

PERSPECTIVES ON THE MEDICAID PROGRAM

THE PARTNERSHIP FOR MEDICAID

SEPTEMBER 2012

Medicaid: Federalism in Action

THE MEDICAID PROGRAM IS A PARTNERSHIP among the states and the federal government to provide health coverage to low-income individuals and families. Each state runs a unique Medicaid program within policy parameters established at the federal level which require the coverage of certain individuals and services (“mandatory” populations and services) and authorize the coverage of others (“optional” populations and services).

This structure has provided state Medicaid programs with the opportunity to be innovative in the way they deliver coverage. Since Medicaid’s inception, states have been taking advantage of this flexibility to create programs that reflect the unique characteristics and challenges found in their states and localities.

The federal government contributes a portion of the costs of the program. States provide the balance. This proportion, which varies by state, is determined by a statutory formula which establishes a “federal medical assistance percentage,” or FMAP. The minimum FMAP a state can receive is 50%. In 2012, the average state FMAP is 58%; the highest is 74.2%. The shared financial and programmatic responsibilities of the federal government and the states make the Medicaid program the largest successful example of federalism in modern America.

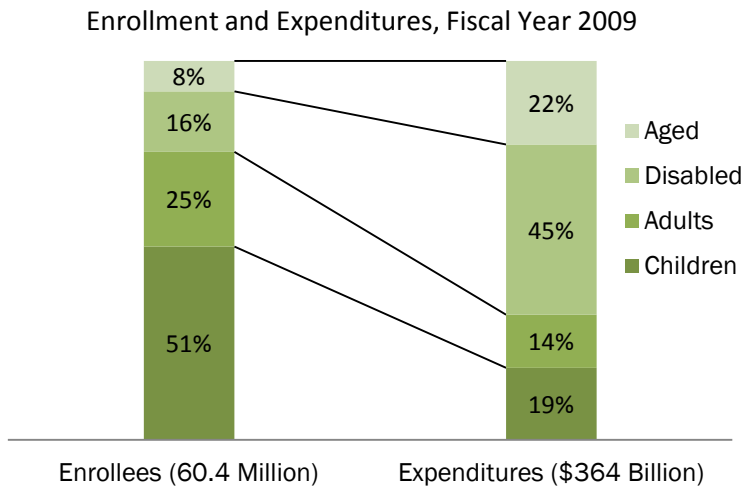
Medicaid: An Overview

The Medicaid program covers more than 60 million Americans nationwide, including one in three children, more than 8 million people with disabilities and nearly two out of three nursing home residents.¹ This includes more than 9 million individuals whose primary source of acute care coverage is Medicare. Medicaid not only provides access to acute health care services, such as hospital, clinic and physician services, but also—unlike most health insurance programs—provides coverage for long-term supports and services, such as nursing home and personal care services, and other care such as behavioral health and substance-abuse services.

Highlights

- The Medicaid program is a state-federal partnership serving more than 60 million Americans.
- Medicaid is an economic engine for State and local economies, creating an average of \$3.35 in economic activity for every \$1 of state spending.
- Medicaid is a cost-effective program; its costs are growing more slowly than other segments of the health care system.
- Consumer satisfaction with the Medicaid program is high.
- Studies show the benefits of having Medicaid coverage.

Figure 1. Most Medicaid Expenditures are for Services for the Elderly and Persons with Disabilities



Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) and CMS-64 net financial management report. Data as of May 2012.

Medicaid covers parents and children whose incomes are near or below the Federal poverty level (less than \$20,000 for a family of three)², disabled adults, and the elderly. However, most states do not cover non-disabled, non-pregnant single adults, and many only cover parents in extreme poverty. Beginning in 2014, states will have the ability to expand this important coverage to all people at or below 138% of the federal poverty level (approximately \$15,000 for a single adult, or \$26,000 for a family of three) under the Affordable Care Act.

