MEDICAID AND COUNTIES

UNDERSTANDING THE PROGRAM AND WHY IT MATTERS TO COUNTIES

NATIONAL ASSOCIATION of COUNTIES NACo

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UNDERSTANDING MEDICAID AND ITS ROLE IN OUR NATION'S HEALTH CARE SYSTEM

Medicaid 101

Established in 1965, Medicaid is a federal entitlement program paid for by taxpayers that provides health and long-term care insurance to low-income families and individuals. **Medicaid operates and is jointly financed as a partnership between federal, state and local governments.** States administer the program, often with assistance from counties, with oversight by the federal government. **The program is the largest source of health coverage in the United States, currently covering more than 76 million individuals, or nearly one-quarter of the population.**

Medicaid Operates as a Joint Federal-State-Local Partnership

Counties are an integral part of the federal-state-local-partnership in the Medicaid program. The **federal government sets broad guidelines** for Medicaid, including minimum eligibility and benefit requirements.

States have flexibility within these guidelines and can seek waivers from the federal government to expand eligibility or available benefits.

Some states **subcontract Medicaid to private insurers,** while others pay health care providers - including county-operated providers - directly.

States utilize **different Medicaid delivery systems,** such as traditional fee-for-service systems that reimburse providers for each service provided and managed or coordinated care systems that involve setting monthly payments.

Counties across the nation deliver Medicaid-eligible services and, in many instances, help states finance and administer the program.

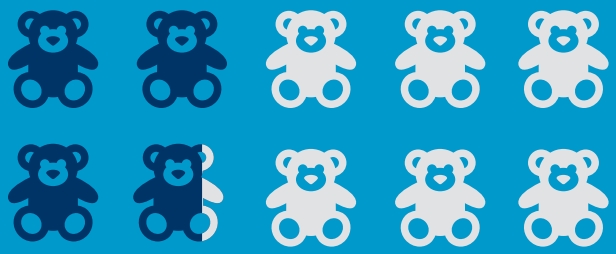
Medicaid vs. Medicare

The Medicaid and Medicare programs differ in how they are financed and the services provided to individuals. Although Medicare is administered solely by the federal government, Medicaid is financed and delivered by both the federal government and states, often with county assistance. In addition, Medicare does not have income requirements, whereas Medicaid does.

Medicaid has Traditionally Served the Elderly, Disabled, Low-Income Families, Children and Pregnant Women

Medicaid serves:

nearly
4 in 10 children



3 in 8
people with disabilities

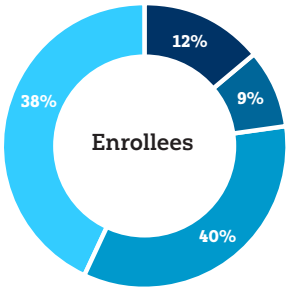
1 in 5
Americans over 65

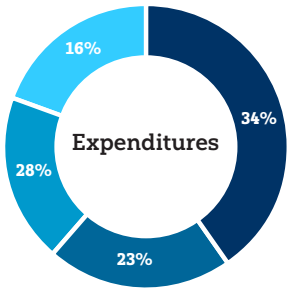
2 in 3
nursing home residents

Source: Kaiser Family Foundation

Snapshot of Medicaid Expenditures

More than half of all Medicaid spending for services is attributable to the elderly and persons with disabilities, who make up one in five Medicaid enrollees. Medicaid covers special services for these individuals **that may not be covered by private insurance**, including long-term care, dental and vision care, case management and therapies.



