NATIONAL ASSOCIATION of COUNTIES NACo®

MEDICAID AND COUNTIES

Understanding the Program and Why It Matters to Counties

FEBRUARY 2020

TABLE OF CONTENTS

NATIONAL ASSOCIATION of COUNTIES NACo®

CHAPTER 1

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

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 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, covering more than 74 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

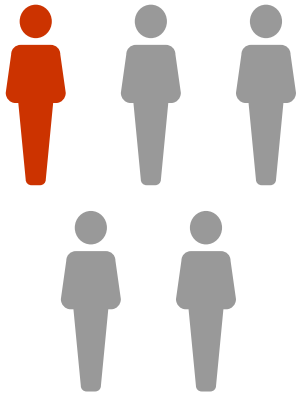
States utilize **different Medicaid delivery systems**, such as traditional fee-for-service systems that reimburse providers for each service provided and manage care systems that involve setting monthly payments

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

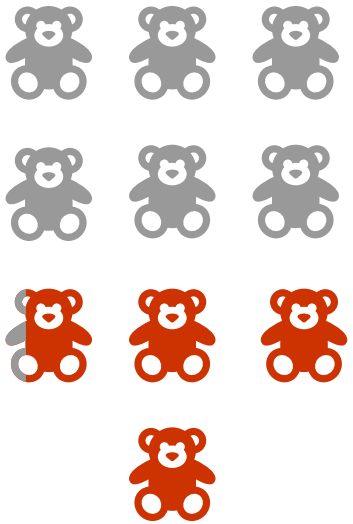
MEDICAID HAS TRADITIONALLY SERVED THE ELDERLY, DISABLED, AND FAMILIES, CHILDREN AND PREGNANT WOMEN

Medicaid serves:

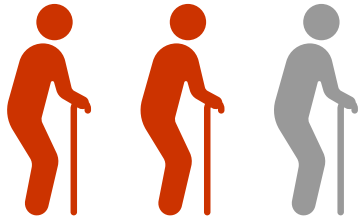
1 in **5**
Americans
over 65



nearly
4 in
10
children



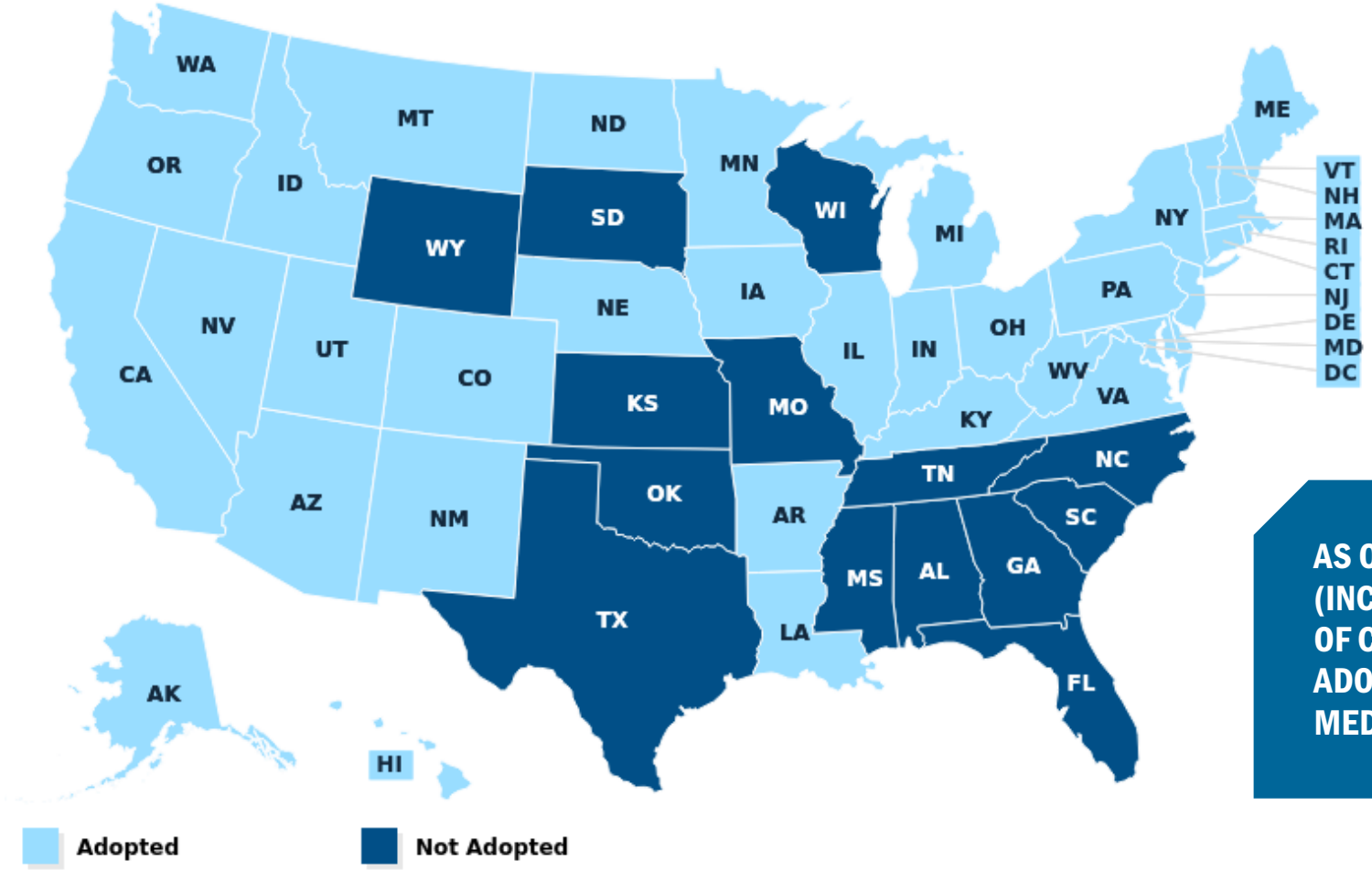
2 in **3**
nursing home
residents



Source: Kaiser Family Foundation

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** ($28,180 for a family of three in 2017).

