Michigan League for Human Services

February 23, 2004

Federally Defined "Optional" Medicaid Populations and Services are Mandatory for Positive Health Outcomes, but May be at Great Risk Due to the Current Budget Shortfalls

On February 12, 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.

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). During the last 20 years, the program has evolved into *the* health program for low-income individuals as additional federally mandated groups have been added to the program. By the end of FY2003, only one-third of the individuals eligible for Medicaid were also receiving cash assistance, the remaining two-thirds were eligible only for Medicaid benefits. Since the 1980's, 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. There is no health link between federally defined Medicaid mandatory covered services and those defined as optional.

Did You Know:

- Medicaid provides coverage to 1.4 million residents.
- The caseload, in FY2004, is projected to increase 29% since FY2000.
- Total funding for the program has increased by more than 40% since FY2000.
- Average Medicaid expenditure per eligible person increased 17% from FY2000 to FY2003. (Many private insurances have increased by more than 17% in each of last 4 years.)

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Eligibility

As indicated on the first page, states are required to cover certain populations and have the option to expand and cover others. The following groups must be covered under a state's Medicaid program:

In addition, states have the option to expand eligibility to other groups. In general, they fall under the basic mandatory groups, but have more liberal eligibility standards. These ''optional'' groups are identified below.

Mandatory

- 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, and
- certain low income Medicare beneficiaries.

Optional

- 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.'' In addition, for those individuals with income and resources in excess of the medically needy standards, there is a ''spend-down'' 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 income. 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 reflects the monthly average number of Medicaid eligibles for fiscal years 1994 through 2003 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 1994—2003

Fiscal Year	Cash[2] Assistance Recipients	Medicaid Only	Total Persons Elligible for Medicaid
1994	860,700	334,100	1,194,800
1995	802,700	376,200	1,178,900
1996	739,500	408,800	1,148,300
1997	658,200	460,700	1,118,900
1998	569,100	533,900	1,103,000
1999	468,000	600,200	1,068,200
2000	414,200	651,900	1,066,100
2001	402,700	714,900	1,117,600
2002	412,600	799,200	1,211,800
2003	414,400	878,800	1,293,200

[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.

The following table specifies the basis of eligibility for those eligible for Medicaid only for fiscal years 1994—2003.

Monthly Average Number of Persons Eligible for Medicaid Only[1] by Basis for Eligibility
Fiscal Years 1994—2003

Fiscal 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
1994	50,000	287	38,617	117,368	44,260	83,622	334,200	N/A
1995	52,882	280	43,294	125,396	39,680	114,623	376,200	13%
1996	55,158	265	47,110	127,849	39,375	138,999	408,800	9%
1997	56,665	265	52,634	145,469	40,566	165,102	460,700	13%
1998	57,573	279	55,021	195,974	41,246	183,812	533,900	16%
1999	59,429	264	56,763	212,501	38,889	232,329	600,200	12%
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%

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

Services

In addition to mandated coverage of certain low income groups, the federal requirements also mandate coverage of specific services. The federally mandated services, a total of 10, under the Medicaid program 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 mandatory services.

Mandated	Optional
• Inpatient hospital services/outpatient hospital services, • Physicians' services, • Medical/surgical services of a dentist, • Laboratory and X-ray services, • 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 • Family planning services and supplies, • Nurse-midwife services.	• Prescribed drugs, • Dental services, • Clinic services, • Emergency hospital services, • Personal care services, • Respiratory care services, • Transportation services, • Podiatrists services, • Optometrists services, • Chiropractic services, • Psychologists services, • Medical social worker services, • Nurse anesthetists services, • Private duty nursing services, • Physical and occupational therapy 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, • TB-related services, • Christian Science nurses, • Christian Science Sanitoriums.

