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Variation in Medicaid Spending Across Eligibility Groups

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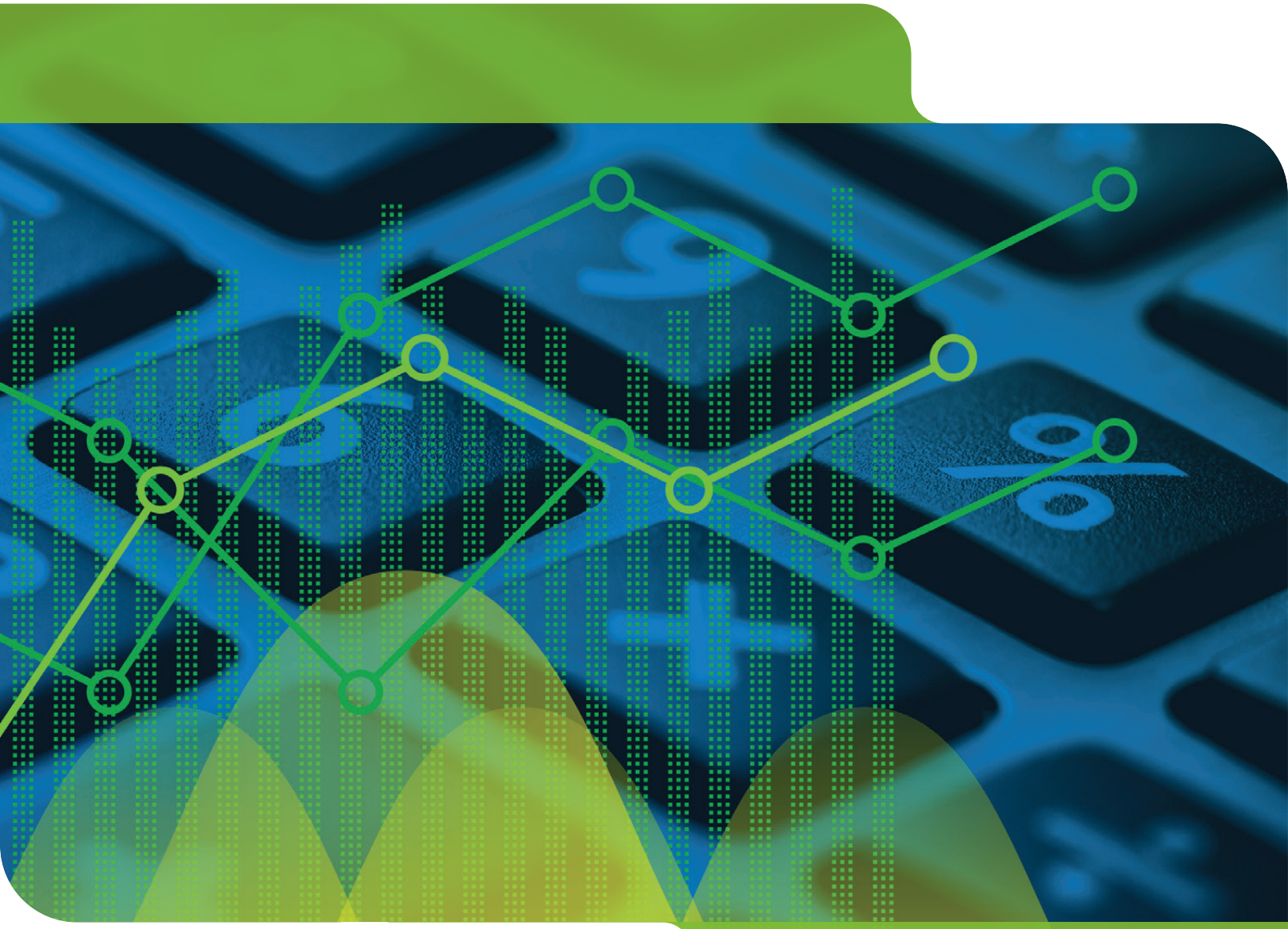
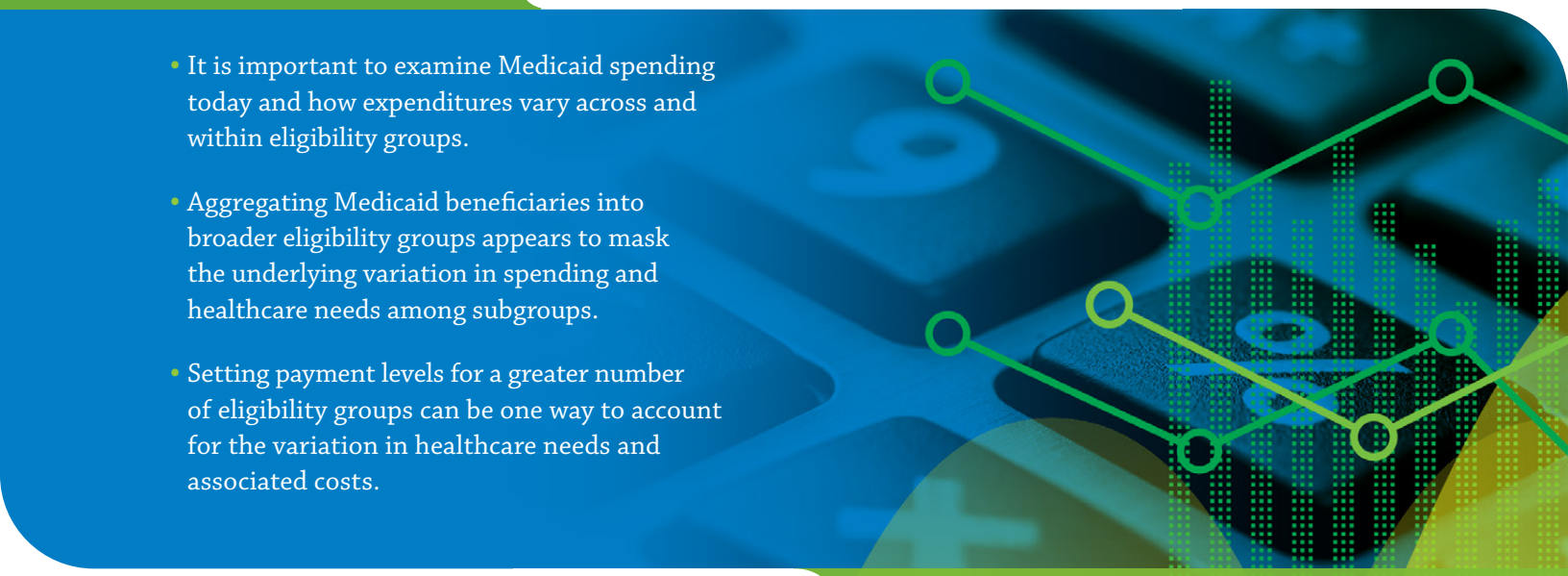


