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CRC Memorandum

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

Medicaid Health Care Services

Federal Law and Regulation

Title XIX of the Social Security Act establishes Medicaid. It defines both those eligible to receive health care services through governmental funding and the services that must or may be provided to them. Medicaid is administered by states and although states are not required to participate in the program, all do.

When Medicaid was passed there were four categories of persons eligible for what was commonly called "welfare." These were Aid to Families with Dependent Children (AFDC), Aid to the Disabled (AD), Aid to the Blind (AB) and Aid for the Aged (AA). The "categorically needy" were the primary focus of Medicaid and states that chose to have a Medicaid program were required to include them as "mandated eligibles." Since Medicaid was enacted in 1965, the nature of the categorical eligibility has changed somewhat, most particularly as the welfare reform program known as Temporary Assistance to Needy Families (TANF) replaced AFDC. Medicaid continues to define these populations as categorically needy in law and regulation.

The second group of eligible persons are the "optionally eligible." Examples of optional groups are: families with income above federal minimums; nursing home residents with incomes above the amount that would make them eligible for Supplemental Security Income (SSI); and, families, disabled or elderly persons with high medical expenses. The primary group of low-income individuals not eligible for Medicaid is childless adults who are not disabled or pregnant.

Some services are mandated to be provided to mandated eligibles and others may be provided (optional services) to mandated eligibles. Similarly if states elect to include the medically needy, Title XIX mandates that certain services be available and permits coverage of optional services (See matrix on page 3). Every state has acted to include both the categorically needy and the optionally eligible in their programs although federal Medicaid law requires only that mandated services be available to mandated individuals. If a state chooses to provide an optional service to its mandatory eligible population, however, it must also provide that service to its optionally eligible individuals. About two-thirds of all Medicaid spending supports optional services for mandated eligibles or services to optionally eligible persons. (A later web publication will address eligibility.)

Section 1915 of Title XIX contains language that permits the Secretary of Health and Human services to waive compliance with many provisions.[1] Section 1115 of the Social Security Act also permits the Secretary to waive compliance for demonstration projects.[2]

The legal document governing the relationship between any state and the federal government is called the "State Plan." Each state must designate a "single state agency" to be responsible for Medicaid. It negotiates the state plan with the Centers for Medicare and Medicaid Services in the Department of Health and Human Services. In Michigan, the Department of Community Health is the single state agency although others have involvement in the program. For example, the Attorney General has fraud investigation responsibilities and the Department of Consumer and Industry Services licenses and certifies health care facilities. But it is Community Health that is responsible to the federal government for all aspects of the program. Federal funds are technically called federal financial participation (FFP) and, if the terms of the state plan are not met, FFP is withheld.

[1] Social Security Act Title XIX, Section 1915, 42 U.S.C. Sec 1396n (http://www.ssa.gov/OP_Home/ssact/title19/1915.htm).

[2] Social Security Act Section 1115, 42 U.S.C. Sec 1315 (http://envirotext.eh.doe.gov/data/uscode/42/1315.shtml).

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Particulars

While the law requires that inpatient and outpatient hospital care be covered for both mandated and optionally eligible persons, regulations found in the Code of Federal Regulations (CFR) define these services and the terms under which care is to be provided.[3]

For example, regulations have specific provisions dealing with the amount, duration and scope of services stating:[4]

1. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. This provision resulted from experience early in the history of Medicaid when a small number of physicians billed Medicaid for 20 or more visits per hour – an average of 3 minutes per person. The amount, duration and scope regulation provided the legal basis to refuse payment for these billings.

2. The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service provided in a non-mental health inpatient or outpatient hospital facility or by a rural health clinic solely because of the diagnosis, type of illness, or condition. This provision prohibits Medicaid from denying payment to a hospital solely on the basis of a diagnosis.

3. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. This permits states to deny payment for unnecessary services.