The majority of Medicaid enrollees are low-income children and their parents from working families. But these enrollees account for only a fraction of Medicaid spending; the majority of spending—almost 70 percent—is for services for the elderly and persons with disabilities, which make up less than one-fourth of the population (Figure 1).

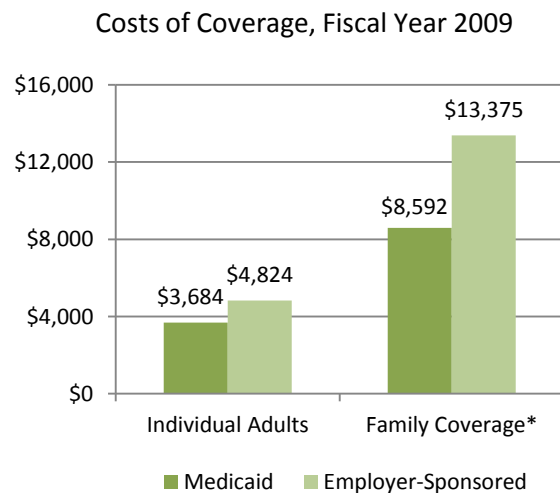
Medicaid is Cost-Effective

MEDICAID PROVIDES HEALTH COVERAGE at a fraction of the cost of employer-based coverage.

In fiscal year 2009, Medicaid spent an average of \$3,684 per adult enrollee³, while the average cost of employer-sponsored insurance for a single adult was \$4,824 (Figure 2).⁴ This efficiency extends to families; the average cost to cover a parent and two children through Medicaid was \$8,592 in 2009, compared with an average cost of \$13,375 through employer-sponsored insurance—more than one and a half times as expensive as Medicaid.⁵

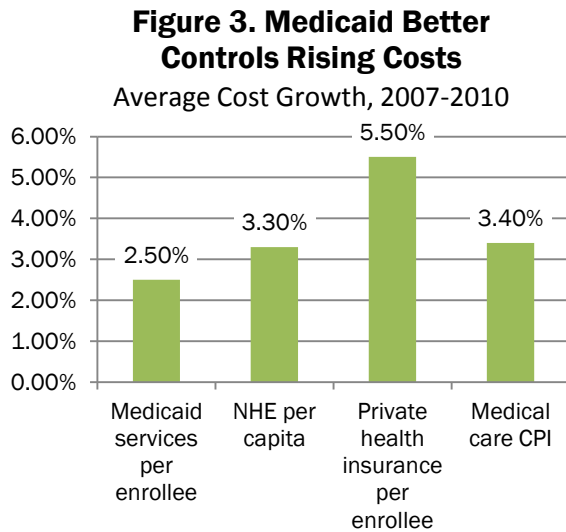
Medicaid also does a better job in controlling cost growth. From 2007 to 2010, Medicaid spending per enrollee grew at less than half

Figure 2. Medicaid Coverage is Substantially Less Expensive than Employer-Based Insurance



*Family defined as an adult and two children. Sources: MACPAC analysis of MSIS and CMS-64 net financial management report data as of May 2012; Kaiser/HRET Health Benefits 2009 Annual Survey.

the rate of private insurance, and at a rate lower than both the medical care consumer price index (CPI) and national health expenditures per capita⁶ (Figure 3).

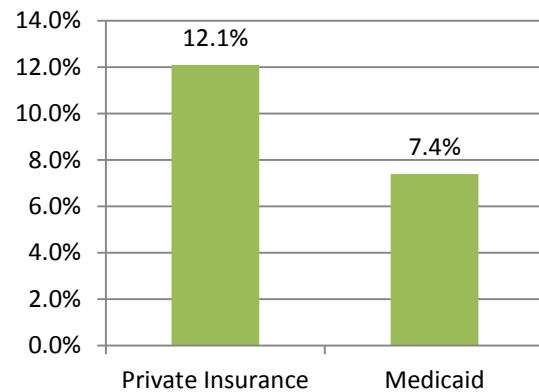


Source: Enrollment-Driven Expenditure Growth: Medicaid Spending During the Economic Downturn, FFY 2007-2010, Kaiser Family Foundation.

