Medicaid Overview

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The Henry J. Kaiser Family Foundation

Council of State Governments / Medicaid Leadership Policy Academy
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Medicaid’s Origins

- Enacted in 1965 as title XIX of the Social Security Act
- Means-tested; originally focused on the public assistance population

**Entitlement**

Eligible Individuals are entitled to a defined set of benefits

States are entitled to federal matching funds

**Federal**

Sets core requirements on eligibility and benefits

**State**

Flexibility to administer the program within federal guidelines

Partnership
Medicaid plays a central role in our health care system.

Health Insurance Coverage

Assistance to Medicare Beneficiaries

Long-Term Care Assistance

Support for Health Care System and Safety-Net

State Capacity for Health Coverage
Medicaid spending is mostly for the elderly and people with disabilities.

Enrollees
Total = 68.0 Million

Expenditures
Total = $397.6 Billion

SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.
Medicaid and private insurance provide similar access to care – the uninsured fare far less well.

NOTES: Access measures reflect experience in past 12 months. Respondents who said usual source of care was the emergency room are not counted as having a usual source of care. *Difference from ESI is statistically significant (p<.05)
SOURCE: KCMU analysis of 2014 NHIS data.
NOTE: FMAP percentages are rounded to the nearest tenth of a percentage point. These rates are in effect Oct. 1, 2014-Sept. 30, 2015. These FMAPs reflect the state’s regular FMAP; they do not reflect the FMAP for newly eligibles in states that adopted the ACA Medicaid expansion.

Figure 6

Medicaid is a spending item and a source of federal revenue in state budgets.

- Total State Spending (Including Federal Funds): $1.69 Trillion
- State General Funds (Not Including Federal Funds): $680.8 Billion
- Federal Funds Spent by States: $512.5 Billion

SOURCE: Kaiser Commission on Medicaid and the Uninsured estimates based on the NASBO’s November 2014 State Expenditure Report (data for Actual FY 2013.)
Growth in per-enrollee Medicaid spending is lower than private health insurance (2007-2013).

Average Annual Growth Rate, FY 2007-2013:

- Medicaid Acute Care Spending Per Enrollee: 3.1%
- NHE Per Capita: 3.1%
- Private Health Insurance Per Enrollee: 4.6%
- Medical Care CPI: 3.2%

NOTE: Medicaid acute care spending includes payments to managed care organizations.
Medicaid spending and enrollment are affected by changes in economic conditions and policy.

NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

SOURCE: Implementing the ACA: Medicaid Spending & Enrollment Growth for FY 2014 and FY 2015
NOTE: The June 2012 Supreme Court decision in National Federation of Independent Business v. Sebelius maintained the Medicaid expansion, but limited the Secretary’s authority to enforce it, effectively making the expansion optional for states. 138% FPL = $16,424 for an individual and $27,724 for a family of three in 2015.
All states were required to modernize Medicaid application and enrollment processes.

**PAST**
- Apply in person
- Provide paper documentation
- Wait for eligibility determination

**ACA Vision**
- Multiple options to apply
- Electronic verification
- Real-time determination

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**Figure 10**

Medicaid CHIP Marketplace

No Wrong Door to Coverage
NOTES: Based on KCMU analysis of state executive activity. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.


In states that have not expanded Medicaid under the ACA, there are large gaps in coverage available for adults.

Median Medicaid Eligibility Limits as of April 2015

- **Limited to Specific Low Income Groups**
  - 0% FPL
    - Childless adults
  - 44% FPL
    - $8,840 for parents in a family of three

- **No Coverage**
  - 100% FPL
    - $11,770 for an individual

- **Marketplace Subsidies**
  - 400% FPL
    - $47,080 for an individual
A limited number of states have approved or are seeking waivers for expansion.

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<th>Waiver Provision</th>
<th>Approved Waivers</th>
<th>Proposed Waivers</th>
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Note: *Governor Wolf (PA) transitioned from a waiver to a SPA. New Hampshire will transition from a SPA to a waiver.
The Medicaid expansion has implications beyond the Medicaid program.

- **Reduction in the Number of Uninsured**
- **Increased Provider Revenue**
- ** Increased State Savings**
  - ↓ Uncompensated Care Costs
  - ↓ State-funded health programs (e.g. Corrections and Mental health)
- **Increased State Economic Activity**
  - ↑ Jobs and Revenues

**Federal + State Funds**

*The Kaiser Family Foundation*
Medicaid hospital stays up and uninsured stays down in Medicaid expansion states, 2013-2014.

NOTE: Change is measured as change between first two quarters of 2013 and first two quarters of 2014.

The typical expansion state spent more per capita on Medicaid and K-12 Education than the typical non-expansion state.

Median State and Local Government Expenditures per capita, 2012

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<tr>
<th>Category</th>
<th>Expansion States</th>
<th>Non-Expansion States</th>
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<td>Corrections</td>
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NOTE: Data reflect medians for each group; all data were inflated to real 2013 $ per the GDP price index. Median values exclude DC. Excluded are intergovernmental transfers made by state and local governments. SOURCE: KCMU/Rockefeller Institute analysis of Census data on State and Local Government Finances, 2012.
Over half of all Medicaid beneficiaries receive their care in comprehensive risk-based MCOs.

Share of Medicaid beneficiaries enrolled in risk-based managed care plans

U.S. Overall = 51%

0% (14 states) 1-50% (11 states) 51-80% (23 states, including DC) >80% (3 states)

States continue to expand and improve their managed care programs.

Actions to Expand Managed Care

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<tr>
<th>Category</th>
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Policy Changes in Either Year

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<td>Quality Initiatives</td>
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SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2014.
States are implementing an array of delivery system reforms to coordinate care and control costs.

NOTE: Expansions of existing initiatives include roll-outs of existing initiatives to new areas or groups and significant increases in enrollment or providers. Dual Eligible Initiatives include both those through the CMS financial alignment demonstration and those outside of the CMS financial alignment demonstration.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2014.
Over time, the share of Medicaid long-term care spending going to home and community-based settings has increased.

NOTE: LTSS means long-term services and supports. Home and community-based LTSS includes state plan home health, state plan personal care services and section 1915(c) HCBS waivers. Institutional LTSS includes intermediate care facilities for individuals with intellectual/developmental disabilities, nursing facilities, and mental health facilities.

SOURCE: KCMU and Urban Institute analysis of Centers for Medicare & Medicaid Services (CMS)-64 data.
What are state priorities going forward?

- ACA implementation
- Payment and delivery system reforms
- Systems and administration
- Population health and social determinants of health
There are many “Faces of Medicaid”.

For more information on the Medicaid program and health reform, visit...

www.kff.org