KEY HIGHLIGHTS

- It is important to examine Medicaid spending today and how expenditures vary across and within eligibility groups.
- Aggregating Medicaid beneficiaries into broader eligibility groups appears to mask the underlying variation in spending and healthcare needs among subgroups.
- Setting payment levels for a greater number of eligibility groups can be one way to account for the variation in healthcare needs and associated costs.



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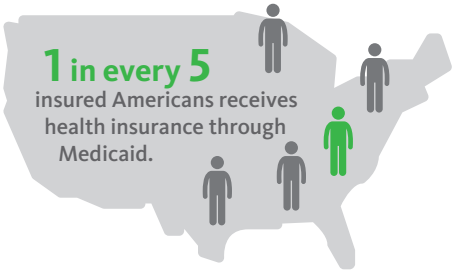
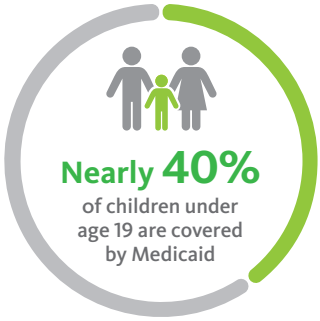
Overview

As federal policymakers focus on reducing the deficit and slowing growth in federal spending, attention generally turns to spending on healthcare entitlement programs—where the greatest amount of mandatory spending resides.