Medicaid spends a lower percentage on administration than private insurance. The Medicaid program’s administrative cost proportion is less than two-thirds that of private insurance (Figure 4). While administrative costs are necessary to assure accurate claims payment, eligibility determination, and fraud prevention, most health care program spending should go directly to care.

When combined with the slower growth in costs per enrollee, the lower cost per enrollee, and lower administrative costs, it is clear that the Medicaid program is cost-effective.

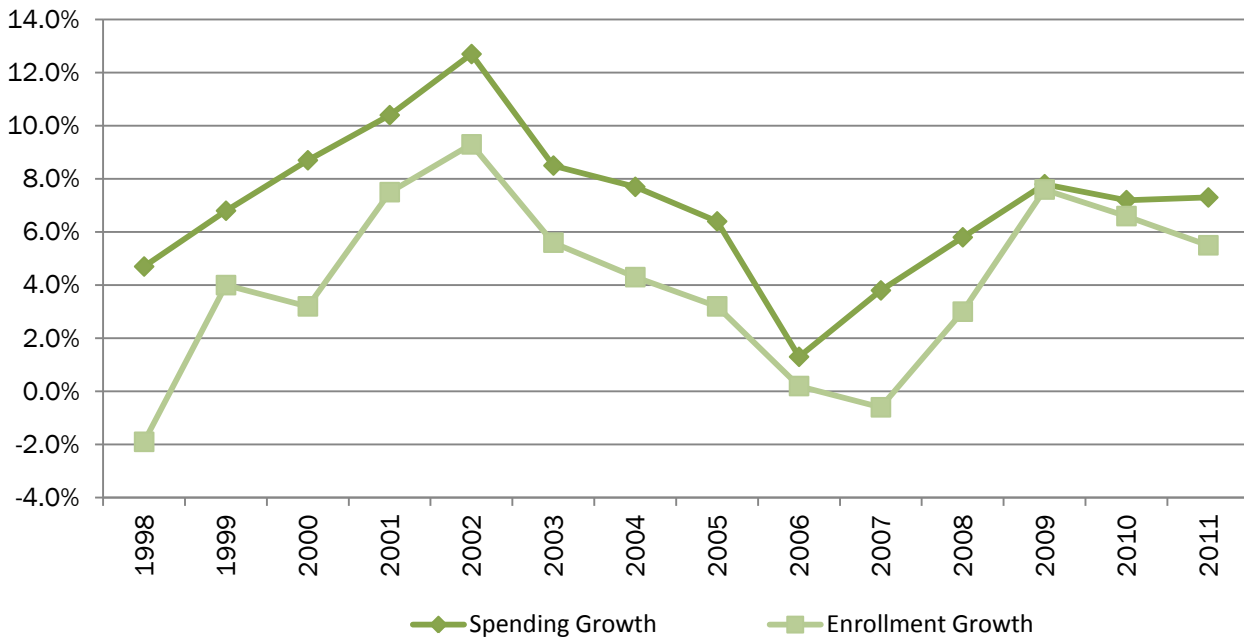
Figure 4. Medicaid Administrative Costs are 60% Those of Private Insurance



Sources: Office of the Actuary (OACT), CMS, National health expenditures by type of service and source of funds, January 2012; OACT, National Health expenditure accounts: Methodology paper, 2010, 2012.

Those calling for significant restructuring of the Medicaid program choose to focus on the overall growth in spending. This fails to recognize that, as a counter-cyclical program, Medicaid enrollment increases during economic downturns. When people become unemployed, their income level drops and they often lose access to private health insurance. Economists studying the relationship between employment and health coverage have found that a percentage point increase in the unemployment rate corresponds with a 0.95% drop in the percentage of children receiving employer-sponsored insurance; the percentage of children receiving Medicaid or Children’s Health Insurance Program coverage grows 0.79%.⁷ It does not take long to realize that a rising unemployment rate means a significant growth in the Medicaid program.

