# Medicaid in the United States: A Snapshot

As the largest health coverage program in the country, Medicaid serves approximately 67 million individuals[1]—many with a complex and costly array of chronic illnesses and disabilities. No longer linked to welfare in many states, Medicaid provides coverage to individuals well beyond its traditional base, including working parents, childless adults and the recently unemployed. While poor health care quality confronts all Americans, the quality gap is substantially greater for Medicaid beneficiaries, who have lower measures of care for many chronic conditions compared to those with commercial coverage.[2] Managing the care of Medicaid enrollees more effectively could improve health outcomes for millions of Americans and reduce health care expenditures.

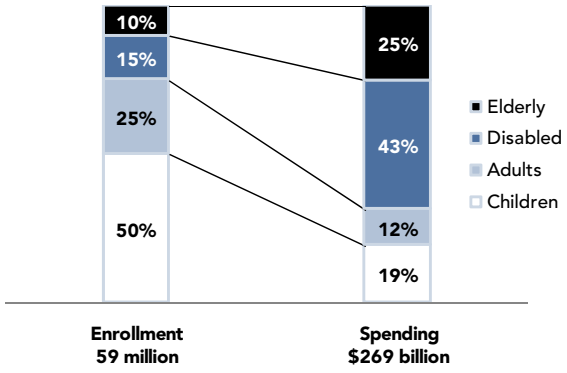
With Medicaid enrollment and costs continuing to rise—one million additional enrollees are expected for each one percent increase in unemployment[3]—innovations that produce better financial and clinical outcomes are increasingly essential. Such advances will become even more important if a large Medicaid expansion occurs under federal health care reform efforts. Medicaid is uniquely positioned to partner in system-wide initiatives due to its:

- ***High prevalence of chronic illness:*** Sixty-one percent of adult Medicaid enrollees have a chronic or disabling condition, representing a significant opportunity to test and lead advances in care management.[4,5]

- ***High percentage of racial/ethnic diversity:*** People in racial and ethnic minority populations, who make up roughly half of Medicaid beneficiaries under age 65,[6] experience more barriers to care, a greater incidence of chronic disease, lower quality of care and higher mortality than the general population.[7]

- ***High proportion of small provider practices:*** About half of all Medicaid beneficiaries and a large proportion of minority patients in select states go to practices with three or fewer providers. Small practices have gaps in chronic care performance, creating significant opportunities for improving quality and reducing disparities.[8]

**Total Medicaid Enrollees and Expenditures Nationally, by Enrollment Group, 2006**




SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2006 MSIS data.

- ***Leadership in value-based purchasing***: State Medicaid programs are increasingly using purchasing leverage to measure provider and plan performance; mine data to target improvement efforts; and realign financial incentives and reimbursement. States can maximize these efficiencies by aligning financial incentives with other public and commercial payers to reward better outcomes.

- ***Existing systems for managing care:*** More than 60 percent of Medicaid beneficiaries are in a managed health care system (e.g., full risk, primary care case management, etc.),[9] linking them directly to a primary care provider. Managed care can be leveraged to provide more integrated care, particularly for those with complex needs.

[1] Health Management Associates estimate for 2009 based on Congressional Budget Office, *Budget and Economic Outlook*, January 2008. Estimate is for Medicaid beneficiaries ever enrolled in 2009 (not average enrollment).
[2] E.A. McGlynn et al. "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine*, 348, no. 26 (2003); National Committee for Quality Assurance's Quality Compass 2008, available at www.ncqa.org/tabid/177/Default.aspx.
[3] S. Dorn, B. Garrett, J. Holahan, and A. Williams. *Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses*, Kaiser Commission on Medicaid and the Uninsured, April 2008.
[4] Kaiser Commission on Medicaid and the Uninsured, 2001 data; and R.G. Kronick, M. Bella, T.P. Gilmer, and S.A. Somers, *The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions.* Center for Health Care Strategies, Inc., October 2007.
[5] Kronick et al., op cit.
[6] Medicaid Statistical Information System State Summary FY 2004, Centers for Medicare and Medicaid Services, June 2007.
[7] Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Institute of Medicine, 2002.
[8] Data derived from CHCS Practice Size Exploratory Project, 2008.
[9] CMS, Medicaid Managed Care Overview, 2004.

