



The Our American States podcast—produced by the National Conference of State Legislatures—is where you hear compelling conversations that tell the story of America’s state legislatures, the people in them, the politics that compel them, and the important work of democracy.



You can subscribe through iTunes or Google Play.

States Embrace Flexibility in Medicaid Strategies | OAS Episode 70

Gene: Welcome to “Our American States,” a podcast of meaningful conversations that tell the story of America’s state legislatures, the people in them, the politics that compel them, and the important work of democracy. For the National Conference of State Legislatures, I’m your host, Gene Rose.

More than \$1 out of every \$5 in state budgets is targeted toward Medicaid, a federal/state partnership that serves as a health insurance program for low-income individuals, children, their parents, the elderly and people with disabilities. More than \$500 billion is spent on the program with more than 60% of those funds coming from the federal government.

In recent years, some states have worked to reduce their Medicaid costs, while others have expanded their programs under the Affordable Care Act. In this episode of “Our American States,” we explore those strategies and learn of the various Medicaid funding options available to states.

To walk us through the various issues surrounding Medicaid is Emily Blanford, a program principle in NCSL’s Health Program specializing in Medicaid policy. Here’s our conversation with her.

Time Marker (TM): 1:22

Gene: Emily, let’s start out by having you give us a quick 101 description. What is Medicaid and what is it intended to do?

Emily: Sure. Medicaid is a public health insurance program that intends to provide health coverage to people with low income, people with disabilities and people who are older. Medicaid is a federal/state partnership with states responsible for the administration of the program, and the federal government provides oversight and both the state and the federal government then provide funding for Medicaid.

Now nearly 1 in 5 people in the United States has Medicaid coverage, and another way I like to describe what Medicaid is, is by clarifying what it is not. It is not Medicare. Now, a lot of people mix up these two programs and understandably so. They are similarly named, they were

enacted at the same time, and they've got a little bit of overlap between who they cover, but they are very different programs.

So, Medicare is a fully federal program, meaning all the financing comes from the federal government, and the federal government administers the program with no state involvement. So, Medicaid, a key part of that definition is that federal/state partnership administered at the state level.

TM: 2:32

Gene: Thank you for that description. And where I'd like to begin our conversation today is on the amount of resources that are available to states from the federal government and how they're distributed. Can you explain that to us?

Emily: So, as I mentioned, both the states and the federal government provide funding for Medicaid and over \$600 billion were spent in Medicaid in fiscal year 2018. Now, the way that federal government money is shared with states will vary by state, so the federal government uses a calculation, which is largely based on average income in a state, to then determine how much of the Medicaid spending they will cover.

So, for example, the minimum amount that the federal government will cover for Medicaid spending is 50%. So that means when a state puts up \$1 of their funds to support Medicaid, the federal government will match that with a dollar of their own. So, again, that's the minimum amount provided.

And so states with higher incomes on average will be closer to that minimum amount from the federal government, and then states which have maybe lower incomes on average will get increased federal share to cover the Medicaid costs in their state. For example, I think the highest amount is about 75% that the federal government will contribute to states for their Medicaid spending.

TM: 3:52

Gene: Currently that funding is guaranteed to the states, is that correct?

Emily: That is correct.

TM: 3:56

Gene: And some states and the administration now are looking to place certain restrictions on Medicaid, and let's talk about some of these proposals including ways that funding is allocated to the states including block grants. So, tell us about the various proposals that are out there and how they're designed to change the system.

Emily: Sure. So, with the funding being guaranteed currently, part of what that means is it's designed to move with need and be provided as needed. But with a block grant, what that would mean a state would receive a set amount of funding for a year to cover all the costs in their Medicaid program.

So, in that case, if a state receives a block grant, but they spend more than what they received in that block grant, a state will be on the hook for those additional expenditures. But some states are exploring this option of block grants as a way to help contain costs in their Medicaid programs, as well as they're hoping for some increased flexibility in how they administer their programs by agreeing to use block grant financing in this way.

And it looks like Tennessee is going to be the first state to submit a proposal to change their Medicaid financing to a block grant. They passed a bill in their session this year and they're working on a proposal that they'll submit to the federal government to change their financing to a block grant. So it will be very interesting to watch those efforts in Tennessee.

And then also along those lines, Utah is working on a proposal to change their Medicaid financing as well. They're calling it a per capita cap rather than a block grant. And so what do I mean by per capita cap? That is instead of a set amount for your entire program, they are going to set an amount that they can spend per person.

So that means if they see an increase in enrollment, they can still receive additional funds from the federal government to cover that. However, if they spend more per person than they agreed to, Utah would then be on the hook to cover those additional costs. So Utah is also working on a proposal to submit to the federal government to change their financing.

And so we're in the proposal phase and there is some uncertainty regarding whether the Social Security Act will actually allow for this kind of Medicaid financing, so this will definitely be an interesting area for states to watch as these two efforts progress.

