

INNOVATIONS IN HEALTH CARE | A TOOLKIT FOR STATE LEGISLATORS

Background

Over its 50-year history, Medicaid has been an important and evolving issue for state policymakers. Approximately one in five, or **65 million**, Americans received coverage through Medicaid in March 2019, making it the largest source of coverage for low-income children, pregnant women, adults, seniors and people with disabilities.¹ Although federal law sets Medicaid minimum standards related to eligible groups, required benefits and provider payments, it offers states latitude in decisions about program eligibility, optional benefits, premiums and cost-sharing, delivery system and provider payments. States have adopted a wide range of innovative strategies to improve enrollee health and the value of their Medicaid programs. As a result, each state Medicaid program is unique, reflecting that states have options through their state plan amendments or by using [Section 1115](#) waivers to design programs that better meet their needs and priorities.

This brief provides an overview of Medicaid coverage, enrollment, costs and implications for state lawmakers. This introduction to Medicaid is followed by a series of toolkit briefs that address key public and private insurance coverage issues and opportunities for state policymakers.

Medicaid Overview

Medicaid is a publicly financed program that provides health insurance for millions of low-income Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Created by Congress in 1965 under Title XIX of the Social Security Act, Medicaid is a shared program between the federal government and the states. While the federal government provides substantial funding and oversight for Medicaid through the Centers for Medicare & Medicaid Services (CMS), each state manages its own Medicaid program and must contribute matching funds. States vary in the amount of legislative oversight they provide to their programs. Federal statute establishes the fundamental program parameters. Although Medicaid is an optional program, all 50 states, the District of Columbia and the territories participate.

Federal law requires participating states to **cover** certain services and allows states to select from a menu of other optional services. Federal law also requires state Medicaid programs to **cover** certain populations and allows states the option of covering others. One reason Medicaid is called an “entitlement program” is because states must provide coverage to certain groups or “categories” of eligible people as defined by law. In addition, federal funding is



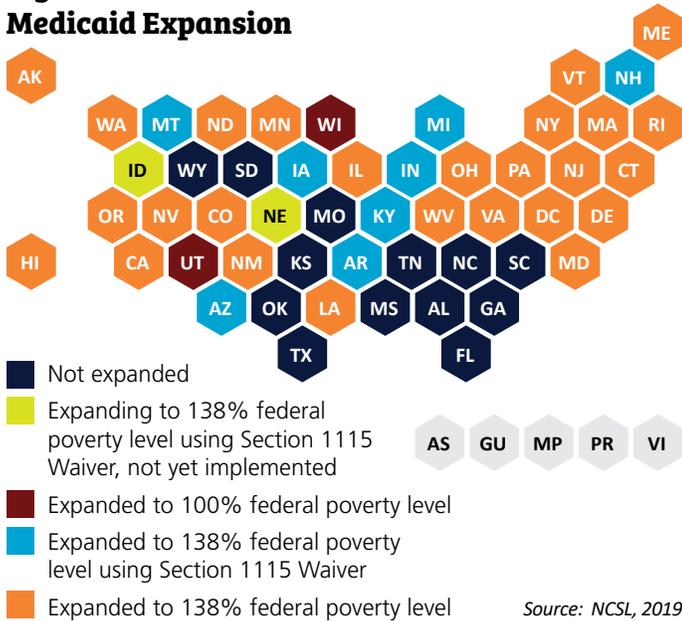
guaranteed for these groups and is provided based on need. When there’s an economic recession and individuals lose income and employment, federal Medicaid funding is designed to automatically grow as enrollment increases.

The following groups are entitled to services through the Medicaid program (they are sometimes referred to as “categorically eligible”):

- Low-income infants and children who qualify for Medicaid and/or the Children’s Health Insurance Program (CHIP) based on income or other guidelines.
- Low-income pregnant women and certain parents of qualified children.
- Low-income individuals of all ages with disabilities.
- Low-income seniors, most of whom are also covered by Medicare, often referred to as individuals who are “dually eligible” for both programs.