Since the passage of the Affordable Care Act (ACA), the Medicaid program has been the subject of much of this discussion largely as a result of the ACA's expansion of Medicaid eligibility, which has led to one in five Americans receiving health insurance through the Medicaid program.[1] In many states, the program now provides healthcare to low-income working age, childless adults in addition to children and families, pregnant women, seniors, and persons with disabilities. Medicaid accounts for about one of every six dollars spent on healthcare, with state and federal spending totaling $553 billion in 2016.[2]





Medicaid is an important source of health insurance coverage, serving a diverse population with differing healthcare needs. Nearly 40 percent of children under age 19 are covered by Medicaid,[3] and Medicaid also funds more than half of all long-term care spending.[4] Medicaid provides critical services and supports, such as medical equipment, personal assistance services, and transportation, that allow children with special healthcare needs and adults with disabilities to live independently in their homes and participate fully in their communities.

Recently, policymakers have considered reforms to the financing structure of the Medicaid program that would limit the federal funding provided to states. One such reform, known as "per capita caps," would cap federal spending on a per-beneficiary basis, requiring states to manage costs within the aggregate federal limits or otherwise fund overages solely with state dollars. These federal funding caps would be set by defined groups of beneficiaries based on broad categories of program eligibility (e.g., children, expansion adults).

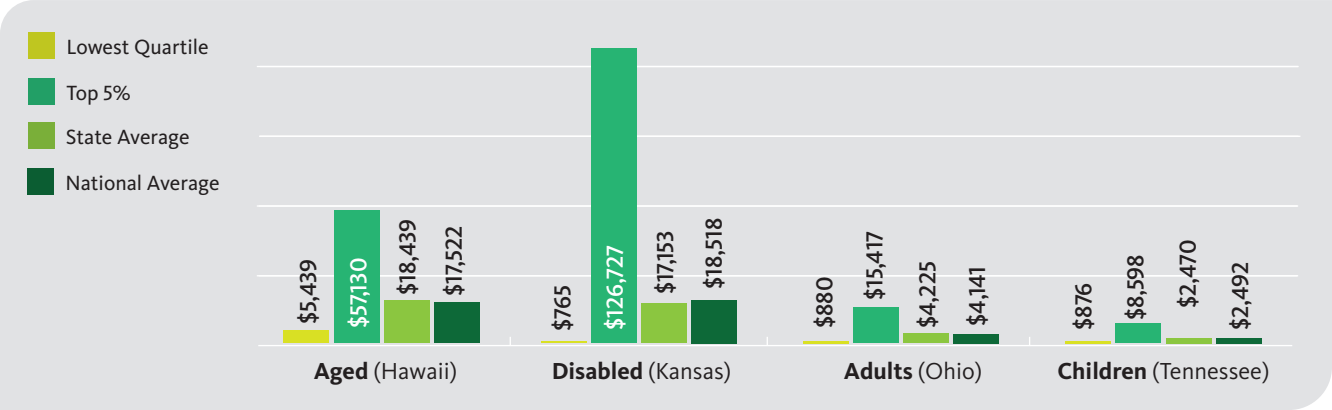
As policymakers continue to debate reforms to the Medicaid program, it is important to first examine Medicaid spending today and how expenditures vary across and within eligibility groups. Variation in spending within and across these groups is indicative of the diverse set of healthcare needs among the Medicaid population, from well-child preventive care to management of chronic conditions to long-term care. Future reforms to the program must bear in mind these important differences to ensure that all Medicaid enrollees can continue to receive the services and supports needed to live healthy, productive lives.

