Medicaid in the United States: A Snapshot

(updated 10/09)

As the largest health coverage program in the country, Medicaid serves nearly 60 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.

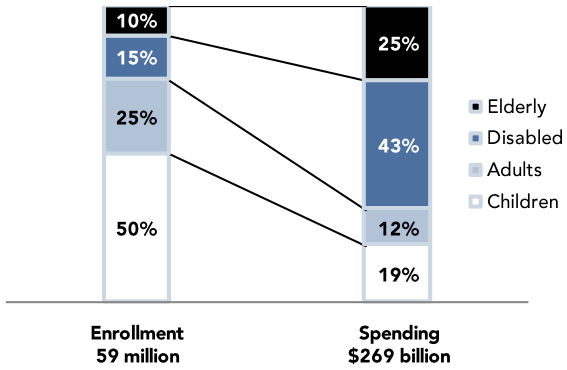
With Medicaid enrollment and costs continuing to rise—one million additional enrollees are expected for each 1 percent increase in unemployment[3]—innovations that produce better financial and clinical outcomes are increasingly essential. Such advances will become even more important if a large Medicaid 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] The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2009.
[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.

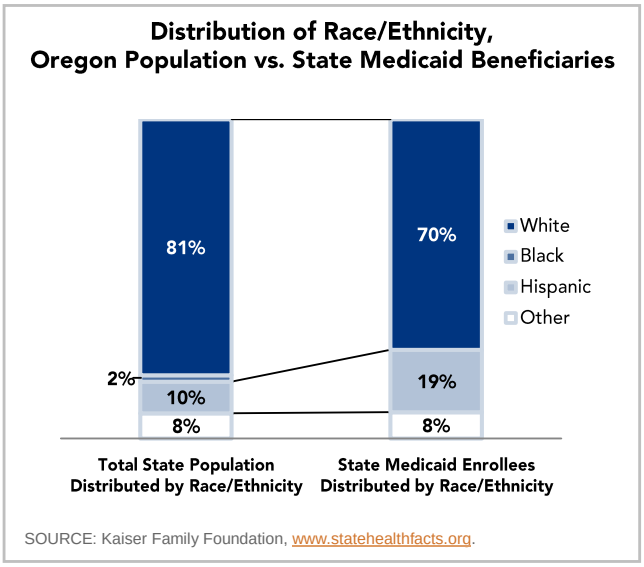
Medicaid in Willamette Valley, Oregon: A Snapshot[10]

Approximately 530,000 Oregon residents (14%) are enrolled in Medicaid, a number that is likely to rise amid the current recession.

- ***Medicaid Demographics:*** Children account for the greatest proportion (49%) of Oregon's Medicaid enrollees, followed by non-disabled adults ages 19-64 (28%), the non-elderly disabled (14%) and the elderly (9%).

- ***Medicaid Spending:*** In FY 2007, Medicaid expenditures reached over $2.9 billion, including $1.1 billion in state spending.

- ***Medicaid Contracting and Delivery of Care:*** As of 2008, 85 percent of Willamette Valley Medicaid beneficiaries (approximately 249,000 individuals) were enrolled in managed care, compared to 64 percent nationally. Eight managed care plans serve those in Willamette Valley's nine counties: CareOregon, FamilyCare, InterCommunity Health Network, Kaiser Permanente Oregon Plus, LIPA, Marion Polk Community Health Plan, Providence Health and Tuality Health Alliance. Of those, CareOregon has the greatest concentration of enrollment. The plans serve children, families, and aged, blind and disabled beneficiaries.



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

- ***Medicaid and Safety Net Providers:*** Oregon has 23 federally qualified health centers, with a total of 155 service delivery sites, serving as safety net providers. Approximately 38 percent of their revenue in 2007 came from Medicaid. There are 76 service delivery sites in Willamette Valley, almost half (36) of which are in Multnomah County.[11]

- ***Medicaid Reimbursement:*** In 2008, the state's fee-for-service (FFS) primary care provider (PCP) rate was 78 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):*** Oregon does not currently operate a P4P plan for its Medicaid health plans or physicians. However, many plans have developed their own provider-level P4P programs.

- ***Collection and Public Reporting of Quality Data:*** Medicaid managed care plans must adhere to numerous reporting requirements, including the annual submission of Key Performance Measures that contain HEDIS measures and CAHPS. Performance reports can be found at *www.oregon.gov/DHS/healthplan/data_pubs/reports/main.shtml*.

- ***State Medicaid Leadership:*** Oregon Medicaid leadership includes: Medicaid Director Jim Edge, Director of Policy and Planning Jean Phillips and Director of Budget and Finance Lynn Read.

- ***Participation in CHCS Systems/Quality Improvement Initiatives:*** Oregon Medicaid has participated in the following Center for Health Care Strategies (CHCS) systems/quality improvement initiatives: *Improving Outcomes for Children Involved in Child Welfare* and *Medicaid Value Program: Health Supports for Consumers with Chronic Conditions.* For more information, visit *www.chcs.org.*

[10] Unless otherwise noted, all Oregon data are from Kaiser State Health Facts (*www.statehealthfacts.kff.org*) or the Oregon Health Plan website (*www.oregon.gov/DHS/healthplan/*).
[11] U.S. Department of Health and Human Services, Health Resources and Services Administration. *http://findahealthcenter.hrsa.gov/Search.aspx*.