The CFR covers those services for which Medicaid law itself places specific requirements and/or limits as well as for services where the law provides authority to the Secretary of Health and Human Services to prescribe regulations relating to services. These are quite extensive and cover such things as organ transplants, home health, optometric, nurse-midwife, and mental health institutional care. Regulations also address a host of administrative matters related to medical services. (See: www.access.gpo.gov/nara/cfr/cfrhtml_00/Title_42/42cfr441_00.html)

[3] The Code of Federal Regulations (CFR) Title 42 details the definition of services available (Part 440) and the requirements and limits applicable to specific services (Part 441). CFR 440.10 and 440.20 of the Code of Federal regulations defines Medicaid services in detail. Service definitions for the various health care providers are found in sections 440.10-440.185. Mandated (required) services for both mandated and optional eligibles are defined in sections 440.210-20 and optional services are defined in section 440.225. (www.access.gpo.gov/nara/cfr/cfrhtml_00/Title_42/42cfrv3_00.html)

[4] Sections 440.230-270 deal with the sufficiency of amount, duration and scope or services, comparability of services between mandated and optional eligibles, methods and standards to assure quality, limited services available to certain aliens, and religious objections.

National Medicaid Services/Costs[5]

Medicaid Services

As noted in CRC Memorandum 1071 (www.crcmich.org/PUBLICAT/2000s/2003/memo1071.pdf), there are two classifications of Medicaid services and two groups of Medicaid eligible persons resulting in four combinations: 1) mandated services for mandated eligible persons; 2) optional services for mandated eligible persons; 3) mandated services for optionally eligible persons; and, 4) optional services for optionally eligible persons.

Eligibles \ Services	Mandated	Optional
Mandated	States must provide mandated services to mandated eligible persons	States may provide optional services to mandated eligible persons
Optional	States must provide mandated services if they choose to include optionally eligible persons	States may provide optional services to persons it chooses to include as optionally eligible

Mandated Services include:

- Inpatient hospital services, other than services in an institution for mental diseases
- Outpatient hospital services and rural health clinic services
- Other laboratory and X-ray services
- Nursing facility services for individuals 21 or older (other than in an institution for mental disease)
- Early periodic screening diagnosis and treatment (EPSDT) for persons under age 21
- Family planning services and supplies
- Physician's services and medical and surgical services of a dentist
- Home health services for individuals entitled to nursing facility care
- Nurse-midwife services within the scope of practice permitted by state law
- Nurse Practitioner services within the scope of practice permitted by state law
- Pregnancy-related services and services for other conditions that might complicate the pregnancy
- For women who received Medicaid pregnancy related services under the plan prior to the last day of pregnancy, all pregnancy related services from the last day of pregnancy through the end of the month in which the 60-day period following termination of pregnancy ends.

Optional Services include:

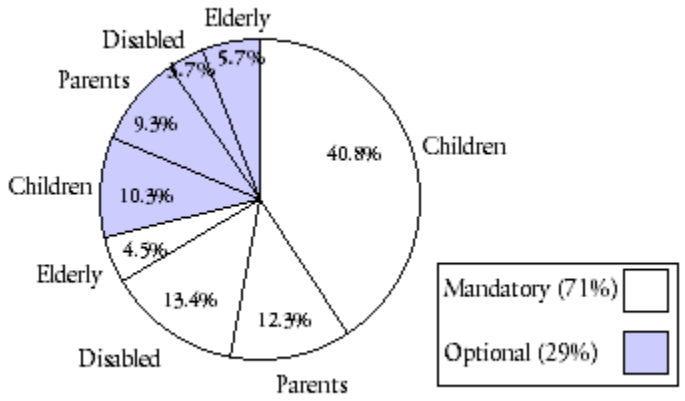
- Prescribed Drugs
- Medical care or remedial care furnished by practitioners under state law
- Diagnostic, screening, preventive and rehabilitative services
- Clinic services
- Dental services and dentures
- Physical therapy and related services
- Prosthetic devices
- Eyeglasses
- TB-related services
- Primary care case management services
- Other specified medical and remedial care
- Intermediate care facility services for individuals with developmental disabilities
- Inpatient and nursing facility services for persons 65 or older in an institution for mental disease
- Inpatient psychiatric hospital services for persons under age 21
- Home health care services for persons not entitled to nursing facility care
- Case management services
- Respiratory care services for ventilator dependent persons
- Personal care services
- Private duty nursing services
- Hospice care
- Services furnished by a PACE (Program of All-Inclusive Care for the Elderly) program
- Home and community-based services under a budget neutrality waiver