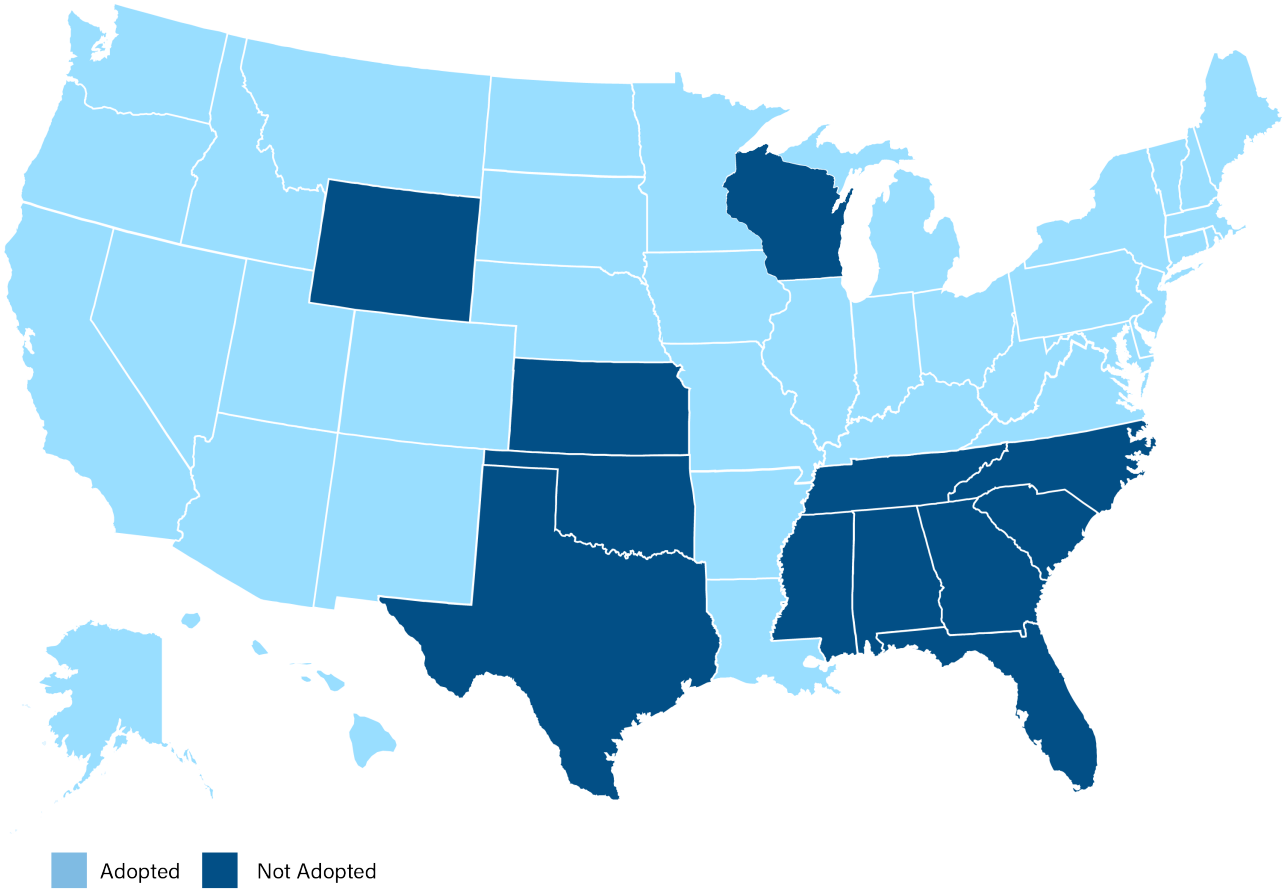


Disabled
Elderly

Adults
Children

Data is based on FY 2020 figures
Source: Kaiser Family Foundation

Status of State Action on the Medicaid Expansion Decision



Source: Kaiser Family Foundation's State Health Facts.

Status of State Action on the Medicaid Expansion Decision as of November 9, 2022

As of 2023, 40 states (including the District of Columbia) have adopted the ACA's Medicaid Expansion.

South Dakota voted approve a ballot measure on November 8, 2022 to expand Medicaid. They plan to implement July 1, 2023.

The Affordable Care Act (ACA) gave states the options to expand Medicaid coverage to nearly all low-income individuals, **including those without children.** In Medicaid expansion states, Medicaid eligibility is extended to those individuals with incomes **at or below 138 percent of the poverty level** ($21,960) for a family of three in 2021.

States are Obligated to Provide Certain Benefits to Medicaid Enrollees

Mandatory services include:

- Inpatient hospital services
- Outpatient hospital services
- Nursing facility services
- Home health services
- Physician services
- Certified pediatric and family nurse practitioner services
- Federally qualified health center services
- Tobacco cessation counseling for pregnant women
- Family planning services
- Nurse midwife services
- Transportation to medical care
- Laboratory and x-ray services
- Rural health clinic services
- Freestanding birth center services (when licensed/recognized by state)
- EPSDT: early and periodic screening, diagnostic and treatment services

States can Choose to Provide Certain Benefits on Top of Basic Medicaid Services

Optional services include:

- Prescription drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language services
- Personal care
- Services in intermediate care facility for mental health
- Dental services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Inpatient psychiatric services for individuals under age 21
- Other diagnostic, screening, preventive and rehabilitative services
- Hospice
- Case management
- Private duty nursing services