Research demonstrates variation in Medicaid spending per beneficiary

The most recent data analyzed by the Kaiser Commission on Medicaid and the Uninsured illustrate the extent to which Medicaid spending varies within and across eligibility groups (see Figure 1).[5] For example, the study found that average U.S. spending for persons with disabilities was more than seven times that for children.

Variation persisted within eligibility groups as well. Kaiser used four states with per enrollee spending at or near the national median for a particular eligibility group to illustrate this variability. For example, per person spending for adults in Ohio ranged from $880 (lowest quartile) to $15,417 (top 5 percent), with average spending of $4,225. Likewise, per person spending for children in Tennessee varied from $876 (lowest quartile) to $8,598 (top 5 percent).[6] Variation was even more substantial for the aged and disabled populations, as illustrated by Hawaii and Kansas, respectively.[7]

Figure 1
Average Medicaid Spending per Beneficiary Within Eligibility Category, 2011



Source: Kaiser Commission on Medicaid and the Uninsured. Data represents average spending for fiscal year 2011.
This table highlights, as an example, one state for each eligibility category in order to demonstrate the variation that can occur within eligibility groups.

Anthem's analysis highlights variation in spending within eligibility groups

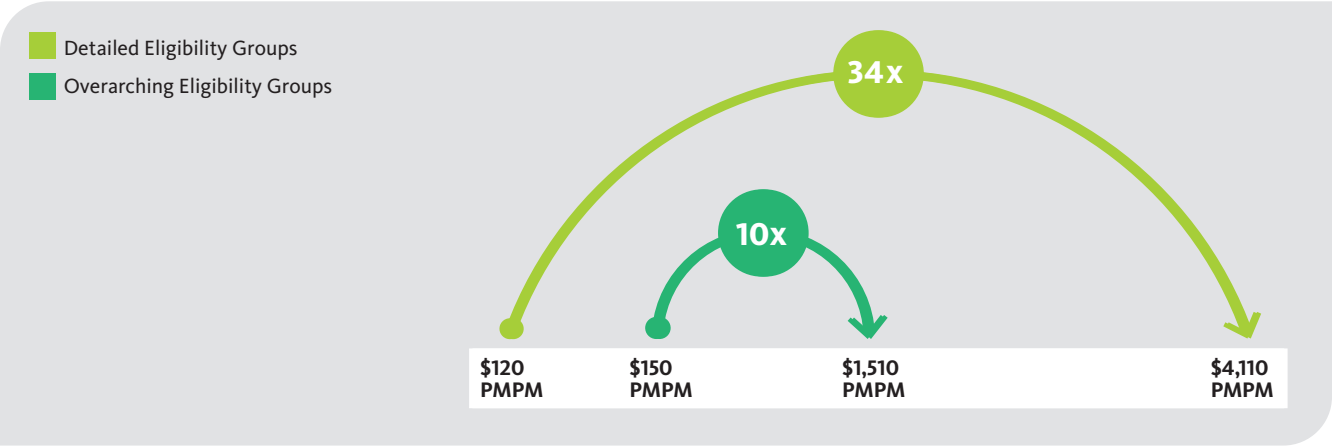
The Kaiser study and other analyses on Medicaid spending variation have focused on several broad Medicaid eligibility groups (i.e., aged, disabled, adults, children),[8] but it is also useful to understand how spending varies among subgroups of Medicaid beneficiaries.

Anthem analyzed 2016 data from a sample of our affiliated Medicaid health plans, reflecting Medicaid managed care enrollees across multiple states, to examine spending variation among subcategories of eligibility.[9, 10]

First, we grouped Medicaid managed care enrollees into six overarching eligibility categories (see Table 1), including a category for individuals eligible for Medicaid as a result of the ACA's Medicaid expansion, and calculated average spending per member per month (PMPM) for each.[11] As Table 1 illustrates, average spending across these eligibility groupings ranged from a low of $150 PMPM for children without disabilities to a high of $1,510 PMPM for beneficiaries with disabilities who receive long-term services and supports (LTSS)—about a 10-fold difference.

