



Understanding Medicaid Complex, Compassionate, Cost Effective

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The Medicaid program is doing its job—providing health care benefits and services to those who qualify, and doing it efficiently. Yet the program is under attack at the federal level and struggles (as do other key public services) to secure needed investment at the state level. While the program is considered “out of control” by some, its misunderstood growth stems from the lack of affordable health care coverage and medical services for low-income children and families, elderly and persons with disabilities, NOT out-of-control spending. **It is critical that policymakers, at the state and federal levels, understand the importance and impact of this program to both current enrollees and those promised coverage in 2014 through the Affordable Care Act, as federal deficit reduction policies are debated.** Dramatic cuts or changes to the Medicaid program would be devastating not only to the people it serves, but also the providers who serve Medicaid recipients, and therefore, to Michigan’s economy.

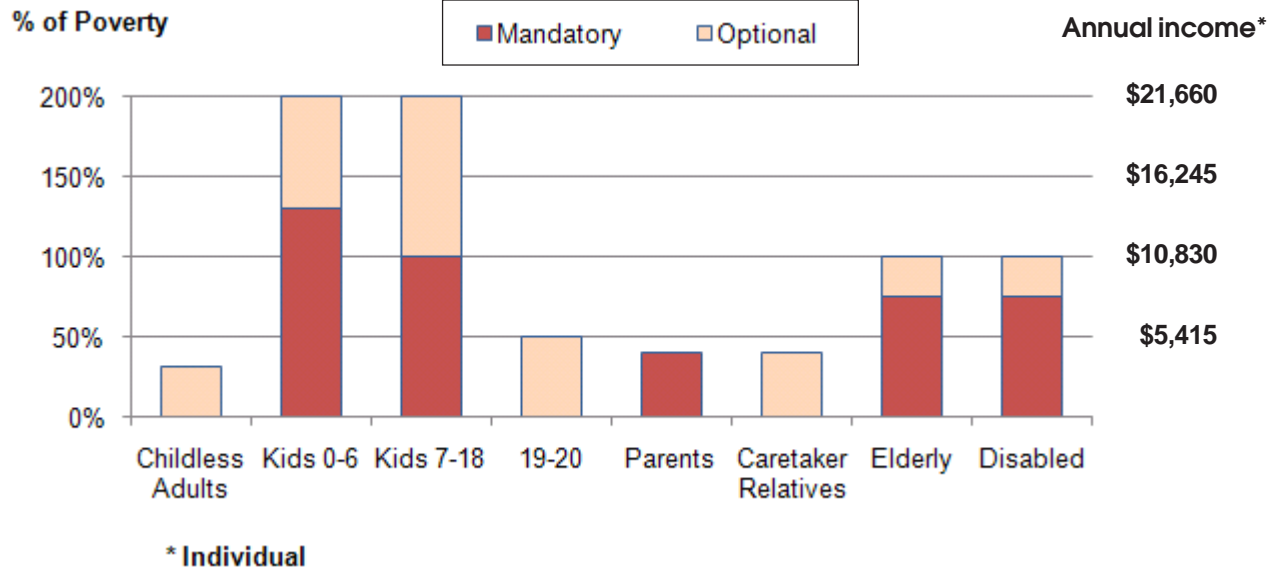
A Telling Headline: Why Medicaid is Growing

In a report released by the Economic Policy Institute in November 2010, **Michigan ranked No. 1** in the number of people, **nearly 1 million, who lost employer coverage** over the period 2000-01 to 2008-09.