STATUS OF STATE ACTION ON THE MEDICAID EXPANSION DECISION

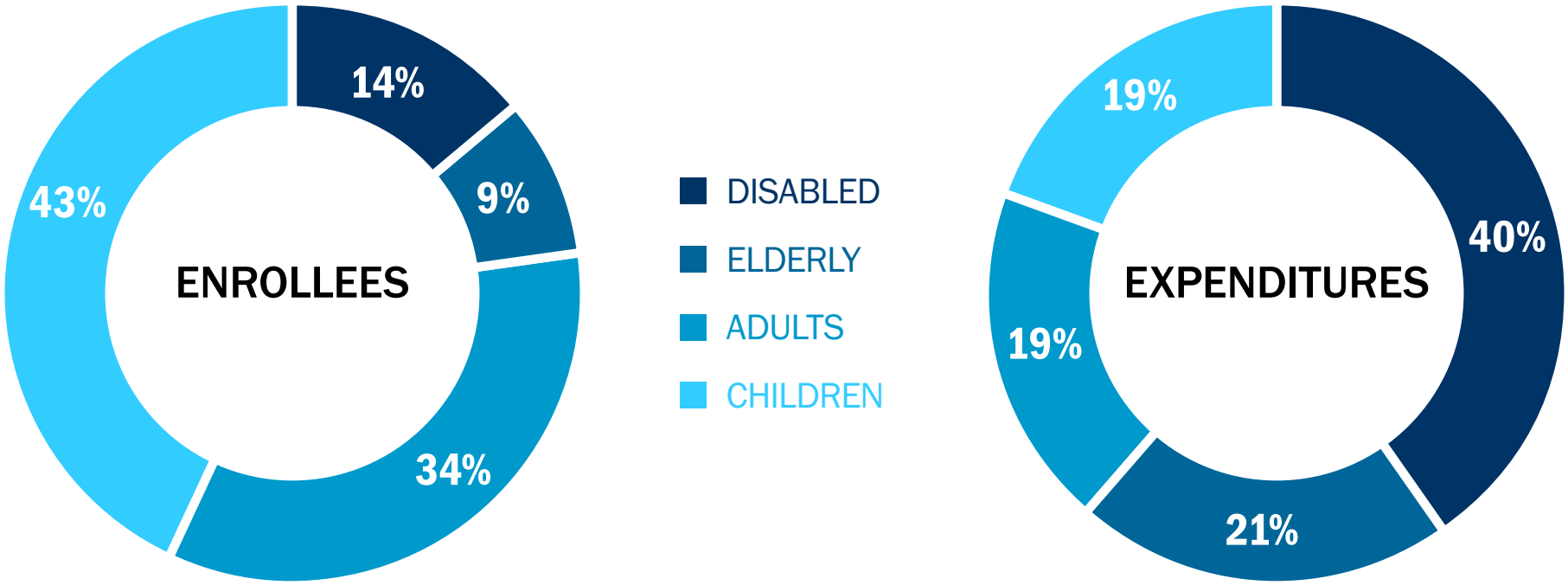


AS OF 2019, 37 STATES (INCLUDING THE DISTRICT OF COLUMBIA) HAVE ADOPTED THE ACA'S MEDICAID EXPANSION.

Source: Kaiser Family Foundation

SNAPSHOT OF MEDICAID EXPENDITURES

In 2014, **nearly two-thirds of Medicaid expenditures benefited disabled and elderly individuals**, though they made up less than one-fourth of the program's 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.



Data is based on FY 2014 figures

Source: Kaiser Family Foundation

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

CHAPTER 2

HOW COUNTIES SUPPORT THE HEALTH AND WELL-BEING OF RESIDENTS

COUNTIES ARE THE FRONT DOOR 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

$28 BILLION
contributed by local governments to non-federal share of Medicaid

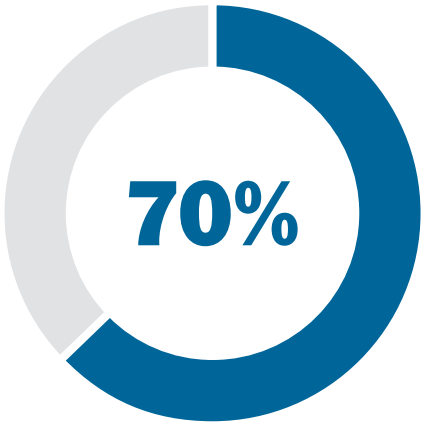
10 MILLION
additional individuals enrolled in Medicaid during the Great Recession

21 PERCENT
increase in local governments' Medicaid contributions during the Great Recession

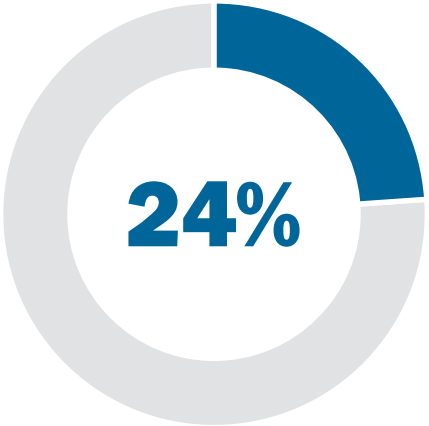
Since being signed into law in 1965, **the Medicaid program has helped counties provide a safety-net for those who are unable to afford medical care**. The program creates increased access to health care services for low-income residents, which improves their health, productivity and quality of life. 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**.

MEDICAID ENABLES COUNTIES TO REACH RURAL RESIDENTS

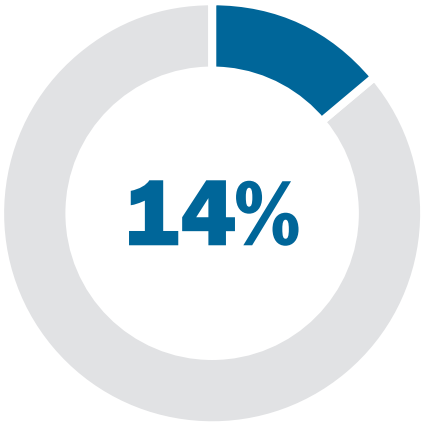
Approximately 70 percent of America's counties have populations of less that 50,000. Medicaid covers 24 percent of rural residents, and has surpassed Medicare as the **largest source of public health coverage in rural areas**. Medicaid provides a key source of patient revenue that enables communities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