Figure 5. Medicaid Expenditures are Driven by Enrollment

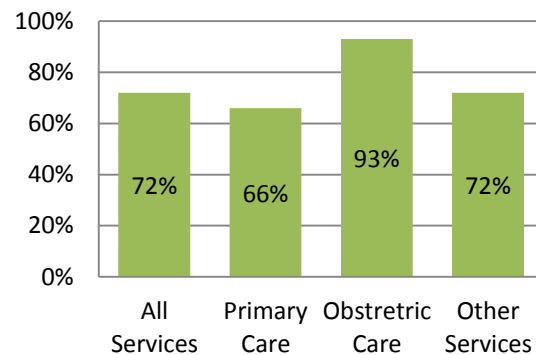


Source: Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends. Kaiser Commission on Medicaid and the Uninsured, <http://www.kff.org/medicaid/upload/8248.pdf>

Providing more people with coverage, whether as the result of economic downturns or federal and state decisions to expand eligibility levels, causes expenditures to rise as well. Over the past decade, changes in enrollment and spending have closely tracked together (Figure 5). This effect makes it virtually impossible to cap the federal government’s support for Medicaid at a predetermined level without shifting significant costs to states during recessions. A capped federal contribution in a recession would force states to either cut other essential programs or drastically reduce provider payments, jeopardizing the effectiveness of the program. This would exacerbate the gap between Medicaid and Medicare payment levels that already exists (Figure 6).

Figure 6. Medicaid Reimburses Physicians at a Lower Rate than Medicare

Average Medicaid Reimbursement as a Percentage of Medicare Rates, 2003-08

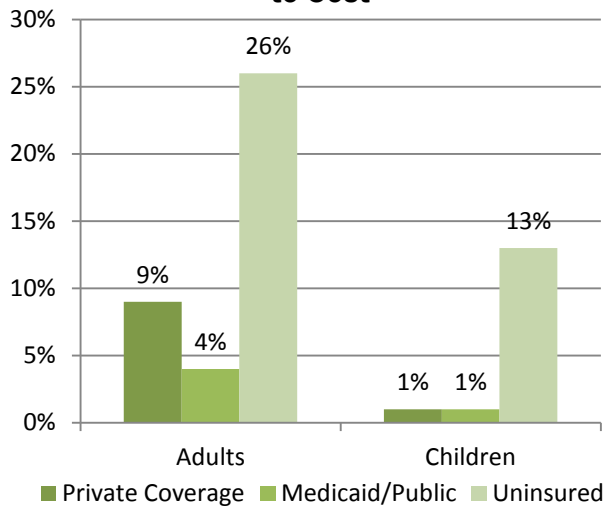


Source: Zuckerman S, Williams A, Stockley K. "Medicaid Physician Fees Grew By More Than 15 Percent From 2003 to 2008, Narrowing Gap With Medicare Physician Payment Rates," Health Affairs, April 2009.

Medicaid Provides Needed, Quality Care

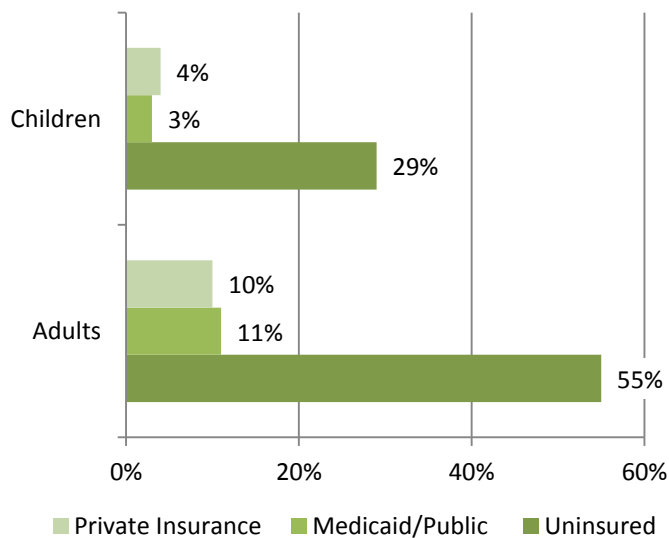
CRITICS OFTEN ARGUE that people on Medicaid are no better off than they would be if they were uninsured. This is not true. Multiple studies show people are better off on Medicaid than being uninsured.