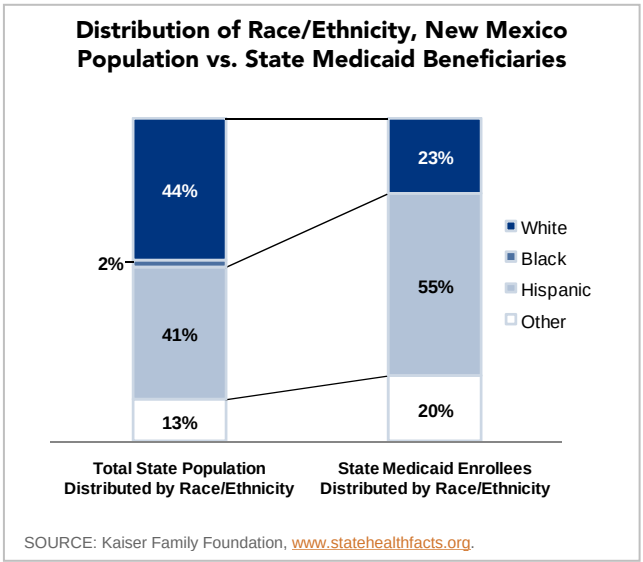
# Medicaid in Albuquerque, New Mexico: A Snapshot[10]

Approximately 514,000 New Mexico residents (26%) are enrolled in New Mexico's Medicaid program. This number is likely to rise amid the current recession. The greatest concentration of Medicaid managed care beneficiaries is in Albuquerque's Bernalillo County, the most populous area of the state.

- ***Medicaid Demographics:*** Children account for the greatest proportion (58%) of New Mexico's Medicaid enrollees, followed by non-disabled adults ages 18-64 (24%), the non-elderly disabled (11%) and the elderly (7%).

- ***Medicaid Spending:*** In FY 2007, New Mexico Medicaid expenditures totaled $2.6 billion, of which $739 million was state spending.

- ***Medicaid Contracting and Delivery of Care:*** *Salud!* is New Mexico's Medicaid managed care program, serving the majority of beneficiaries. In 2009, four managed care plans served beneficiaries residing in Bernalillo County: Blue Cross Blue Shield of New Mexico, Lovelace Community Health Plan, Molina Health Care of New Mexico and Presbyterian Health Plan.



SOURCE: Kaiser Family Foundation, www.statehealthfacts.org.

- ***Medicaid and Safety Net Providers:*** New Mexico has 15 federally qualified health centers (FQHCs), with 110 service delivery sites, serving as safety net providers. Roughly 23 percent of their revenue in 2007 came from Medicaid. There are approximately 11 FQHCs in Bernalillo County.[11]

- ***Medicaid Reimbursement:*** In 2008, New Mexico's fee-for-service (FFS) primary care provider (PCP) rate was 98 percent of Medicare. PCP rates in Medicaid managed care vary, but often are based on, or greater than, Medicaid FFS rates. The closer the Medicaid rate is to the Medicare rate, the more likely providers are to serve Medicaid patients, creating a greater overlap of payers across provider networks.

- ***Pay for Performance (P4P):*** Medicaid requires its plans to participate in a P4P program that focuses on meeting certain HEDIS, EPSDT and other structural performance measures. Managed health plans set aside a portion of their capitation payments in a separate account in order to establish a "Challenge Pool," which funds the incentive payments.

- ***State Medicaid Leadership:*** New Mexico Medicaid leadership includes: Medicaid Director Carolyn Ingram and Deputy Director Larry Heyeck.

- ***Collection and Public Reporting of Quality Data:*** Medicaid managed care plans must adhere to numerous reporting requirements, including submission of annual HEDIS and CAHPS reports. The most recent report, the 2007 Data Summary Report for New Mexico's *Salud*! Program, is available at *www.hsd.state.nm.us/mad/pdf_files/SALUD/HEDIS2007.pdf*.

- ***Participation in CHCS Systems/Quality Improvement Initiatives:*** New Mexico Medicaid has participated in the following Center for Health Care Strategies (CHCS) systems /quality improvement initiatives: *Integrated Care Program, Best Practices for Oral Health Access, Covering Kids and Families–Access Initiative, Rewarding Managed Care Performance,* and *Enhancing Early Child Development Services in Medicaid Managed Care.* For more information, visit *www.chcs.org.*

[10] Unless otherwise noted, all New Mexico data are from Kaiser State Health Facts *www.statehealthfacts.kff.org*, or Department of Health and Human Services, Office of New Mexico Care Services, State of New Mexico, *www.New Mexico.gov/dhhs/oms*.

[11] U.S. Department of Health and Human Services, Health Resources and Services Administration. *http://findahealthcenter.hrsa.gov/Search.aspx*.