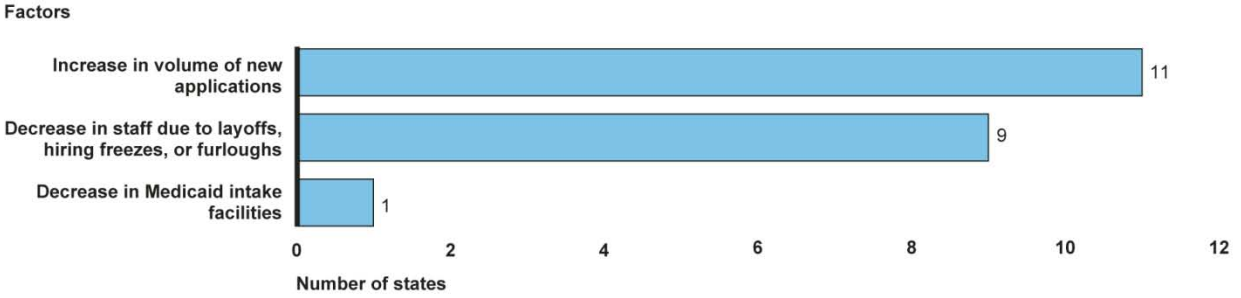
Note: The term "states" includes the 50 states, the District of Columbia, and 4 U.S. territories that responded to the 2012 GAO survey. Fifteen states attributed decreased application time to one or more application streamlining procedures, as described in the figure above. Survey results do not indicate the number of states that use a particular application procedure—only the extent to which a state considered this a factor that affected its application processing time.

[a]Express lane eligibility allows states to rely on findings from certain other state agencies or state income tax data to determine eligibility for Medicaid.

[b]Under presumptive eligibility, states allow authorized entities, such as community-based organizations or schools, to screen for eligibility and immediately enroll eligible individuals for a defined time period.

Almost all of the 13 states that reported an increase in average processing times since 2008 attributed these increases to a growth in the volume of new applications received. (See fig. 2.) States could cite more than one factor, and 9 of these states also identified reductions in staff as a result of layoffs, hiring freezes, or furloughs as factors related to increased application processing time. One state that reported an increase in application processing times indicated that, in addition to an increase in the volume of applications received, its staff were learning to use a new computer system to process applications.

Figure 2: Number of States Attributing Increased Average Application Processing Times, since 2008, to Certain Factors



Source: GAO analysis of state-reported survey data.

Note: The term "states" includes the 50 states, the District of Columbia, and 4 U.S. territories that responded to the 2012 GAO survey. Thirteen states attributed their increased application processing time to one or more factors.

Because of data limitations, we were unable to assess the extent to which the number of applications states processed kept pace with the number of new applications received each month from January 2008 through December 2011. Most states provided incomplete or inconsistent data on new applications received and processed. For example, 25 states provided incomplete data for 2008 and 15 states provided incomplete information for 2011. States cited various reasons for providing incomplete applications data, including upgrades to their data systems since 2008 and data systems that do not differentiate between applications received and applications processed. For the states that did submit monthly applications data, there were differences among states in the way these data were reported. For example, one state reported totals of Medicaid applications processed that were cumulative over time, rather than just those processed within a month. (For more information, see app. I.)

States Made Numerous Changes to Provider Payments and Beneficiary Services

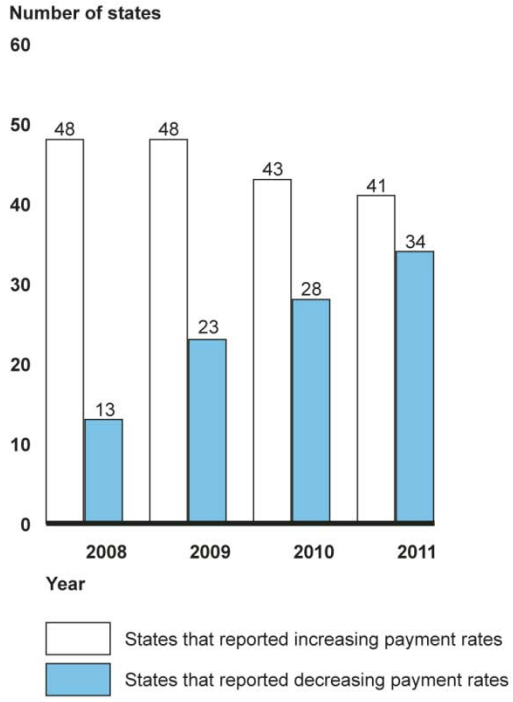
States reported changes—both increases and decreases—to provider payment rates, provider taxes, and beneficiary services since 2008. In a given year, states could make both increases and decreases; for example, states could reduce payment rates to certain types of providers, while increasing payment rates to others. Overall, more states reported payment and service increases than decreases. However, the number of states reporting payment decreases and service limitations grew since 2008.

The Number of States Reducing Providers' Payments or Implementing Supplemental Payments Grew

The number of states that reported making at least one payment rate reduction grew from 13 in 2008 to 34 in 2011, while the number of states increasing at least one provider payment rate fell over the same period. Overall, more states reported increasing provider payment rates in 2011 than reducing them.[30] (See fig. 3.) States most frequently reported reducing payment rates for hospitals across all 4 years. For example, in 2011, 19 states reported payment rate reductions for inpatient hospitals and 17 reported reductions for outpatient hospitals. Of the states that increased provider payment rates, more states generally reported increasing payment rates for nursing facilities than any other provider type across all 4 years. For example, in 2011, 19 states reported an increase in rates for nursing facilities, 18 states reported increased payment rates for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID), and 14 states reported increased payment rates for clinics.

[30]The survey asked states to report whether a certain type of change was made for a provider type in a year, but did not ask for a detailed description of the change, including the magnitude of the change. A state may have made more than one type of change for a provider type in a year.

Figure 3: Number of States Reporting Increases and Decreases to Provider Payment Rates, Calendar Years 2008-2011



Source: GAO analysis of state-reported survey data.

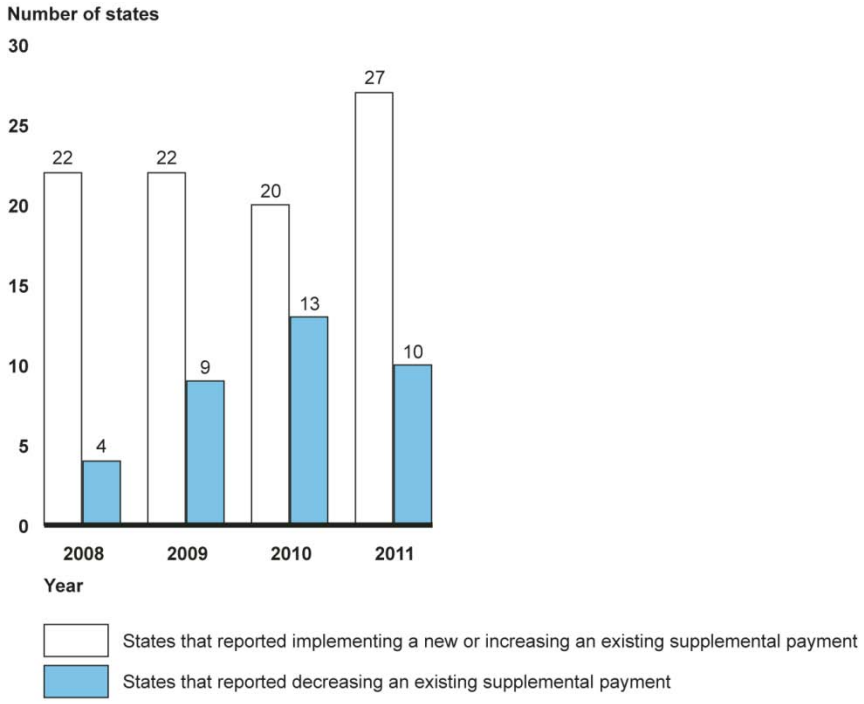
Note: The term "states" includes the 50 states, the District of Columbia, and 4 U.S. territories that responded to the 2012 GAO survey. Fifty-five states responded to questions on changes to payment rates for 13 provider types. States could report multiple increases and decreases in payment rates in a year to different provider types. States that reported more than one increase or decrease in payment rates in a year were counted for one increase or one decrease, respectively, or both, for that year.