[5] National information for fiscal year 1998 can be found in "Medicaid Mandatory and Optional Eligibility and Benefits" published by the Kaiser Foundation (www.kff.org/content/2001/2256/2256.pdf) in July 2001. Data and charts used in this section are taken from that publication. While dollar amounts have increased since 1998, the percentage relationships should have remained essentially the same (with the exception of pharmacy which has increased disproportionately) because federal law has not changed significantly and states have just begun to make changes in their Medicaid programs to reduce costs.

National Spending by Eligibility Type

According to analysis done by the Urban Institute included in the Kaiser report, 71 percent of all Medicaid eligibles were categorically eligible (mandated) and 29 percent were eligible as medically needy (optional) in 1998 (See **Chart 1**).

Chart 1
Mandatory and Optional Medicaid Eligibility Groups, 1998

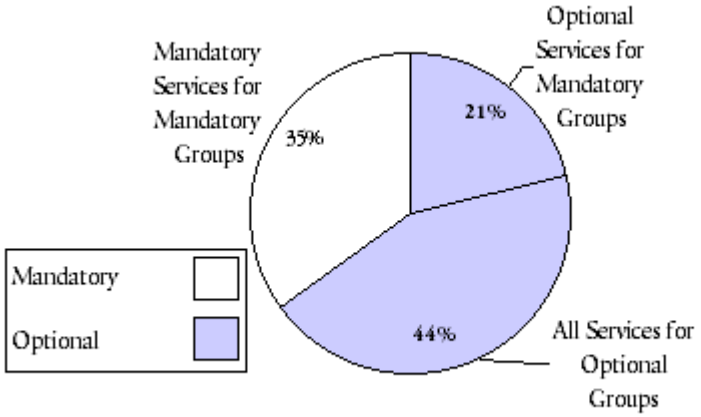


Source: Urban Institute estimate, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Expenditures, however, were almost the reverse. It is not generally understood that two-thirds of national Medicaid expenditures are either for optionally eligible persons or for optional services (**Chart 2**). Of $154 billion in national Medicaid expenditures for 1998, costs of mandated services for mandated eligible individuals accounted for 35 percent while all services to optionally eligible persons and for optional services were 65 percent.

Similar analysis has not been done specifically for the state of Michigan since data is not routinely reported on the basis of optional eligibility and optional service. (A later publication will address this area.) It is likely, however, that the percent of optional costs in Michigan are slightly lower than the national figure of 65 percent because some of the larger states have higher income limits for medically needy than does Michigan.

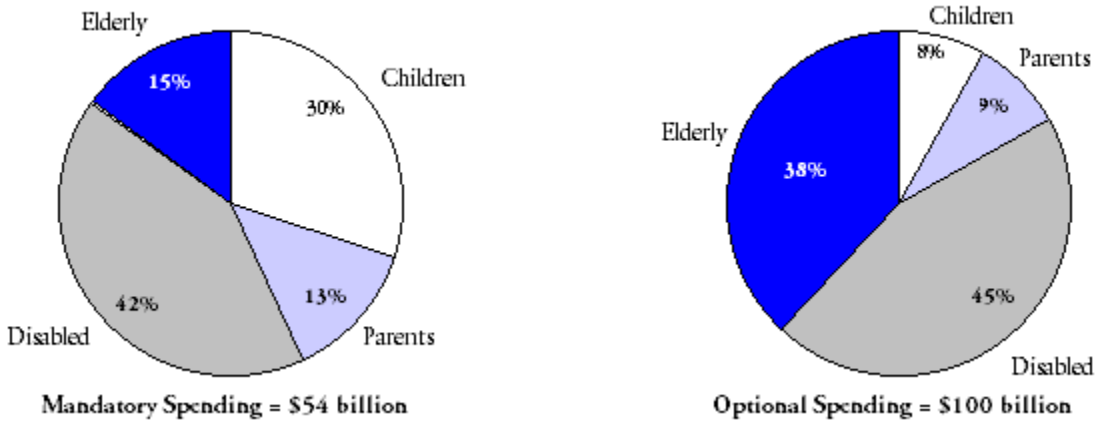
Chart 2
Medicaid Expenditures by Eligibility Groups and Type of Service, 1998



Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
Source: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

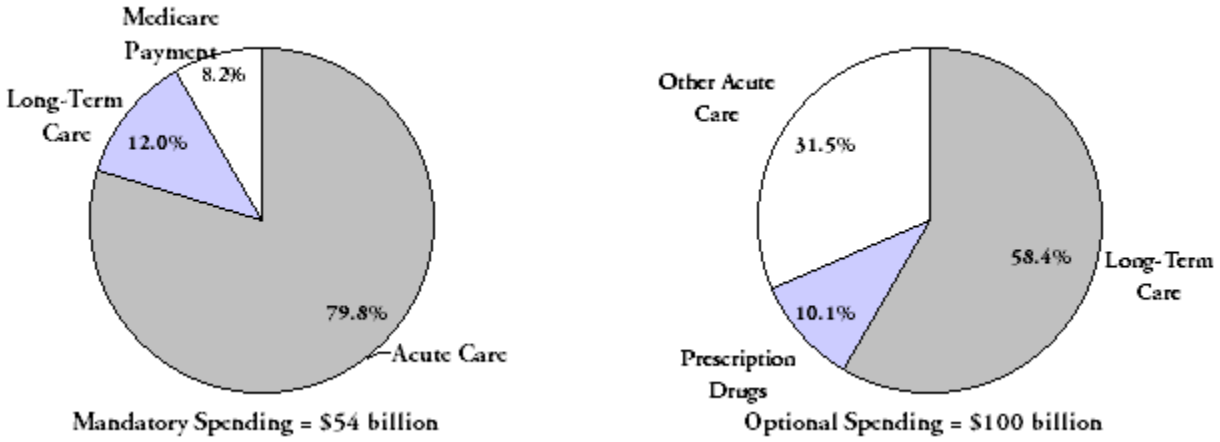
Chart 3 and **Chart 4** show how this division in allocated by eligibility group and type of service.

Chart 3
Medicaid Spending by Eligibility Group, 1998



Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
Source: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Chart 4
Medicaid Spending by Eligibility Service, 1998



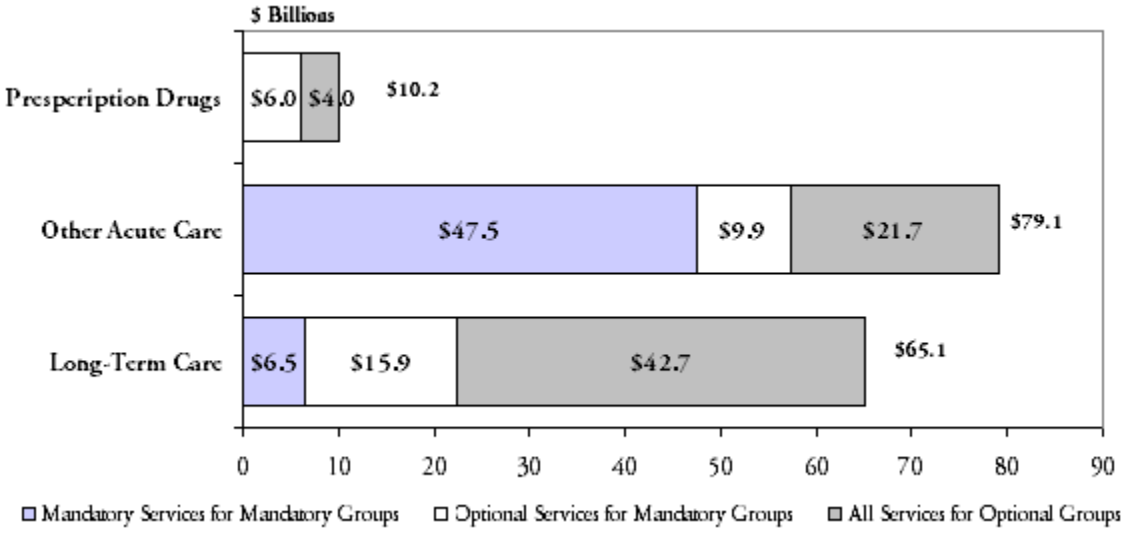
Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
Source: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