During this period, Michigan’s Medicaid caseload grew from 1.1 million persons to nearly 1.7 million persons. It is important to note that during this period of dramatic job loss accompanied by the loss of employer-sponsored coverage, Michigan did not increase its Medicaid eligibility standards, and

HISTORY: In 1965, the Federal government added Title XIX to the Social Security Act, creating a program to provide medical care to certain individuals and families with low incomes and limited resources. Initially, Medicaid only covered federally subsidized cash benefit recipients (the former Aid to Families with Dependent Children and Supplemental Security Income). During the last 30 years, the program has evolved into the health care program for low-income families, with the addition of federally mandated groups. Currently, less than **one-fourth of Medicaid enrollees are also receiving cash assistance**, the remaining three-fourths are eligible only for Medicaid. Since the 1980s, increasing coverage for pregnant women and children has been a federal priority. Under the Medicaid program, states are required to provide coverage to certain populations/groups, and have the option to expand to other groups. In addition, states *must* provide certain services, called mandatory services, and *may* provide additional services that are called *optional* services. The optional services are certainly mandatory for good health outcomes.

Current Medicaid Eligibility



*Source: Michigan Department of Community Health
Produced by the Michigan League for Human Services*

continues to have one of lowest income levels of our neighboring states to qualify. For a single parent, Michigan's eligibility limit, at just under 50 percent of the Federal Poverty Level (\$5,418 annually for an individual), is more than two times lower than the next Great Lakes state, Ohio, which has an income limit of 100 percent of the Federal Poverty Level (\$10,836 annually for an individual). Indiana covers adults with incomes up to 200 percent Federal Poverty Level. For adults without children, the income level to be eligible for the outpatient-only program is 35 percent of the Federal Poverty Level, or just under \$3,800 annually.

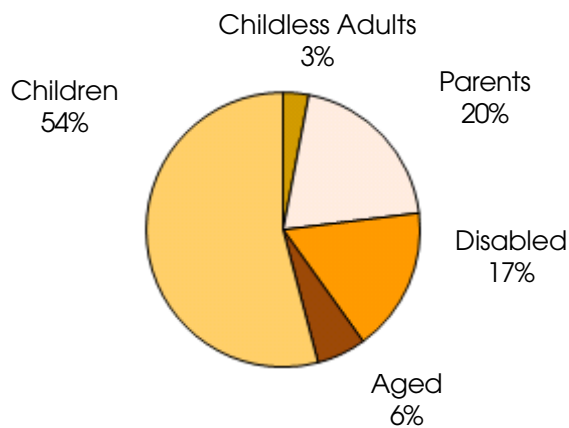
The chart above displays the income limits for the Medicaid program by major category.

As can be readily seen, income eligibility for children, the elderly and those with disabilities is considerably higher than for parents or adults without children. In addition to the extremely low income limit for adults without children, enrollment in that program is limited to 62,000 individuals, and is generally closed.

Medicaid Serves - Children, the Elderly, and Those with Disabilities

The importance of the Medicaid program in the lives of the 1.9 million residents who qualify cannot be overstated. The Michigan Medicaid program covers primarily children, the elderly and those with disabilities. Of the more than 1.9 million Medicaid eligible persons in June 2011, nearly 1,050,000 were under age 21, while nearly 413,600 are elderly and those with disabilities. Of the elderly, it is worth noting that nearly 60,000 are over the age of 75. For low-income elderly and disabled persons, in particular, Medicaid may represent the only financing option when nursing home or institutional care is required. This critical aspect of Medicaid is demonstrated by the fact that nearly 70 percent of nursing home days are paid by Medicaid. The remaining Medicaid enrollees include very low-income parents, pregnant women, and childless adults. The distribution of Medicaid recipients is displayed in the following graph.

Michigan Medicaid Eligibles Served FY2010



Source: Michigan Department of Community Health
Produced by the Michigan League for Human Services

It is striking to note that it is not Michigan's poorest counties that have experienced the highest rates of growth. Livingston County has experienced the largest rate of increase in Medicaid eligibility over the period June 2002–June 2010, with a rate of 191 percent. In other words, the Medicaid caseload in that county has nearly tripled. During that same period, Livingston County's unemployment rate increased from 3.1 percent to 11.8 percent. Macomb County, the county with the next highest rate of Medicaid caseload increase at 146 percent, experienced an increase in their unemployment rate from 7.3 percent to 14.4 percent. Other counties where Medicaid caseloads have more than doubled during this period include: Ottawa, Lapeer, Grand Traverse and Oakland.