From 2008 through 2011, 20 or more states reported increasing their use of supplemental payments, which are payments separate from and in addition to regular Medicaid payments.[31] This included both states that added new supplemental payments or increased existing ones. The number of states that reduced supplemental payments was greater in 2011 (10 states) than 2008 (4 states). (See fig. 4.) States most often cited inpatient hospitals, outpatient hospitals, and nursing facilities as recipients of new or increased supplemental payments across all years. These

[31]Supplemental payments include DSH and non-DSH supplemental payments.

increases in additional supplemental payments coincided with states reporting more payment rate increases for nursing facilities and more rate decreases for inpatient and outpatient hospitals.

Figure 4: Number of States Reporting Changes to Supplemental Payments, Calendar Years 2008-2011



Source: GAO analysis of state-reported survey data.

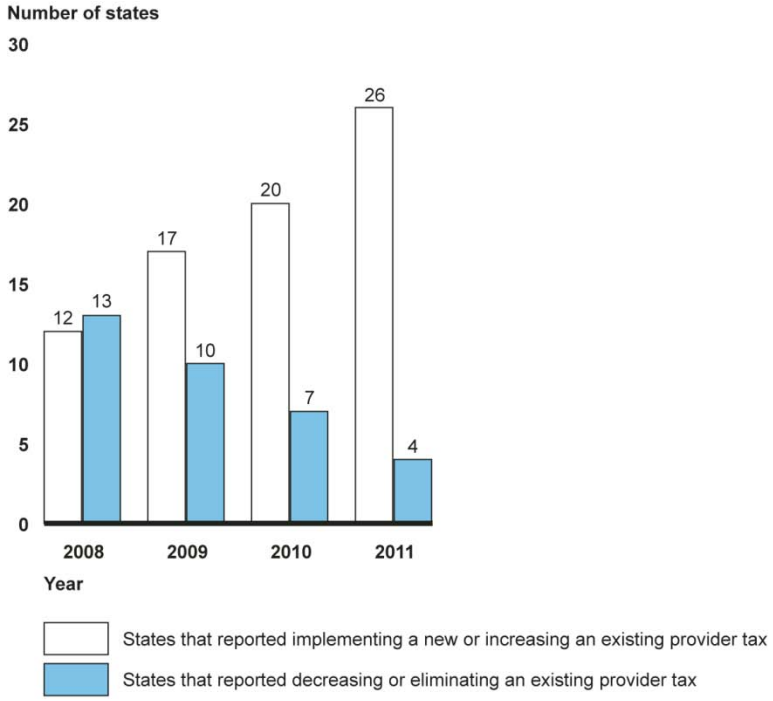
Note: The term "states" includes the 50 states, the District of Columbia, and 4 U.S. territories that responded to the 2012 GAO survey. Fifty five states responded to this question. States could report both implementing a new or increasing an existing supplemental payment and decreasing a supplemental payment in a year. States that reported more than one increase or decrease in supplemental payments in a year were counted for one increase or one decrease, respectively, or both, for that year.

The Number of States Implementing New or Increased Provider Taxes Grew

The number of states implementing new or increasing existing provider taxes more than doubled from 12 states in 2008 to 26 states in 2011. In contrast, the number of states that reported decreasing or eliminating provider taxes fell during the same time period—from 13 states in 2008 to 4 states in 2011. (See fig. 5.) Almost all of the provider taxes that states reported implementing or increasing were for institutional providers—inpatient hospitals, outpatient hospitals, nursing facilities, inpatient mental health providers, and ICF/ID. States most frequently reported that the

purpose was to avoid cuts in services or payment rates, rather than expanding services or increasing provider payment rates.

Figure 5: Number of States Reporting Changes to Provider Taxes, Calendar Years 2008-2011



Source: GAO analysis of state-reported survey data.

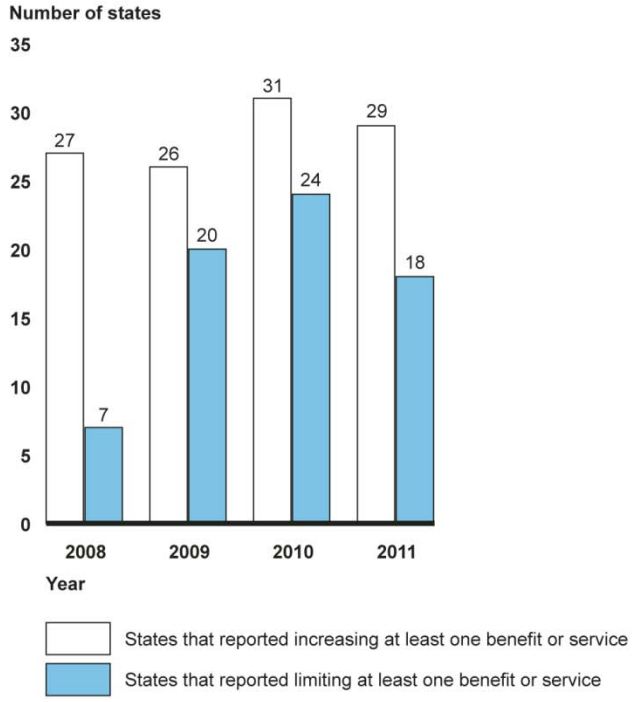
Note: The term "states" includes the 50 states, the District of Columbia, and 4 U.S. territories that responded to the 2012 GAO survey. Fifty-five states responded to this question. States could report both implementing a new or increased provider tax and implementing a decrease in provider taxes. States that reported more than one increase or decrease in provider taxes in a year were counted as one increase or one decrease, respectively, or both, for that year.

The Number of States Implementing Beneficiary Service Limitations Grew

The number of states reporting service increases was relatively stable—ranging from 26 to 31 states—while the number of states reporting service limitations generally grew from 2008 through 2011.[32] (See fig. 6.) From 2008 through 2011, states reported making more changes to coverage for dental, primary, and specialty care services and prescription drug benefits than for other services. For example, in 2011, six states reported increasing coverage for dental services, and nine states reported decreases. Similarly, eight states reported that they increased prescription drug formularies, and seven states reported that they limited them in 2011. From 2008 through 2011, states reported the fewest changes to coverage for ICF/ID and nursing facility services.

[32]States were asked about changes to a variety of specific Medicaid services by provider and benefit type. Changes to benefit types included changes to managed care plan benefits, prescription drug formularies, and beneficiary copays and premiums. For the purposes of this report, services include provider-type services and these Medicaid benefits.

Figure 6: Number of States Reporting Changes to Benefits or Services, Calendar Years 2008-2011



Source: GAO analysis of state-reported survey data.

Note: The term "states" includes the 50 states, the District of Columbia, and 4 U.S. territories that responded to the 2012 GAO survey. Fifty-five states responded to this question. States could report both an increase and limitation in benefits and services in a year. States that reported more than one increase or limitation on a benefit or service in a year were counted as one increase or one decrease, respectively, or both, for that year.

States Reported Challenges Ensuring a Sufficient Number of Providers

Thirty-eight states reported that they experienced challenges ensuring enough participating Medicaid providers.[33] In general, states attributed these challenges to a shortage of providers and Medicaid payment rates, but also cited other issues, such as missed appointments and administrative burden, as factors that influenced provider participation. States reported efforts to simplify administrative processes to retain and

[33]The state responses described here reflect their experiences ensuring a sufficient number of Medicaid providers in fee-for-service Medicaid, primary care case management, and with managed care organizations.