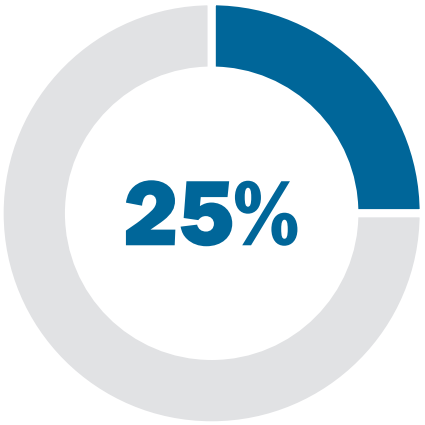
of America's counties have **populations of less than 50,000**



Medicaid covers 24 percent of **rural residents**



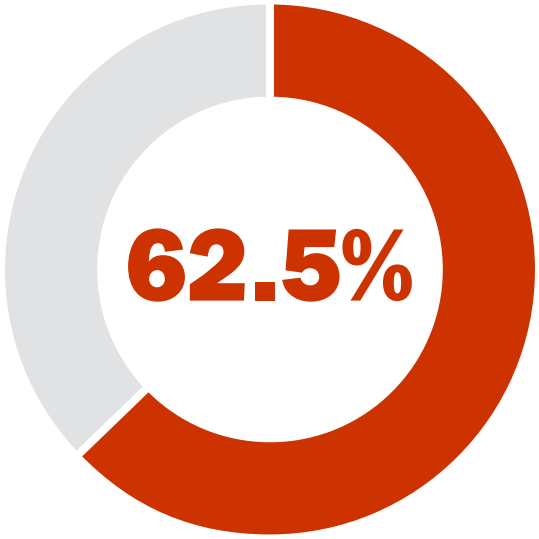
Medicaid payments account for more than 14 percent of **rural hospitals' gross revenues**



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

CHAPTER 3

THE ROLE OF COUNTIES IN FUNDING AND DELIVERING MEDICAID



For FY 2018, the federal share of Medicaid was 62.5 percent. The other 37.5 percent is paid for by a variety of other sources, including local governments.

COUNTIES MAKE KEY FINANCIAL CONTRIBUTIONS TO THE MEDICAID PROGRAM

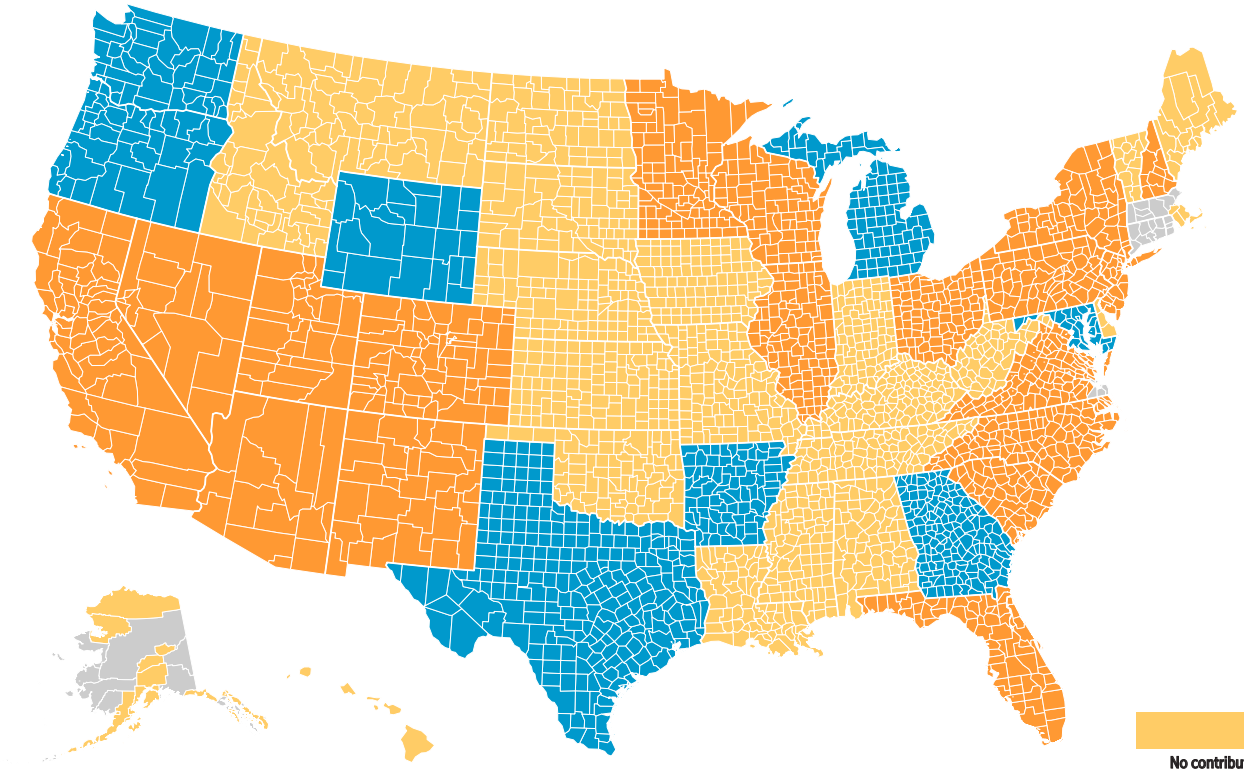
Medicaid is jointly funded by federal, state and local governments, **including counties in many states**. The federal contribution rate for each state varies based on the Federal Medical Assistance Percentage (FMAP) rate. The maximum amount contributed by each state is 50 percent, though some states contribute as little as 26 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**.

