

# Medicaid Costs in Michigan

Prepared by Bill Fairgrieve

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Medicaid is a state and federally funded entitlement program that pays for medical services to qualified low-income Michigan residents. It is one of the largest programs at the state level, providing services to over one million Michigan residents annually. It has also been among the fastest growing budget areas. Total funding for the program exceeds \$5.3 billion, and approximately 20% of the state's GF/GP budget is allocated to Medicaid. Cost concerns have stimulated far-reaching proposals for Medicaid reform at the state and federal level.

This **fiscal forum** provides a brief overview of the program, traces the growth in Medicaid expenditures since 1991, and examines the major factors contributing to the increase in Michigan's Medicaid costs.

## Medicaid Overview

One out of every nine Michigan residents receives health care through the Medicaid program. Included are individuals in the following categories (see Chart 1 *in printed version* for more detail):

- Families receiving cash assistance through the Family Independence program (formerly, the AFDC program);
- Aged, blind, and disabled persons receiving Supplemental Security Income (SSI);
- Pregnant women and newborn children below 185% of the poverty level;
- Children under age 16 below 150% of the poverty level;
- Elderly and disabled persons up to 100% of the poverty level;
- Former AFDC recipients whose cases were closed due to employment; and
- Medically needy persons whose medical expenses reduce them to assistance levels.

Persons receiving cash assistance through the Family Independence program make up one-half of the Medicaid population, while elderly and disabled persons receiving SSI and the Medically Needy population represent over one-third of all Medicaid eligible persons. Former cash assistance recipients receiving Transitional Medicaid coverage and low-income pregnant women/children account for the remaining 14% of those eligible for Medicaid.

Medicaid provides coverage for a broad range of services, including hospital, clinic, and physician services; nursing home care; prescription drugs; lab and x-rays; home health, family planning, dental, vision, and hearing services; and certain mental health and substance abuse services. Because Medicaid is an entitlement program, expenditure levels vary from year to year based on the number of eligibles, the utilization of services, and the costs of providing medical care.

## **Medicaid Financing**

In FY 95, Michigan spent more than \$5.3 billion on the Medicaid program with funding from a variety of revenue sources (see Chart 2 *in printed version*). Currently, the federal government pays approximately 55% of Medicaid costs in Michigan. This rate varies from year to year based on a formula related to the state's per capita income. The state's share of Medicaid costs are funded through GF/GP revenues and several special financing mechanisms that have been devised in recent years.

The vast majority of Medicaid funding is in the Department of Community Health budget. As a result of Executive Order 1996-1, the Medical Services components (Basic Medicaid and Special Payments) and the Medical Services Administration were transferred from the Department of Social Services to the Department of Community Health and merged with the former Departments of Mental Health and Public Health.

In recent years, Medicaid has become a significant funding source for services provided through the former Department of Mental Health, including inpatient psychiatric facilities, intermediate care services for the mentally retarded, and clinic services offered through the community mental health system. Substance abuse services and services to children with special health care needs formerly in the Department of Public Health and Adult Home Help services administered by the Family Independence Agency are also funded through Medicaid. Chart 3 (*in printed version*) details FY 1995 total Medicaid expenditures.

## **Medicaid Expenditure Trends**

Medicaid grew by an average of about 10% annually, from \$3.6 billion in FY 91 to \$5.3 billion in FY 95. These increases were not evenly distributed across all program components, as shown in Chart 4 (*in printed version*).

While gross Medicaid expenditures in Michigan grew by 48.7% since 1991, Special Financing payments increased the most (104.1%), followed by Mental Health (51.4%), Administration (47.3%), and Basic Medicaid (39.7%). The smallest percentage increases occurred in Public Health services (37.5%) and Adult Home Help services, which only went up 14.7%.

The escalation in Medicaid expenditures has slowed considerably. The aggregate growth in Michigan's Medicaid costs was just 2.1% in FY 95. Basic Medicaid services went up 3.2 % and Special Financing Payments actually decreased by 9.1% in that year. Preliminary cost data for FY 96 indicate that overall growth will be less than 5% above FY 95 levels.