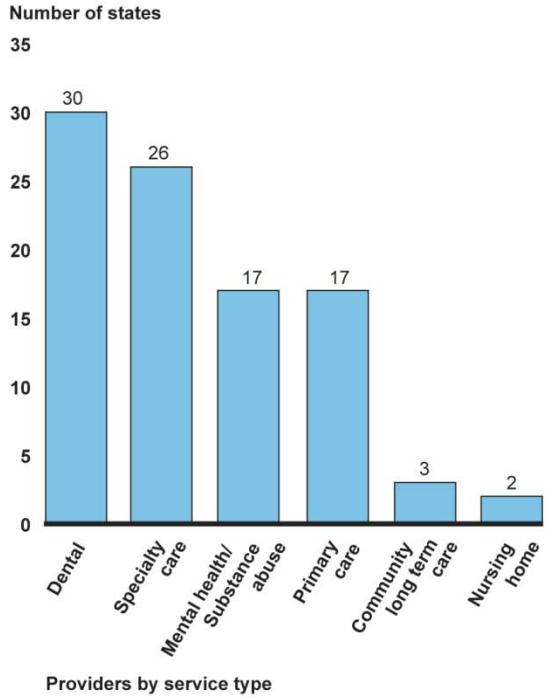
attract Medicaid providers and, to a lesser extent, reported efforts to increase payment rates or other financial incentives.

Over Two-Thirds of States Reported Challenges Ensuring Sufficient Providers, Including Dental and Specialty Providers

Of the 55 states responding to our survey, 38 states reported experiencing challenges to ensuring enough participating providers for Medicaid beneficiaries.[34] Ensuring sufficient dental providers was particularly challenging—but states also reported that ensuring sufficient provider participation in specialty care was problematic. Specifically, states most frequently reported having difficulty ensuring sufficient Medicaid providers for psychiatry, obstetrics and gynecology, surgical specialties, and pediatric services. To a lesser extent, states also cited challenges ensuring enough dermatology and orthopedic service providers. In contrast, fewer states indicated challenges to ensuring adequate nursing facility and community long-term care providers. (See fig. 7.)

[34]One recent study found that physicians' acceptance rate of new Medicaid patients varied across the states, ranging from about 40 to 99 percent of physicians accepting new Medicaid patients in 2011. Overall, physicians were less likely to take new Medicaid patients than they were to take patients with Medicare, private insurance, or who self-pay. See S. Decker, "In 2011 Nearly One-third of Physicians Said They Would Not Accept New Medicaid Patients, but Rising Fees May Help, Health Affairs," vol. 31, no. 8 (August 2012).

Figure 7: Number of States Reporting Challenges to Ensuring Enough Participating Medicaid Providers, by Service Type



Source: GAO analysis of state-reported survey data.

Note: The term "states" includes the 50 states, the District of Columbia, and 4 U.S. territories that responded to the 2012 GAO survey. Fifty-five states responded to this question. States could select more than one service for which they considered it challenging to ensure enough participating providers.

To monitor provider participation, states reported using provider enrollment data, utilization or claims data, and datasets such as the Healthcare Effectiveness Data and Information Set.[35] For example, 34 states reported that they analyze provider enrollment data and 24 states reported that they analyze utilization or claims data to monitor provider participation in primary or specialty care, or both.[36] Additionally, 18 states indicated that they have identified data sources that they plan to

[35]The Healthcare Effectiveness Data and Information Set, which is managed by the National Committee for Quality Assurance, is a tool used by health plans across the country to measure the plans' performance on certain dimensions of care and service.

[36]These data reflect states' fee-for-service Medicaid programs.

use to meet future requirements to measure beneficiary access to services under CMS's proposed regulation, which if finalized, would require states to conduct access reviews for a subset of services each calendar year and release the results to the public.[37] Most states reported that they will analyze claims data or provider enrollment data to meet this requirement. To a lesser extent, states noted that they will assess other sources such as provider and beneficiary surveys as a means to measure access to services in the state. States that use managed care organizations also cited oversight of contract requirements as a way to ensure access.

When asked about factors affecting provider participation, states cited an overall shortage of providers, low payment rates, and other factors—such as missed appointments, and physicians' difficulties referring Medicaid patients to specialists.[38] (See table 1.) The factors cited by states are similar to those found in published research. For example, some studies have shown that Medicaid payment rates strongly influence provider willingness to participate in the program,[39] while other studies have indicated that the level of payment was not the sole driver of the decision to participate. For example, a study that examined the willingness of primary care providers to accept new Medicaid patients found that while higher Medicaid payment rates were associated with a greater probability of primary care providers accepting all or most new Medicaid patients, the effects were relatively modest—suggesting that other factors affect the decision to accept Medicaid patients.[40] According to this study, other

[37]See 76 Fed. 26342 (May 6, 2011).

[38]Our prior work also found that physicians reported difficulties referring Medicaid children to specialists. See GAO, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, GAO-11-624 (Washington, D.C.: June 30, 2011).

[39]One study that analyzed data the years before and after Maryland increased Medicaid payment rates to physicians found that physician participation had increased in the state following the rate increases. See S. H. Fakhraei, "Payments for Physician Services: An Analysis of Maryland Medicaid Reimbursement Rates," *International Journal of Healthcare Technology and Management*, vol. 7, numbers 1 / 2 (2006). Also, another study found a positive relationship between state Medicaid payment levels and pediatrician participation. See S. Berman, J. Dolins, S. Tang, and B. Yudkowsky, "Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients," *Pediatrics*, vol. 110, no. 2 (2002).

[40]P. Cunningham, *State Variation in Primary Care Physician Supply: Implications for Health Reform Medicaid Expansions*, Research Brief, no. 19 (Center for Studying Health System Change, March 2011).

factors, such as the structure of the practice and Medicaid administrative requirements can affect the decision to participate as well.

Table 1: Factors States Reported That Affect Provider Participation in Medicaid

Factors affecting provider participation	Number of states
Shortage of providers serving all insurance groups	33
Low Medicaid payment rates	33
Missed appointments	31
Administrative burden of enrolling as a Medicaid provider	17
Administrative burden relating to submitting claims and claims processing	15
Difficulty referring to specialists	14

Source: GAO analysis of states' survey responses.

Note: The term "states" includes the 50 states, the District of Columbia, and 4 U.S. territories that responded to the 2012 GAO survey. Fifty-five states responded to this question. States could report more than one factor.

Another study of physicians found that, in light of the multiple factors that may influence willingness to serve Medicaid beneficiaries, an increase in Medicaid payment rates must be accompanied by other program simplifications in order to influence physician participation.[41] Similarly, in a study on dental care, states reported particular challenges ensuring enough participating dental providers. While this study found that dental provider participation increased following rate increases in the states examined, the rate increases were not sufficient on their own to improve Medicaid beneficiaries' access to dental care. The study also noted that streamlining administrative processes and changing dentists' perception of Medicaid could improve participation among them as well.[42]