HOW COUNTIES SUPPORT THE HEALTH AND WELL-BEING OF RESIDENTS

Counties are the Gateway to our Nation's Health System, Investing $100 Billion Annually in Community Health

843 county-supported hospitals

758 county-owned and supported long-term care facilities

750 county behavioral health authorities

1,943 county public health departments

Many States Mandate Counties to Provide Some Level of Health Care for Low-Income, Uninsured or Underinsured Residents

Since being signed into law in 1965, **the Medicaid program has helped counties provide a safety-net for those who are unable to afford medical care.** The program creates increased access to health care services for low-income residents, which improves their health, productivity and quality of life. Medicaid also reduces the frequency of uncompensated care provided by local hospitals and health centers to low-income residents and **lessens the strain on county budgets.**

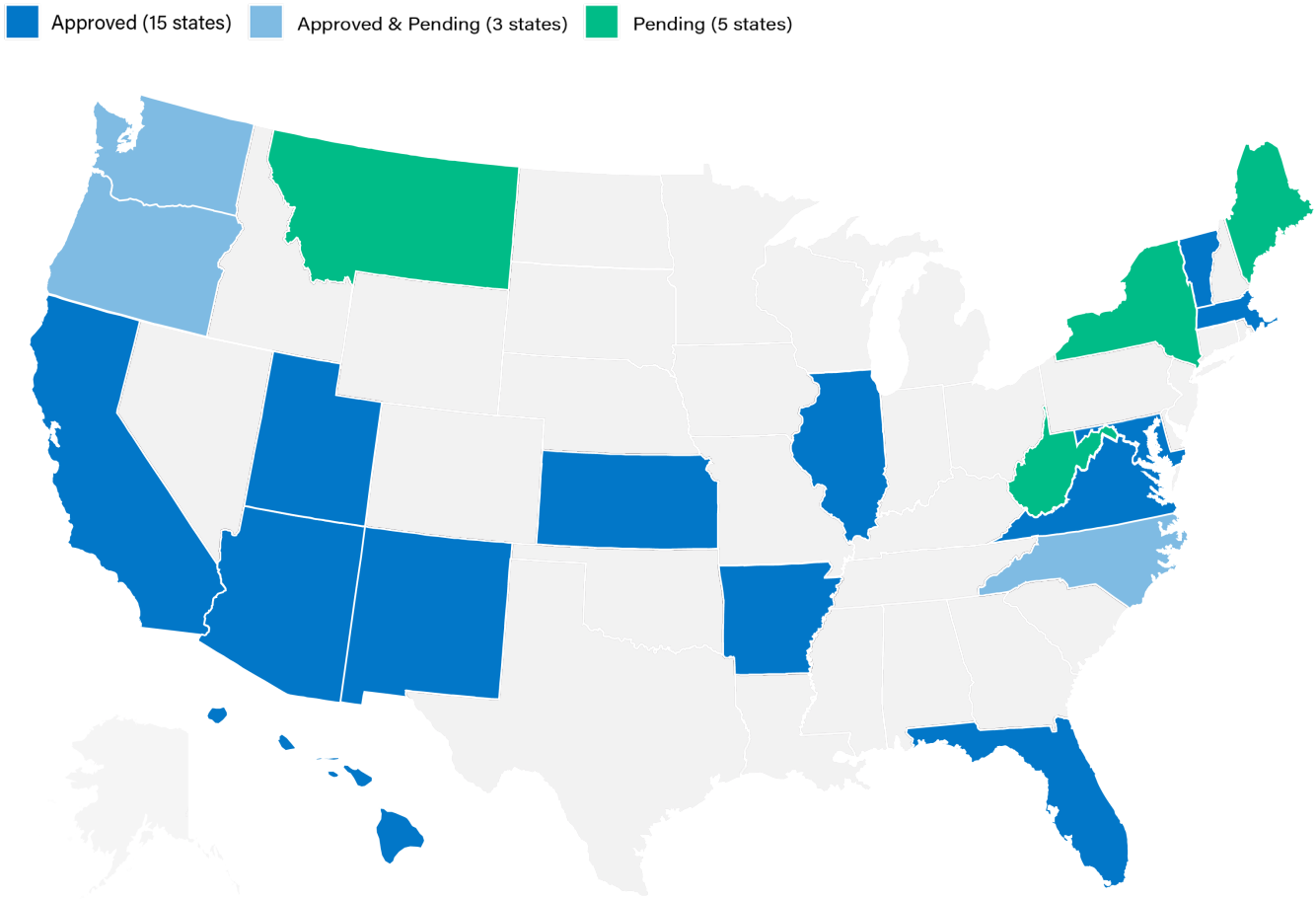
States and Counties can Leverage the Medicaid Program to Address Health Related Social Needs