National Spending by Service

Chart 4 and **Chart 5** show that the majority of funds used for mandatory services given to mandatory eligible individuals go for hospital and physician care (included in Other Acute Care) while the greatest portion of expenditure for optional service is for long-term care. All pharmacy services are optional.

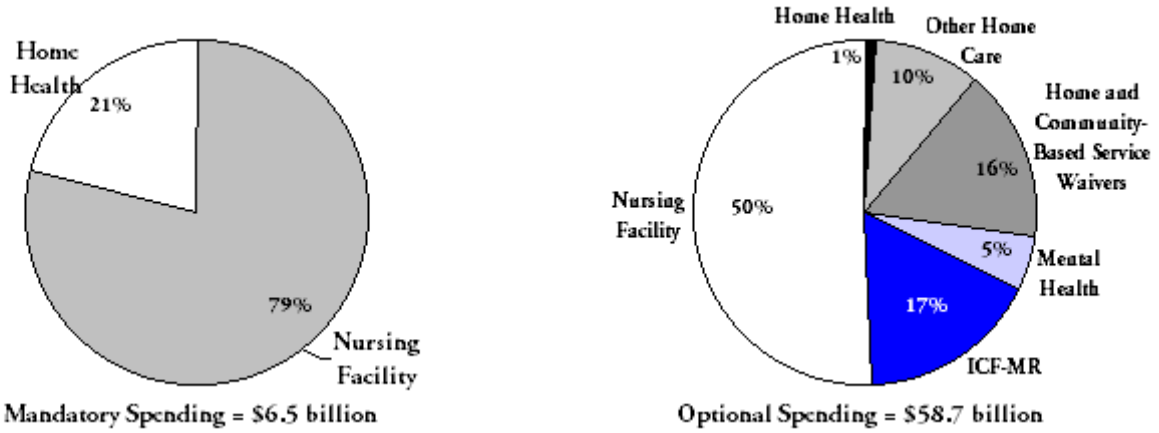
National spending of $100.5 billion for optional services can be summarized as: prescription drugs $10.2; other acute care $31.6; and, long-term care $58.7.

Chart 5
Mandatory and Optional Medicaid Spending by Service



Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
Source: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Chart 6
Long-Term Care Medicaid Spending by Service, 1998



Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.
Source: Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

Michigan Medicaid Services/Costs

Medicaid Payments by Type for Fiscal Year 2002

The Michigan Medicaid program currently includes all the services permitted under federal law and regulation. Additionally, Michigan provides certain services under the terms of waivers granted by the Secretary of Health and Human services. These include: mental health and substance abuse services to persons with developmental disabilities; managed care services; and home and community based care for children, the aged and the disabled (http://cms.hhs.gov/medicaid/waivers/miwaiver.asp). **Table 1** details expenditures in FY 2002 by service provider or benefit type. Explanation of some payment items follows the table.