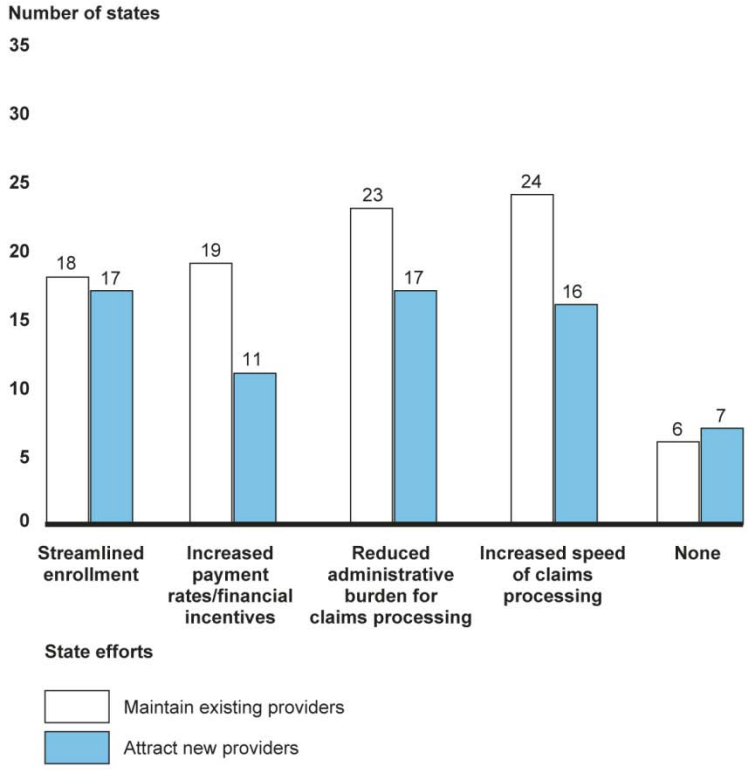
[41]See P. Cunningham and A. O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation by Physicians?" *Health Affairs*, Web Exclusive, (November 2008), doi: 10.1377/hlthaff.28.1.w17.

[42]See A. Borchgrevink, A. Snyder, S. Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care* (National Academy for State Health Policy, March 2008).

States Implemented Administrative and Payment Changes to Encourage Provider Participation

Thirty-eight states reported making at least one administrative or payment rate change to encourage provider participation. These efforts included streamlining enrollment, increasing payments, increasing the speed of claims processing, and reducing administrative burdens. (See fig. 8.) Other efforts cited by states included direct recruitment of providers, improved prior authorization of services, and assistance to providers through training, education efforts, and improved claims resolution.

Figure 8: State Reported Efforts to Maintain Existing Pool or Attract New Medicaid Providers



Source: GAO analysis of state-reported survey data.

Note: The term "states" includes the 50 states, the District of Columbia, and 4 U.S. territories that responded to the 2012 GAO survey. Fifty-five states responded to this question. States could report more than one type of effort to maintain existing or attract new Medicaid providers. Survey results do not indicate the overall number of states that use a particular application procedure—only the extent to which a state considered this an effort to maintain existing or to attract new Medicaid providers.

PPACA provided an increase in Medicaid payments for primary care services in 2013 and 2014, and we asked states the extent to which these payments will assist in increasing primary care participation. Of the 55 states that responded to this question, 24 indicated that they were uncertain whether such an increase would assist the state in boosting participation of Medicaid primary care providers. Seventeen states reported that the increase will help to some extent, while 3 reported it will help a great extent. Nine states reported that the increase will not help with participation. Various states reported a number of possible reasons that the increase may not help with provider participation, including its temporary nature, because provider payment with the increase will still fall below commercial rates, and because of a provider shortage in the state, among other reasons.

Few Full-Year Medicaid Beneficiaries Reported Difficulty Obtaining Care, but Experiences Varied

In calendar years 2008 and 2009, less than 4 percent of all Medicaid beneficiaries enrolled for a full year reported difficulty obtaining necessary medical care or prescription medicines, a percentage similar to individuals with full-year private insurance. The extent to which Medicaid beneficiaries reported difficulties obtaining medical care varied by age and whether they were enrolled for a full or partial year. Medicaid beneficiaries also reported delaying care for a variety of reasons, most commonly due to not having transportation, a long wait once at the doctor's office, and being unable to get an appointment soon enough.

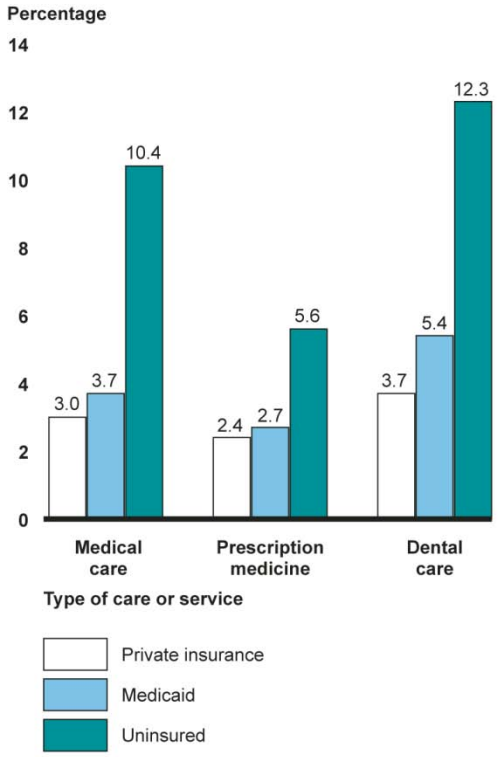
Full-Year Medicaid Beneficiaries Reported Similar Difficulty Obtaining Needed Medical Care as Privately Insured Individuals

Beneficiaries covered by Medicaid for a full year reported low rates of difficulty obtaining necessary medical care and prescription medicine, similar to those with private insurance for a full year.[43] In calendar years 2008 and 2009, approximately 3.7 percent of Medicaid beneficiaries enrolled for a full year and 3 percent of individuals enrolled in private insurance for a full year reported difficulties obtaining needed medical care; the difference between these two groups was not statistically significant. In addition, 2.7 percent of full-year Medicaid beneficiaries reported difficulty obtaining needed prescription medicines and about 2.4 percent of individuals with full-year private insurance reported the same issue—also not statistically significant. Full-year Medicaid

[43]We added together those individuals who reported being unable to obtain or had delays in obtaining needed medical care to report on those who had difficulty obtaining care.

beneficiaries did however, report experiencing greater difficulty obtaining necessary dental care than those with full-year private insurance. (See fig. 9.) Individuals who were uninsured for a full year reported the greatest difficulty obtaining medical care, prescription drugs, and dental services—at least twice the reported rate of full-year Medicaid beneficiaries.

Figure 9: Percentage of Individuals Who Reported Difficulties Obtaining Necessary Care or Services, by Full-Year Insurance Status, Calendar Years 2008-2009



Source: GAO analysis of Medical Expenditure Panel Survey data.

Note: This figure includes only those individuals who reported insurance coverage or lack of coverage for the entire year (2008 or 2009, or both). The difference between the percentage of individuals with Medicaid and the percentage of individuals with private insurance who reported difficulty obtaining necessary dental care is statistically significant at the 95 percent confidence level. The difference between the percentage of individuals with Medicaid and the percentage of the uninsured who reported difficulty obtaining dental care is also statistically significant at the 95 percent confidence level. The differences between the percentage of individuals who were uninsured who reported difficulty obtaining medical care and the percentages of individuals with Medicaid or private insurance were statistically significant at the 95 percent confidence level. Other differences—such as comparisons between Medicaid and private insurance for medical care and prescription medicine—were not statistically significant. The 95 percent confidence intervals for estimates in this figure are within +/- 1.5 percent of the estimates themselves. Medicaid data include children enrolled in the Children's Health Insurance Program.

The percentage of individuals experiencing difficulty accessing needed care was higher for those who reported fair or poor health status, with little difference in the rates between those with Medicaid or private health insurance. Approximately 9.9 percent of full-year Medicaid beneficiaries and 8.4 percent of individuals with full-year private insurance reporting fair or poor health indicated difficulty obtaining necessary medical care; again, the difference between these two groups was not statistically significant. The percentage of individuals who were uninsured for an entire year, reported being in fair or poor health, and indicated difficulty obtaining medical care was significantly higher—approximately 29.3 percent.