Why These Facts Matter

- Individuals who have lost their jobs and employer health care coverage can rarely afford COBRA coverage when their incomes are significantly reduced or are limited to unemployment benefits.
- Private insurance may be too costly, even for those who are healthy, when they have lost their jobs and are trying to manage on reduced incomes.

- Private coverage may not be affordable for someone with a pre-existing condition.
- Medicaid, the payer of last resort, may be the only health care coverage option for a family, if they can qualify based on the extremely low income levels.
- Losing health care coverage does not reduce or eliminate health care needs, it often exacerbates them when needed care is delayed and conditions escalate and patients must be treated in a more expensive setting, for example, in the hospital emergency room rather than a doctor's office.
- The Affordable Care Act requires that states maintain their Medicaid eligibility at the level in place on March 23, 2010. All Republican governors, except Michigan Gov. Rick Snyder, have written to Congress requesting relief from that requirement. It is laudable that Governor Snyder is maintaining his priority that "every citizen has access to affordable, quality health care" even in tough economic times.

Medicaid enables nearly **40 percent** of Michigan's **children to receive their recommended well-child doctor visits and immunizations** as well as go to the doctor when they are ill. It allows children with asthma to obtain the drugs they need to keep it under control and keep the child out of the hospital. Medicaid provides dental coverage and those children who live in one of the 65 counties with a Healthy Kids Dental program (expanded to Mason, Muskegon, Newaygo and Oceana counties in October 2011) will be able to find a dentist to treat them (extremely difficult in the remaining 18 counties) and maintain their oral health. Dental disease continues to be the most common childhood disease, far more common even than asthma.

As indicated above, the Medicaid program pays for nearly **70 percent** of the **nursing homes days** used in Michigan. While this is a critical financing mechanism for those who are elderly or have a disability and need nursing home care, of equal importance is the fact that Medicaid covers services in the community for these populations. For those Medicaid recipients who prefer to remain in their own homes or their communities, the Medicaid program provides supportive services, under

the Adult Home Help program, as well as comprehensive services under the Home and Community Based Waiver. Because this waiver is also capped, there is a significant waiting list (6,700 as of December 2010 according to the Area Agencies on Aging Association) at any point in time.

In FY2010, the Medicaid program paid for **51 percent of the births** in Michigan, up from 35 percent in FY2003. During this period, Michigan's Medicaid income eligibility for pregnant women has remained constant at 185 percent FPL (\$33,900 for a family of 3). This increase likely reflects the decline in employer-sponsored coverage due to:

- layoffs;
- employers restricting coverage or increasing employee participation to the point employees are forced to opt out;
- employers covering only the employee or providing a subsidy only to the employee, pricing many families out of dependent coverage; or
- workers only securing part-time positions that do not include health care benefits.

In addition, maternity coverage is not included in many individual private policies. According to a **Commonwealth Fund Report**, nationally, only 13 percent of individual private plans currently include maternity benefits.

Broad Array of Services Covered by Medicaid

Because Medicaid serves such a large portion of Michigan's population, about **1 in 5**, and covers individuals from birth to death, it is critical that the program include a comprehensive set of benefits, particularly given the low-income population that it serves. Numerous studies have documented the poorer health status and higher, more complex needs of low-

income populations. The comprehensive set of services covered by the Medicaid program are divided into two groups: those mandated by the federal government and those that the federal government has defined as optional. States can cover optional services and receive federal matching funds. Michigan covers nearly all of the federally defined optional services because of their importance in health outcomes. When the services to be covered by the Medicaid program were initially defined in 1965, medical care and practice were very different from today. This is best demonstrated by the fact that prescription drugs are included as a federally defined optional service. Clearly, prescription drugs are not optional for good health outcomes and are a key method of treatment today.