Figure 7. Fewer Medicaid Enrollees Forego Needed Care Due to Cost



Source: KCMU Analysis of 2010 NHIS Data.

Figure 8. Percentage of Enrollees Reporting No Consistent Source of Care



Source: KCMU Analysis of 2010 NHIS Data.

- A randomized study done in Oregon showed that Medicaid enrollees were 70% more likely to report having a regular place of care, and 55% more likely to report having a usual doctor than similar people who were uninsured. Medicaid enrollees were also 40% less likely to have to borrow money or skip other payments because of medical bills. Most importantly, Medicaid enrollees are 25% more likely to indicate they are in good, very good, or excellent health.⁸
- A recent study in the New England Journal of Medicine shows that states that expanded Medicaid saw a reduction in their mortality rate, as well as improved access to care, and better self-reported health among the expansion population.⁹

Medicaid enrollees are less likely than the uninsured or privately-insured individuals to go without needed medical care due to cost (Figure 7). Medicaid enrollees are also less likely to lack a usual source of care.

- Only 4% of adults on Medicaid went without care due to cost, compared with 9% of privately-insured adults, and more than one-quarter of uninsured adults¹⁰.
- Medicaid does even better among children: only 1% went without needed care due to cost, compared to 13% of the uninsured¹¹.
- 11% of Medicaid-covered adults and 3% of Medicaid-covered children report no usual source of care, compared with more than half of all uninsured adults and 29% of uninsured children (Figure 8)¹².

Quality and performance in Medicaid are measured in a variety of ways. In comprehensive, risk-based managed care, which covers 47 percent of Medicaid

enrollees,* plans submit data based on national quality measures that states and the federal government can use to assess specific plan and overall program performance. Depending on state reporting requirements, plans provide data for some or all of the following measures:

- HEDIS (Healthcare Effectiveness Data and Information Set): a standardized set of 76 measures constructed to assess effectiveness of care, access and availability of care, experience of care, and utilization and relative resource use¹³.
- CAHPS (Consumer Assessment of Healthcare Providers and Systems): a standard survey to assess patient experience and satisfaction¹⁴.

The performance of health plans on these measures speaks for itself. Recent CAHPS surveys have shown Medicaid enrollees rate their experience highly. Respondents were asked to assign a rating from “0” (the worst) to “10” (the best) to their health plan. Adults on Medicaid, or parents with children on Medicaid, are more likely to rate their experience as above satisfactory (a score of 7 or higher) or give their plan a top (9 or 10) rating than those enrolled in commercial plans (Figure 9). Other types of oversight – such as requirements for network adequacy – help to ensure that enrollees have access to care, not merely health insurance coverage.

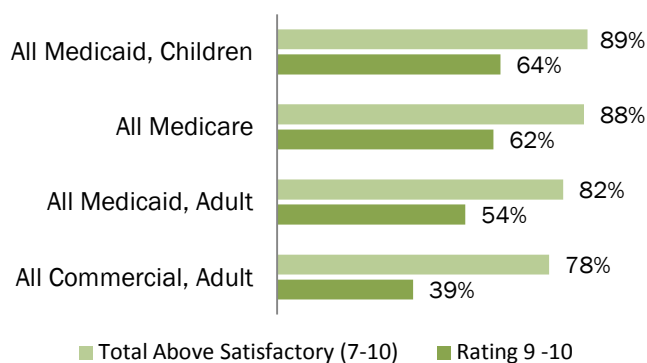
There is considerable variation across states in the way they choose to address and measure quality outside of comprehensive,