Working-Age Adult Medicaid Beneficiaries Reported Greater Difficulties Obtaining Care Than Those with Private Insurance

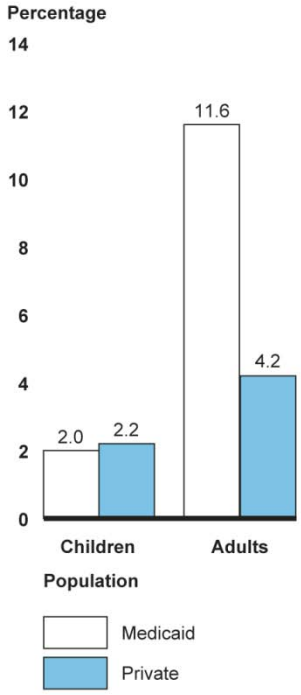
When looking specifically at the experience of working-age adults, individuals aged 18 through 64,[44] we found differences between those with Medicaid and those with private health insurance. Working-age adults with full-year Medicaid coverage reported greater difficulty obtaining needed medical care than similar adults with private health insurance. Specifically, about 7.8 percent of working-age adults with full-year Medicaid reported difficulty obtaining care compared with 3.3 percent of similar adults with private insurance—a statistically significant difference.[45] With respect to dental care, working-age adults with full-year Medicaid were nearly three times more likely to report difficulty obtaining services than similar adults with private insurance, and about six times more likely than children with Medicaid. Children with full-year Medicaid were reported to have no greater difficulties obtaining dental care than children with full-year private insurance.[46] (See fig. 10.)

[44]This includes all working-age adults, including those with disabilities.

[45]We also explored reported difficulties obtaining medical care for children but the sample sizes were too small to provide reliable results and so we are not presenting them here.

[46]We reported in more detail on difficulties children enrolled in Medicaid have in obtaining dental care in GAO, *Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay*, GAO-08-1121 (Washington, D.C.: Sept. 23, 2008). The MEPS analysis in that report examined children who were enrolled in Medicaid for any part of the year, and thus included both full-year and part-year beneficiaries.

Figure 10: Percentage of Working-Age Adults and Children with Full-Year Coverage Who Reported Difficulties Obtaining Necessary Dental Care, by Insurance Status, Calendar Years 2008-2009



Source: GAO analysis of Medical Expenditure Panel Survey data.

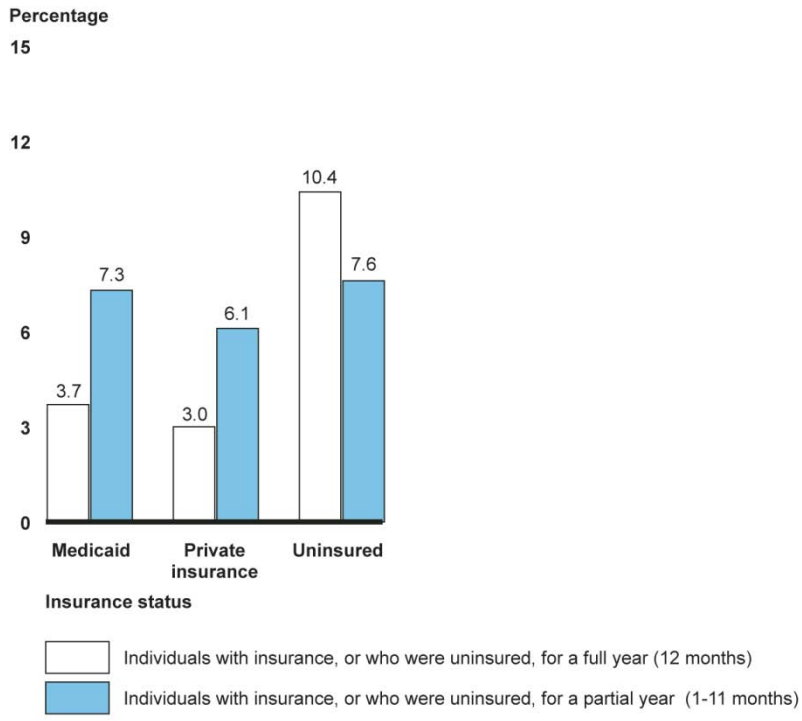
Note: Working-age adults include individuals aged 18 through 64, including those with disabilities. This figure includes only those individuals who reported insurance coverage for the entire year (2008 or 2009, or both). Sample sizes for uninsured children and for adults age 65 and older were below 100, limiting confidence in their results. As such, the results for the uninsured and for beneficiaries 65 and older are not included in the figure. The difference between the percentage of adults with Medicaid and private insurance who reported difficulty obtaining necessary dental care is statistically significant at the 95 percent confidence level. The difference between children with Medicaid and private insurance was not statistically significant. The 95 percent confidence intervals for estimates in this figure are within +/- 1.8 percent of the estimates themselves. Medicaid data include children enrolled in the Children's Health Insurance Program.

Individuals with Partial-Year Coverage Reported Almost Double the Rate of Difficulty Obtaining Medical Care

Individuals with partial year health insurance—coverage for between 1 and 11 months—were more likely to report difficulties obtaining needed care, whether covered by Medicaid or private health insurance. In calendar years 2008 and 2009, the percentage of Medicaid beneficiaries enrolled for a partial year who reported difficulties obtaining needed medical care was almost double that of full-year Medicaid beneficiaries.[47] Similarly, individuals with private insurance for a partial year also reported difficulties at more than double the rate of those with full year coverage. Finally, individuals who were uninsured for a partial year reported less difficulty obtaining care than those uninsured for a full year—likely because they had some type of insurance for part of the year. There were no statistically significant differences across all groups with partial year coverage. (See fig. 1.)

[47]Partial year insurance groups overlap. For example, some individuals had both Medicaid and private insurance for part of the year, or had Medicaid and were uninsured for part of the year.

Figure 11: Percentage of Individuals Who Reported Experiencing Difficulty Obtaining Necessary Medical Care, by Insurance Status, Partial or Full Year, Calendar Years 2008-2009

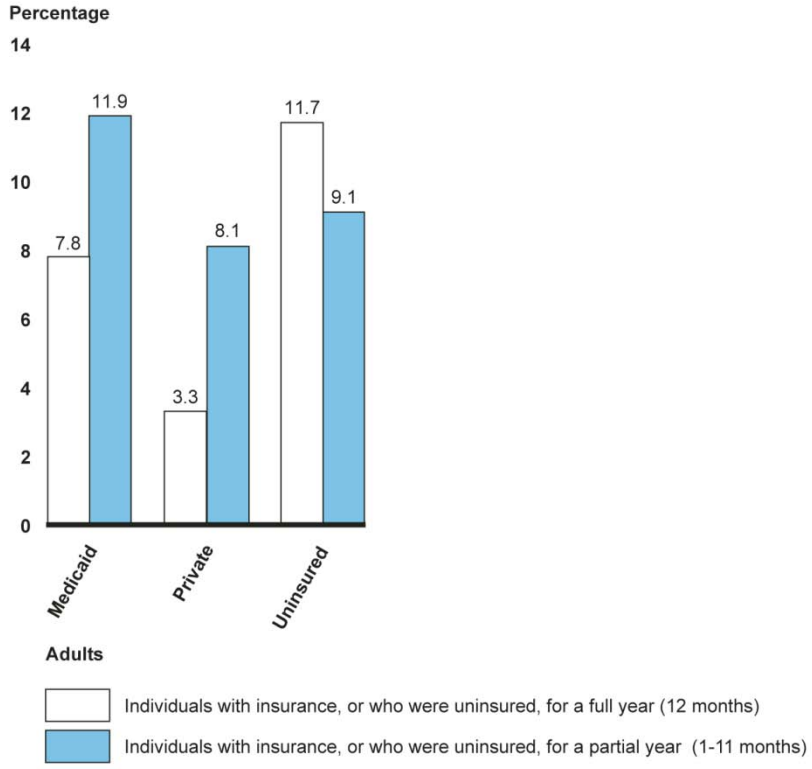


Source: GAO analysis of Medical Expenditure Panel Survey data.