In general, all services are mandatory for children as specified in the Early and Periodic Screening, Diagnostic, and Treatment provision. If a condition requiring treatment is discovered during a screening, treatment of the condition must be provided to comply with EPSDT requirements.

Following (page 5) is a list of the federally mandated services, as well as those that are defined as optional services that states may elect to cover. Michigan covers all of the optional services listed except as noted.

Mandatory Services	Optional Services
<ul style="list-style-type: none"> • Inpatient hospital services • Outpatient hospital services • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services • Nursing facility services • Home health services • Physician services • Rural health clinic services • Federally qualified health center services • Laboratory and X-ray services • Family planning services • Nurse Midwife services • Certified Pediatric and Family Nurse Practitioner services • Freestanding Birth Center services (when licensed or otherwise recognized by the State) • Transportation to medical care • Smoking cessation for pregnant women 	<ul style="list-style-type: none"> • Prescription drugs • Clinic services • Most mental health services • Physical therapy • Occupational therapy • Speech, hearing and language disorder services • Respiratory care services • Other diagnostic, screening, preventive and rehabilitative services • Podiatry services • Optometry services (limited for adults) • Dental services • Dentures • Prosthetics and Orthotics • Eyeglasses (limited for adults) • Chiropractic services (not available for adults) • Hospice • Durable medical equipment and medical supplies • Other practitioner services (as medically necessary) • Private duty nursing services • Home and community-based long term care supports and services
<p><i>Source: U.S. Department of Health and Human Service website, www.hhs.gov and Michigan Department of Community Health. Produced by the Michigan League for Human Services</i></p>	

Why These Facts Matter

- Eliminating some federally defined optional services (dental, vision, podiatric and chiropractic) for adults, as has been legislated twice in the last few years, has been neither compassionate nor cost effective. At Medicaid budget hearings, cardiologists testified about the impact of dental service elimination for Medicaid recipients who ended up in cardiac intensive care due to untreated dental disease that caused serious heart conditions which could have been avoided through appropriate dental treatment in a dentist's office.
- Pregnant women need dental services to improve birth outcomes as untreated gum disease has been linked to premature and low-birth weight babies.
- Diabetics rely on dental, vision, and podiatric exams to successfully manage their disease. Eliminating "optional" services for diabetics can be devastating.
- In one of the first ever **studies of its kind**, released by the National Bureau of Economic Research, researchers from Harvard, Massachusetts Institute of Technology, the National Bureau of Economic Research, and Providence Health and Services found that "expanding low income adults' access to Medicaid substantially increases health care use, reduces financial strain on covered individuals, and improves their self-reported health and well-being." In addition, researchers found that "Medicaid substantially expands access to and use of care for low-income adults relative to being uninsured."

Medicaid's Low Reimbursement Rates Limit Access

The size and cost of the Medicaid program are determined by the enrollment and eligibility policies, the services provided, and the rates paid to providers. As mentioned above, restricting or reducing eligibility is currently prohibited under the provisions of the Affordable Care Act. Past efforts to reduce costs have included the elimination of "optional

services," which were subsequently restored, as well as provider rate reductions, which for the most part have not been restored.

According to the Medical Services Administration, there have been no across-the-board rate increases since 2001. Since FY2002, provider rate reductions were implemented in five of the nine years. The most recent provider reduction of 8 percent has been in place since FY2009. While the Snyder Administration acknowledged the need for Medicaid provider rate increases, none was proposed in the FY2012 budget, and the 8 percent reductions were continued. **The low provider payment rate base, coupled with the ongoing reduction policies over the last several years, has led to many providers declining to serve Medicaid patients.** This has resulted in access problems in many areas of the state as well as access problems with many specialists.