The Affordable Care Act (ACA) extended Medicaid coverage to all adults under the age of 65 with incomes below 138 percent of the federal poverty line. The ACA faced almost immediate legal challenges. The June 2012 Supreme Court ruling in *National Federation of Independent Business (NFIB) v. Sebelius* upheld the constitutionality of the ACA, but essentially made the Medicaid expansion provision an option for states, rather than mandatory. As shown in Figure 1, as of February 2019, 36 states including

Figure 1. State Decisions on ACA-Related Medicaid Expansion

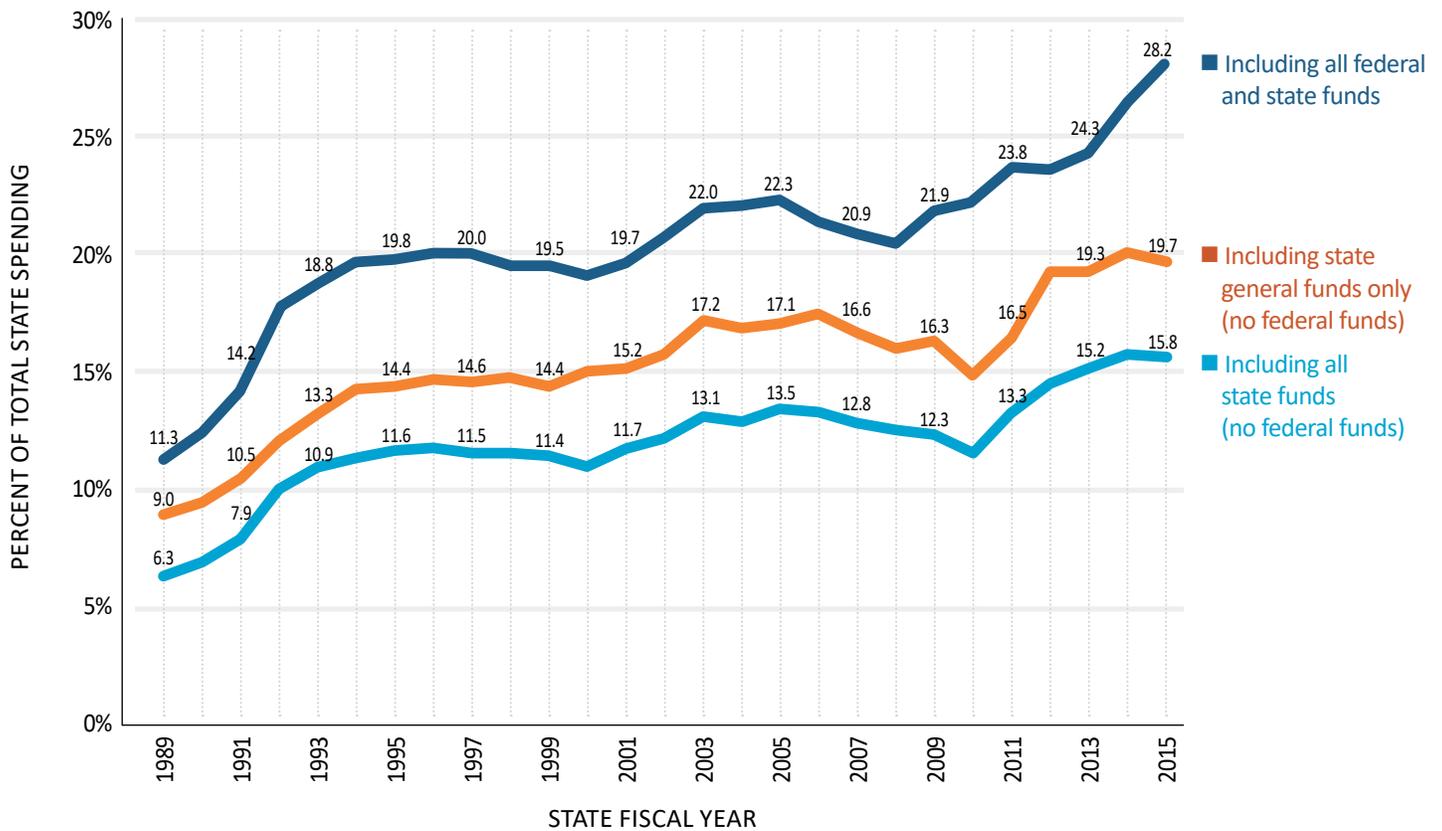


the District of Columbia had adopted Medicaid expansion as permitted under provisions of the ACA. Most states that opted to expand Medicaid did so through a legislative process and a state plan amendment, while seven states—Arizona, Arkansas, Indiana, Iowa, Michigan, Montana and New Hampshire—used a Section 1115 waiver, which allowed them to modify some of the federal requirements. Information on each state’s eligibility levels is [available on the website](#) for the Centers for Medicare & Medicaid Services.

Medicaid and State Budgets

States bear substantial costs of providing health care for indigent patients. When low-income people have access to care through Medicaid, the costs are shared with the federal government rather than shifted elsewhere, such as other tax-funded programs, emergency rooms or private insurance plans in the form of higher premiums. Medicaid helps states pay for uncompensated care for indigent patients, those who are uninsured and cannot pay for their health care. Medicaid reimbursement can help support hospital services,

Figure 2: State Spending on Medicaid as a Percent of Total State Spending, 1989-2015



Notes: The all federal and state funds category reflects amounts from any source. The state general funds category reflects amounts from revenues raised through income, sales and other broad-based state taxes. Posted online April 4, 2018.

Source: MACPAC, 2017, National Association of State Budget Officers

particularly rural hospitals, hospitals with a high volume of Medicaid clients and [Federally Qualified Health Centers](#). When people have access to care, chronic conditions can be managed more effectively—possibly preventing a crisis or emergency care, and ultimately reducing costs.