States may submit Section 1115 demonstration waivers help to expand reduce health disparities, and/or advance "whole-person care," including by addressing health-related social needs (HRSN), also commonly referred to as social determinants of health (SDOH). As of November 2, 2022, 18 states have approved Section 1115 demonstration waivers authorizing Medicaid coverage for SDOH services and 8 states have pending SDOH requests.

Source: Kaiser Family Foundation, 2022

Section 1115 Waivers with Provisions Related to Social Determinants of Health (SDOH), as of 11/2/2022

Status of Section 1115 SDOH Provisions:

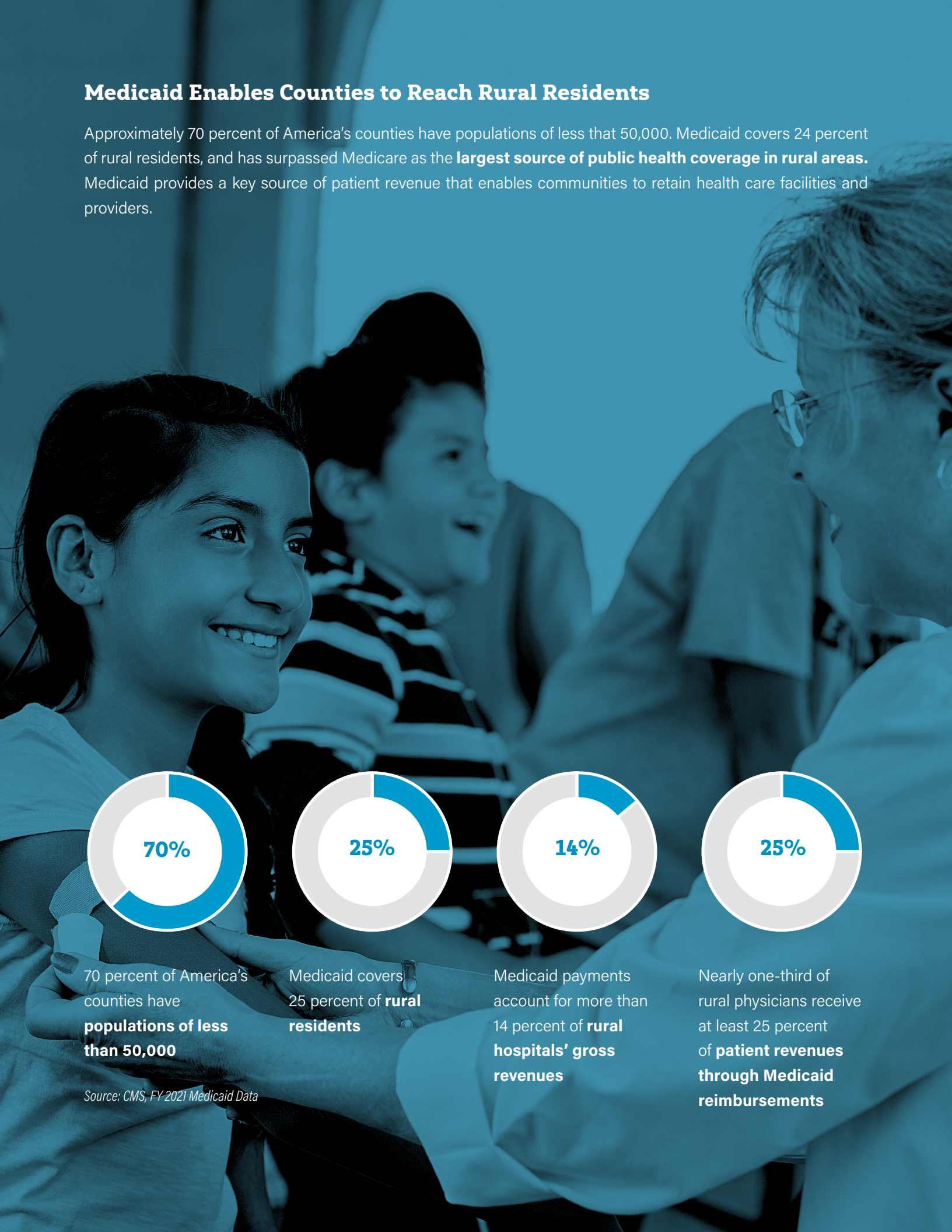


NOTE: Through Section 1115 authority, states can test approaches for addressing the SDOH of Medicaid enrolles, including the use of federal matching funds to test SDOH-related services and supports in ways that promote Medicaid program objectives. For more information on approved and pending SDOH provisions across states, see SDOH tables of KFF's waiver tracker.