Nationwide, Medicaid expenditures grew by more than 70% from 1991 to 1995, a substantially higher rate than in Michigan during the same period.

## **Major Factors Affecting Medicaid Costs**

Medicaid costs are influenced by a variety of factors including the size and health care needs of the eligible population, the scope of medical benefits provided, service utilization levels, and the amount of payment for services provided. The double digit Medicaid increases in the first half of the 1990s were primarily attributable to: (1) increases in eligibility; (2) inflation in the costs of medical services paid for through the program; and (3) special financing measures to maximize federal funds.

**Eligibility Increases:**

Overall, the number of Medicaid eligible persons grew by 7.6% from FY 91 to FY 95. There was a decline in the number of AFDC recipients by more than 12%, but it was offset by a 44% increase in the SSI population and by a more than doubling of the number of low-income pregnant women and children under the age of 16 who are eligible for Medicaid.

Much of the growth in the number of eligible persons resulted from: (1) various federally mandated coverages for low-income elderly and disabled persons, pregnant women, and children; (2) implementation of the state's own Healthy Kids initiative expanding coverage to 150% of the poverty level for persons under age 16; and (3) a broadening of SSI eligibility, especially for children.

It is not surprising that there were corresponding increases in Medicaid costs during the last five years. The increases in eligibility among the elderly and disabled are particularly significant as these populations are more costly (\$7,786 per SSI recipient annually) than the AFDC population (\$1,058 per AFDC recipient annually) where participation declined. The elderly and disabled represent about one-fourth of all Medicaid recipients, but because they tend to utilize more medical services and more intensive services, they account for over 70% of expenditures for Medicaid services.

**Medical Inflation:** Medicaid purchases medical services delivered by hospitals, nursing homes, physicians, and other health care providers. Although the Medicaid program generally pays less for medical care than the price charged to private individuals and insurers, the program's costs are affected by prevailing health care prices. Consequently, the escalation of health care prices has the effect of driving up Medicaid costs as well.

Within certain parameters, the state Medicaid program has the ability to set provider payment levels. In the case of hospitals and nursing homes, which are the two largest expenditure areas, Medicaid reimbursement automatically reflects cost changes from year to year, as required by federal law. During the past five years, these inflation adjustments have generally been in the range of 3-5% annually.

The medical care cost component of the Consumer Price Index is one measure of health care inflation. From 1991 to 1995, the medical care component for the Detroit area grew by an average of 5.1% annually. In 1995, the Index grew by just 3.4%, and the latest monthly figure (October 1996) is just 1.5% above the level from one year ago.

Average Medicaid costs per recipient have increased 6.8% per year since 1991, as noted in the table below. The growth rate has moderated in the last few years, but remains above the CPI medical cost index. The change in the makeup of the eligible population referred to previously is one reason for the difference.

<b>Year</b>	<b>Medical Care Component Detroit CPI:</b>	<b>Average Medicaid Cost Per Recipient:</b>
	<b>% Change</b>	<b>% Change</b>
1991	6.4 %	9.0 %
1992	5.6 %	8.7 %

1993	4.4 %	5.8 %
1994	5.6 %	5.0 %
1995	3.4 %	5.7 %
5-Year Average	5.1 %	6.8 %

Source: Detroit Consumer Price Index; HCFA 2082 Report

**Maximizing Federal Funds:** Since 1991, Michigan has utilized a variety of special financing mechanisms, including disproportionate share payments to hospitals and long-term care adjustor payments to county medical care facilities to earn additional federal Medicaid funds and reduce state GF/GP for Medicaid services. Under these arrangements, the state makes a special payment to the eligible provider and claims federal match on the payment. Subsequently, a payment or intergovernmental transfer is made back to the state from the provider, resulting in a net financial gain to Michigan.