Source: Kaiser Family Foundation

COUNTIES CONTRIBUTE TO MEDICAID IN 26 STATES

Counties contribute to Medicaid in 26 states. Of these states, **18 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 nearly $7 billion per year – or $140 million per week – to the state for Medicaid costs.

2016 FEDERAL MEDICAL BENEFITS: MEDICAID CONTRIBUTION MANDATE FOR COUNTIES



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 data is unavailable if the county is colored grey

Source: NACo County Explorer explorer.naco.org, NACo Research, 2016

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.

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 that treat disproportionately large numbers of Medicaid beneficiaries. These are known as Medicaid Disproportionate Share Hospital (DSH) payments and in FY 2017, the federal share of DSH payments was $16 billion.

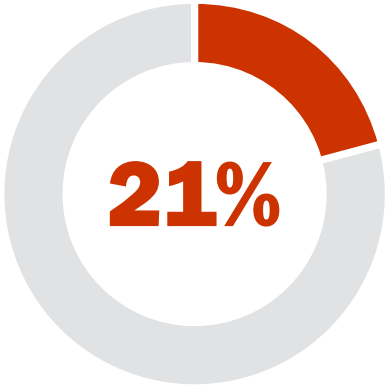
COUNTIES DELIVER LONG-TERM CARE SERVICES TO THE ELDERLY

Medicaid covers nursing home services for all eligible individuals who are 21 or older. In FY 2017, **Medicaid accounted for 52 percent of overall national spending on long-term services and supports.**

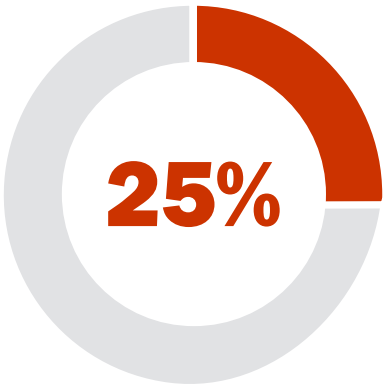
Counties deliver long-term care services to residents through **758 county-owned and supported nursing homes**, which represents 75 percent of all publicly-owned nursing homes in the U.S. Medicaid also covers home and community-based services for people who would otherwise need to be based in a nursing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



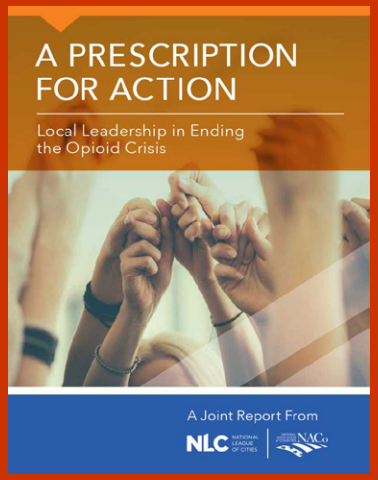
Medicaid accounts for 21 percent of all **health spending on substance use disorders**



