Michigan League FOR Human Services

May 2010

Déjà Vu:
Michigan Struggles to Fund Medicaid Program

Six years ago: *On February 12, 2004, Governor Granholm released her FY2005 Executive Budget. In it, she protected the most vulnerable citizens on Medicaid by recommending few reductions and by recommending revenue increases to finance necessary program expenditure increases and to replace lost federal revenue. If the Legislature does not approve the recommended revenue increases, or find alternative revenue sources, services or eligibility of some Medicaid recipients could be in jeopardy. It has been reported that as many as 200,000 recipients could lose Medicaid eligibility. (MLHS report on optional services and populations dated February 2004.)*

Fast forward to February 11, 2010, to find the same situation shaping up. In her FY2011 Executive Budget, the governor again recommended state revenue increases (a physician provider tax) to replace lost federal revenue and provide ongoing funding to maintain the Medicaid program without cuts to eligibility. Prior rate and service reductions were not restored. The Senate rejected the proposed revenue increase, instead recommending elimination of optional eligibility groups and further rate and service cuts. The Senate did restore some optional services that were previously eliminated (dental, vision and podiatric). The Senate completed its work on the Department of Community Health budget on March 24, 2010.

In the meantime, as part of the federal health care reform, the Patient Protection and Affordable Care Act (Public Law 111-148) was signed into law on March 23, 2010, and requires states to maintain their Medicaid and SCHIP eligibility standards in place on that date. If a state violates this requirement, it will forgo its federal Medicaid matching funds. The Michigan House will have the benefit of knowing the contents of the newly signed law as it deliberates the FY2011 Department of Community Health budget.

Did You Know:

- Medicaid currently provides coverage to more than 1.8 million residents.
- The FY2009 monthly average caseload increased 60 percent over FY2000.
- In 2009, 38 percent of Michigan's children were covered by Medicaid.
- Michigan's Medicaid spending per beneficiary per month is the lowest in the Great Lakes region, with Michigan's spending ($411) nearly half of that of Minnesota ($818).
- Michigan's Medicaid spending per capita ranks in the bottom 1/3 of the states at 35th.

Program History

In 1965, the Federal government added Title XIX to the Social Security Act, which created a program to provide medical assistance to certain individuals and families with low incomes and limited resources. At its inception, Medicaid's focus was to cover federally subsidized cash benefit recipients (the former Aid to Families with Dependent Children and Supplemental Security Income programs). Over the last 25 years, the Medicaid program has evolved into *the* health care program for low-income individuals, as additional federally mandated groups have been added to the program.

1115 SOUTH PENNSYLVANIA AVENUE • SUITE 202 • LANSING, MICHIGAN 48912
517.487.5436/PHONE • 517.371.4546/FAX • WWW.MILHS.ORG
A UNITED WAY AGENCY

With increasing unemployment and fewer employers offering insurance, more and more families have turned to Medicaid for their health care coverage, demonstrated by the fact that 38 percent of Michigan's children qualified for Medicaid during FY2009. It is important to note that in spite of Michigan's extremely high unemployment rate and severely stressed economy, only one-fourth of the individuals eligible for Medicaid were also receiving cash assistance. The remaining three-fourths were eligible only for Medicaid benefits at the end of FY2009.

The following table reflects the monthly average number of persons eligible for Medicaid for fiscal years 2000 through 2009, based on receipt of cash assistance or eligibility for Medicaid only.

Monthly Average Number of Persons Eligible[1] for Medicaid by Eligibility Group
Fiscal Years 2000 – 2009

Fiscal Year	Cash[2] Assistance Recipients	Medicaid Only	Total Persons Eligible
2000	415,400	651,900	1,067,300
2001	402,100	714,800	1,116,900
2002	412,600	799,200	1,211,800
2003	414,400	878,800	1,293,200
2004	428,100	938,100	1,366,200
2005	431,400	998,700	1,430,100
2006	439,100	1,036,600	1,475,700
2007	462,400	1,078,000	1,540,400
2008	438,100	1,121,300	1,559,400
2009	422,800	1,242,900	1,665,700

[1]Eligible recipients are those who qualify for Medicaid; they may or may not have received a benefit.

[2]Includes recipients of Family Independence Program and Supplemental Security Income program benefits. These persons are automatically eligible for Medicaid.

Since the 1980s, the major federal focus has been to increase coverage for pregnant women and children. Under the provisions of the Medicaid program, states are *required* to provide coverage to certain populations/groups, and have the *option* to expand coverage to other groups. In addition to providing coverage to certain populations, in order to participate in the program and to receive federal funding, states *must* provide certain services, defined as mandatory services, and *may* provide additional services that are defined as optional services. The services classified as "optional" are certainly mandatory for good health outcomes. Unfortunately, there is no health link between federally defined Medicaid mandatory covered services and those defined as optional.

