Medicaid: Current Challenges and Future Prospects

Diane Rowland, Sc.D.
Executive Vice President, Henry J. Kaiser Family Foundation
Executive Director, Kaiser Commission on Medicaid and the Uninsured

The Future of Medicaid: Building a Sustainable Program through Innovation
Muskie School of Public Service, University of Southern Maine

Augusta, Maine
November 22, 2013
Medicaid is an integral part of the health system.

**Health Coverage**

- Uninsured: 16%
- Medicaid: 16%
- Medicare: 13%
- Other Public: 1%
- Private Non-Group: 5%
- Employer-Sponsored Insurance: 49%

**Total = 307.9 million**

**Health Spending**

- Consumer Out-of-Pocket: 13%
- Private Health Insurance: 35%
- Other Private Funds: 8%
- Other Government Programs: 4%
- Medicaid: 16%
- Medicare: 24%

**Total = $2.3 trillion**

NOTE: Health spending total does not include administrative spending.

Medicaid has many roles in our health care system.

- **Health Insurance Coverage**
  - 32 million children & 18 million adults in low-income families;
  - 16 million elderly and persons with disabilities

- **Assistance to Medicare Beneficiaries**
  - 9.6 million aged and disabled — 20% of Medicare beneficiaries

- **Long-Term Care Assistance**
  - 1.6 million institutional residents; 2.9 million community-based residents

- **Support for Health Care System and Safety-net**
  - 16% of national health spending; 40% of long-term care spending

- **State Capacity for Health Coverage**
  - For FY 2014, FMAPs range from 50 – 73.1%
# Medicaid Benefits

<table>
<thead>
<tr>
<th>Mandatory</th>
<th>State Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Care</strong></td>
<td></td>
</tr>
<tr>
<td>• Inpatient &amp; outpatient hospital services</td>
<td>• Care by other licensed practitioners (chiropractic, podiatry, etc.)</td>
</tr>
<tr>
<td>• Laboratory and x-ray services</td>
<td>• Pharmacy</td>
</tr>
<tr>
<td>• Physician, nurse practitioner services, nurse midwife, and other advanced practice nursing services</td>
<td>• Dental services</td>
</tr>
<tr>
<td>• Federally-qualified health centers; rural health centers</td>
<td>• Diagnostic, screening, preventive, and rehab services</td>
</tr>
<tr>
<td>• EPSDT for children</td>
<td>• Clinic services</td>
</tr>
<tr>
<td>• Family planning services</td>
<td>• Primary care case management</td>
</tr>
<tr>
<td>• Transportation</td>
<td>• Occupational &amp; physical therapy</td>
</tr>
<tr>
<td>• No cost sharing for children</td>
<td>• Speech, hearing, and language disorder services</td>
</tr>
<tr>
<td><strong>Long Term Care</strong></td>
<td></td>
</tr>
<tr>
<td>• Nursing facility for age 21 and up</td>
<td>• Medical supplies and durable medical equipment, eyeglasses, and orthotic and prosthetic devices</td>
</tr>
<tr>
<td>• Home health (if entitled to NF care)</td>
<td>• Limited nominal cost sharing for adults</td>
</tr>
</tbody>
</table>

- Inpatient psychiatric services—if age under 21 or over 65
- Intermediate care facilities for people with developmental disabilities
- Home health
- Case management
- Community-based care (private duty nursing, personal care, hospice, adult day health)
- Community-based care (licensed social worker protective services, etc.)
Medicaid spending is mostly for the elderly and people with disabilities, especially in Maine.

SOURCE: KCMU/Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. MSIS FY 2009 data were used for CO, ID, MO, NC, and WV, but adjusted to 2009 CMS-64.
Disability and long-term care needs drive higher spending.

Medicaid Payments Per Enrollee by Acute and Long-Term Care, FY 2010

- **Acute Care**
  - Children: $2,296
  - Adults: $3,012
  - Individuals with Disabilities: $10,037
  - Elderly: $12,958

- **Long-Term Care**
  - Children: $2,359
  - Adults: $3,025
  - Individuals with Disabilities: $6,203
  - Elderly: $9,344

**SOURCE:** Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64 reports. Because 2010 data were unavailable, 2009 MSIS data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS-64 spending levels.
Connecting People to Coverage
Medicaid plays a critical role for selected populations.