TM: 6:18

Gene: Well, and I understand some states are also seeking federal approval to implement work requirements in order for citizens to receive Medicaid services. Is that correct?

Emily: That is correct. Many states are seeking federal approval and several actually already have approval to implement work requirements. And so work requirements in Medicaid, essentially the idea is that people who are able-bodied should be working in order to maintain their Medicaid coverage. The idea is in these states that it might help reduce the need for Medicaid coverage if people are able to maintain stable employment, and it's a way of encouraging personal responsibility.

And so, as I mentioned, several states have approval, but they are facing legal challenges in this arena. And two states, Kentucky and Arkansas, are both currently under a court injunction and are not at this time able to impose work requirements on their Medicaid beneficiaries. But the administration continues to approve work requirement proposals and states are continuing to submit these kinds of proposals.

So these legal challenges will definitely be an area of interest for states to watch. The administration is appealing these current decisions, and so we'll wait to see what the final outcome is on those.

TM: 7:36

Gene: So, are there other actions some states are taking to reduce their Medicaid budgets?

Emily: Oh, yeah. States are always looking for ways to contain costs in their Medicaid budgets with the work requirements and encouraging personal responsibility. So, along those same lines, some states are imposing what we call some cost-sharing requirements where they require people to, say, pay a monthly premium in order to maintain their Medicaid coverage. And, again, the idea is thinking if you've got personal responsibility and skin in the game, that maybe it could reduce unnecessary use of services in some of those states.

Another area that states are looking at is managed care as a way to reduce spending in their states. A lot of times coordination of services, it can be very fragmented, and states are looking to using managed care organizations to help coordinate services and hopefully deliver services more effectively and efficiently, thereby reducing costs.

Now results are kind of mixed on whether states are seeing savings from these managed care arrangements, but it is the arrangement used by most of the states in the country.

Another strategy some states look at is high cost/high needs individuals. Again, a lot of this boils down to coordination of care. Oftentimes people with chronic conditions, they are seeing a lot of different providers, but there's not a lot of coordination between those service providers. And so states are looking at targeting those high cost/high needs individuals in order to provide more supports and services to better coordinate their care, thereby hopefully reducing costs in serving those individuals.

Those are just some strategies states are employing.

TM: 9:20

Gene: So, we've talked about states looking at ways to cut Medicaid spending, but we also had some states expand Medicaid coverage under the Affordable Care Act. Can you tell us what's currently allowed under the act and what ways states are looking to perhaps expand coverage?

Emily: Yeah. So originally under the Affordable Care Act, Medicaid expansion was actually required for states. But with the Supreme Court decision related to the Affordable Care Act, it became an option for states to pursue.

So traditionally Medicaid has covered or provided coverage for low-income families and people with disabilities, but not so much single adults without kids with low incomes. And so this Medicaid expansion option under the Affordable Care Act gave states the ability to expand their coverage to this group of single individuals up to 138% of the federal poverty level, or in more plain terms, an individual making about \$17,000 per year would now qualify for Medicaid under this option; and so 36 states and the District of Columbia have adopted this option at this point in time.

Most of the states did what I'll call a traditional expansion where they just increased their coverage to this population. But there are a few states which took more what I'll call a

nontraditional approach to expansion. So as we were just talking about with work requirements and some of those cost-sharing requirements, a few states have imposed those requirements specifically on these expansion populations.

And there are a couple of states that did something interesting where, rather than fully enrolling these individuals into the Medicaid program, they have decided to purchase private health plans on the marketplace in their states for these individuals. Now if these individuals need services that aren't covered by those private plans and Medicaid does cover it, they can get coverage from Medicaid on the back end. But it's just another kind of different way of approaching Medicaid expansion.

TM: 11:21

Gene: Some states have even had citizen-driven ballot initiatives to expand Medicaid, correct?

Emily: That is correct. In November of 2018 three states saw citizen-driven ballot initiatives pass in their states, those being Idaho, Utah and Nebraska. And in each of those states they needed to have supporting legislation to provide funding and to implement those ballot initiatives. So those three states are currently working on implementation and are in that process.

And then it looks like there may be a couple other states coming up which might have ballot initiatives on the ballot either this year or next, and that's Florida and Oklahoma. In fact, Oklahoma's Supreme Court actually heard arguments pertaining to this ballot initiative and has given it the go-ahead. So in Oklahoma they will now be working to collect signatures to get that on the ballot.

So I don't think these initiatives are on the ballot just yet, but those will be some states to watch.

Gene: Right after this short break we'll talk to Emily about Medicaid's relationship to mental health, behavioral health, housing, nutrition, and other programs under consideration in the states.

Break

TM: 13:01

Gene: I'd like to get into a couple of areas of care that have received national attention recently. States seem to be working in ways to integrate physical health with mental health, and I believe you call this behavioral health. Talk to us about why states are exploring these types of services.

Emily: Yeah. So mental health is a term I think a lot of people might be more familiar with than, say, behavioral health, or a lot of people use those two terms interchangeably. But behavioral health is an umbrella kind of term: It includes mental health as well as consideration for behavioral factors that impact people's overall health and wellbeing.