Table 1
Michigan Medicaid Payments for Services and Benefits
Fiscal Year 2002

	Payments in Fiscal Year 2002
Hospital Services & Therapy	
Hospital Inpatient	$ 549,987,466
Hospital Outpatient	94,795,203
Private Mental Hospital - Outpatient	152,522
Private Mental Hospital - Inpatient	76,683
Hospital Inpatient Psychiatric Unit	21,347
Hospital Outpatient Psychiatric Unit	1,571
Returned Warrants	(70,486)
Undifferentiated Expenditures	(818,351)
Total	**$ 644,145,955**
% of Total Payments	**8.5%**
Physician Services	
Physician - M.D.	$ 126,302,146
Physician - D.O.	31,518,135
Podiatrist/Chiropodist	737,397
Family Planning Clinic	369,202
Medical Clinic	31,189,514
Returned Warrants	(167,762)
Undifferentiated Expenditures	(2,381,210)
Total	**$ 187,567,423**
% of Total Payments	**2.5%**
Home Health Services	
Home Health Agency/Hospice	$ 28,692,819
Returned Warrants	(66,730)
Undifferentiated Expenditures	(2,048,692)
Total	**$ 26,577,397**
% of Total Payments	**0.3%**
Pharmaceutical Services	
Independent Clinical Laboratory	$ 3,340,822
Pharmacy	159,450
Pharmacy (First Health - PBM)	647,494,386
Pharmacy (First Health - Psychotropics)	6,817,482
Orthotist & Prosthesis	1,329,719
Medical Supplier/Durable Medical Equipment	42,540,089
Oxygen Supplier	0
Returned Warrants	(8,827)
Undifferentiated Expenditures	(149,498,233)
Total	**$ 552,174,889**
% of Total Payments	**7.3%**

Table 1 (continued)

Health Plan Services		
Health Plans	$	1,441,419,348
Returned Warrants		(348,207)
Undifferentiated Expenditures		17,677,768
Total	**$**	**1,458,748,909**
% of Total Payments		**19.2%**
Transportation	**$**	**8,166,910**
% of Total Payments		**0.1%**
Auxiliary Medical Services		
Dentist - D.D.S.	$	55,272,404
Chiropractor		418,543
Ambulance		8,086,553
Dental Clinic		24,359,419
Hearing & Speech Center		473,084
Optical Company		396,763
Shoe Store		99
Hearing Aid Dealer		3,635,619
Optometrist		2,240,007
Optical House (Vision Contractor)		1,188,780
Returned Warrants		(97,342)
Undifferentiated Expenditures		(3,591,613)
Total	**$**	**92,382,315**
% of Total Payments		**1.2%**
Medicare Premium Payments		
Medicaid Eligible (Part A)	$	51,711,903
Medically Needy (Part B)		11,394
Categorical & Qualified Medicare Beneficiary (Part B)		96,445,587
AIDS Insurance Buy-In		478,223
Qualified Individuals 120-130% Federal Poverty Level		3,304,262
Qualified Individuals 135-175% Federal Poverty Level		105,984
Total	**$**	**152,057,353**
% of Total Payments		**2.0%**
Ambulance Services	**$**	**7,996,557**
% of Total Payments		**0.1%**
MiChild Program	**$**	**30,174,869**
% of Total Payments		**0.4%**
Hospital Disproportionate Share Payments	**$**	**45,000,000**
% of Total Payments		**0.6%**
Long Term Care Services		
Nursing Facility	$	848,322,918
County Medical Care Facility- Inpatient		173,432,113
Hospital Long Term Care Unit		64,597,509
Pediatric Nursing Facility		16,791,885
County Medical Care Facility- Outpatient		1,902
Returned Warrants		(230,529)
Undifferentiated Expenditures		135,263,798
Total	**$**	**1,238,179,595**
% of Total Payments		**16.3%**
Maternal & Child Health	**$**	**12,105,282**
% of Total Payments		**0.2%**

Table 1 (continued)

