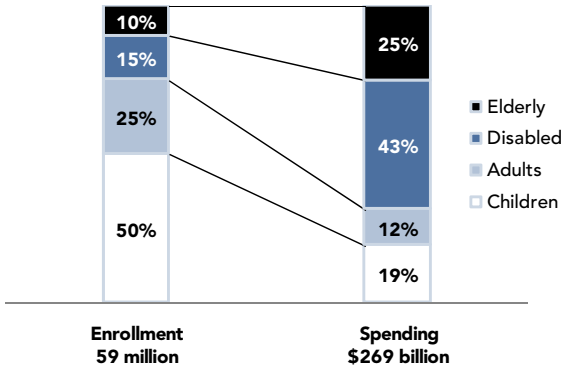
Medicaid in the United States: A Snapshot

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 1 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 in select states go to practices with three or fewer providers. These practices have large gaps in chronic care performance—especially for minority populations—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] R.H. 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, October 2007.
[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 Cincinnati, Ohio: A Snapshot[10]

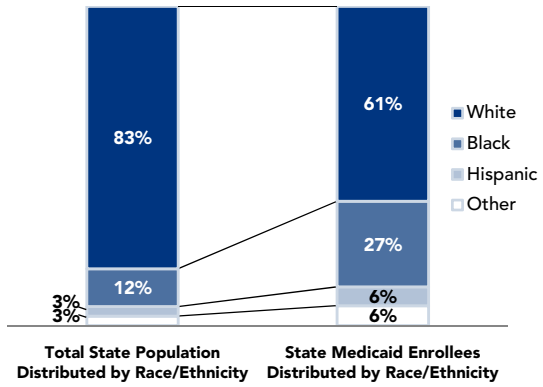
Approximately two million Ohio residents (18%) are enrolled in Medicaid. With the state's economy among the hardest hit in the nation – Ohio ranks 38th in job creation and 42nd in overall productivity[11] – that number is likely to rise. In Cincinnati's Hamilton County, approximately 806,000 residents are enrolled in Medicaid.[12]

- ***Medicaid Demographics:*** Children account for the greatest proportion (51%) of state Medicaid enrollees, followed by non-disabled adults ages 19-64 (24%), the disabled (17%), and the elderly (8%).

- ***Medicaid Spending:*** In FY 2007, Ohio Medicaid expenditures reached over $13 billion, including $5.2 billion in state spending. For beneficiaries in Hamilton County, expenditures were $900 million.[13]

- ***Medicaid Contracting and Delivery of Care:*** In 2007, approximately 1.2 million individuals –70 percent of Medicaid beneficiaries in Ohio and 57 percent of those in Hamilton County – were enrolled in managed care, compared to 64 percent nationally.[14] Four managed care plans serve the county's beneficiaries: AMERIGROUP Corp., CareSource, Centene Corp.'s Buckeye Community Health Plan and Molina Healthcare, Inc.[15]

Distribution of Race/Ethnicity, Ohio Population vs. State Medicaid Beneficiaries



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

- ***Medicaid and Safety Net Providers:*** Ohio has 26 federally qualified health centers, with a total of 130 service delivery sites, serving as safety net providers. Approximately 30 percent of their revenue in 2007 came from Medicaid.

- ***Medicaid Reimbursement:*** In 2008, the state's fee-for-service (FFS) primary care provider (PCP) rate was 66 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 health plans are required to participate in a P4P program. Performance measures are based on HEDIS and CAHPS related to quality of care, access, consumer satisfaction, and administrative capacity. Plans adhering to or exceeding the standards are eligible for retaining at-risk premium payments and receiving targeted P4P rewards.[16]

- ***Collection and Public Reporting of Quality Data:*** Medicaid health plans must adhere to numerous reporting requirements, including submission of annual HEDIS and CAHPS reports. The statewide report for Annual Medicaid Managed Health Care Clinical Performance Measures (in aggregate) is available at: *http://jfs.ohio.gov/OHP/bmhc/documents/reports/mcspr_cy2006.pdf*.

- ***State Medicaid Leadership:*** Leadership in the state's Medicaid program includes: Interim Medicaid Director, Ohio Department of Job and Family Services, Maureen Corcoran; and Executive Director, Executive Medicaid Management Administration, Cristal Thomas.[17] Medical directors for contracting Medicaid plans include: Dr. John Hinton (AMERIGROUP), Dr. Ronald Charles (Buckeye), Dr. Terry Torbeck (CareSource) and Dr. Kevin Smith (Molina).

- ***Participation in CHCS Systems/Quality Improvement Initiatives:*** Ohio Medicaid has participated in the following Center for Health Care Strategies (CHCS) systems /quality improvement initiatives: *Business Case for Quality: Phase II, Long-Term Care Partnership Expansion, Pay-for-Performance Purchasing Institute* and *Toward Improving Birth Outcomes.* For more information, visit *www.chcs.org.*

[10] Unless otherwise noted, Ohio data are from Kaiser State Health Facts (*www.statehealthfacts.kff.org*).
[11] Health Policy Institute of Ohio, The. (2009). Ohio Medicaid Basics 2009, Columbus, OH. Available at: *www.healthpolicyohio.org/pdf/MedicaidBasics_2009.pdf*
[12] The Ohio Medicaid Report SFY 2006 Statewide & County Data, Ohio Department of Job and Family Services, Research and Evaluation Unit. Available at *http://jfs.ohio.gov/OHP/reports/documents/OMR_SFY2006.pdf*.
[13] Ibid. Note: county figure is for fiscal year 2006.
[14] Ibid. Note: county figure is for fiscal year 2006; county enrollment percentage based on member months.
[15] *http://jfs.ohio.gov/ohp/bmhc/documents/pdf/CFC_RegionalMap_Color_0408.pdf* and *http://jfs.ohio.gov/ohp/bmhc/documents/pdf/ABDRegMap.pdf*
[16] *http://jfs.ohio.gov/OHP/bmhc/documents/pdf/CFC_FINAL_Generic_PA_1-01-09.pdf*
[17] National Association of State Medicaid Directors (*www.nasmd.org/Home/home_news.asp*)