2019 POLICY BRIEF

PROTECT THE FEDERAL-STATE-LOCAL PARTNERSHIP FOR MEDICAID

QUICK FACTS

- Medicaid provides health and long-term care insurance to nearly 73 million low-income families and individuals
- Counties annually invest $83 billion in community health
- Counties deliver health services, including those covered by Medicaid, through 903 county-supported hospitals, 824 county-owned and supported long-term care facilities, 750 county behavioral health authorities and 1,943 local public health departments
- Counties may contribute up to 60 percent of the non-federal share of Medicaid in each state
- Medicaid benefits local economies by reducing counties' costs for uncompensated care and providing patient revenue that help counties retain health professionals

ACTION NEEDED:

Urge your Members of Congress to support the federal-state-local partnership structure for financing and delivering Medicaid services and to oppose any measure that would further shift federal and state Medicaid costs to counties – including cuts, caps, block grants and new limits on counties' ability to raise the non-federal match or receive supplemental payments.

BACKGROUND:

Medicaid is a federal entitlement program administered by states, with assistance from counties, that provides health and long-term care insurance to over 70 million low-income families and individuals, or one in five Americans. Authorized under the Social Security Act, Medicaid is jointly financed by federal, state and local governments, including counties, who contributed the majority of the $28 billion in local government contributions to the non-federal share of Medicaid in 2012. During the recession, these contributions increased by 21 percent as more than 10 million additional people enrolled in Medicaid.

Counties take our responsibility seriously for protecting the health and well-being of our 314 million residents, and annually invest $83 billion in community health. Through 903 county-supported hospitals, 824 county-owned and supported long-term care facilities, 750 county behavioral health authorities and 1,943 local public health departments, counties deliver health services, including to those that are eligible for Medicaid reimbursement.

While the federal government sets broad guidelines for Medicaid, states have flexibility to expand benefits or eligibility. For instance, states must provide physician, hospital and nursing facility services, but can also cover services such as prescription drugs, dental and vision care. Traditionally, Medicaid has served three categories of low-income people: (1) families, children and pregnant women, (2) the elderly and (3) the disabled. However, under the Affordable Care Act, 37 states including the District of Columbia have exercised their option to expand coverage to low-income adults without children.

Counties may contribute up to 60 percent of the share of Medicaid costs that are not covered by the federal government in each state (also called the non-federal share) and counties contribute to Medicaid in 26 states. Of these, 18 mandate counties to contribute to the non-federal share of Medicaid costs and/or the administrative, program, physical health and behavioral health costs.

Medicaid benefits local economies by increasing access to health care services for low-income, uninsured, or underinsured residents, which in turn improves residents' health,

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productivity and quality of life. In addition, Medicaid reduces counties' costs for providing otherwise uncompensated care, including those mandated by state laws. Patient revenue from Medicaid also helps counties retain doctors and other health professionals, especially in rural and underserved areas.

In the 115th Congress, Medicaid was targeted for major cuts. Health legislation introduced in 2017 would have cut federal funding for Medicaid by one-fourth, or $800 billion, over the next decade. While these efforts were ultimately unsuccessful, they normalized methods for changing the Medicaid program through methods such as a per capita cap or block grant.

Under a per capita cap, states would receive a fixed amount of federal funding per beneficiary category. Under a block grant, states would receive a fixed amount of federal funding each year, regardless of changes in program enrollment and mandates. These measures would further shift costs to counties and reduce counties' capacity to provide health services to their residents.

In addition to attempts to cut federal funding for the program, in January 2018, the Trump Administration announced it would support state efforts to introduce Medicaid work requirements. State implementation of Medicaid work requirements could increase the administrative burden for counties, as well as costs associated with uncompensated care.

KEY TALKING POINTS

- **Medicaid is already a lean program.** Medicaid's average cost per beneficiary is significantly lower than private insurance, even with its comprehensive benefits and lower cost-sharing. 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. New limits on counties' ability to receive supplemental payments or raise the non-federal match (e.g., through intergovernmental transfers or certified public expenditures) would compromise the stability of the local health care safety-net
- **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 ultimately counties would 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.** Previous legislative proposals would have cut approximately $800 billion in federal funding for Medicaid over the next ten years. States would be forced to increase health care spending beyond their capacity, resulting in decreased access to care for beneficiaries. This would shift costs to county taxpayers and reduce counties' capacity to provide health care services – including those mandated by state laws

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