School Based Services - Federal Match	**$**	**73,227,978**
% of Total Payments		**1.0%**
State and Local Medical Programs	**$**	**100,716,314**
% of Total Payments		**1.3%**
Elder Prescription Insurance Coverage (EPIC)	**$**	**21,909,836**
% of Total Payments		**0.3%**
Adult Home Help Services	**$**	**172,626,963**
% of Total Payments		**2.3%**
Social Services to Physically Disabled	**$**	**1,295,987**
% of Total Payments		**0.0%**
Personal Care Services	**$**	**26,787,012**
% of Total Payments		**0.4%**
Wayne County Medical Program	**$**	**44,012,800**
% of Total Payments		**0.6%**
Special Adjustor Payments	**$**	**1,302,953,886**
% of Total Payments		**17.1%**
Cuban/Indo-China Repatriation	**$**	**1,101,370**
% of Total Payments		**0.0%**
Public Health	**$**	**137,659,508**
% of Total Payments		**1.8%**
Mental Health		
Community Mental Health Board	$	1,247,001,843
Alternative to Institutional Services Homes (AIS)		4,619
Children's Waiver		16,247,372
Nursing Facility (Developmental Disability)		178,189
Nursing Facility (Mental Illness)		1,670,991
Total	**$**	**1,265,103,013**
% of Total Payments		**16.6%**
TOTAL PAYMENTS	**$**	**7,602,672,120**
TOTAL PERCENT		100.0%

Source: Michigan Department of Community Services

* The net School Based Services Expenditures reflects the amount of Federal Dollars paid to the Schools.
** In FY'02, a separate appropriation, 33600, has been set up for PT 18, Ambulance. In MMIS, we are continuing to pay PT 18 expenditures from the 33580 Auxiliary Medical Services appropriation and are JV'ing the costs to the 33600 appropriation. MMIS and First Health Payrolls are not always posted to MAIN in the proper calendar month. Reconciliations to MAIN totals may be required.

Payments categories include some that are not typically considered as provider payments. These include: transportation; Medicare premium payments; hospital disproportionate share payments; school based services; state and local medical programs; Wayne County medical program; Cuban Indo-China repatriation; public health; mental health; and, special adjuster payments.

Health Plan Services expenditures include both expenditures for services provided through the health plans themselves and payments by the plans to other providers.

Transportation payments are not formally a benefit category but states are required to ensure necessary transportation to and from providers.

Medicare premium, co-cap and deductible payments are made by Medicaid for Medicare eligible persons. This is done so that Medicare pays for services that would otherwise be charged to Medicaid.

Hospital disproportionate share payments are made under terms of a 1981 amendment to federal law requiring that hospitals that serve a disproportionate share of Medicaid and uninsured individuals receive added compensation from Medicaid.

School based service payments represent the federal match for medical services provided by schools to Medicaid eligible students.

State and local medical programs provide services to persons who qualify for the State Medical Program and for county-based indigent health care. The State Medical Program is designed for very low-income individuals who do not meet Medicaid requirements typically because they are single adults under age 65.

Wayne County medical program payments are made to support outpatient services to the indigent enrolled in the Wayne County PlusCare program.

Cuban Indo-China repatriation is a special program for persons from Cuba and Indo-China defined by federal law.

Public health payments support maternal and child health program operated by or through local health departments.

Mental health payments include funds for community mental health boards, and nursing facility services related to developmental disabilities and mental illness.

Special adjustor payments are made to publicly owned hospitals and long-term care facilities and result in the state receiving additional Medicaid federal matching money. Recently enacted federal law results in the loss of this income over the next few years.[6]

[6] For more information on special adjustor payments see "Michigan Special Financing Payments and Intergovernmental Transfers" House Fiscal Agency, November 2000. (www.house.state.mi.us/hfa/PDFs/medicaid.pdf)

Policies Impacting Medicaid Benefits in Michigan

There are policies affecting the way certain Medicaid services in Michigan are provided. These include prior authorization; use of a prescription drug formulary; and, mandatory enrollment in a managed care organization. Each of these addresses a combination of service and cost considerations. By requiring the prior authorization of certain services, the state works to both limit the cost of unnecessary services and to see that they are provided in a manner that gives the best opportunity for a successful outcome. The drug formulary, among other things, limits the use of brand-name prescriptions for which a generic equivalent exists. The requirement that many Medicaid eligible persons receive their care through a managed care organization seeks to both limit costs and provide coordinated health care.