So, yeah, behavioral health services, they've often been carved out of, as in these services have been provided in an entirely different structure from physical health services. And there's often not been a lot of coordination between the two. For example, as we were talking about

managed care organizations and states earlier, a lot of the states using those managed care organizations do not include behavioral health services within those organizations.

So, many states are now working to fully integrate those behavioral and physical health services as a way to reduce costs and unnecessary utilization, again, to better coordinate services in these particular realms.

Now, some strategies that states are employing here are something like simply co-locating physical and behavioral health providers together. It's a lot easier to refer someone across the hall than it is to refer them to a provider downtown. So they're working just to get people in the same space.

Another strategy they're using includes universal screenings, meaning you have your physical health providers conducting behavioral health screenings to see if there might be some behavioral health needs, and vice versa, having your behavioral health providers screen for common physical health needs, again to just better coordinate and make appropriate referrals to hopefully help people more efficiently use their Medicaid services.

Now there have been some benefits seen from this integration, particularly for adults with depression and anxiety; definitely seeing some improved outcomes in that area. But evidence is a bit limited for how this integration is impacting say kids or adolescents or people with substance use disorders. So, it will be an interesting area to watch as states continue to further integrate both these behavioral health and physical health services.

TM: 15:24

Gene: And then I know another sector being explored by states is the living conditions of Medicaid recipients, reasoning that people with housing, adequate nutrition and other things that many of us take for granted contribute to poor health and thus greater dependency on Medicaid.

Now you say while these areas have received some attention in terms of appropriations, is there some shifting in states' thinking on this issue?

Emily: Yeah, more and more there is growing recognition and growing evidence that these nonmedical factors like housing and adequate nutrition, or you may hear it called social determinants of health, but that these nonmedical factors actually have a bigger impact on our quality and our length of life than just simply our access to medical services.

For example, if you have someone with asthma and you're trying to get your asthma symptoms under control, and you've got a great doctor and you've got plenty of access to that doctor, but if your home environment is triggering your asthma symptoms and you aren't able to change that home environment, it doesn't really matter how many times you're able to get to the doctor, your home is going to continue to trigger your asthma symptoms.

So, there's been this greater recognition that we need more supports in these kinds of nonmedical or social grounds.

Now, historically Medicaid has not provided a lot of funding or supports in this nonmedical area and there have been some services that have been targeted to some specific smaller populations, like for example, people with disabilities, many states have programs that offer these kinds of nonmedical supports to people with disabilities; or we've seen a lot of states, in implementing their substance treatment programs, they're including things like housing supports in there because they're recognizing just how important that is for substance use treatment. But again, those are pretty targeted and not necessarily addressing or impacting or helping the Medicaid population overall.

So one state that's going to be an interesting example to watch is North Carolina. They recently appropriated \$650 million over the course of five years to try and support building some infrastructure for these nonmedical services. Their appropriation is for a broad Medicaid reform effort and so these nonmedical supports will be a component of that, and they're looking to pilot it in a couple areas of their state.

And so, like what we were just talking about with behavioral and physical health integration, North Carolina is looking to really set up the infrastructure to better integrate these nonmedical supports or these social services supports with these more medical services.

So a lot of states will be interested to watch what's going on in North Carolina. They received federal approval to do this within their Medicaid program, so there's also support for this at the federal level. So again, this will definitely be an emerging area for states to watch.

TM: 18:27

Gene: So, Emily, I've asked you quite a few questions here. What else should legislators and legislative staff know about Medicaid?

Emily: You know, one thing I think I'd really like to emphasize for legislators and legislative staff is just how much flexibility there is within the Medicaid program. Since it is a federal program, I think a lot of people think about the strings that are attached to the funding and the hoops that you have to jump through. There's definitely plenty of that that can kind of stymie innovations.

But there's also just a lot of flexibility to really design your Medicaid program in a way that can meet your state's unique needs. You know, I hear this in a lot of realms, but definitely in Medicaid in particular you hear: If you've seen one Medicaid program, well, you've seen one Medicaid program. And I think that's just an indication of just how much flexibility there is for states to really design things that can meet their unique needs.

And so I would really encourage, you know, if legislators and legislative staff have ideas about things they want to do in Medicaid, don't be afraid to reach out to your executive branch Medicaid agency if appropriate and talk with them about what kind of flexibility is available. Or NCSL is available to help with that as well.

But again, there are just so many opportunities within the Medicaid program to really design really unique and interesting benefits and services for your populations.

Gene: We've been talking with Emily Blanford, a program principle in NCSL's Health Program specializing in Medicaid policy. Emily, thanks for sharing your knowledge with us today.

Emily: Thank you.

Music and Gene VO:

And that concludes this edition of "Our American States." We invite you to subscribe to this podcast on iTunes and Google Play. Until our next episode, this is Gene Rose for the National Conference of State Legislatures. Thanks for listening.