Medicaid accounts for 25 percent of all **spending on mental health services**

COUNTY ACTION ON DRUG OVERDOSE PREVENTION

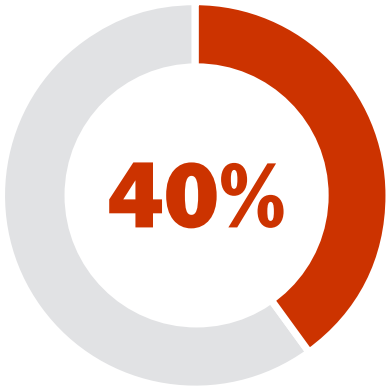
To prevent drug overdoses and deaths, counties have implemented services such as public training sessions on using overdose-reversing drugs such as Naloxone, syringe exchange programs and door-to-door educational visits.



For more information, visit www.opioidaction.org/report

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 opioid epidemic, as it **supports a full continuum of care (e.g., addiction prevention, treatment and recovery)** for people struggling with addiction and enhances local and state capacity to provide early interventions and treatments. For example, the Affordable Care Act's Medicaid expansion has provided states with additional resources to cover many adults with addictions who were previously excluded from the program.



In 2017, Medicaid covered nearly 4 in 10 **nonelderly adults with opioid addiction**.

CHAPTER 4
CHALLENGES FOR COUNTY GOVERNMENTS

MAJOR CHALLENGE: UNCOMPENSATED CARE COSTS REMAIN AS COUNTIES WORK TO CREATE PATHWAYS OUT OF POVERTY

Approximately 27 million people still lack health insurance, and are more likely to have problems paying medical bills. This inability to pay results in uncompensated care costs for counties. **States and localities spend upwards of $20 billion annually on uncompensated care**, according to the Urban Institute. 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.

For more information, see NACo's report, 'Serving the Underserved: Counties Addressing Poverty'