Although such payments increase total Medicaid expenditures, they actually lessen the state's financial share of program costs. The amount of the various special payments and the GF/GP savings generated have grown significantly during the last five years. In FY 95, Michigan's total special Medicaid payments were nearly \$900 million while the net state benefit from these transactions was close to \$500 million, more than double the comparable FY 91 amounts. In response to the rapid growth in such financing mechanisms in Michigan and other states, the federal government has taken steps to limit future increases in these special Medicaid payments.

Michigan has also sought to maximize federal funds by aggressively claiming federal Medicaid matching funds for various mental health and public health services and administrative support functions related to the operation of the program. Overall, federal Medicaid funding in these areas increased by over 50% from 1991 to 1995.

**Utilization of Medical Services:** The level at which services are utilized is another key determinant of Medicaid expenditures. As was previously mentioned, the broad scope of covered services and growth in the size of the eligible population has contributed to increased utilization of Medicaid-covered benefits. Similarly, the traditional reliance on fee-for-service payment as the primary form of Medicaid reimbursement also encouraged higher use rates.

In general, there has been some decline in the number of inpatient hospital and nursing home days of care paid for by Michigan's Medicaid program during the last five years. At the same time, there has been an increase in the number of outpatient hospital, physician, and other ambulatory visits, as well as in the number of prescribed drugs reimbursed through Medicaid.

The Medicaid program employs a variety of methods to control utilization including nominal recipient co-payments for selected services (prescription drugs, dental, vision, hearing, podiatric, and chiropractic services) and prior authorization for certain non-emergency services. Recently, managed care has become a primary strategy for controlling utilization and holding down Medicaid costs.

## **Managed Care and Medicaid Costs**

Over the past decade, there has been an increased emphasis on enrolling Medicaid eligible persons in health maintenance organizations (HMOs) and other kinds of managed care arrangements. Managed care has been promoted as a means to control Medicaid costs, reduce unnecessary utilization, and also to improve access to mainstream care.

In essence, managed care plans seek to constrain costs by: (1) minimizing utilization particularly for more costly and intensive services such as specialty and inpatient care; (2) emphasizing primary and preventive care that may reduce the need for more expensive services in the future; and (3) negotiating discounted payment rates from participating medical providers and other reimbursement incentives to hold down expenditures.

Medicaid managed care enrollment in Michigan grew from 241,261 in September 1991 to 767,754 in September 1995 (see Chart 5 *in printed version*). 60% are participants in the Physician Sponsor Plan where primary care physicians provide or approve most medical care, but continue to be reimbursed on a fee-for-service basis, plus a \$3.00 monthly case management fee. The remaining 40% of the Medicaid population in managed care obtain services through HMOs and clinic plans which provide or authorize all medical care for a fixed monthly payment. Managed care approaches also have been introduced for mental health and substance abuse services where patient assessments and prior authorization are required for more intensive levels of care. The Department of Community Health estimates that managed care plans result in cost savings of about 10% compared to traditional Medicaid fee-for-service reimbursement.

As a result of the rapid rise in Medicaid costs and the prospects of capped federal Medicaid funding increases in the future, the Department is developing plans to contract for virtually all Medicaid funded services on a capitated basis. New managed care plans are being developed for basic Medicaid services, children's special health care services, long-term care, behavioral services (mental health and substance abuse), and services to the developmentally disabled.

## **Medicaid Costs in the Future**

It is likely that Medicaid spending will continue to escalate for the foreseeable future, but at a somewhat more moderate pace than during the first half of the 1990s.

The growth in Medicaid expenditures is a function of a variety of factors including eligibility, benefits, utilization levels, payment rates to providers, and state efforts to maximize federal funding. Other influences include broad social and economic conditions such as increases in the poverty level, unemployment rates, the number of uninsured, the aging of the population, the explosion of new medical technologies, and inflationary trends in the health care system which also place spending pressures on the Medicaid program. Many of these pressures will continue well into the future.

Holding down Medicaid costs while ensuring access to appropriate health care for the vulnerable populations which the program serves will be one of the challenges facing Michigan in the years ahead.