### Percent with Medicaid Coverage

**Families**
- All Children: 36%
- Children Below 100% FPL: 71%
- Parents Below 100% FPL: 40%
- Births (Pregnant Women): 46%

**Elderly and People with Disabilities**
- Medicare Beneficiaries: 20%
- Nonelderly Adults with Functional Limits: 16%
- People with HIV in Regular Care: 50%
- Nursing Home Residents: 63%

NOTE: FPL--Federal Poverty Level. The FPL was $23,050 for a family of four in 2012.
SOURCE: Kaiser Commission on Medicaid and the Uninsured (KCMU) and Urban Institute analysis of 2012 ASEC Supplement to the CPS; Birth data from Maternal and Child Health Update, National Governors Association, 2012; Medicare data from MCBS Cost and Use file, 2009; Functional Limitations from KCMU Analysis of 2012 NHIS data; Nursing Home Residents from 2011 OSCAR data.
Medicaid’s benefits reflect the needs of the population it serves.

| Low-Income Families | • Pregnant Women: Pre-natal care and delivery costs  
|                     | • Children: Routine and specialized care for childhood development (immunizations, dental, vision, speech therapy)  
|                     | • Families: Affordable coverage to prepare for the unexpected (emergency dental, hospitalizations, antibiotics)  
| Individuals with Disabilities | • Child with Autism: In-home therapy, speech/occupational therapy  
|                           | • Cerebral Palsy: Assistance to gain independence (personal care, case management and assistive technology)  
|                           | • HIV/AIDS: Physician services, prescription drugs  
|                           | • Mental Illness: Prescription drugs, physicians services  
| Elderly Individuals | • Medicare beneficiary: help paying for Medicare premiums and cost sharing  
|                   | • Community Waiver Participant: community based care and personal care  
|                     | • Nursing Home Resident: care paid by Medicaid since Medicare does not cover institutional care |
Medicaid is central for children’s coverage.

Data may not total 100% due to rounding.

SOURCE: KCMU/Urban Institute analysis of 2013 ASEC supplement to the CPS.
Medicaid provides access to care that is comparable to private insurance and better than access for the uninsured.

**Children**

- No Usual Source of Care: 29%
- Postponed Seeking Care Due to Cost: 18%
- Went Without Needed Care Due to Cost: 11%

**Nonelderly Adults**

- No Usual Source of Care: 55%
- Postponed Seeking Care Due to Cost: 29%
- Went Without Needed Care Due to Cost: 25%

**NOTES:** In past 12 months. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between the uninsured and the two insurance groups are statistically significant (p<0.05).

**SOURCE:** KCMU analysis of 2013 NHIS data.
Even though adults with Medicaid are both poorer and sicker than low-income adults with private health insurance.

Selected characteristics of adults <139% FPL:

- **< 100% FPL**: 82% ESI, 72% Medicaid, 57% Uninsured
- **Fair/Poor Health**: 36% ESI, 18% Medicaid, 11% Uninsured
- **Fair/Poor Mental Health**: 26% ESI, 12% Medicaid, 7% Uninsured
- **>1 Chronic Condition**: 48% ESI, 19% Medicaid, 12% Uninsured
- **Any Limitation**: 53% ESI, 21% Medicaid, 29% Uninsured

*Difference from Medicaid is significant at .01 level.

Medicaid is also key to filling Medicare gaps for the elderly and people with disabilities.

**Medicaid Enrollment, 2010**

- Children: 49%
- Adults: 27%
- Other Aged & Disabled: 10%
- Dual Eligibles: 14%

Total = 66.4 Million

**Medicaid Spending, 2010**

- Non-Dual Spending: 64%
- Long-Term Care: 24%
- Acute Care: 9%
- Premiums: 3%
- Prescribed Drugs: 0.3%
- Dual Spending: 36%

Total = $383.0 Billion

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64 reports. 2009 MSIS data was used for CO, ID, MO, NC, and WV, because 2010 data were unavailable.
And Medicaid is a major financer of long-term care.