Eligibility

As indicated above, states are required to cover certain populations and have the option to expand and cover others. Following are the groups that must be covered under a state's Medicaid program:

- Persons who meet the former AFDC program requirements that were in effect as of July 16, 1996.
- Pregnant women and children under age 6 with incomes up to 133 percent of the federal poverty level.
- All children under age 19 in families with incomes below 100 percent of the federal poverty level.
- Supplemental Security Income (SSI) recipients.
- Children receiving foster care or adoption assistance under Title IV-E.
- Certain low-income Medicare beneficiaries.

In addition, states have the option to expand eligibility to other groups. In general, they fall under the basic groups identified above, but have more liberal eligibility standards. These "optional" groups include:

- Individuals who do not meet the specific financial criteria, but fit into one of the above categorical groups, and meet income and resource standards established by the state. These individuals are often referred to as "medically needy." The often targeted-for-elimination caretaker relatives and 19- and 20-year-olds are included in this category. In addition, for those individuals with income and resources in excess of the medically needy standards, there is a "spend-down" or "deductible" option that allows individuals to meet eligibility standards by incurring medical expenses that are greater

than their excess (in terms of the eligibility standards) income/resources.

- Pregnant women and infants with family incomes between 133 percent and 185 percent of the federal poverty level.
- Individuals residing in long-term care medical institutions or receiving long-term care services in community settings whose incomes are less than 300 percent of the SSI payment level.
- Individuals who do not receive a federal Supplement Security Income payment, but who receive a state-only cash supplement.
- Individuals who are working, but are disabled and do not qualify for the above Medicaid programs due to their incomes. If states choose to cover this group, they may also cover individuals who lose SSI eligibility due to medical improvement.

States can further expand eligibility through the use of demonstration projects and waivers. Michigan Medicaid currently covers more than 30 categories of families/individuals. Most eligible persons, however, fall into one of five or six major categories.

The following table specifies the basis of eligibility for those eligible for Medicaid only for the period FY2000 – FY2009.

Services

In addition to mandated coverage of certain low-income groups, the federal requirements also mandate coverage of specific services. The federally mandated services follow. In addition, a number of services can be provided at the state's option, thus, the term "optional" services. As can be readily seen, the list of optional services far exceeds the list of required services.

Mandated Services:

- Inpatient hospital services/outpatient hospital services
- Physicians' services
- Medical/surgical services of a dentist
- Laboratory and X-ray services
- Certified nurse practitioner services
- Nursing facility services
- Home health services for individuals over age 21
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21
- Rural health clinic and Federally Qualified Health Centers (FQHC) services
- Family planning services and supplies
- Nurse-midwife services
- Ambulance services
- Nonemergency medical transportation
- Physical and occupational therapy

Monthly Average Number of Persons Eligible for Medicaid Only[1] by Basis for Eligibility
Fiscal Years 2000 – 2009

Year	Aged	Blind	Disabled	Families with Dependent Children	Other Children Under Age 21	Pregnant Women and Children	Total Number of Persons Eligible	Percent Change from Prior Year
2000	61,026	259	60,029	216,739	39,448	274,384	**651,900**	9%
2001	62,364	237	63,069	232,328	42,177	314,661	**714,800**	10%
2002	64,251	453	69,742	273,070	45,263	346,449	**799,200**	12%
2003	65,739	732	77,051	308,220	48,296	378,719	**878,800**	10%
2004	65,602	939	82,296	338,046	50,652	400,536	**938,100**	7%
2005	67,021	1,116	90,339	360,671	53,493	428,654	**1,001,300**	7%
2006	68,922	1,268	97,695	356,133	54,063	463,001	**1,041,100**	4%
2007	69,623	1,145	104,168	343,043	55,318	511,393	**1,084,700**	4%
2008	70,371	1,159	110,083	370,594	56,240	512,891	**1,121,300**	3%
2009	72,197	1,293	117,494	420,388	61,514	569,972	**1,242,900**	11%

[1]Includes persons eligible for Medicaid only; no cash assistance is provided to these persons.