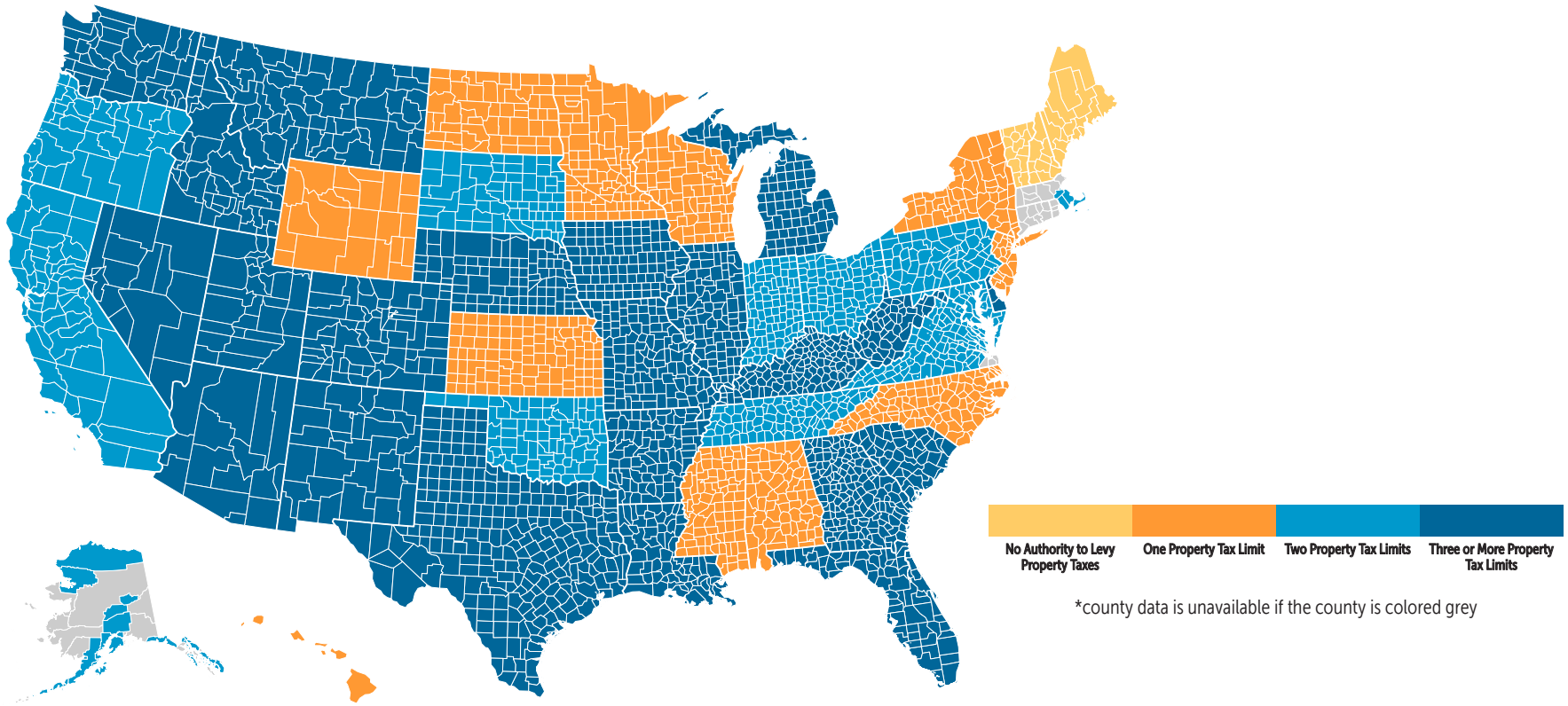
MAJOR CHALLENGE: COUNTIES' ABILITY TO RAISE REVENUE

Although the need for health care services and assistance remains pressing in communities across the country, many states place limits on counties' already limited options for raising revenue.

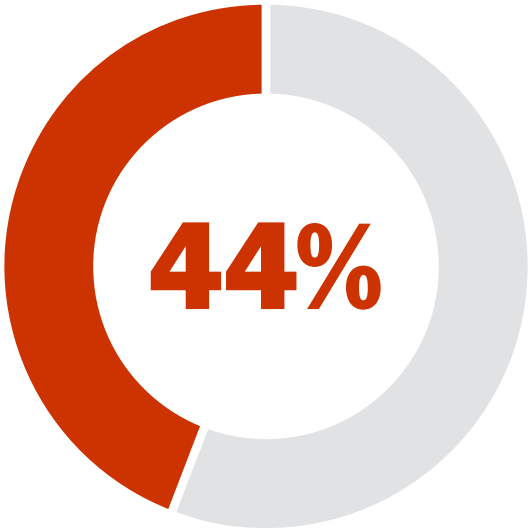
In fact, **43 states** impose some form of county property tax limits, affecting the main revenue source for counties.

At the same time, many states mandate delivery of indigent care and human services, often forcing counties to choose between critical programs.

STATE PROPERTY TAX LIMITATIONS FOR COUNTIES, AS OF APRIL 2017



Source: NACo County Explorer explorer.naco.org, NACo interviews with state associations, as well as county and state officials; NACo analysis of state legislation.