Note: The differences between individuals who had insurance (Medicaid or private) or were uninsured for a full year versus those with the same insurance status for a partial year were statistically significant at the 95 percent confidence level. Among those who had insurance or were uninsured for a partial year, there were no statistically significant differences. The 95 percent confidence intervals for estimates in this figure are within +/- 1.2 percent of the estimates themselves. Medicaid data include children enrolled in the Children's Health Insurance Program.

Among working-age adults with Medicaid, 7.8 percent with full-year coverage and 11.9 percent with partial-year coverage reported difficulty obtaining necessary medical care. Those with partial year Medicaid were more likely to report difficulty obtaining medical care than those with partial year private insurance or who were uninsured for part of the year. (See fig. 12).

Figure 12: Percentage of Working-Age Adults (Age 18 to 64) Who Reported Difficulty Obtaining Necessary Medical Care, by Insurance Status, Partial or Full Year, Calendar Years 2008-2009



Source: GAO analysis of Medical Expenditure Panel Survey data.

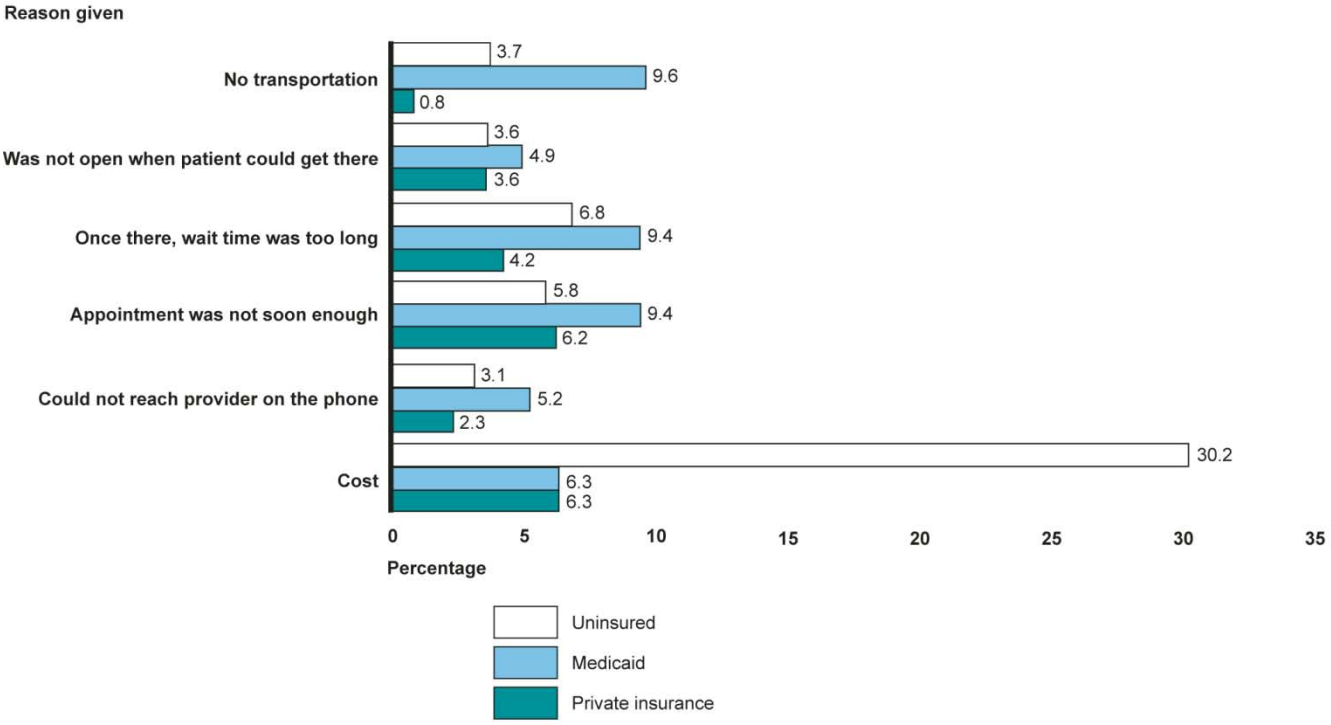
Note: The differences between adults who had insurance (Medicaid or private) for a full year versus those with the same insurance status for a partial year were statistically significant at the 95 percent confidence level. Similarly, differences between those who were uninsured for a full year versus a partial year were statistically significant at the 95 percent confidence level. Those with partial-year Medicaid were more likely to report difficulty obtaining Medical care than those with partial-year private insurance or who were uninsured for part of the year. The 95 percent confidence intervals for estimates in this figure are within +/- 1.7 percent of the estimates themselves.

Medicaid Beneficiaries Most Frequently Reported Delaying Care Due to Lack of Transportation and Long Wait Times

Medicaid beneficiaries were more likely than individuals with private insurance to report factors such as lack of transportation and long wait time as reasons for delaying medical care. In 2009, approximately 9.6 percent of Medicaid beneficiaries reported delaying medical care because they had no transportation, compared with less than 1 percent of individuals with private insurance. Similarly, about 9.4 percent of Medicaid beneficiaries indicated that they delayed medical care because they could not get an appointment soon enough, or once they arrived for the appointment, the wait was too long. In contrast, 4.2 percent of individuals

with private insurance reported delaying care because, once they arrived for the appointment, the wait was too long. Individuals who were uninsured were the most likely to cite cost as a reason for delaying care. (See fig. 13.)

Figure 13: Percentage of Individuals Who Cited Specific Reasons for Delaying Medical Care in Calendar Year 2009, by Insurance Status



Source: GAO analysis of National Health Interview Survey data.

Note: This figure reflects individuals who reported their insurance status at the time the survey was administered. The responses related to delays in care for cost reasons are from the Person file of the National Health Interview Survey (NHIS) and include all age groups. The remaining reasons for delayed responses were from the Sample Adult component of NHIS and include only adults over 18 years old. The differences between Medicaid beneficiaries and individuals with private insurance reporting delaying medical care to due to a lack of transportation, too long of a wait time once at an appointment, not being able to get an appointment soon enough, and being unable to get through on the phone were all statistically significant at the 95 percent confidence level. While there was not a statistically significant difference between individuals with Medicaid and private insurance citing cost as a reason for delayed medical care, the uninsured were significantly more likely than both to report delaying care due to cost. Among individuals reporting that a provider was not open when he or she could get there, there were no statistically significant differences across insurance statuses. The 95 percent confidence intervals for estimates in this figure are within +/- 1.4 percent of the estimates themselves.

We provided a draft of this report to HHS for its review and comment. HHS provided technical comments, which we incorporated as appropriate. This report is intended for use by HHS management. We are sending copies of this report to interested congressional committees and members, and other interested parties. The report is also available at no charge on the GAO website at http://www.gao.gov. If you or your staff have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix III.

Sincerely yours,

Carolyn L. Yocom
Director, Health Care

Appendix I: Scope and Methodology

To examine states' experiences processing Medicaid applications, changes states made to provider payment rates and beneficiary services, and challenges, if any, states face ensuring sufficient provider participation, in February 2012 we surveyed Medicaid officials in all 50 states, the District of Columbia, and the 5 largest territories.[1] The survey was e-mailed to the Medicaid officials on February 22, 2012. Respondents were initially given 3 weeks to respond, and extensions were granted to encourage survey participation. The survey was available online through May 22, 2012. Fifty states, the District of Columbia, and 4 U.S. territories completed the survey, for a response rate of 98 percent. The U.S. Virgin Islands did not complete the survey.

Development and Analysis of GAO Survey of States

To examine states' experiences processing Medicaid applications, states were asked to report their current average processing time for new regular Medicaid applications—those not based on disability—and how those times changed since 2008.[2] The survey also included questions about the factors states attributed to any reported changes in the average processing time for Medicaid applications. In addition, to assess the extent to which states were keeping pace with processing new applications, the survey asked for monthly data on the number of new regular applications received and processed from January 2008 through December 2011.