SOURCE: KKF Section 1115 Waiver Tracker

Medicaid Enables Counties to Reach Rural Residents

Approximately 70 percent of America's counties have populations of less that 50,000. Medicaid covers 24 percent of rural residents, and has surpassed Medicare as the **largest source of public health coverage in rural areas.** Medicaid provides a key source of patient revenue that enables communities to retain health care facilities and providers.



70 percent of America's counties have **populations of less than 50,000**

Medicaid covers 25 percent of **rural residents**

Medicaid payments account for more than 14 percent of **rural hospitals' gross revenues**

Nearly one-third of rural physicians receive at least 25 percent of **patient revenues through Medicaid reimbursements**

Source: CMS, FY 2021 Medicaid Data

THE ROLE OF COUNTIES IN FUNDING AND DELIVERING MEDICAID

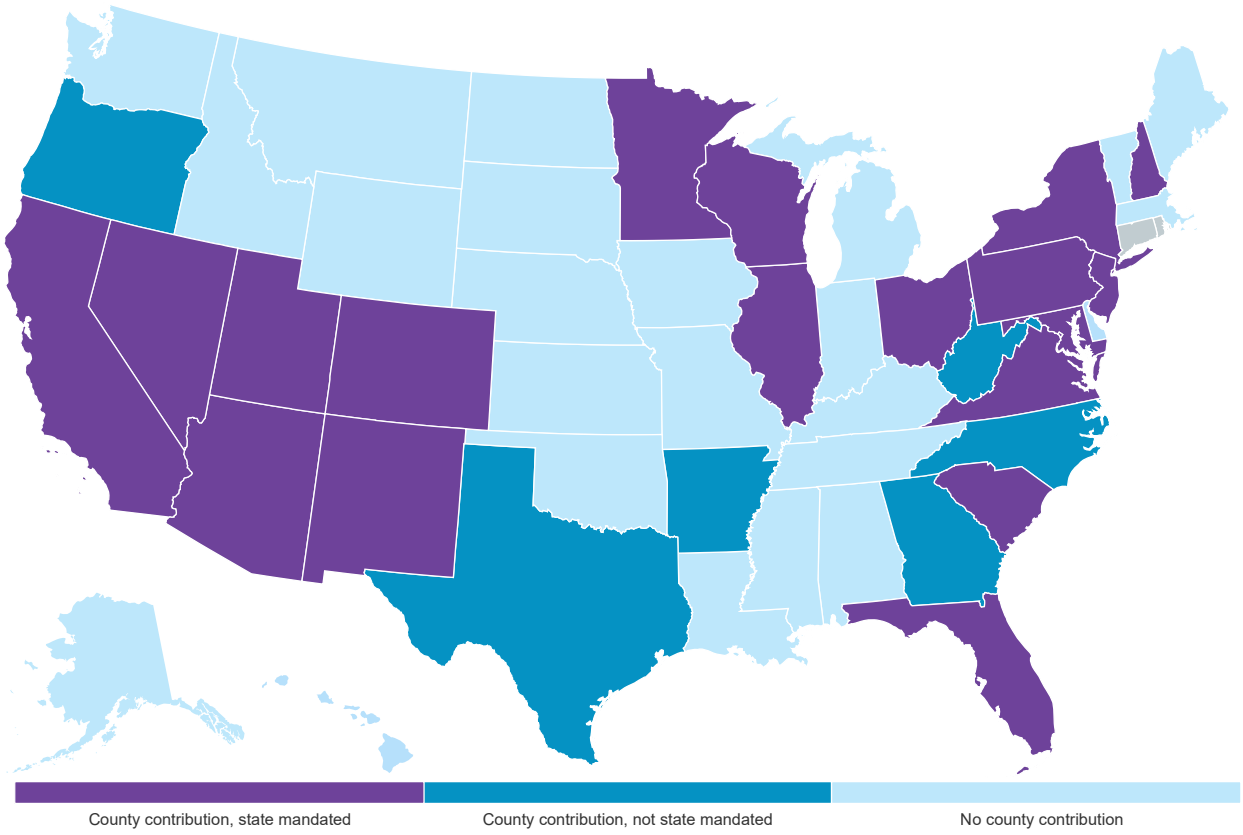
Counties make Key Financial Contributions to the Medicaid Program