Within each of these categories, we also found notable variation in spending across the states included in the analysis. Table 1 shows the degree to which spending varied across states for each eligibility group.

Figure 2
Variation in Spending Across Eligibility Groups, 2016



Source: Analysis of data from 15 of Anthem's affiliated Medicaid plans.
Data cover the period of January 2016 through September 2016. Figures are rounded.

Table 1

Average Medicaid Spending by Overarching Medicaid Eligibility Groups, 2016

State variation for the eligibility group reflects the difference between the state with the highest average PMPM and the state with the lowest average PMPM for that eligibility group among the states included in the analysis.

Source: Analysis of data from 15 of Anthem's affiliated Medicaid plans. Data covers the period of January 2016 through September 2016. Figures are rounded.

	Eligibility Group	Average PMPM Spending	State Variation for Eligibility Group
1	**Blind/Disabled who use LTSS** (under age 65)	$ 1,510	<5x
2	**Aged** (under age 65)	$ 1,090	>10x
3	**Blind/Disabled who do not use LTSS** (under age 65)	$ 810	<5x
4	**Medicaid Expansion Population**	$ 360	<5x
5	**Adults**	$ 350	<5x
6	**Children without disabilities** (under age 19)	$ 150	<5x

Next, we took a closer look at Medicaid spending by categorizing Medicaid enrollees into one of 16 mutually exclusive detailed eligibility groups. Table 2 lists these detailed groups and illustrates the substantial variation in Medicaid spending that is not evident when only considering the broader six eligibility categories. In this detailed analysis, spending ranged from $120 PMPM for children without disabilities or LTSS needs to $4,110 PMPM for individuals with traumatic brain injury (TBI)—about a 34-fold difference.

Table 2

Average Medicaid Spending by Detailed Medicaid Eligibility Groups, 2016

State variation for the eligibility group reflects the difference between the state with the highest average PMPM and the state with the lowest average PMPM for that eligibility group among the states included in the analysis. No measurement of variation is included for the Medically Needy/Spend Down group, since only one state tracked specific data.

Source: Analysis of data from 15 of Anthem's affiliated Medicaid plans. Data covers the period of January 2016 through September 2016. Figures are rounded.

	Eligibility Group	Average PMPM Spending	State Variation for Eligibility Group
1	**Traumatic Brain Injury**	$ 4,110	<5x
2	**HIV/AIDS**	$2,850	5x – 10x
3	**Intellectual and/or Developmental Disability**	$1,830	5x – 10x
4	**Non-Dual Eligibles who use LTSS**	$1,420	5x – 10x
5	**Dual Eligibles who use LTSS**	$1,390	5x – 10x
6	**Serious Emotional Disturbance**	$ 1,310	>10x
7	**Serious Mental Illness**	$970	<5x
8	**Pregnant Women**	$930	<5x
9	**Non-Dual Eligibles who do not use LTSS**	$870	<5x
10	**Medically Needy/Spend Down**	$840	N/A
11	**Children with Disabilities and/or who use LTSS** (under age 19)	$690	>10x
12	**Autism**	$620	>10x
13	**Other Adults**	$260	<5x
14	**Foster Care**	$220	<5x
15	**Dual Eligibles who do not use LTSS**	$ 180	<5x
16	**Children with Disabilities and who do not use LTSS** (under age 19)	$ 120	<5x

Examining spending for these 16 groups highlights differences in the spending, and by extension the healthcare needs, of Medicaid members whose circumstances are not noticeable in the analysis of the overarching categories. For example, included among the Medicaid expansion group (average $360 PMPM) might be individuals with HIV/AIDS (average $2,850 PMPM) or serious mental illness (average $970 PMPM). Likewise, spending for children varies from an average of $120 PMPM for those without disabilities or LTSS needs to $220 PMPM for children in foster care to $1,310 PMPM for children with serious emotional disturbance.