Why These Facts Matter

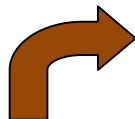
- There are 17 contiguous counties in the Lower Peninsula with no obstetric care at their hospitals. In testimony before the Department of Community Health Appropriations subcommittees, hospital administrators have identified insufficient Medicaid reimbursement rates as the dominant factor in the decisions to close obstetrics units. The decision to close an obstetric unit impacts not just Medicaid recipients, but the entire community.
- Medicaid recipients may not be able to receive the services they need in an appropriate setting, or in a timely fashion due to lack of access to needed providers.
- Low Medicaid payment rates result in more uncompensated care which results in more upward pressure on commercial insurance premiums, resulting in a "hidden tax" on business and individuals who purchase private coverage.

Education Level Impacts Medicaid Cost

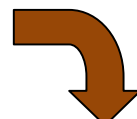
In its report, **Investing in Higher Education for Latinos: Payoffs for State Economies**, (July 2011),

The Medicaid Rate Cut 'Death Spiral'

Fewer Michigan workers can afford coverage; so enroll in Medicaid



Growing number of Medicaid beneficiaries seek health care

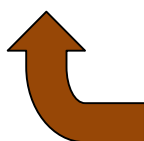


Michigan Medicaid reimburses providers at less than cost

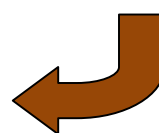
Employers sponsor fewer and less affordable plans

Uncompensated care

Health care costs increase for employers and employees



Higher private health plan premiums



Health care providers charge more to higher-reimbursing payers

*Source: Michigan Department of Community Health
Produced by the Michigan League for Human Services*

the National Conference of State Legislatures noted: “Higher incomes mean higher tax revenue for states. College graduates pay more in income and sales taxes and depend less on social service programs such as food stamps and Medicaid. States **save an average of \$1,377** annually in Medicaid costs for every person with a college degree.”

However, in the budget that began on Oct. 1, 2011, needed investments to achieve higher educational attainment were not among the top priorities of policymakers as evidenced by cuts to all levels of education including cuts to:

- the K-12 foundation grant by \$470 per pupil,
- community colleges by 4 percent,
- universities and colleges by 15 percent.

Adult education funding—cut dramatically in previous years—remained flat at \$22 million, while no state funding was provided for the second year in a row for No Worker Left Behind, a program focused on training adult workers for high-demand jobs.

Why These Facts Matter

- In 2010, only 29.3 percent of Michigan’s labor force, age 18 - 64, had a bachelor’s degree or higher, according to the League’s **Labor Day Report 2011**.

Federal Funding Is Critical to Michigan’s Program

Medicaid is an entitlement program. Everyone who meets the eligibility requirements is entitled to participate in the program without eligibility waiting lists or being denied due to state fiscal problems. Waiver programs are an exception and can have waiting lists. The federal government shares in the cost of the program and in Michigan pays the majority of the cost at more than 66 percent in FY2012. For every dollar the state contributes, about \$3 in health care services can be purchased, with the federal government contributing \$2. Michigan has experienced a significantly increasing federal matching rate since FY2007, with the matching

percentage, called the Federal Medical Assistance Percentage increasing from 56.38 percent to 66.14 percent for FY2012. Changes during the prior six years were less than 1 percent. The increasing matching rates reflect in part Michigan's economic woes and declining personal income, demonstrating the countercyclical nature of the program. When the economy declines and state revenues decline, the demand for Medicaid increases (due to the loss of employer-sponsored coverage) as does the federal matching rate.

Why These Facts Matter

- Increases in the federal matching rate during economic downturns help to maintain the program as demand increases and state revenues decline.
- As the federal match rate increases, a reduction in state funding requires greater total cuts in the program. In FY2007, a \$1 state funding cut resulted in total program cuts of just over \$2 (\$2.29); in FY2012 that same \$1 cut results in nearly \$3 of total program cuts.
- Every 1 percent increase (reduction) in the federal match rate provides a \$120 million increase (reduction) in federal revenue to the state.