Medicaid is jointly funded by federal, state and local governments, **including counties in many states.** The federal contribution rate for each state varies based on the Federal Medical Assistance Percentage (FMAP) rate. The maximum amount contributed by each state is 50 percent, though some states contribute as little as 15 percent. **States have various options for financing the non-federal share; counties may contribute up to 60 percent of the non-federal share in each state.**

Counties Contribute to Medicaid in 25 States

Counties contribute to Medicaid in 25 states including the District of Columbia. Of these states, **19 mandate** counties to contribute to the non-federal share of Medicaid costs and/or administrative, program, physical health and behavioral health costs. Mandated county contributions are the **highest in New York.** Counties in New York send over $7 billion per year – or $140 million per week – to the state for Medicaid costs.

2022 Federal Medical Benefits: Medicaid Contribution Mandate for Counties

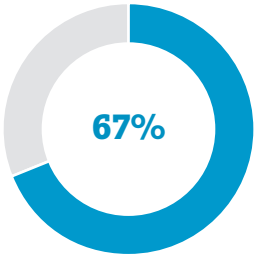


Source: NACo County Explorer explorer.naco.org, NACo Research, 2022

County Health Systems are Innovating with Medicaid to Provide Services to Low-Income Populations

County health systems - including 843 hospitals, 758 nursing homes and 750 behavioral health authorities - provide specialized care that is often unavailable elsewhere, while operating on lower margins than other providers.

Medicaid is essential to ensuring county health systems can provide high quality services to residents that improve health outcomes while simultaneously decreasing costs to local taxpayers.



For FY 2021, the federal share of Medicaid was 69%. The other 31 percent is paid for by a variety of other sources, including local governments.

Source: Kaiser Family Foundation

Mandated County Contributions Are Highest In New York. Counties In New York Send Nearly $7 Billion Per Year – $140 Million Per Week – To The State For Medicaid Costs

County-Supported Hospitals Deliver Care to Medicaid Patients

843 county-supported hospitals—2/3 of which are in rural or small counties—are the providers of last resort, providing care to all patients regardless of their ability to pay.

Medicaid covers in-patient and out-patient hospital services. While Medicaid reimbursement has historically been below costs, it remains **a vital source of revenue for county-supported hospitals.**

To help offset revenue losses, the federal government has partially compensated county-supported hospitals that treat disproportionately large numbers of Medicaid beneficiaries. These are known as Medicaid Disproportionate Share Hospital (DSH) and in the federal share of DSH payments was billion.

Counties Deliver Long-Term Care Services to Older Adults

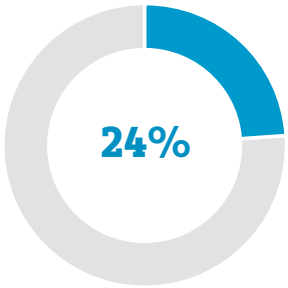
Medicaid covers nursing home services for all eligible individuals who are 21 or older. In FY 2019, **Medicaid accounted for 54 percent of overall national spending on long-term services and supports.**

Counties deliver long-term care services to residents through 758 county-owned and supported nursing homes, which represents 75 percent of all publicly-owned nursing homes in the U.S. Medicaid also covers home and community-based services for people who would otherwise need to be based in a nursing home. Area agencies on aging, 25 percent of which are county-based, are crucial to developing, coordinating and delivering aging services.

Medicaid is the Largest Source of Funding for Behavioral Health Services in the United States

Counties deliver behavioral health services, including mental health and substance use services, through 750 behavioral health authorities across the country. Medicaid coverage and financing facilitate access to a variety of behavioral health services, including psychiatric care, counseling, prescription medication, inpatient treatment, case management and supportive housing.

In FY 2021, 10 states reported new or expanded mental health and/or SUD benefits and 14 states reported such expansions planned for FY 2022. These include expanded coverage of intensive outpatient services, clinic services, school-based services, and supportive employment services. Some behavioral health benefit expansions are targeted to specific populations such as children or pregnant/postpartum women.