Looking across the 15 states that are included in this analysis, we also observed differences in spending on these detailed eligibility groups. As Table 2 also demonstrates, across-state differences were greatest for members with autism, children with serious emotional disturbance, and children with disabilities and/or who use LTSS. Spending was relatively consistent across states for groups such as pregnant women, individuals with TBI, and children without disabilities or LTSS needs.

It's critical to determine the right groups, how many, and at what level of detail when designing per capita caps or similar financing reforms.

These findings are consistent with other research that has examined the extent to which spending varies across state Medicaid programs.[12, 13] Still other studies have highlighted the factors that can influence variation, such as the number of doctors per capita, local prices and practice patterns, and the demographics and health status of the population.[14, 15] Furthermore, features unique to a state's Medicaid program—such as covered benefits, eligibility criteria, and provider reimbursement to name a few—can also result in spending differences.[16]

Conclusion

Gain important insights by looking at smaller, more homogeneous subgroups of beneficiaries.

This analysis suggests that aggregating Medicaid beneficiaries into broader eligibility groups appears to mask the underlying variation in spending and healthcare needs among the subgroups of individuals in these broad categories.[17]

While spending across six overarching categories varied by a factor of 10, when considering 16 more detailed eligibility categories, spending varied by a factor of 34. This underscores the importance of determining the right groups—how many, at what level of detail—when designing per capita caps or similar financing reforms.

These findings are consistent with observations of the Government Accountability Office (GAO) in assessing key policy decisions related to Medicaid reform. GAO noted that because variation in healthcare needs can vary substantially across and within Medicaid eligibility groups, and spending can shift over time, setting payment levels for a greater number of eligibility groups can be one way to account for the variation in healthcare needs and associated costs.[18]

GAO also noted that the subgroups within broader eligibility categories can have wide variation in per person spending, given different levels of need among individuals.[19] For example, older seniors are more likely than younger seniors to need long-term services and supports; similarly, children with serious emotional disturbance tend to have higher costs than other children enrolled in Medicaid. In other words, grouping all children into a single category or all seniors into the same category may fail to account for underlying variation—which can be substantial within many of the broad beneficiary groups.

This analysis, along with other studies in the literature, demonstrates the variation in spending that exists among broad groups of Medicaid beneficiaries. Looking at spending patterns associated with smaller, more homogeneous subgroups of beneficiaries can offer important insight as policymakers consider approaches to reforming the financing of Medicaid programs.

Endnotes

[1] Henry J. Kaiser Family Foundation. (2016). Health Insurance Coverage of the Total Population. Retrieved January 17, 2018 from: www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[2] Gifford, K., et al. (2017, October). Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. Retrieved January 17, 2018 from: files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018, and Henry J. Kaiser Family Foundation. (2016). Federal and State Share of Medicaid Spending. Retrieved January 17, 2018 from: www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[3] Henry J. Kaiser Family Foundation. (2016). Health Insurance Coverage of Children 0–18. Retrieved January 17, 2018 from: www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[4] Reaves, E.L., and Musumeci, M. (2015, December). Medicaid Long-Term Services and Supports: A Primer. The Kaiser Commission on Medicaid and the Uninsured. Retrieved January 17, 2018 from: files.kff.org/attachment/report-medicaid-and-long-term-services-and-supports-a-primer.

[5] Young, K., et al. (2015, January). Medicaid Per Enrollee Spending: Variation Across States. The Kaiser Commission on Medicaid and the Uninsured. Retrieved April 6, 2017 from: files.kff.org/attachment/issue-brief-medicaid-per-enrollee-spending-variation-across-states-2.

[6] Ibid.

[7] Ibid.