**Total National LTSS Spending**

- **Medicaid, 40%**
- **Medicare Post-Acute Care, 21%**
- **Other Public and Private, 18%**
- **Out-of-Pocket, 15%**
- **Private Insurance, 7%**

**And Medicaid is a major financer of long-term care.**

**Total National LTSS Spending**

- **Home and Community-Based Services**
  - **2002: $93** (32%)
  - **2006: $111** (41%)
  - **2010: $123** (45%)

- **Institutional Services**
  - **2002: $68** (68%)
  - **2006: $59** (59%)
  - **2010: $55** (55%)

**NOTE:** Total long-term care expenditures include spending on residential care facilities, nursing homes, home health services, personal care services (government-owned and private home health agencies), and § 1915(c) home and community-based waiver services (including home health). Long-term care expenditures also include spending on ambulance providers. All home and community-based waiver services are attributed to Medicaid.

**SOURCE:** KCMU estimates based on FY 2011 Centers for Medicare & Medicaid Services (CMS) National Health Expenditure Accounts data.
Health Needs Drive Spending and Spending Drives Budget Concerns
Federal and state governments share Medicaid costs.

Federal Medicaid Matching Rates, FFY 2014

- **Maine FMAP: 61.55%**

### FFY 2014 FMAP
- 50 percent (15 states)
- 50.1-59.9 percent (12 states)
- 60.0-66.9 percent (13 states)
- 67.0-73.1 percent (11 states, including DC)

**NOTE:** FMAP percentages are rounded to the nearest tenth of a percentage point. These rates are in effect Oct. 1, 2013-Sept. 30, 2014.

For Medicaid, cost is always a challenge.

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

SOURCE: Medicaid Enrollment June 2012 Data Snapshot, KCMU, August 2013. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2012 - 2014 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.
Although Medicaid cost growth is slower than overall health care costs.

![Spending Growth, FY 2007-2011](figure)

SOURCE: Medicaid estimates from Urban Institute analysis of data from the Medicaid Statistical Information System (MSIS), Medicaid Financial Management Reports (CMS Form 64), and Kaiser Commission on Medicaid and the Uninsured and Health Management Associates data. NHE and private health insurance data from Centers for Medicare & Medicaid Services Office of the Actuary, National Health Statistics Group.
NOTE: Spending includes both state and federal payments to Medicaid. These figures represent the average (mean) level of payments across all Medicaid enrollees. Spending per enrollee does not include disproportionate share hospital payments (DSH). Some enrollees are only eligible for a limited set of benefits. A small fraction of elderly and disabled enrollees in every state qualify only for assistance with their Medicare premiums and coinsurance.

Most Medicaid spending is driven by a few with high health needs.

Enrollees
FY 2010 Total = 66.4 million

Expenditures
FY 2010 Total = $369.3 billion

SOURCE: KCMU/Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. MSIS FY 2009 data were used for CO, ID, MO, NC, and WV, but adjusted to 2010 CMS-64.
State Options and Opportunities
### Core Requirements

<table>
<thead>
<tr>
<th>Eligibility and Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Federal minimum coverage of certain low-income groups (pregnant women, children, elderly and disabled, parents)</td>
</tr>
<tr>
<td>- Maintenance of Eligibility (MOE)</td>
</tr>
<tr>
<td>- Streamlined and simplified enrollment procedures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Coverage beyond federal minimum levels</td>
</tr>
<tr>
<td>- ACA early expansion option for childless adults</td>
</tr>
<tr>
<td>- ACA Medicaid Expansion to 138% FPL (requirement with limited authority to enforce)</td>
</tr>
<tr>
<td>- Additional enrollment simplifications (e.g., ELE, 12-month continuous eligibility)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits and Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Required benefits set in statute</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Optional benefits</td>
</tr>
<tr>
<td>- Cost sharing within federal rules</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Delivery and Provider Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Payments must be “consistent with efficiency, economy, quality and access”</td>
</tr>
<tr>
<td>- Some requirements for specific providers/services (FQHCSs, MCOs, etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Delivery systems (FFS, MCOs, PCCM, combination)</td>
</tr>
<tr>
<td>- New ACA options (CMMI, new grants)</td>
</tr>
<tr>
<td>- Premium assistance options</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long-Term Services and Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Nursing home coverage and quality standards</td>
</tr>
<tr>
<td>- Olmstead</td>
</tr>
<tr>
<td>- Resource and asset tests</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Level of need determinations</td>
</tr>
<tr>
<td>- Community-based care options (HCBS and new ACA requirements)</td>
</tr>
<tr>
<td>- Duals demos</td>
</tr>
</tbody>
</table>
Section 1115 waivers enable demonstrations.