Medicaid accounts for about [17 percent of total state spending](#), according to The Pew Charitable Trusts. As health care costs rise faster than other sectors of the economy, states struggle to keep costs down while preserving other programs and safety-net services. Medicaid spending per person is growing at a comparable or slower rate than private insurance but increasing Medicaid enrollment continues to drive overall increases in state expenditures for Medicaid.²

Outside of enrollment increases, one of the key cost drivers in Medicaid is providing coverage for people with complex health care needs such as multiple chronic conditions and serious disabilities, as well as being the primary payer for high-cost services like long-term care. As described in a subsequent brief in this series, the top 5 percent of patients, ranked by their health care expenses, account for about half of the nation’s health care expenditures,³ including a large share of Medicaid budgets. Individuals with disabilities and the elderly comprise 24 percent of the Medicaid population, but they account for 63 percent of all Medicaid costs.⁴

Figure 2 illustrates trends in Medicaid’s share of state budgets between 1989 and 2015.⁵ As of 2015, Medicaid accounted for greater than 28 percent of spending from all sources (federal and state funding), almost 20 percent of spending from state general funds only, and nearly 16 percent of spending from all sources of state funds (including other dedicated sources of revenue like tobacco master settlement agreement funds or health care related taxes).

State Medicaid Policy Levers and Options

Since Medicaid is a joint state-federal partnership with shared authority and financing, state lawmakers have important roles in funding and overseeing their programs. These roles may include expanding Medicaid, enacting legislation to define Section 1115 waiver components, defining payment and delivery system reforms, implementing new eligibility rules or incentives, improving data capacity to inform decisions, and establishing work groups or task forces. Although federal law sets Medicaid minimum standards related to eligible groups and required benefits, states have significant latitude to make decisions about program eligibility, optional benefits, premiums and cost sharing, delivery system and provider payments. These decisions are then implemented either through a state plan amendment process or through a Medicaid waiver process.

■ **A Medicaid state plan** is an agreement between a state and the federal government describing how that state administers its Medicaid program (as well as CHIP in states that administer their CHIP programs through Medicaid) within federal requirements.