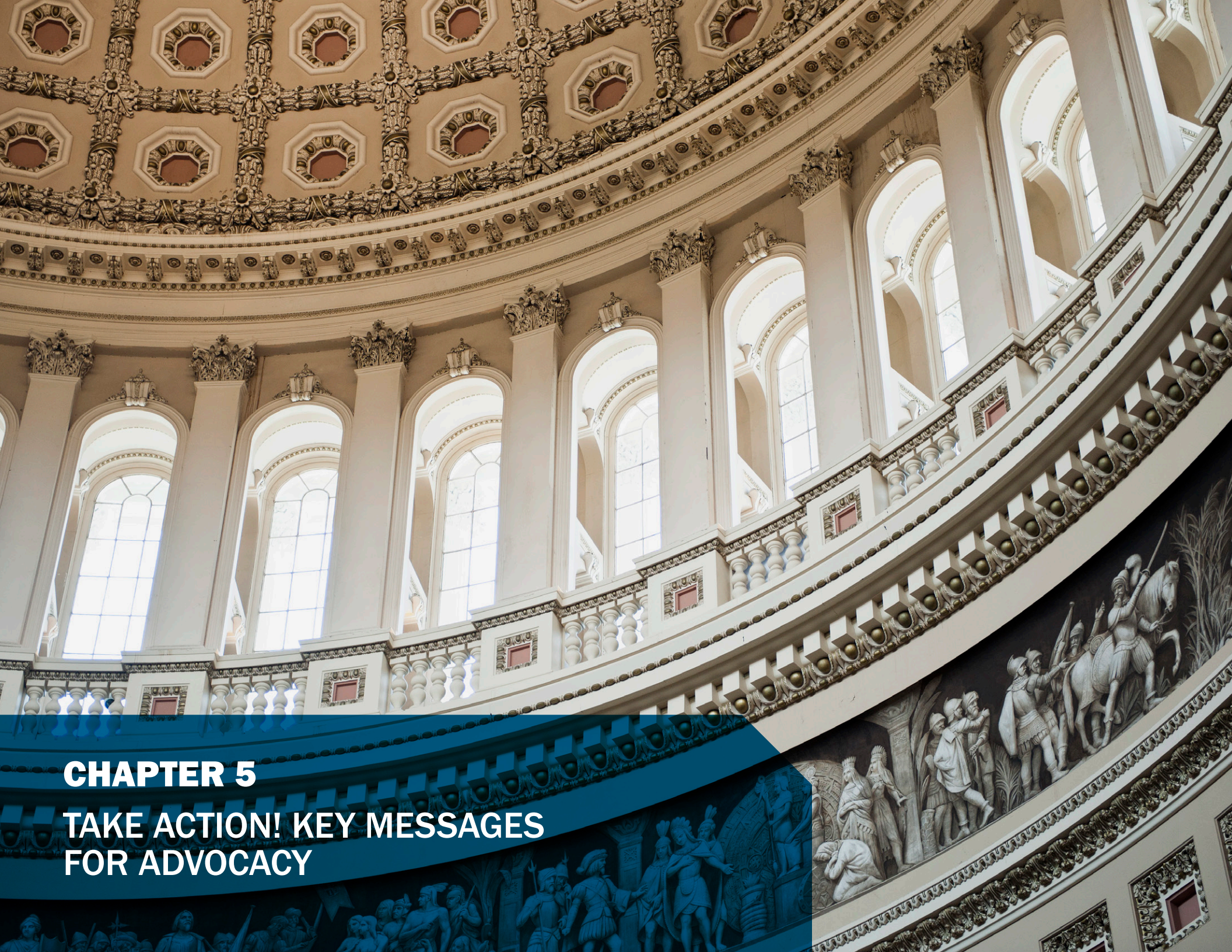
of county officials mentioned that their county **reduced and/or eliminated programs and services because of budget constraints** in their last fiscal year

MAJOR CHALLENGE: COUNTIES' ABILITY TO RAISE REVENUE

Given the fiscal limitations counties already face from states, the federal government's commitment to programs helping those most in need and to supporting local stakeholders and service providers is increasingly crucial.

Without the support of federal and state funds, many counties would have to reduce service levels for critical programs and cut any non-mandated services, such as economic development activities.

In a 2016 NACo survey, 44 percent of county officials mentioned that their county reduced and/or eliminated programs and services because of budget constraints in their last fiscal year.



CHAPTER 5

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

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.

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

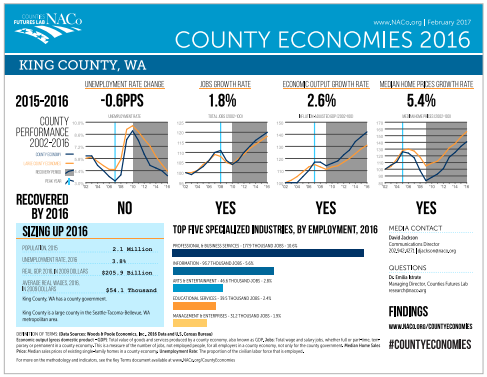
Work with your local media to publish an op-ed on the importance of Medicaid to your county and residents

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



For more information and resources, please visit NACo's website at http://explorer.naco.org/

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