- Section 1115 waiver authority provided for “experimental, pilot, or demonstration projects,” which are “likely to assist in promoting the objectives” of the program

- Secretary of HHS has authority to:
  - Waive compliance with certain federal Medicaid requirements
  - Provide federal matching funds for costs that would not otherwise be included as Medicaid expenditures

- Required to be budget neutral for the federal government
  - Enforced through a cap on federal matching funds over the life of the waiver

- Approved through a series of negotiations between a state and HHS
  - Generally approved for an initial five-year period
  - Can be extended, typically for three years
  - Can be amended, subject to federal approval
# Approval Process Requirements for Section 1115 Waivers, Effective April 27, 2012

**Timeline of Minimum Public Comment and Approval Requirements for Section 1115 Waivers:**

<table>
<thead>
<tr>
<th>State Posts Waiver Proposal</th>
<th>State Holds At Least 2 Public Hearings</th>
<th>Earliest End Date for State Notice and Comment Period</th>
<th>State Submits Application to CMS</th>
<th>Latest Date for Federal Notice of Receipt to State</th>
<th>End of Federal Notice and Comment Period*</th>
<th>Earliest Date for Federal Approval*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Days</td>
<td>15 Days</td>
<td>30 Days</td>
<td>0 Days</td>
<td>15 Days</td>
<td>30 Days</td>
<td>45 Days</td>
</tr>
</tbody>
</table>

* If the federal government provides the notice of receipt to the state earlier than within 15 days of the state submission, the timelines for the end of the federal notice and comment period and earliest date for federal approval could be shorter.
Other Waiver Authorities in Medicaid

- **Section 1115A: Center for Medicare and Medicaid Innovation (ACA)**
  - Waiver authority to test, evaluate, and expand different service delivery and payment methodologies to foster patient-centered care, improve quality, and slow cost growth in Medicare, Medicaid, and CHIP
  - $10 billion in funding over 10 years

- **Section 1915(b):** To enroll many Medicaid beneficiaries in mandatory managed care

- **Section 1915(c):** To provide home and community-based services to people who would otherwise need institutional care

- **Section 1916(f):** To approve higher cost-sharing than otherwise allowed if a demonstration meets specified requirements and criteria
States are expanding their use of managed care in Medicaid through a range of actions.

NOTE: States were asked to report new initiatives or expansions in these areas; the data do not reflect ongoing state efforts in these areas. While states have reported managed care quality initiatives in the past, there was not a comparable count available for FY 2011.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2011 and 2012.
In 26 states, over half of Medicaid beneficiaries are enrolled in comprehensive risk-based plans.

Penetration of comprehensive risk-based managed care, July 1, 2011:

U.S. Overall = 51%

0% (14 states)
1-50% (11 states)
51-65% (10 states)
66-80% (13 states, including DC)
>80% (3 states)

NOTE: Comprehensive risk-based managed care includes Health Insuring Organizations (HIOs), comprehensive commercial and Medicaid managed care organizations (MCOs), and Program of All-Inclusive Care for the Elderly (PACE).

Examples of Payment and Delivery System Changes

• Expanding managed care to high-need populations and more services, including long-term services and supports

• Supporting hospital delivery system improvements through safety-net care pools

• Delivery and payment system changes focused on coordinating care and changing financial incentives for plans and providers

• Many states are pursuing concurrent initiatives through the “health homes” state plan option and/or duals integration initiative under CMMI
Figure 29

States are also focusing on long-term services and supports.

