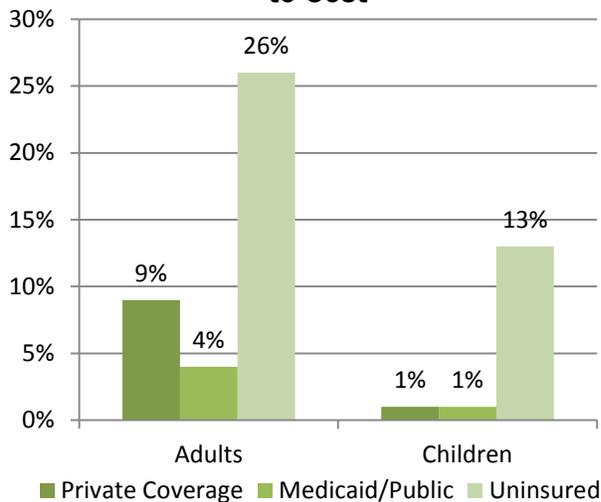


## Medicaid Provides Access to Needed, Quality Care

Critics often argue that people using Medicaid are no better off than they would be if they were uninsured. Multiple studies demonstrate that this is untrue and individuals do, in fact, benefit from being enrolled in Medicaid versus being uninsured.

**Figure 1. Fewer Medicaid Enrollees Forego Needed Care Due to Cost**



Source: KCMU Analysis of 2010 NHIS Data.

through 2040, resulting in a large increase in LTSS demand. Due to demographics alone, LTSS spending for older adults may increase by more than two-and-a-half times between 2000 and 2040, and could nearly quadruple spending between 2000 and 2050 to \$379 billion, according to some estimates. Additionally, recent research points to higher than previously estimated numbers of older adults with disabilities who likely will need LTSS further driving up demand and costs.

- A recent study in the New England Journal of Medicine shows that states that expanded Medicaid saw a reduction in their mortality rate, as well as improved access to care and better self-reported health among the expansion population.<sup>2</sup>

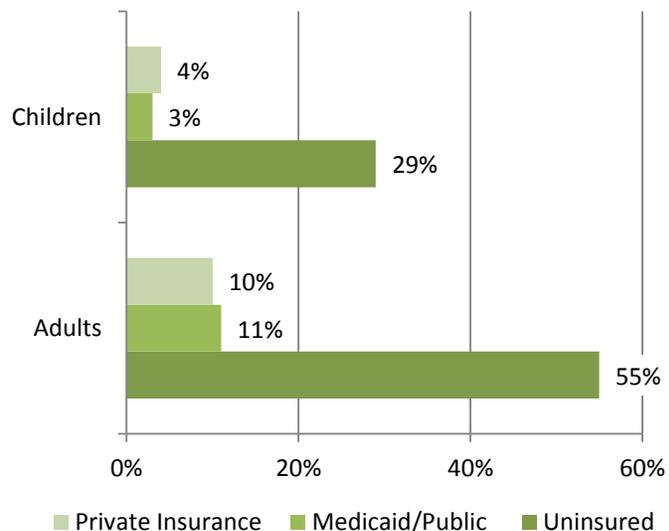
<sup>1</sup> Baicker, Katherine, Ph.D., and Finkelstein, Amy, Ph.D. "The <http://www.nejm.org/doi/pdf/10.1056/NEJMp1108222>

<sup>2</sup> Sommers, Benjamin D. M.D., Ph.D., Baicker, Katherine Ph.D. "State Medicaid Expansions" <http://www.nejm.org/doi/pdf/1>

- A randomized study done in Oregon showed that Medicaid enrollees were 70% more likely to report having a regular place of care, and 55% more likely to report having a usual doctor than similar people who were uninsured. Medicaid enrollees were also 40% less likely to have to borrow money or skip other payments because of medical bills. Most importantly, Medicaid enrollees are 25% more likely to indicate they are in good, very good, or excellent health.<sup>1</sup>

- Medicaid is the primary funding source of form, paid long term services and supports (LTSS). Estimates suggest the future number of the older adult population who are unable to perform basic activities of daily living without assistance may as much as double from 2000

**Figure 2. Percentage of Enrollees Reporting No Consistent Source of Care**



Source: KCMU Analysis of 2010 NHIS Data.

Medicaid enrollees are less likely than uninsured or privately-insured individuals to go without needed medical care due to cost (Figure 2). Medicaid enrollees are also less likely to lack a usual source of care.

- Only 4% of adults on Medicaid went without care due to cost, compared with 9% of privately-insured adults, and more than one-quarter of uninsured adults.<sup>3</sup>
- Medicaid does even better among children: only 1% went without needed care due to cost, compared to 13% of the uninsured.<sup>4</sup>
- 11% of Medicaid-covered adults and 3% of Medicaid-covered children report no usual source of care, compared with more than half of all uninsured adults and 29% of uninsured children (Figure 8).<sup>5</sup>

Quality and performance in Medicaid are measured in a variety of ways. In comprehensive, risk-based managed care, which covers 47% of Medicaid enrollees, plans submit data based on national quality measures that states and the federal government can use to assess specific plan and overall program performance.<sup>6</sup> Among other examples of the efforts states are undertaking to improve and reward quality inside and outside comprehensive, risk-based managed care are pay-for-performance (P4P) incentive programs. States have considerable discretion in designing P4P initiatives and the providers included (e.g., nursing facilities, hospitals, physicians, health plans). Programs, therefore, vary from state to state. They are, however, typically based on a variety of measures which can address staffing, survey outcomes, consumer satisfaction, and clinical quality. To qualify for incentive payments, a provider or plan must meet certain quality thresholds established by the state, or demonstrate a set degree of improvement.

Among nursing facilities, quality has considerably improved. While the proportion of residents with severe Activities of Daily Living (ADL) impairment has been increasing, key quality measures have improved.<sup>7</sup> The incidences of pressure ulcers, use of physical restraints, and use of tube feeding continue to decline.<sup>8</sup>

Some states are also tying payment to quality outcomes as they develop accountable care organizations (ACOs) for their Medicaid populations. This model changes financial incentives to encourage better-coordinated care delivery across providers and accountability for patients at the practice level. While they all apply core ACO concepts, such as value-based purchasing, data-sharing, and care management targeted to high-risk patients that use health services at an avoidably high rate,

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<sup>3</sup> KCMU Analysis of 2010 NHIS Data.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> Approximately 71% of Medicaid enrollees receive some type of service through a managed care arrangement, which CMS defines to include comprehensive, risk-based managed care, primary care case management, and limited-benefit plans.

<sup>7</sup> Nursing Home Data Compendium 2010 Edition. Centers for Medicare and Medicaid Services; AHCA Analysis of OSCAR Data.

<sup>8</sup> Ibid.

each state is able to tailor these strategies to address the needs of their unique state and local markets.<sup>9</sup>

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<sup>9</sup> <http://www.commonwealthfund.org/Blog/2012/Aug/Advancing-Accountable-Care-Organizations-in-Medicaid.aspx?omnicid=20>