The Safety Net’s New Future: The State Level

Kathleen Nolan
HMA’s Washington, DC Office
Regardless of Federal action, it falls to the states to implement health system and Medicaid changes:

- Medicaid expansion changes
- Capped Medicaid funding or block grants
- Waivers and other program changes
ACA CHANGES: EXPANSION STATES

- Taking coverage away is always a problem.
- State expansion legislation written with an “exit clause.”
- Health problems would reemerge:
  - Opioids
  - Hepatitis C
- Funding that used to support these programs has eroded in past three years
  - Mental health
  - Public health programs like family planning or adult vaccines
- Hospitals/Health Systems financing has also shifted
If expansion funding is eliminated or curtailed, states could still cover these adults, but at 50/50 federal funding instead of 90/10. Options:

- Try to continue coverage for some of these adults
- Develop/redevelop state only insurance products
- Buy people into the exchanges for those 100-138% of federal poverty
- Invest in some specific services like opioid treatment
- Support hospitals and health systems
ACA CHANGES: NON-EXPANSION STATES

- Uninsured still a problem
- That number could grow again—as people lose exchange coverage
- Is there federal support for any programs for the uninsured.
- What happens to hospitals’ financial support as DSH funding continues to decline?
PER-CAPITA CAPS AND BLOCK GRANTS

- Impact relevant in EVERY state, whether they expanded or not
- Dramatic reductions in federal support over several years
- Over time, likely to especially hit those with disability the hardest
  - Frail elderly in nursing homes and home care
  - Disabled adults with physical or mental health conditions
  - Reductions in services that help people live in the community, work, or promote quality of life, including adults with developmental disabilities or other groups.
CAPPED PROGRAM WILL BE EVEN MORE STATE-SPECIFIC AND STATE-DRIVEN

- Each state would work with HHS to reshape and trim their program.
- Likely to be an annual negotiation at the state level (legislature, governor setting the budget and the program parameters each year).
- Per-capita cap a little more responsive to economic shifts
- Block grant would not be responsive to shifts (recession), but may offer more ability to tailor.
- The state legislative and budget fights will pit Medicaid populations and providers against each other.
BUT WHAT IF NOTHING HAPPENS...

- HHS leaders are rolling out the red carpet for innovations.
  - Work requirements
  - Drug testing
  - Eligibility restrictions and waiting periods
  - Cost-sharing/premiums
  - Benefit redesign

- These ideas are more relevant in expansion states, as many apply to only non-disabled adults.

- But also the opportunity to change regular Medicaid as well, based on what states want to do.
FOR NOW: IT’S ALL ABOUT WAIVERS

- 1115 waivers offer broad authority to states to redesign benefits and delivery.
- New Admin may offer new options on Expansion coverage.
- 1332 waivers are new. Could do something like buying adults into Exchange coverage?
- 1332-1115 combo waivers that would get at insurance market reforms in tandem with Medicaid changes.
Everything happening in DC will come back to what states do to reshape their programs.

Public expectations and our health systems have changed under Obamacare. Changing back will be painful for some, but no change could be challenging for others.

Medicaid participants are a diverse group, and changes will affect them differently.
QUESTIONS FOR LEGISLATORS

What is on your immediate horizon for Medicaid?
- Either looming problem or new ideas given no Congressional action

What is the appetite for change in your state?

What are the 1-2 priority issues that you will focus on in your work?