- **Enrollees**: 94%
  - People Who Did Not Use LTSS: 43%
  - People Who Used Institutional LTSS: 22%
  - People Who Used Community-Based LTSS: 4%

- **Expenditures**: 57%
  - People Who Did Not Use LTSS: 21%
  - People Who Used Institutional LTSS: 22%
  - People Who Used Community-Based LTSS: 4%

Total = 66.4 million
Total = $369.3 billion

NOTE: Individuals who used both institutional and community-based services in the same year are classified as using institutional services in this figure.

SOURCE: KCMU and Urban Institute estimates based on data from FY 2010 Medicaid Statistical Information System (MSIS) and Centers for Medicare & Medicaid Services (CMS)-64 reports. Because the 2010 data were unavailable, 2009 data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS-64 spending levels.
There are still waiting lists for Home and Community Based Services (HCBS).

<table>
<thead>
<tr>
<th>Year</th>
<th>Others</th>
<th>Aged/Disabled</th>
<th>I/DD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>3%</td>
<td>43%</td>
<td>53%</td>
</tr>
<tr>
<td>2003</td>
<td>1%</td>
<td>51%</td>
<td>47%</td>
</tr>
<tr>
<td>2004</td>
<td>1%</td>
<td>53%</td>
<td>45%</td>
</tr>
<tr>
<td>2005</td>
<td>6%</td>
<td>41%</td>
<td>53%</td>
</tr>
<tr>
<td>2006</td>
<td>5%</td>
<td>42%</td>
<td>53%</td>
</tr>
<tr>
<td>2007</td>
<td>6%</td>
<td>26%</td>
<td>68%</td>
</tr>
<tr>
<td>2008</td>
<td>6%</td>
<td>30%</td>
<td>64%</td>
</tr>
<tr>
<td>2009</td>
<td>10%</td>
<td>29%</td>
<td>61%</td>
</tr>
<tr>
<td>2010</td>
<td>9%</td>
<td>28%</td>
<td>63%</td>
</tr>
<tr>
<td>2011</td>
<td>8%</td>
<td>29%</td>
<td>62%</td>
</tr>
<tr>
<td>2012</td>
<td>10%</td>
<td>32%</td>
<td>58%</td>
</tr>
</tbody>
</table>

Total: 192,447 180,347 206,427 260,916 280,176 331,689 393,096 365,553 428,571 511,174 523,710

NOTE: The “Other” enrollment group includes waiver enrollees who are people with physical disabilities, children, people with HIV/AIDS, people with mental health needs, and people with traumatic brain and spinal cord injuries. Percentages may not sum to 100% due to rounding.

SOURCES: KCMU and UCSF analysis of CMS Form 372 data and program surveys.
New options are available to support community care.

*Approved states actively participating

- **Money Follows the Person Demonstration**: 46 states
- **Health Home State Plan Option**: 29 states
- **Balancing Incentive Program**: 16 states
- **HCBS State Plan Option**: 12 states
- **Duals Demonstrations**: 8 states
- **Community First Choice State Plan Option**: 2 states

SOURCE: KCMU internal tracking based on federal and state websites, as of October 2013.
Medicaid in Perspective

- Medicaid is the primary health coverage program for low-income Americans with significant health needs.

- Medicaid increases access to care and limits financial burdens for its 63 million beneficiaries.

- Medicaid is a critical source of financing for our health care system and safety net facilities.

- Medicaid spending is concentrated among a small number of beneficiaries with complex health needs.

- Medicaid cost growth needs to be managed with delivery and payment system reforms to improve care coordination and quality.
Diane Rowland, Executive Vice President & Executive Director
The Henry J. Kaiser Family Foundation
Kaiser Commission on Medicaid and the Uninsured
1330 G Street, NW
AnneW@kff.org
202.654.1323

Visit our new, improved site: www.kff.org
twitter.com/kaiserefamfound | facebook.com/kaiserfamilyfoundation