* Approximately 71 percent of Medicaid enrollees receive some type of service through a managed care arrangement, which CMS defines to include comprehensive, risk-based managed care, primary care case management, and limited-benefit plans.

risk-based managed care arrangements. A number of states are attempting to develop robust Medicaid fee-for-service quality measurement systems, recognizing the importance of being able to measure quality throughout the Medicaid program.¹⁵

Among other examples of the efforts states are undertaking to improve and reward quality inside and outside comprehensive, risk-based managed care are pay-for-performance (P4P) incentive programs. States have considerable discretion in designing P4P initiatives and the providers included (e.g., nursing facilities, hospitals, physicians, health plans). Programs, therefore, vary from state to state. They are, however, typically based on a variety of measures which can address staffing, survey outcomes, consumer satisfaction, and clinical

Figure 9. Medicaid Managed Care Plans Are More Highly Rated By Their Members Than Commercial Plans



Source: Agency for Healthcare Research and Quality, CAHPS 2011 data.

quality. To qualify for incentive payments, a provider or plan must meet certain quality thresholds established by the state, or demonstrate a set degree of improvement.

Some states are also tying payment to quality outcomes as they develop accountable care organizations (ACOs) for their Medicaid

populations. This model changes financial incentives to encourage better-coordinated care delivery across providers and accountability for patients at the practice level. While they all apply core ACO concepts, such as value-based purchasing, care management targeted to high-risk patients that use health services at an avoidably high rate, and data-sharing, each state is able to tailor these strategies to address the needs of their unique state and local markets.¹⁶

Medicaid is an Integral Part of the Economy

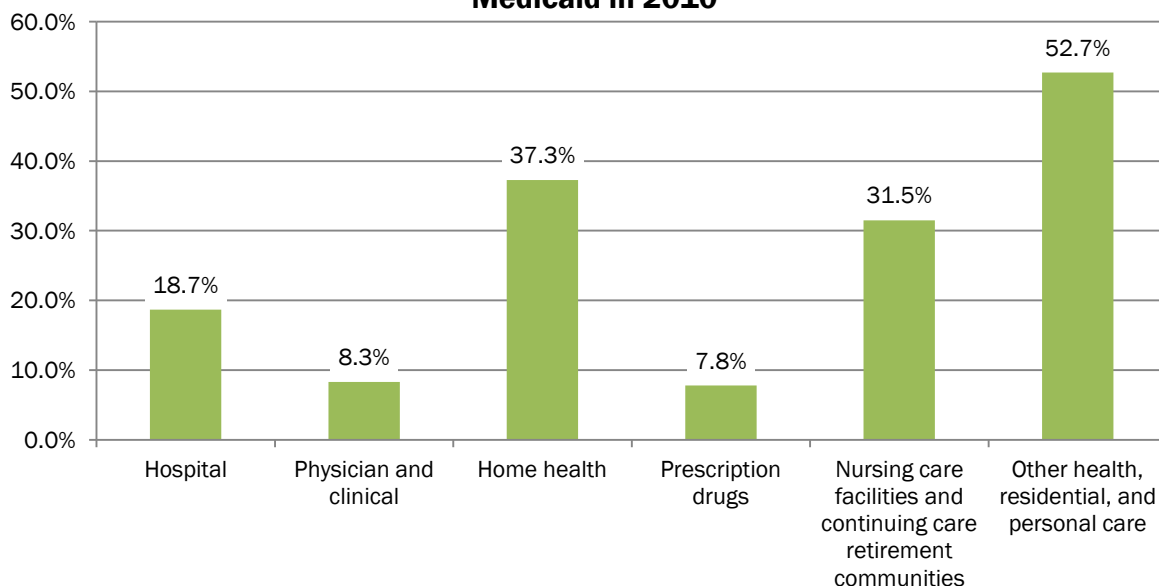
MEDICAID PLAYS A VITAL ROLE in supporting the health care system as a whole. In 2010, the state and federal share of Medicaid accounted for 17% of all national health spending. For providers such as hospitals, physicians and clinics, and long term supports and services providers such as nursing homes and home and personal care services, Medicaid payments represent a significant portion of revenues (Figure 10).

