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# CRC Memorandum

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First in a series on *Medicaid and the Michigan Budget*

## Medicaid - What It Is and How It Works

### National

Medicaid is a state-administered federal health insurance program established by the addition of Title XIX to the Social Security Act (SSA) in 1965. At the time of passage, its companion, Medicare (Title XVIII) received the major attention.

Medicaid's purpose was to provide health care services to "categorically needy" individuals who were receiving federally funded income maintenance (welfare). In 1965, these included: the aged; the blind; the disabled; and, families and children who were receiving Aid to Families with Dependent Children. (AFDC was replaced by the Temporary Assistance to Needy Families [TANF] program with the passage of welfare reform in 1996.) States were mandated to include the "categorically needy" individuals in a Medicaid program and were given the option of including "medically indigent" persons. Over the years, Medicaid eligibility has expanded beyond the tie to cash assistance programs but the two types of eligible persons - mandated and optional - remain.

Medicaid is now the single largest health insurance program in the country, recently eclipsing Medicare in both persons covered and dollars expended. It covers one-fifth of all children in the United States and pays for one-third of all births. It finances over two-fifths of all long-term care; over one-sixth of all prescription drugs: and funds one-half of all state mental health programs.

Not surprisingly, it has also become the largest source of pressure on state budgets across the nation. Virtually every governor and legislature is addressing the cost of Medicaid as fiscal year 2003 spending plans are being revised and 2004 budgets are being prepared.

Medicaid law and regulation is a highly complex. In a 1994 case, *Rehabilitation Association of Virginia, Inc. v. Kozlowski* (42 F.3d 1444, 1450), the 4th Federal Circuit Court characterized it as "among the most impenetrable texts within human experience" and "dense reading of the most tortuous kind."

### Michigan

Public Act 321 of 1966 authorized Michigan Medicaid. Section 105 stipulated that: the Department of Social Services was to: "establish a program for medical assistance for the medically indigent under Title XIX".

Title XIX required that eligibility for Medicaid be established by the state agency responsible for welfare eligibility determination. It also required that each state designate a "single state agency" to be responsible to the federal government for the administration of the program. Some states designated the Public Health Department as the single state agency but many, including Michigan, placed responsibility for Medicaid in the state's social service agency. The Department of Community Health now administers it.

From a FY 1968 amount of $150.0 million (original appropriation of $131.5 plus a supplemental of $18.5), Michigan Medicaid appropriations have grown to $7.2 billion in FY 2003. This 4,725 percent increase over 35 years (average annual rate of 11.7 percent) is largely the result of 5 things: 1) increases in eligible persons; 2) increases in the types of services covered; 3) utilization rates of services; 4) gaining Medicaid coverage for what had been state-supported services (primarily mental health and substance abuse); and, 5) health care cost increases. Data are not available to determine just how much each of these contributed to the overall total but each has played a role. For example the number of Medicaid eligible persons grew by 476 percent from a first year total of 220,240 to 1,267,731 as of December 2002 and mental health and substance service costs under Medicaid increased from virtually nothing in FY 1968 to $1.4 billion in FY 2003.

Citizens Research Council of Michigan

www.crcmich.org

38777 Six Mile Road • Suite 208 • Livonia, Michigan • 48152-2660 • (734) 542-8001 • Fax (734) 542-8004 • E-Mail crcmich@crcmich.org

124 West Allegan • Suite 1502 • Lansing, Michigan • 48933-1738 • (517) 485-9444 • Fax (517) 485-0423 • E-Mail tclay@crcmich.org

**Table 1**
**Growth Rates of Selected Items 1968 - 2002/3**
(Dollar amounts in millions, CPI 1982-84 = 100.0)

| Item | 1968 | 2002* | Value Change | Percentage Increase | Annual Percentage Increase |
|---|---|---|---|---|---|
| Department of Corrections | $ 22.7 | $ 1,701.0 | $ 1,678.3 | 7393.4% | 13.1% |
| Medicaid | $ 150.0 | $ 7,237.8 | $ 7,087.8 | 4725.2% | 11.7% |
| State & Local K-12 Spending | $1,300.0 | $14,900.0 | $13,600.0 | 1046.2% | 7.2% |
| All Other General Fund | $ 773.0 | $ 5,019.3 | $ 4,246.3 | 549.3% | 5.5% |
| Medical Cost Component of CPI | 29.9 | 285.6 | 255.7 | 855.2% | 6.9% |
| Consumers Price Index (CPI) | 34.8 | 179.9 | 145.1 | 417.0% | 5.0% |
| Michigan Per Capita Income (2001) | $ 3,703 | $ 29,788 | $ 26,085 | 704.4% | 6.5% |
| Michigan Population | 8,730,000 | 10,050,000 | 1,320,000 | 15.1% | 0.4% |