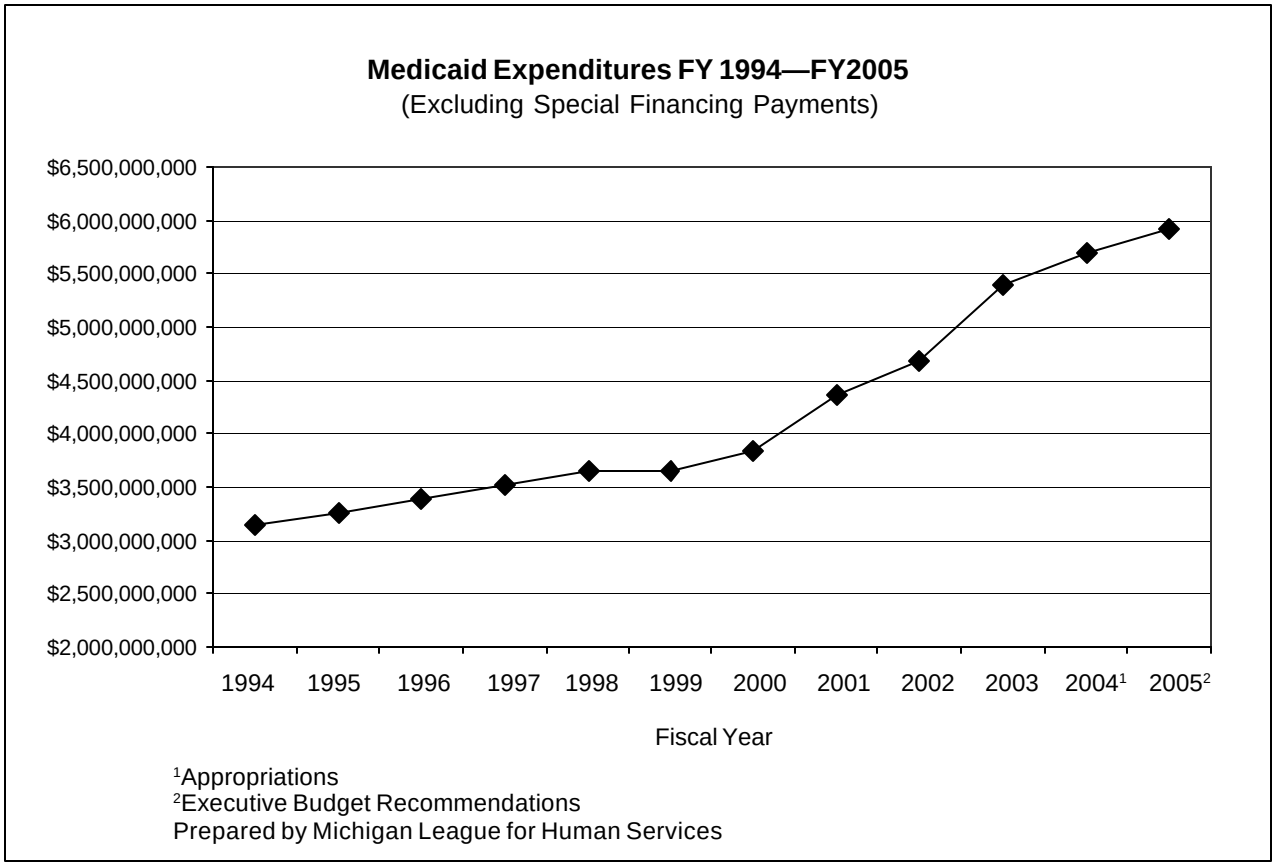
The Michigan Medicaid program, from a coverage perspective, is very generous. Michigan includes nearly all of the optional services in its program. The fact that Michigan's program covers such a large range of services, however, does not insure that they are readily available to those who are eligible. Finding a provider for some of the Medicaid covered services is not always possible due to Medicaid's low reimbursement rates and other program requirements/restrictions.

Current Budget Situation

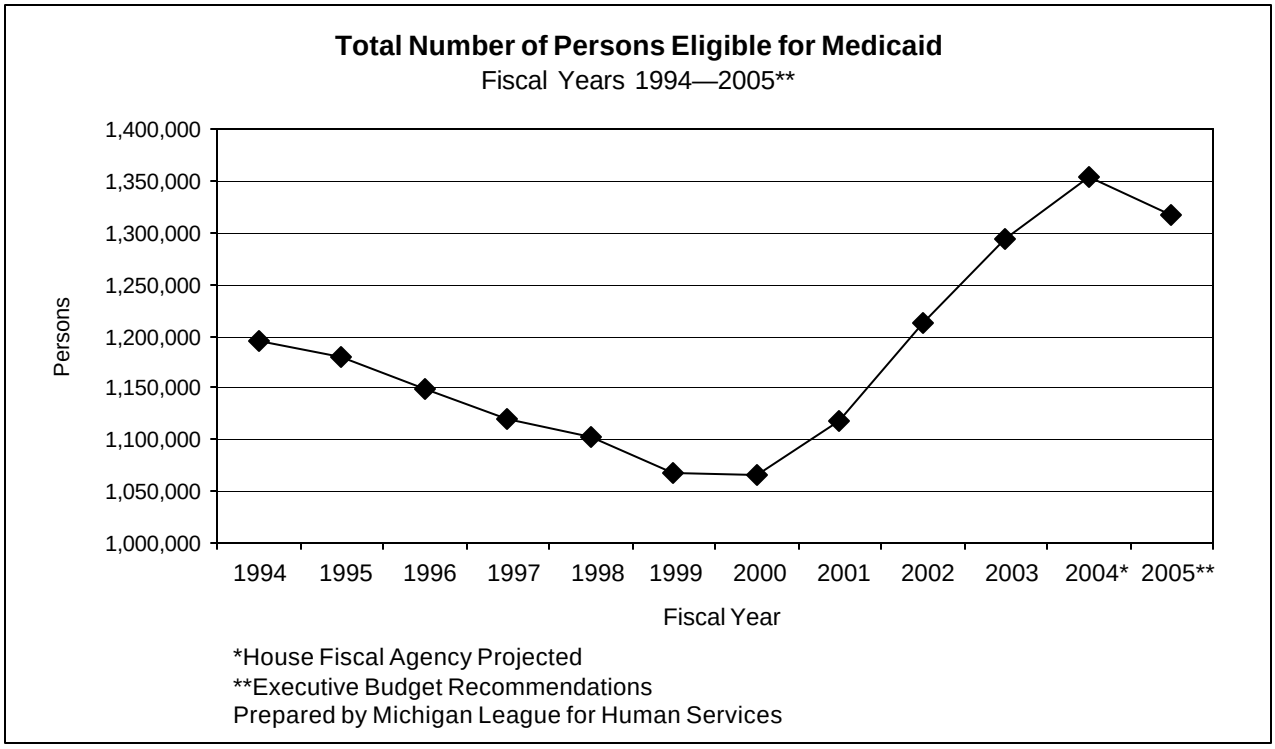
With continued increases in the number of persons eligible for Medicaid forecast for the current year, nearly a 7 percent increase over FY2003, it is easy to understand why an increase of only 1.2 percent in funding in the initial annual appropriation was acknowledged as being inadequate. At the time that the Executive Order reductions for FY2004 were executed, a supplemental appropriation, $239 million gross, $100 million general fund, was passed. The supplemental is expected to cover the higher than budgeted caseload costs as well as Adult Benefit waiver savings that will not be achieved due to federal delay in approving the waiver. Savings from the waiver were assumed for the full fiscal year; approval of the waiver did not occur until January 2004. It is not clear that, even with the enacted supplemental, appropriations will be adequate to cover program costs.