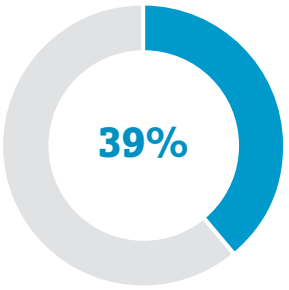


Medicaid accounts for 24 percent of all health spending on substance use disorders and spending on mental health services.

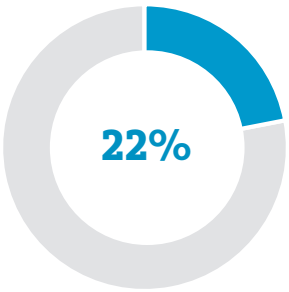
Medicaid is a Vital Source of Health Coverage for Individuals with Substance Use Disorders

Medicaid is a key tool for counties responding to the nation's ongoing substance use disorder crisis as it **supports a full continuum of care (e.g., addiction prevention, treatment and recovery)** and enhances local and state capacity to provide early interventions and treatments. The Affordable Care Act's Medicaid expansion has provided states with additional resources to cover many adults with substance use disorder who were previously excluded from the program.

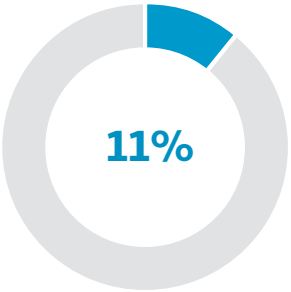
Medicaid plays a key role in covering and financing behavioral health care: in 2020, Medicaid covered 23% of nonelderly adults with mental illness, 26% of nonelderly adults with serious mental illness (SMI), and 22% of nonelderly adults with SUD; in comparison, Medicaid covered 18% of the general nonelderly adult population.



39 percent of Medicaid enrollees have a mental illness and/or substance use disorder



In 2020, Medicaid covered **22 percent of nonelderly adults with substance use disorders**



Approximately 11 percent of Medicaid enrollees have both a mental illness and a substance use disorder

Source: Kaiser Family Foundation, 2022

Opioid Solutions Center

To prevent drug overdoses and deaths, counties have invested in resources for effective treatment, recovery, prevention and harm reduction practices that save lives and address underlying causes of substance use disorder. For more information, visit www.naco.org/resources/opioid-solutions-center

THE IMPACT OF COVID-19 ON THE MEDICAID PROGRAM

Counties have been on the Front Lines of The Nation's Response to the Covid-19 Pandemic

Medicaid has historically played an essential role in facilitating the county response to public health emergencies, most recently in response to the COVID-19 pandemic. The program has provided millions with coverage for COVID-19 testing, treatment and vaccinations for enrollees.

The federal **Public Health Emergency (PHE) declaration provided states and counties the flexibility to simplify beneficiary enrollment and expand eligibility**; modify or suspend out-of-pocket cost sharing and premium requirements; add telehealth benefits and payment policies; and **cover COVID-19 related testing, treatment and vaccination**.[i] The Centers for Medicare and Medicaid Services (CMS) also allows states to use Section 1135 and 1115 waivers to override certain federal requirements such as permitting out-of-state providers to provide care for Medicaid enrollees in states where they are not licensed and receive payment for such services. [ii]

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[i] MACPAC, "Disaster relief state plan amendments," (June 10, 2020), available at https://www.macpac.gov/subtopic/disaster-relief-state-plan-amendments/ (January 12, 2022).

[ii] MACPAC, "Section 1135 waivers," (June 10, 2020), available at https://www.macpac.gov/subtopic/section-1135-waivers/ (January 13, 2022).

Congressional Covid-19 Relief Packages have Provided Enhanced Federal Support for the Medicaid Program a Number of Key Policy Wins for Counties to Include:

- A 6.2% increase in the federal share of Medicaid spending
- Delayed cut to Disproportionate Share Hospital (DSH) supplemental payment until 2024
- A federal matching rate of 95% for 2 years for states to expand Medicaid
- A new option to extend post-partum coverage for women from 60 days to 1 year
- A new option to provide community-based mobile crisis intervention services with an 85% federal matching rate for 3 years
- A 10% increase in federal matching funds for Medicaid home and community-based services (HCBS)

Key Facts: Medicaid During Covid-19

Between February 2020 and June 2022, **the number of Medicaid enrollees grew to 89.4 million, an increase of 18.2 million or 25.6%**

Currently **all 50 states and the District of Columbia have an approved Section 1135 waiver** to enact emergency authorities due to the COVID-19 pandemic