* Medicaid, Corrections, K-12, and all other General Fund amounts are for FY 2003. Figures include federal and other funds as well as General Fund/General Purpose monies for both years. Medicaid amount includes all applicable departments of Michigan state government but does not include school based services or the "special finance generated" match (See page 3).

Sources: Michigan Office of the State Budget; U.S. Department of Labor; Bureau of Economic Analysis, U.S. Department of Commerce; Bureau of the Census, U.S. Department of Commerce.

## Michigan Medicaid Cost Components

Five components combine to determine the state cost of Medicaid in any given year: 1) the number of persons eligible for the program; 2) the types of services provided; 3) the utilization of services; 4) the rates paid to providers; and, 5) the share paid by the Federal government.

**Eligibility.** The number of Medicaid eligible persons can be expected to increase as population increases unless a growing economy results in fewer residents with low income. It increases as the numbers of low-income persons increase and/or lose health insurance in economic downturns. It also grows as the terms of eligibility are broadened. Also, because of the heavy subsidization of long-term care by Medicaid, the number of eligibles grows as the population ages.

**Health Care Services.** Since the introduction of Medicaid, services have been expanded. Much of this has occurred as states sought Federal matching funds for previously uncovered state supported services such as mental health, and as law and policy changes broadened the range of required services such as early periodic screening, diagnosis and treatment (EPSDT) for babies and youngsters.

**Utilization.** The number of times health services are provided on average varies. Many cite the introduction of managed care with its emphasis on reducing utilization of services as the reason Medicaid expenditures grew at reduced rates in the 1990s. Additionally, the growth in pharmacy costs in recent years is attributable to an increase in their use as well as higher drug costs.

**Provider Reimbursement.** States are relatively free to determine the amount paid to health care providers. An original requirement that hospitals be reimbursed their costs fell in 1981 and the "Boren Amendment," which had the effect of tying long-term care facilities payments to inflation, was repealed in 1997. Federal law and regulation generally require that payments be reasonable but reasonability standards are usually not detailed. In Michigan, as elsewhere, virtually every health care provider group states that Medicaid payments are the lowest of any governmental program or insurance plan and many say that payments are less than cost. (See CRC Memorandum 1069, *Michigan Hospitals and State Administered Federal Health Insurance Programs: Payments and Participation*, November 2002 for hospital data.)

A major shift away from fee-for-service payment to individual providers occurred in the 1990s with the transfer of sizable Medicaid populations to managed care organizations (MCO). Competitively bid contracts under which MCOs provide comprehensive services at a per capita rate to a given population have largely replaced ambulatory fee-for-service care.

**Federal Match.** The amount of money that the federal government pays as its share of Medicaid has always varied substantially from state to state in an attempt to recognize their various spending capacities. For FY 2003, the Federal Medical Assistance Percentage (FMAP) rate ranges from a high of 76.62 percent in Mississippi to the minimum 50 percent in 12 states. Michigan's rate for 2003 is 55.42 percent.

Special federal rates apply to: the licensing and certification of health facilities (75 percent); fraud investigation by the Office of Attorney General (75 percent); and, certain information technology projects (90 percent) among others.

Michigan was early and aggressive in seeking ways to maximize federal funds. It was instrumental in getting the 90 percent match for information technology projects and has been creative in determining ways to improve federal funding. By using a mechanism available through what are known as disproportionate share hospital payments (DSH), Michigan has benefited from over $14 billion in what is commonly called a "special finance generated match." Recent federal action will result in the loss of these funds in the next few years. Between FY 2004 and FY 2006, $430 million will no longer be available. The loss in FY 2004 alone is $175 million.

In 2002, the state enacted quality assurance programs for hospitals, managed care organizations and long-term care facilities. These use funds paid to the state by these providers to gain additional federal matching money.