Under the Federal Fiscal Relief Provision of the Tax Bill of 2003, states are prohibited from reducing Medicaid eligibility to a level below that in effect on September 2, 2003 if they wish to receive the additional federal funding available to states in that bill. That provision remains in effect for the first three quarters of FY2004. The FY2004 Michigan impact is a federal matching rate of nearly 60 percent. Should program reductions be proposed for FY2004, they can only be achieved through covered services (elimination of ''optional'' services), or in the rates paid to providers for services. Further provider rate reductions would likely exacerbate the current provider access issues.

The following graphs display the dramatic upward trends of both the number of persons eligible for Medicaid, and the program expenditures.



The number of persons eligible for Medicaid, and the program expenditures.



What Lies Ahead

FY2005 is shaping up to be a very difficult year. As can be seen from the above charts, should trends continue rather than following the Executive Budget assumptions, both the number of persons eligible and the expenditures could experience significant increases in FY2005. This is particularly problematic as State general fund revenues are projected to decline. For FY2004, it is worth noting that the Medicaid general fund appropriation represents nearly 24 percent of the State's total general fund appropriations. To add to an already bleak picture, Michigan will lose $168.4 million in federal fiscal relief (that expires in June 2004), and will lose about $130 million from Medicaid special financing that is no longer permitted by the federal government. Nearly $300 million of state dollars will be required just to maintain the current program BEFORE considering the impact of FY2005 caseload and utilization increases and mandated cost increases.

While the Executive Budget does include a 4 percent increase in funding over FY2004, when compared with health insurance year-to-year increases, it represents not only a very constrained recommendation, but perhaps inadequate. The year-to-year Medicaid increases have not been that low since FY2000 when the caseload began its current upward trend. The Executive Budget assumes a caseload reduction in FY2005 based on an improved economy. While this would be good news for Michigan's citizens, if it does not occur at the rate assumed in the budget, further Medicaid pressures will be brought to bear, and reductions may once again be under discussion.

Because such a large percentage of Medicaid spending is for the elderly and disabled recipients, there could be significant risk to those recipients and their families should reductions be proposed that eliminate either their eligibility or the services on which they (or their families) depend. The House Fiscal Agency reports that 70 percent of all Medicaid expenditures are paid on behalf of elderly, disabled, and blind recipients who represent only about 27 percent of the eligible population. With the aging of the current population, those statistics are bound to increase substantially in next few years as the ''baby boomers'' reach retirement age.

While the impact of the Medicare legislation that creates a prescription drug benefit for those who qualify for Medicare is not yet known, it is clear that there could be negative impacts on both the Medicaid program and its recipients. Recipients will lose their traditional Medicaid expanded coverage for Medicare services, and the State will be required to pay the federal government a phased share (ranging from 90 percent to 75 percent in 2015) of the federally estimated cost the state would have incurred absent the new program.

If major Medicaid program reductions are proposed and enacted in FY2005, in lieu of the Governor's revenue proposals, the impact will not only affect the Medicaid recipients and providers, but also will contribute to the state's continued job loss woes as the health care industry eliminates jobs. According to U. S. Labor statistics, each health care layoff takes about $55,000 in payroll spending out of the economy. Those health care providers, who cannot refuse to see and treat persons without any health care coverage, will likely experience an increase in their uncompensated care, increasing the negative impact on their economic situations. Emergency care will be provided with or with out payment.