Congress has authorized a **6.2% increase in the Federal share of Medicaid** for the duration of the public health emergency

Source: Kaiser Family Foundation, 2022

CHALLENGES FOR COUNTY GOVERNMENTS

Major Challenge: Uncompensated Care Costs Remain High as Counties Work to Drive Economic Mobility

In 2021, 8.3 percent of people, or 27.2 million, did not have health insurance at any point during the year and are more likely to have problems paying medical bills. This inability to pay results in uncompensated care costs for counties. Between 2015 -2017 states and localities spent an average of $42.4 billion per year on uncompensated care according to Kaiser Family Foundation. In Harris County, Texas, for example, residents pay more than $500 million per year in property taxes to cover the cost of uncompensated care costs in the county's public hospitals.

Health and poverty are inextricably linked. Poor health and high health care costs often trace back to underlying social needs of patients, such as housing and nutrition. Providing health coverage and access are critical to helping counties ensure all of their residents reach their full potential.

TAKE ACTION!
KEY MESSAGES FOR ADVOCACY

Recommendations for the Federal Government

NACo supports protecting the federal-state-local partnership for financing and delivering Medicaid services while maximizing flexibility to support local systems of care. Counties are concerned about measures that would further shift Medicaid costs to counties, including proposals to institute block grants or per-capita caps. These proposals would increase the amount of uncompensated care provided by counties and reduce counties' ability to provide for the health of our residents.

As Congress looks to update and improve our nation's health safety-net, counties across the country urge Congress to:

- **Support** the federal-state-local partnership structure for financing and delivering Medicaid
- **Promote** measures that provide flexibility and incentivize program efficiency and innovation
- **Oppose** measures that would further shift federal and state Medicaid costs to counties

Take Action!

Invite your Member of Congress to tour a county-supported hospital, nursing home or behavioral health authority.

A tour gives legislators an opportunity to see their contribution to constituents and serves as an opportunity for the local community and local elected officials to provide on-site feedback to your Members of Congress.

Work with your local media to publish an op-ed on the importance of Medicaid to your county and residents.

Submitting an op-ed or guest commentary to your local paper is an excellent way to keep your residents informed about what you are doing on their behalf.

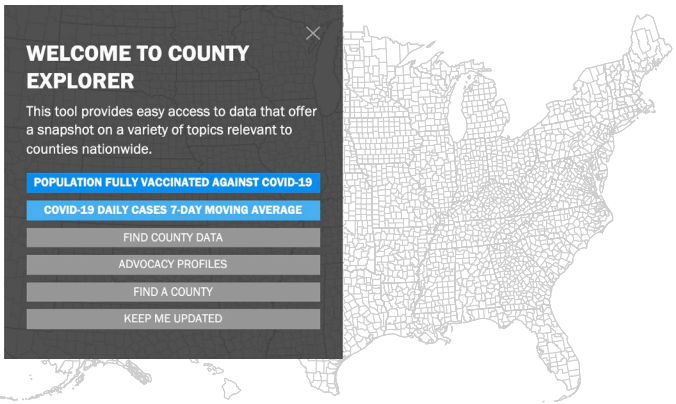
Amplify personal stories from constituents who have benefited from Medicaid.

Sharing personal stories helps legislators put a face to policy issues.

Utilize county-level data from NACo's County Explorer to demonstrate how your county delivers and invests in health and Medicaid services.

Explore ways to work with your state to advance innovation in Medicaid in the County Medicaid Playbook.

For more information and resources, please visit NACo's website.



Key Talking Points

Medicaid operates as a lean federal program

Medicaid's average cost per beneficiary is significantly lower than private insurance. Counties have made the most of Medicaid's flexibility by leveraging local funds to construct systems of care for populations that private insurance does not cover.

Imposing spending caps on Medicaid will not address the underlying drivers of the program's costs

Caps do not account for long-term trends like the aging population and rising health care costs that are projected to drive higher federal entitlement spending in the coming years. Complying with a cap designed to significantly reduce the deficit would require major cuts to the federal contribution – states and counties would ultimately absorb this cost shift.

A Medicaid per capita cap or block grant would not reform Medicaid — it would merely shift expenses to state and county taxpayers

Implementing per capita caps or block grants would force states to increase health care spending beyond their capacity and decrease access to care for beneficiaries. This would also shift costs to county taxpayers and reduce counties' capacity to provide health care services – including those mandated by state laws.

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