## Michigan Medicaid Today

The following is a brief description of key Medicaid components as the program operates in FY 2002-3. More detailed information and data will be coming from CRC in the near future.

**Eligible Persons.** Persons eligible for Medicaid fall into 2 groups: mandated and optional.

*Mandated group* persons include: low income families receiving Family Independence Program (FIP) and Low Income Family (LIF) support; Supplemental Security Income (SSI) recipients; infants born to Medicaid eligible women; children under age 6 and pregnant women whose family income is at or below 133 percent of the federal poverty level ($19,977 for a family of three in 2002); recipients of adoption and foster care under Title IV-E of the SSA; and certain others.

*Optionally eligible group* falls into 2 classifications. One is those who have characteristics of the "categorically needy" but whose income and/or assets exceed the limits. The second is that of "medical indigence," persons with too much income to qualify under the mandatory or optional "categorical needy" groups. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income. The majority of these are people aged 65 or older residing in long-term care facilities.

As of December 2002, there were 1,267,731 individuals enrolled in the Medicaid program. This compares with 1,004,000 who were without health insurance coverage of any kind for the entire calendar year 2000 (latest available information). With a population of 10 million, some 20 percent of Michigan residents are either without any health coverage or are enrolled in Medicaid.

Sixty percent of Medicaid beneficiaries are aged 0 through 19 while those 65 and older represent 9 percent of the Medicaid population.

**Medicaid Providers.** In addition to the 19 managed care organizations that contract with the Department of Community Health, thousands of health care providers participate in Michigan Medicaid. Among them are:

26,000 Physicians
3,200 Dentists
2,300 Pharmacies
2,100 Medical Supply Stores
1,100 Chiropractors
850 Optometrists
545 Long-term Care Facilities
316 Ambulance Agencies
260 Hospitals
284 Home Health Agencies
227 Hearing Aid Dealers

**Medicaid Services.** Federal law requires that certain services be provided to mandated eligibility groups. It also provides that if states elect to cover optional eligible persons that certain services are mandated for them. Additionally, there are optional services for mandated individuals and optional services for optionally eligible persons. Among the services required for both

Citizens Research Council of Michigan
38777 Six Mile Road, Suite 208
Livonia, Michigan 48152-2660



mandated and optional groups are inpatient and outpatient hospital, laboratory and x-ray, physician, and long-term care.

*Medicaid Reimbursement* Until the mid-90s the vast majority of Medicaid payments were made to providers on a fee-for-service basis. That is, the provider sent an invoice for services provided and they were paid according to reimbursement policies set by the state. Michigan began a concerted effort to serve Medicaid eligible persons through managed care organizations in the mid-1980s. Today, over 66 percent of Medicaid eligibles are enrolled in a managed care organization. Payments to MCOs are budgeted at $1.476.8 million in FY2003.

*Federal Cost Sharing* is now determined by a formula that considers each states economic condition as measured by its per capita income relationship to the U.S. average over a rolling 3-year period. The 2003 rate is based on 1998-2000 data. While over time this assists states whose per capita income is in relative decline, it can have the reverse effect in the short term. Michigan's rate was reduced from 56.36 in 2002 to 55.42 in 2003. This translated to a $64.5 million loss in federal funds. The rate is expected to rise to 55.89 in 2004 and 56.55 in 2005.

## Summary

Medicaid is an important program to over 1 million Michigan residents and is a significant source of income to thousands of medical care providers, but its cost is rising faster than general inflation as state revenues are shrinking. In fiscal year 2003, total appropriations for Medicaid health care payments are $7.2 billion of which $2.1 billion is supported by state tax dollars. It should be noted that non-tax monies are also used to gain federal matching funds so that the general fund/general purpose portion is less than 30 percent for FY 2003.

If Medicaid were to take its proportionate share of the general fund $1.7 billion shortfall in FY 2004, it would need to be trimmed by some $400 million in state funds. This would result in the loss of $497.3 million in federal funds at the 55.42 percent match for a total reduction of $897.3 million. While it may be possible to lessen the cost of the program through approaches other than reducing provider reimbursement, or reducing benefits and/or eligibility, this is not likely in the near term because: the amount of reduction to be considered is so large; it is difficult to fully analyze the effects of non-reimbursement changes; there are significant legal and regulatory restraints inherent in the program; and some options that are legal would likely be viewed as unacceptable public policy.

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