Medicaid revenues support an even greater proportion of the services provided by safety net providers:

- Medicaid is the most important source of financing for National Association of Public Hospitals (NAPH) members, representing 35% of total net revenue in 2010. Medicaid DSH (disproportionate share hospital) funding, which is designed to make up for uncompensated care and Medicaid’s lower reimbursement rates, represented 8% of total revenue and financed 24% of the unreimbursed care provided by NAPH members in 2010. NAPH-member hospitals account for 800,000 jobs annually.
- In 2010, Medicaid comprised 38% of revenue for Community Health Centers.
- Medicaid is the largest single payer in the country for mental health services.

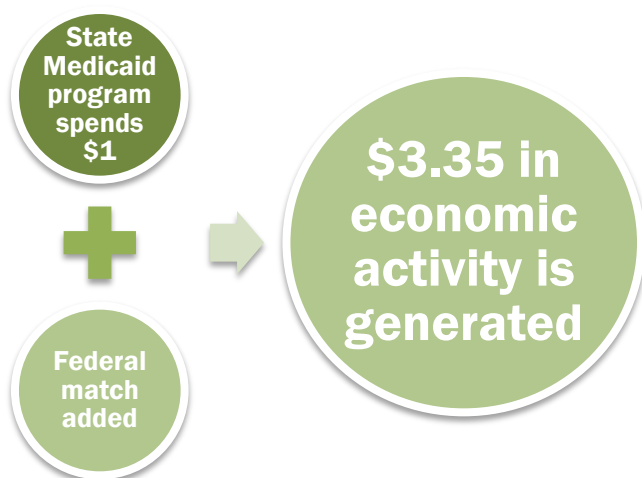
Federal spending on the Medicaid program helps to drive state and local economies. Federal funds support wages for people

Figure 10. Percentage of National Health Expenditures Paid by Medicaid in 2010



Sources: Office of the Actuary (OACT), CMS, National health expenditures by type of service and source of funds, January 2012; OACT, National Health expenditure accounts: Methodology paper, 2010, 2012, <http://www.cms.gov/NationalHealthExpendData/downloads/dsm-10.pdf>

providing services to Medicaid enrollees, that are in turn spent on other goods and services, producing what economists call the “multiplier effect,” increasing commerce and tax revenue in a local area. An analysis done by the University of Baltimore looked at the multiplier effect across all 50 states. The analysis found that, on average, every state dollar spent by the Medicaid program resulted in \$3.35 worth of state and local economic activity¹⁷.



The Kaiser Commission on Medicaid and the Uninsured also found strong evidence of the multiplier effect when it examined the results of 29 studies on the economic impact of Medicaid spending on state economies. The Commission found that all 29 studies, despite using different economic models, concluded that Medicaid had a positive impact on state economies.¹⁸ Other studies reached similar conclusions:

- Medicaid spending supports jobs; an Oklahoma study showed the State program to be responsible for supporting 99,036 jobs.¹⁹

- Medicaid spending increased workforce earnings; a study of the Utah program showed that for every \$1 million spent on Medicaid, earnings for Utah workers increased \$2.2 million²⁰.
- Medicaid spending increased business activity; a study showed Florida’s Medicaid program generated an additional \$8.7 billion in economic activity²¹.

These effects will be even more pronounced for those states which enact the Medicaid expansion authorized in the Affordable Care Act; the federal match on state spending for this expansion will be substantially greater than that evaluated in any of these studies.

In addition to the benefit Medicaid provides to state and local economies, Medicaid is an important part of one of the strongest and fastest growing parts of the economy, the health care and social assistance sector.