Other policies are directed at the recipients of services. With the exception of children and pregnant women, federal law and regulation permit the imposition of a deductible of up to $2.00 per family per month and states may also impose co-payments in varying amounts. These include up to 50 percent of the cost of the first day in a hospital and between $0.50 -$3.00 (or up to 5 percent) per visit to certain practitioners; and, $0.50 -$3.00 (or up to 5 percent) per prescription. At present, Michigan has the following co-payment provisions: pharmacy $1.00; vision, podiatry, and chiropractic $2.00; hearing aid and dental $3.00. Managed care organizations may impose co-payments up to these amounts if they choose.

Summary

Michigan Medicaid provides an extensive range of health and medical services to eligible individuals and makes payments totaling over $7 billion per year to thousands of medical providers. Services provided include long-term care that is covered, but in a limited way, by Medicare and prescription drugs which are not a Medicare benefit. Medicaid also pays for a broad range of services for children and pregnant women including prenatal care and early screening, diagnosis and treatment for youngsters. As states, including Michigan, prepare to reduce the cost of Medicaid it is likely that some reduction in optional services will be considered. Among those most often mentioned are dental, vision, podiatric, and chiropractic services. The state could also increase co-payments or impose a deductible for Medicaid eligible persons 21 and older.

As policy makers review changes in current services, the following questions might be considered:

- Is the service widely used by a great number of individuals or is it little used or used by a few?
- Is the service preventive in nature so that it results in lowering future costs?
- Is the service critical or can it be postponed without increasing Medicaid costs at a later time?
- Is the imposition or increase of a deductible or co-payment preferable to elimination or curtailment of the service?
- Will the imposition or increase of a deductible or co-payment result in individuals not receiving a needed service?
- Is there a more effective or efficient way to deliver the service?
- If the service is dropped, will doing without it result in greater expense when another provider gives a higher cost service made necessary by not having access to the dropped service?

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2002 CRC Publications

- *Michigan Hospitals and State Administered Federal Health Insurance Programs: Payments and Participation*, CRC Memo 1069, (November 2002) 16 pages
- *Michigan Budget Outlook*, Presentation 02-02, (November 2002) 27 slides
- *State Constitutional Issues on the November General Election Ballot - II Proposal 02-03: Collective Bargaining and Binding Arbitration for State Employees*, CRC Memo 1068, (September 2002) 8 pages
- *Proposal K: An Arts and Culture Tax for Oakland and Wayne Counties*, CRC Memo 1067, (September 2002) 4 pages
- *State Constitutional Issues on the November General Election Ballot - I Proposal 02-04: Reallocate the Tobacco Settlement Revenue Received by the State from Cigarette Manufacturers*, CRC Memo 1066, (September 2002) 8 pages
- *State Ballot Issues on the November General Election Ballot Proposal 02-01: Straight-Ticket Voting; Proposal 02-02: Great Lakes Water Quality Bond Authorization Act*, CRC Memo 1065, (September 2002) 8 pages
- *The State Constitution: Its Nature and Purpose*, Misc. (September 2002) 3 pages
- *The SMART Millage Vote*, CRC Memo 1064, (July 2002) 4 pages
- *Election of Detroit City Council Members*, CRC Memo 1063, (July 2002) 4 pages
- *State Ballot Issues on the August Primary Ballot*, CRC Memo 1062, (June 2002) 8 pages
- *Health Insurance Coverage and Uninsured/Uncompensated Care in Michigan Hospitals*, CRC Memo 1061, (June 2002) 12 pages
- *Michigan Hospital Finances*, CRC Memo 1060, (June 2002) 12 pages
- *Michigan's Budget Problem*, Presentation 02-1, (May 2002) 39 slides
- *The Prospects for a Long-Term Solution to Michigan's General Fund Structural Deficit*, State Budget Notes 2002-04 (April 2002) 6 pages
- *Proposed New Federal Medicaid Funds for Michigan*, CRC Note 2002-01 (April 2002) 2 pages
- *Prospects for School Aid in the Economic Recovery*, State Budget Notes 2002-03 (March 2002) 4 pages
- *The FY2003 Executive Budget: Short-Term Balance, Long-Term Gaps*, State Budget Notes 2002-02 (February 2002) 2 pages
- *The Problem Facing the New Budget*, State Budget Notes 2002-01 (January 2002) 3 pages