[8] See for example: Park, C. (2016, January 26). Illustrations of Design Elements in Alternative Financing Proposals. Medicaid and CHIP Payment and Access Commission. Retrieved April 6, 2017 from: www.macpac.gov/wp-content/uploads/2017/01/Alternative-Approaches-to-Medicaid-Financing-Choice-of-Design-Elements-in-Alternative-Financing-Proposals.pdf. Also, the Congressional Budget Office typically uses these eligibility categories when developing its thrice-yearly baseline estimates and scoring legislation pertaining to the Medicaid program.

[9] This analysis was developed using claims data from a subset of Anthem's affiliated Medicaid health plans. Data covers the period of January 2016 through September 2016. Per member per month (PMPM) amounts were calculated using total spending and total member months in each eligibility category. For the analysis looking at overarching categories of beneficiaries, all members were assigned to a category using a hierarchy of: 1) eligibility for Medicaid through the Affordable Care Act's Medicaid expansion; 2) eligibility for Medicaid on the basis of a disability for individuals under 65 (segmented by members who use LTSS and those who do not use LTSS); and then 3) all other Medicaid beneficiaries by age group (children under age 19, adults, and elderly age 65 and above). For example, a child or adult under age 65 who has a disability would be grouped in the "Blind/Disabled" category. For the analysis looking at more detailed categories, all members were grouped first by disease-based categories (HIV/AIDS, Autism, SED, SMI) using a list of diagnosis codes. Then, members were categorized as Foster Care, I/DD, Medically Needy, or TBI based upon states where Anthem's affiliated health plans operate specific programs for these populations. All remaining members were assigned to categories based on their Medicaid eligibility status (e.g., TANF/Disabled) and segmented further based on age, use of LTSS, and whether the member was a pregnant woman.

[10] It is possible that some of the variation observed in this study is attributable to differences in the scope of services covered under states' managed care programs. For instance, while some states may include all long-term services and supports in their managed care contracts, other states may limit coverage of LTSS to institutional settings while carving out home and community-based services. Similar carve-outs from managed care or partial benefit coverage may also be adopted with respect to behavioral health services and prescription drug coverage. This analysis does not control for differences in covered services across states.

[11] Average per member per month (PMPM) spending was calculated for each category. State variation for the eligibility group reflects the difference between the state with the highest average PMPM and the state with the lowest average PMPM for that eligibility group, among the states included in the analysis.

[12] U.S. Government Accountability Office. (2014, June). Assessment of Variation Among States in Per-Enrollee Spending. GAO-14-456. Retrieved April 6, 2017 from: www.gao.gov/assets/670/664115.pdf.

[13] Young, K., et al.

[14] U.S. Government Accountability Office. (2016, August). Key Policy and Data Considerations for Designing a Per Capita Cap on Federal Funding. GAO-16-726. Retrieved April 5, 2017 from: www.gao.gov/assets/680/678968.pdf.

[15] Lipson, D., et al. (2009, March 12). Defining and Measuring State Medicaid Spending Efficiency: A Literature Review. Prepared by Mathematica Policy Research for the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. Contract No. 100-03-0017. Retrieved April 7, 2017 from: aspe.hhs.gov/system/files/pdf/180461/report.pdf.

[16] Ibid.

[17] Even for more detailed eligibility groupings, some amount of variation in spending will always be present. One of the ways in which Medicaid managed care organizations (MCOs) add value for a state is by taking on the risk inherent in the variation in healthcare needs and spending among their members and ensuring delivery of high-quality care within a capitated payment amount. While this is not the focus of this paper, please see our paper "Medicaid Managed Care Delivers Value and Efficiency to States" for further discussion of this topic.

[18] U.S. Government Accountability Office. (2016, August).

[19] Ibid.

ABOUT US

Anthem Public Policy Institute

Anthem's Public Policy Institute was established to share data and insights to inform public policy and shape the healthcare programs of the future. The Public Policy Institute strives to be an objective and credible contributor to healthcare innovation and transformation through publication of policy-relevant data analysis, timely research, and insights from Anthem's innovative programs.

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