Proposals to Reduce Federal Medicaid Funding

At the **federal level**, numerous proposals have recently been made to cap or reduce Medicaid spending in the name of deficit reduction, but those proposals would simply shift costs to states or to Medicaid recipients, with no actual reduction in health care costs. **Health care needs are not reduced or eliminated simply by reducing funding.** In his budget proposal, Pathway to Prosperity, House Budget Committee Chairman Paul Ryan, called for capping federal Medicaid spending and creating a limited grant to states for their Medicaid programs. Limiting federal funds would dramatically reduce states' abilities to respond to the countercyclical nature of Medicaid (Medicaid demand rises during economic downturns when people lose their jobs and insurance coverage, at the same time

state revenues decline) as well as natural disasters, such as Katrina or the recent devastating tornadoes and hurricanes.

Debt Ceiling Increase Agreement Protected Medicaid, but . . .

During the recent debt ceiling increase negotiations, resulting in spending reduction mandates, entitlement programs were again under consideration for reduction. While they were protected in the agreement reached on Aug. 2, 2011 to increase the debt ceiling, part of the agreement was the creation of a bipartisan committee to recommend policy and funding changes to save \$1.5 trillion over 10 years. The committee's recommendations must be completed by Nov. 23, 2011, with an up or down vote (no amendments) in both the House and Senate by Dec. 23, 2011. The President can veto the legislation.

This committee has broad authority and can consider cuts to or restructuring of entitlement programs, including Medicaid. If the committee cannot develop an approvable plan by the House and Senate that the president will sign, then automatic, pre-defined cuts will occur. While Medicaid would again be exempt from automatic cuts, the resulting cuts would be devastating to the impacted programs as well as defense. To avoid the automatic cuts, the committee will have a strong incentive to develop an approvable plan.

The Obama administration has already proposed an option to reduce federal Medicaid funding. The proposal would "blend" the various federal matching rates currently in place for the Medicaid and Children's Health Insurance Program, and the Medicaid expansion under the Affordable Care Act, which is 100 percent federally funded in the first three years, phasing down to 90 percent in 2020. Because the ACA expansion will not occur until 2014, it would be impossible to accurately calculate a blended rate, and rates would have to be set at significantly below the individual rates to save federal funds. The result would be a significant cost shift to states.

Why These Facts Matter

- A strong program is critical for those who are currently eligible, and those who will gain Medicaid coverage in 2014 under the ACA Medicaid expansion.
- Michigan Medicaid could add between 500,000 and 800,000 new beneficiaries under the expansion.
- Michigan policymakers struggle each year to fund the current Medicaid program, and finding additional state funds to offset sizable federal reductions would be a great challenge. Funding for the FY2012 Medicaid expenditure levels approved in May was not completed until late August.
- Shifting costs to recipients to offset federal reductions through cost sharing or benefit reductions are not effective means to reduce costs. Studies have repeatedly confirmed that cost sharing both diminishes beneficiaries' access to care and negatively impacts health status, as well as increasing use of emergency rooms and increasing uncompensated care.
- The governor's stated policy is that "every citizen should have access to affordable quality health care."

Conclusion

The Medicaid program will remain the **key health** care program for low-income families and individuals as well as the elderly and those with disabilities for the foreseeable future. It is critical that beneficiaries are able to receive the right care, in the right place, at the right time to be both cost effective and result in good health outcomes. **The general public understands the importance of the Medicaid program as is repeatedly demonstrated in polling by Kaiser Family Foundation** "The generally positive feeling about the program among those who have experienced it may explain why the poll also finds that 60 percent of people want to keep Medicaid as it is." (**national poll in May 2011**), and **EPIC/MRA (state poll in February 2011)**. It is a good lesson for policy makers to take from their constituents—support a strong Medicaid program at both the state and federal levels. It is cost effective to be healthy.