- According to the Bureau of Labor Statistics, the health care and social assistance sectors will add 5.6 million additional jobs to health care to the economy over the next decade²².
- In current projections, jobs in the health care field account for one-third of the fastest growing occupations in the United States²³.
- During the recent recession, as unemployment rose, the health care sector continued to grow, actually adding 482,000 jobs between 2007 and 2009 in part due to increased Medicaid spending. Over the same time period, the non-farming economy lost 7.5 million jobs²⁴.

Summary

Medicaid is an integral part of the nation's economic and social fabric. It provides needed, quality care to low-income children and families, adults, the elderly and those with disabilities. Many of those on the program are from a family whose workplace does not offer health insurance or does not offer it at an affordable price. Less costly than private coverage, Medicaid has also controlled per enrollee spending growth. Medicaid funding supports the health care system, the safety net, economic activity and jobs—within both the health care system and the economy at large.

The Partnership for Medicaid

The **Partnership for Medicaid** is a nonpartisan, nationwide coalition made up of organizations representing doctors, health care providers, safety net health plans, counties and labor. The goal of the coalition is to preserve and improve the Medicaid program.

REFERENCES

- ¹ Medicaid Matters: Understanding Medicaid's Role in Our Health Care System," Kaiser Family Foundation, March 2011, accessed at www.kff.org/medicaid/upload/8165.pdf
- ² <http://aspe.hhs.gov/poverty/12poverty.shtml/>
- ³ MACPAC analysis of Medicaid Statistical Information System (MSIS) and CMS-64 net financial management report data as of May 2012.
- ⁴ Kaiser Family Foundation and Health Research Education Trust Employer Health Benefits 2009 Annual Survey
- ⁵ MACPAC analysis of Medicaid Statistical Information System (MSIS) and CMS-64 net financial management report data as of May 2012
- ⁶ Kaiser Family Foundation. Enrollment-Driven Expenditure Growth: Medicaid Spending During the Economic Downturn, FFY2007-2010
- ⁷ Rising Unemployment, Medicaid and the Uninsured. John Holahan, A. Bowen Garrett, The Urban Institute. January 2009
- ⁸ Baicker, Katherine, Ph.D., and Finkelstein, Amy, Ph.D. "The Effects of Medicaid Coverage — Learning from the Oregon Experiment" <http://www.nejm.org/doi/pdf/10.1056/NEJMp1108222>
- ⁹ Sommers, Benjamin D. M.D., Ph.D., Baicker, Katherine Ph.D., and Epstein, Arnold M. M.D. "Mortality and Access to Care among Adults after State Medicaid Expansions" <http://www.nejm.org/doi/pdf/10.1056/NEJMs1202099>
- ¹⁰ KCMU Analysis of 2010 NHIS Data.
- ¹¹ Ibid.
- ¹² Ibid.
- ¹³ National Committee on Quality Assurance. "What is HEDIS"
- ¹⁴ Agency for Healthcare Research and Quality. "The CAHPS Program."
- ¹⁵ Lind, A., et. al. "Performance Measurement in Fee-for-Service Medicaid: Emerging Best Practices." Center for Health Care Strategies October 2010
- ¹⁶ <http://www.commonwealthfund.org/Blog/2012/Aug/Advancing-Accountable-Care-Organizations-in-Medicaid.aspx?omnicid=20>
- ¹⁷ FAMILIES USA, Medicaid: Good Medicine for State Economies, May 2004
- ¹⁸ Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid in State Economies: A Look at Research. January 2009.
- ¹⁹ C. St. Clair and G. Doekson, "The Economic Impact of the Medicaid Program on Oklahoma's Economy" May 2007
- ²⁰ J. Crispin-Little, "The Economic Impact of Medicaid and the Home and Community Based Services Waiver Program" January 2006
- ²¹ P. Sampath, "Penny Wise and Pound Foolish: Why Cuts to Medicaid Hurt Florida's Economy" October 2003
- ²² <http://www.fiercehealthcare.com/story/healthcare-jobs-will-grow-fastest-all-industries/2012-02-03>
- ²³ Ibid.
- ²⁴ <http://www.bls.gov/opub/mlr/2011/04/art2full.pdf>