The survey also asked states about changes to benefits, provider payment rates, provider taxes, and supplemental payments in each year from 2008 through 2011. The questions in this section asked about changes by provider and benefit type, including both those benefits that are mandatory and optional.[3] The survey asked, generally, about any

[1]The U.S. territories included in our sample are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. For the purposes of this report, we are referring to all 56 jurisdictions we surveyed as states.

[2]Average processing time is the average number of calendar days between the day that a new application is received and the day that a final eligibility determination is made.

[3]States were asked to report on a number of provider and service types, including inpatient hospitals, outpatient hospitals, nursing facilities, intermediate care facilities for the intellectually disabled, primary care, specialty care, dental, home health services, clinics, targeted case management, rehabilitative and therapeutic services, managed care plans, beneficiary copayments or premiums, and prescription drug formularies.

changes by provider type (i.e., increased, decreased, eliminated, etc.) and did not ask states to report the details of these changes. States could report more than one type of change for a provider type in a year. For example, a state could report both an increase and a decrease in a provider payment rate for a given provider type in a year. The survey asked whether the state made a particular change for a provider type in a year and did not ask for the actual number of those changes it made in a year or the magnitude of those changes. The survey also asked about the purpose of any new or increased provider taxes, including avoiding cuts in benefits, expanding benefits, avoiding cuts in payment rates, increasing payment rates, or other purposes. Finally, states were asked to report any changes to supplemental payments by provider type and the role of provider taxes or county and local government funds in any changes to the supplemental payments.[4]

To examine any challenges to ensuring sufficient provider participation, the survey included questions asking how states monitor whether they have sufficient providers, which provider types are challenging for states to ensure sufficient participation, and any steps the states have taken since January 2008 to maintain their existing pools of providers. The survey asked how the states monitor the sufficiency of providers across three service delivery arrangements—fee-for-service, primary care case management, and risk-based managed care organizations. The survey included questions about any planned efforts to meet potential increases in demand for primary care providers due to the Medicaid expansion under the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA), and whether the increase in payment rates for primary care providers under PPACA would likely assist in increasing provider participation in Medicaid. The survey also asked states about plans to measure access to care for Medicaid beneficiaries in response to recently proposed federal regulations that, if finalized, would provide a framework under which

[4]Supplemental payments are payments separate from and in addition to those made at a state's standard Medicaid payment rate, including Disproportionate Share Hospital payments and Upper Payment Limit payments. Disproportionate Share Hospital payments are payments required under federal law that are made to hospitals that treat large numbers of Medicaid and uninsured individuals. Upper Payment Limit payments are payments to certain providers above the standard Medicaid payment rates but within the Upper Payment Limit, the estimated amount that Medicare pays for comparable services.

states can demonstrate Medicaid payments are adequate for access to providers.[5]

We took steps in developing the survey and collecting and analyzing the data to minimize nonsampling errors.[6] However, any survey may introduce nonsampling errors, such as difficulties in interpreting a particular question or limited sources of information available to respondents. We pretested the draft survey with Medicaid officials in three states in January 2012 to ensure that the questions were relevant, clearly stated, and easy to understand. The states selected for a pretest were diverse with respect to the population size, geography, and total Medicaid spending in 2009. We modified the survey as appropriate as a result of the pretests. Finally, since this was a web-based survey, respondents entered their answers directly into the electronic survey, eliminating the need to key data into a database, which helps to minimize error. We did not independently verify the data reported by states in the survey; however, we reviewed published data submitted by state Medicaid programs to us for another engagement and to outside researchers to assess the reasonableness of the data reported. We also assessed the internal consistency of answers to certain questions. We determined that the data from the survey included in this report were sufficiently reliable for the purposes of this report.

It is important to note that while the data that we reported were sufficiently reliable for the purposes of this report, we did not use the data on monthly application processing submitted by states for 2008 through 2011, because much of the data were either incomplete or inconsistently reported. In particular, we noted that for some states, data provided to us in a 2010 survey did not match the data provided for our current survey.[7] We contacted four states to inquire about the inconsistencies in the data about which the states provided differing responses. For example:

[5]76 Fed. Reg. 26342.

[6]The survey was not a sample survey and so sampling errors were not a concern.

[7]We used data provided in response to our 2010 survey of Medicaid directors to determine any changes in states' application processing volumes and rates between October 2007 and February 2010. See GAO, *Recovery Act: Increased Medicaid Funds Aided Enrollment Growth, and Most States Reported Taking Steps to Sustain Their Programs,* GAO-11-58 (Washington, D.C.: Oct. 8, 2010).

- One state official was not certain why the data would be reported differently in the prior survey and suggested that it could be related to interpretation of the prior survey question because the state does not collect information in the way we requested it.
- Officials from two states noted that there were changes in the staff that responded to the survey and could not be certain why the data reported were different.
- An official from a third state indicated that the data provided to us in 2010 appeared to have included a broader array of applications (such as those for disability, long-term care, and food stamps), noting that the same application process is used for multiple programs in the state.

Analysis of Other Federal Health Care Consumer Survey Data

To examine the extent to which Medicaid beneficiaries reported difficulties obtaining care, we analyzed data from the Medical Expenditure Panel Survey (MEPS) and the National Health Interview Survey (NHIS).[8] MEPS is administered by the Department of Health and Human Services' (HHS) Agency for Healthcare Research and Quality and collects data on the use of specific health services; NHIS is conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. We analyzed results from the MEPS household component, which collects data from a sample of families and individuals in selected communities across the United States. These families and individuals are drawn from a nationally representative subsample of households that participated in the prior year's NHIS.

MEPS

Our MEPS analysis was based on data from surveys conducted in 2008 and 2009, the most recent data available at the time of our analysis. MEPS includes insurance status for respondents for each month of the year and NHIS includes respondent information on insurance status at a point in time. Analyzing MEPS allowed us to use information on insurance status for each month to create variables for full-year and partial-year

[8]We considered using data from other federal surveys, such as the Consumer Assessment of Healthcare Providers and Systems Health Plan Survey, but determined that the questions in the MEPS and NHIS made them better surveys to use to determine the extent to which Medicaid beneficiaries had difficulty accessing medical care and the reasons for any difficulties.

coverage.[9] As a result, we determined that the MEPS insurance status data provided more options to report on the extent to which Medicaid beneficiaries reported difficulties obtaining medical care. In addition to determining the extent to which full-year Medicaid beneficiaries had difficulty accessing care, we also compared Medicaid beneficiaries' reported experiences to the experience of respondents with private insurance and respondents who were uninsured, in order to provide context.[10] Further, we examined whether working-age adults 18 to 64 in Medicaid for a full year reported greater difficulty accessing medical care than children in Medicaid or full-year Medicaid beneficiaries 65 and older. We also compared full-year and partial-year Medicaid beneficiaries, to determine if the extent of reported difficulties obtaining care varied by length of coverage. Finally, we compared responses from full-year and partial-year privately insured individuals, and full-year and partial-year uninsured individuals to provide additional context for the Medicaid beneficiaries' reported difficulties.

The MEPS household interviews feature several rounds of interviewing covering 2 full calendar years. MEPS is continuously fielded; each year a new sample of households is introduced into the study. MEPS collects information for each person in the household based on information provided by one adult member of the household. This information includes demographic characteristics, use of medical services, reasons for medical visits, and health insurance coverage. We analyzed responses to MEPS questions about individuals' reported delays and inability to obtain necessary medical care, dental care, and prescription medicine, the reasons for those delays, and the perceived health status of those individuals who delay or are unable to obtain care.

For the delays and inability to obtain care measures we used responses to the following questions:

- In the last 12 months, was anyone in the family delayed in getting medical care, tests, or treatments they or a doctor believed necessary?