Optional Services:

- Prescribed drugs
- Dental services
- Clinic services
- Emergency hospital services
- Personal care services
- Hospice care services
- Respiratory care services
- Home-based long term care
- Podiatrists' services
- Optometrists' services
- Chiropractic services
- Psychologists' services
- Medical social worker services
- Nurse anesthetists' services
- Private duty nursing services
- Speech, hearing and language disorder services
- Dentures, prosthetic devices, eyeglasses
- Diagnostic services, screening services, preventive services
- Rehabilitative services
- Intermediate care facilities/mentally-retarded (ICF/MR)
- Nursing facility services for individuals under age 21
- Inpatient psychiatric services for individuals under age 21
- Case management services
- Inpatient and nursing facility services for individuals over age 65 in institutions for mental disease

The Michigan Medicaid program has historically covered nearly all optional services. By some standards, Medicaid is seen as a very "generous" program; however, the population it serves has generally poorer health status, and therefore, its recipients require this broad array of services. The fact that Michigan's program covers such a large range of services, however, does not ensure that they are readily available to those who are eligible. Finding a provider for some of the Medicaid-covered services is not always possible due to Medicaid's extremely low reimbursement rates and other program requirements/restrictions.

It is important to note that in FY2009, dental, vision, chiropractic, podiatric, and hearing aid services were eliminated for adults. These policies are continued in FY2010. The Senate-passed budget for FY2011 restores dental, podiatric, and some optical services. As of this writing, House action on the Department of Community Health FY2011 budget has not been completed. The House Appropriations Subcommittee did concur in restoring the optional services restored by the Senate.

Current Budget Situation

With Michigan's persistently high unemployment, the highest in the nation for the last 48 months as of March 2010, and most health care coverage (for those under age 65) tied to employment, thousands of Michiganians have lost their coverage over the last several years. At the same time that demand for public services is very high and growing, state revenues have plummeted. It is only with federal Recovery Act funds that Michigan has been able to maintain the Medicaid program in FY2010 and FY2011. Over the period included in the Recovery Act of 2009, October 1, 2008 – December 31, 2010, Michigan will have received more than $2.2 billion in enhanced federal Medicaid funds. If proposed federal legislation is signed into law, the enhanced federal funding will continue until June 30, 2011, at an estimated benefit of over $500 million.

Under the American Recovery and Reinvestment Act (ARRA) of 2009, states are prohibited from reducing Medicaid eligibility to a level below that in effect on July 1, 2008, if they wish to receive the additional federal funding available to states in that bill. In addition, the health reform legislation, signed into law on March 23, 2010, extends that prohibition until January 1, 2014 for adult Medicaid recipients and October 1, 2019 for children in Medicaid or MIChild.

Services and provider payment rates have both been cut in the last two years, and further cuts have been recommended by the Senate for FY2011. These reductions have greatly exacerbated already serious access issues for many Medicaid recipients,

making it more difficult and sometimes impossible to obtain the care they need in the appropriate setting. Medicaid recipients are sometimes forced to seek needed care in hospital emergency rooms when services are eliminated or providers are unwilling to see them due to the program's abysmal reimbursement rates (that could be slated for even further reductions in FY2011).

Forcing people to seek care in the highest cost setting makes little fiscal sense and is certainly not an efficient use of scarce state resources. With such a favorable federal matching rate—nearly 75 percent under ARRA in FY2010 and FY2011, then nearly 66 percent subsequently—it also makes little fiscal sense to turn away millions of federal dollars for a small state investment, which could pay for needed care and provide economic stimulus in communities. However, few policymakers to date have acknowledged the need for additional revenue to fund needed services, preferring instead to maintain a 'cuts only' agenda, while maintaining there are simply no revenue options available. If revenues are not available to fund critical public services it is because policymakers simply choose not to pursue them; there are many options.

What Lies Ahead

Even if policymakers find a way to balance the FY2011 budget, FY2012 will present an enormous challenge when hundreds of millions of federal dollars will be exhausted and no longer available to fund the Medicaid program, or other state priorities. The state will be precluded from reducing Medicaid eligibility categories and will need millions in state resources to offset the lost federal funds. Further reimbursement cuts, on top of those in effect during FY2010 and recommended for FY2011, will only serve to drive more providers out of the program, and in some instances, out of the community. This may leave only the hospital emergency room to serve as the safety net in some communities, and emergency care will be provided with or with out payment. *Medical care needs do not go away when services are eliminated or provider payment rates are reduced to the point of driving the providers out of the program. Rather the medical care needs tend to escalate to the point of requiring higher cost care.*

The business community is also hurt by these public policies when their health care premiums are increased as they shoulder a portion of the resulting cost shifting and uncompensated care. Some call this a hidden tax. A better outcome is possible.

A balanced approach is needed to solve this structural problem and stop the disinvestment in state services. The cuts-only approach, or reliance on one-time federal funding, cannot continue, as the resulting harm to Medicaid recipients and the financial damage to providers and other members of the business community are unsustainable. A tax structure that provides adequate funding for critical public services must be implemented. Without a healthy population, Michigan cannot thrive.

mar/MA MandatoryOptSvs.4-10