■ **A Medicaid waiver** is a written approval from the federal government (reviewed and determined by CMS) that allows states to vary from the rules of the standard federal program. In other words, the state is allowed to “waive” some of the requirements of the federal program. States have long used waivers for increased flexibility in how they deliver services in their state program in a way that meets their unique needs. Waivers authorized by the Social Security Act include Section 1915 and Section 1115. Section 1915 waivers allow states to require beneficiaries to use a specified provider network. In addition, Section 1915 waivers are a key tool for states to deliver long-term services and supports in community-based settings.

■ **Section 1115 waivers** are demonstration or pilot projects that states can use to test new concepts. As of April 2019, 39 states had at least one [approved](#) 1115 waiver and 17 states had one or more waivers [pending](#) approval by CMS, according to tracking by the Kaiser Family Foundation.⁶ States have used these waivers to extend coverage to additional populations not defined in law, use healthy behavior incentives to reduce cost-sharing obligations and require some cost-sharing. They also have used them to deliver Medicaid long-term services and supports through capitated managed care, under which the provider is paid a flat fee for each patient covered. In addition, states have received federal approval to use these waivers to charge premiums or require beneficiaries to work to maintain coverage—approaches not previously approved for use in the Medicaid program.

A significant number of Section 1115 waivers involve behavioral health. For example, state legislators are taking steps to integrate primary medical care and behavioral health delivery systems to improve health outcomes and control Medicaid costs for the 9 million enrollees with a behavioral health diagnosis and the 3 million with a substance use disorder.⁷ According to the Kaiser Family Foundation, as of April 2019, 28 states were using Section 1115 Medicaid waivers to provide enhanced behavioral health services to targeted groups, expand Medicaid eligibility to additional populations with behavioral health needs, and fund physical and behavioral health integration and other delivery system reforms.

Conclusion

As Medicaid consumes a larger share of state budgets, policymakers seek ways to improve outcomes, reduce costs and make sure their state’s program is managed as efficiently and effectively as possible. While there is no silver bullet, states are adopting a wide array of strategies to reduce spending, improve care outcomes and quality, and provide states with a return on their health investments. Companion briefs in this toolkit on high-need, high-cost Medicaid enrollees and behavioral and physical health integration outline various steps states are taking to fund and implement care coordination models or care management programs that improve outcomes for people with complex needs.

Notes

1. Centers for Medicare & Medicaid Services (CMS), March 2019 Medicaid and CHIP Enrollment Data Highlights (Baltimore, Md.: CMS, n.d.).
2. Medicaid and CHIP Payment and Access Commission (MACPAC), “Trends in Medicaid Spending” (Washington D.C.: MACPAC, June 2016).
3. Peter Long et al., eds. *Effective Care for High Needs Patients: Opportunities for Improving Outcomes, Value, and Health* (Washington, D.C.: National Academy of Medicine, 2017).
4. Ibid.
5. Medicaid and CHIP Payment and Access Commission, “Medicaid’s Share of State Budgets” (Washington, D.C.: MACPAC, n.d.).
6. Kaiser Family Foundation (KFF), *Approved Section 1115 Medicaid Waivers* (Washington, D.C.: Kaiser Family Foundation, August 2018).
7. Julia Zur, MaryBeth Mucumeci, and Rachel Garfield, *Medicaid’s Role in Financing Behavioral Health Services for Low-Income Individuals* (San Francisco, Calif.: Kaiser Family Foundation, June 29, 2017).

Supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers or staff.

NCSL Contact:

Colleen Becker
Policy Specialist, NCSL Health Program
303-856-1653
Colleen.Becker@ncsl.org

Emily Blanford
Policy Principal, NCSL Health Program
303-856-1448
Emily.Blanford@ncsl.org

Kristine Goodwin contributed to this report.

William T. Pound, Executive Director

7700 East First Place, Denver, Colorado 80230, 303-364-7700 | 444 North Capitol Street, N.W., Suite 515, Washington, D.C. 20001, 202-624-5400

www.ncsl.org

© 2018 by the National Conference of State Legislatures. All rights reserved. ISBN 978-1-58024-968-3