[9]In contrast, the variable "any Medicaid" includes individuals with coverage that could range from 1 to 12 months for a given year.

[10]The Medicaid category in MEPS includes children enrolled in the Children's Health Insurance Program.

- Which of these best describes the main reason (PERSON) (were/was) delayed in getting medical care, tests, or treatments (he/she) or a doctor believed necessary?[11]

- In the last 12 months, was anyone in the family unable to obtain in getting medical care, tests, or treatments they or a doctor believed necessary?

- Which of these best describes the main reason (PERSON) (were/was) unable to obtain medical care, tests, or treatments (he/she) or a doctor believed necessary?

We also analyzed responses to similar questions related to delays or the inability to obtain needed dental care and prescription medicines. To address sample size concerns and obtain frequencies above 100 responses, we combined data from 2008 and 2009 and the responses from the questions on both the delays and inability to obtain needed health care.

We examined the insurance status of respondents who answered that they delayed or were unable to obtain needed health care.[12] To understand the differences in responses by insurance status we identified the percentage of respondents who delayed or were unable to obtain care with a variety of insurance statuses as well as those who were uninsured. We looked at those respondents who indicated they had Medicaid and private insurance for each month of the year, as well as looking at the responses for those with Medicaid or private insurance for a partial year (1-11 months). We also examined the percentage of respondents who were uninsured for a full and partial year as well as those with mixed insurance statuses, such as Medicaid part year and uninsured for part of the year. In addition, we examined demographic variables—such as age,

[11]Possible answers to this question were: could not afford care, insurance company would not approve/cover/pay, doctor refused family insurance plan, problems getting to doctor's office, different language, could not get time off work, could not get child care, did not have time or took too long, don't know where to go to get care, was refused services, and other.

[12]MEPS respondents were asked whether they needed medical care, and if they responded that they did, they were then asked if they were able or unable to receive care. If they responded they were unable to receive care, they were then asked about the main reason they were unable to receive care. A similar pattern of questions asked about whether a respondent had delayed care.

sex, education, and perceived health status—for those respondents who indicated they delayed or were unable to obtain care as well as those that did not delay care. We also looked at responses to the questions by age group and insurance status to identify potential differences. Small sample sizes for some analyses limited the reliability of the results, and in those cases, we did not report the analyses. In this report, we used a 95 percent confidence level and compared upper and lower confidence intervals to determine whether any differences we found were statistically significant. Statistical significance indicates that the difference between observations is unlikely due to chance alone.

NHIS

We supplemented our MEPS analysis with analysis of data from the 2009 NHIS survey. NHIS data are collected continuously throughout the year for the National Center for Health Statistics, Centers for Disease Control and Prevention, by interviewers from the U.S. Bureau of the Census. NHIS collects information about the health and health care of the civilian, noninstitutionalized U.S. population. Interviews are conducted in respondents' homes, but follow-ups to complete interviews may be conducted over the telephone. We analyzed NHIS data to obtain information on reasons Medicaid beneficiaries reported delays obtaining needed medical care, and compared those to privately insured individuals and the uninsured, for context. We analyzed NHIS data for these questions because the sample size for those questions in NHIS was larger than for similar questions on delays or the inability to obtain care in MEPS. Because NHIS asks about insurance coverage at a point in time, individuals identified as Medicaid beneficiaries would include those with full-year and partial-year coverage. Data from the 2010 NHIS survey were available, but we chose to analyze the 2009 survey so the time period would be compatible with the MEPS analysis.

NHIS collects information from the civilian, noninstitutionalized population about demographic characteristics, use of medical services, and health insurance coverage and organizes the data into several data files. NHIS collects information on each family member. More information is collected on a randomly selected adult (the Sample Adult component) and a randomly selected child (the Sample Child component) within each family if a child is present. More information is collected on a sample of adults and children within each family and household. To match the insurance status variables with the answers to the selected questions, we merged

data from the Person file, which has information on each family member, with the Sample Adult file, which has more information on sampled adults.[13] We analyzed responses to the following NHIS question from the Person file of the survey: During the past 12 months, [have you delayed seeking medical care/has medical care been delayed for anyone in the family] because of worry about the cost?

From the Sample Adult component of the survey, we looked at the following questions:

- Have you delayed getting care for any of the following reasons in the past 12 months?[14]
  - You couldn't get through on the telephone
  - You couldn't get an appointment soon enough
  - Once you get there, you have to wait too long to see the doctor
  - The (clinic/doctor's) office wasn't open when you could get there
  - You didn't have transportation.

We examined the insurance status of respondents to those questions using the suggested variables for Medicaid, private insurance, and uninsurance.

For all estimated percentages for both MEPS and NHIS, we calculated a lower and upper bound at the 95 percent confidence level using the appropriate sampling weights and survey design variables provided for each survey.

[13]Information from the Sample Child file was not used for the purposes of our analysis.

[14]Each of these questions is asked separately. Possible answers included: Yes, No, Refused, Don't Know.

Data Reliability for MEPS and NHIS

To determine the reliability of the MEPS and NHIS data, we reviewed related documentation, and identified other studies that used MEPS to address similar research questions to compare the published data with our findings. We determined that the MEPS and NHIS data were sufficiently reliable for the purposes of our report.

Appendix II: States Use of Electronic Medicaid Application Processing and Renewal Procedures

Given the potential of electronic application processing to reduce processing time and related provisions of the Patient Protection and Affordable Care Act of 2010 (PPACA), we asked all of the states about their use of electronic application processing. PPACA required states to begin to accept electronic signatures by 2014, as part of a coordinated enrollment process that includes using a federally defined uniform application and verifying income electronically through a federally managed data hub.

We found states varied in the extent to which new Medicaid applications were currently available and processed electronically. (See table 2.) For example, fewer states reported that the application is submitted electronically with an electronic signature than those reporting that the application is available electronically. Twenty-six states reported the percentage of their new Medicaid applications that were accessed, signed, and submitted electronically. In these 26 states, the median proportion of applications accessed, signed, and submitted electronically was 25 percent. Only 11 states reported that the applications were approved or denied electronically.

Table 2: State Electronic Processing Procedures for New Medicaid Applications

Procedure	Number of states
Medicaid applications available electronically	35
Medicaid applications can be submitted electronically	31
Processed at least some Medicaid applications electronically, with electronic signature	26
Medicaid applications approved or denied electronically	11

Source: GAO analysis of state-reported survey data.

Note: States could report more than one procedure.

We also asked all states about their efforts to streamline processing through improved renewal procedures, and a number of states reported implementing procedures to streamline the renewal application process for adults and children since 2008. (See table 3.) Such efforts can help limit interruptions in Medicaid coverage for beneficiaries. For children, the streamlined procedures states most frequently reported using were 12-month renewal periods, as opposed to shorter renewal periods; telephone or electronic renewals, or both, instead of in-person interviews;

and prepopulated renewal forms.[1] For adult Medicaid beneficiaries, the most commonly reported efforts were 12-month renewal periods and telephone or electronic renewal, or both, instead of in-person interviews.

Table 3: State Medicaid Renewal Procedures

	Number of states	
Procedure	**For children**	**For adults**
Twelve-month renewal periods	26	24
Telephone or electronic renewals, or both, instead of in-person interviews	24	24
Prepopulated renewal forms	22	15
Continuous eligibility	18	n/a[a]

Source: GAO analysis of state-reported survey data.

Notes: n/a = not applicable. The term "states" includes the 50 states, the District of Columbia, and 4 U.S. territories that responded to the 2012 GAO survey. Fifty-four states responded to this question. States could report more than one procedure.

[a]States may use continuous eligibility to allow children to remain eligible for Medicaid or the Children's Health Insurance Program for up to a full year before any redetermination of eligibility.

[1]Some states send families renewal forms pre-populated with the families' information. If a family's circumstances, as reflected on the form, have not changed, the family simply returns the signed form to renew their eligibility.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

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