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Recent Changes in Health Policy for Low-Income People in Michigan

Jane Tilly, Frank C. Ullman, and Julie Chesky

Michigan has taken a number of steps to change its delivery of acute care services, including increasing reliance on Medicaid managed care and replacement of its existing pharmaceutical assistance programs with a more generous program.

Overview

Since the late 1990s, Michigan has expanded and implemented changes in its publicly funded health care programs by creating a new health care program for children, implementing a relatively generous prescription drug program for its senior residents, and expanding Medicaid managed care. For most of this period, Michigan had the financial resources to support these efforts.

Fewer adults and children lived in poverty in Michigan than in the nation as a whole in the late 1990s. And employer-sponsored health insurance played a larger role in health care coverage for Michigan's low-income population than in the rest of the country. Only 7 percent of the state's children and 11 percent of its adults were uninsured, compared with roughly 13 percent of children and 16 percent of adults nationally.

However, by the fall of 2001, the state's economy began deteriorating, due in part to the terrorist attacks of September 11. The resulting projected revenue shortfalls are likely to affect state health programs, including Medicaid, because Michigan is considering serious budget cuts.

Health care consumes a significant portion of the state's budget; Michigan's total spending (including federal aid) on Medicaid in state fiscal year 2000 was estimated at 18 percent of the budget. During the late 1990s Michigan undertook a shift from fee-for-service delivery of health care services to a system dominated by health maintenance organizations (HMOs) in an effort to contain Medicaid costs. The transition to managed care was somewhat controversial because of complaints about low Medicaid payment rates; the state responded by raising payment rates and altering the competitive bidding process for Medicaid HMO contracts. The state also takes its role as a purchaser of services quite seriously; it has improved its HMO quality assurance measures and has commissioned several recent studies of beneficiaries' experiences with managed care. While Medicaid cost increases have moderated under managed care, state officials worry about growth in pharmaceutical expenditures, which currently absorb 15 percent of the Medicaid budget and are increasing more rapidly than any other service.

Although Medicaid is the primary source of public health care coverage, the state has three other major sources of health care coverage: the State Children's Health Insurance Program (SCHIP), indigent care programs financed largely by Medicaid disproportionate share hospital and upper payment limit strategies, and the Elder Prescription Insurance Coverage (EPIC) program. The State Children's Health Insurance Program, which Michigan began in 1998, is a new source of coverage for children. Using SCHIP funds, the state expanded Medicaid to include children ages 16 through 18 in families with incomes up to 150 percent of the federal poverty level (FPL). Another SCHIP program—MIChild—covers children through age 18 with family incomes between 150 and 200 percent of FPL. Medicaid was not the major focus of expansion under SCHIP because such an expansion would have created a new enti-

tlement and policymakers wanted to give children access to a program resembling mainstream health insurance. The state relies on HMOs and the Blue Cross Blue Shield preferred provider organization (PPO) network to deliver services to MIChild enrollees.

Medicaid disproportionate share hospital (DSH) and upper payment limit (UPL) strategies are another significant source of funds for health care programs, amounting to over $1 billion a year. In Michigan, three such programs exist: (1) Disproportionate Share Payments to Public Hospitals; (2) Long-Term Care Adjuster Payments to County Medical Facilities and Hospital Long-Term Care Units; and (3) Outpatient Adjuster Payments to Public Hospitals.

Michigan is among those states implementing a prescription drug coverage program for its older citizens. The new program replaces two others that relied on tax credits and vouchers. In 2001, Michigan began enrolling people age 65 and over in the Elder Prescription Insurance Coverage program, which receives funding from state general revenues and tobacco settlement funds. This program will provide pharmaceutical assistance to persons age 65 and older with incomes below 200 percent of FPL. Beneficiaries will pay a sliding-scale premium to enroll in EPIC.

Michigan has two large Medicaid home and community services programs and several much smaller state-funded programs that provide services to qualified persons with disabilities. The MI Choice Waiver for the Elderly and Disabled provides a range of home care agency–based services to about 14,000 people who would otherwise be eligible for nursing home care. The Medicaid Home Help program (an optional personal care service), which began in the 1970s, provides personal care services using a consumer-directed model, where most beneficiaries hire and fire individual workers.

As in its acute health care programs, Michigan has increasingly used managed care principles to reform its programs for people with disabilities. The system for Medicaid beneficiaries who are aged or disabled is beginning a transition to managed care, and those with developmental disabilities or behavioral health problems are already served by managed care plans.

The Michigan Department of Community Health (MDCH) in 2001 created a new administrative entity—the Long-Term Care Initiative—to coordinate all long-term care programs serving older persons and younger adults with physical disabilities, including the Medicaid MI Choice Waiver and the Home Help program. The Initiative is also responsible for developing and implementing a new, comprehensive long-term care system based on models designed to contain costs through capitated payment and to offer more choice to beneficiaries.

In 1998, Michigan moved to person-centered planning for persons with developmental disabilities and to managed care for both persons with developmental disabilities and those with mental health conditions because the state and consumer advocates wanted more flexibility for participants than was possible under the old fee-for-service system. In 1998, Michigan received approval for a Medicaid waiver to establish a statewide Medicaid managed care program for long-term recipients of mental health, substance abuse, and developmental disability services. The Department of Community Health contracts with local or regional Community Mental Health Service Programs (CMHSPs) to manage and provide Medicaid mental health, substance abuse, and developmental disability services and supports under a prepaid, shared-risk arrangement.

These findings about changes in the health care system for people with low incomes in Michigan build upon a previous case study conducted in 1997.[1] The purpose of this second study is to examine how Michigan and other states have responded to both federal constraints and state flexibility since the late 1990s. Constraints have included funding limitations such as restrictions on the use of the Medicaid disproportionate share hospital and upper payment limit strategies. Flexibility has included expanded use of Medicaid waivers and the availability of new funding such as the State Children's Health Insurance Program. To conduct a comprehensive examination of Michigan's reactions to the constraints and flexibility, we explored five topics. First, how have the political and fiscal cir-

TABLE 1. Selected Michigan Characteristics

	Michigan	United States
Population Characteristics		
Population (2000) (in thousands)[a]	9,938	281,422
Percent under age 18 (1999)[a]	26.1%	25.7%
Percent Hispanic (1999)[b]	2.9%	12.5%
Percent black (1999)[b]	15.0%	12.8%
Percent Asian (1999)[b]	1.9%	4.1%
Percent nonmetropolitan (1999)[b]	17.9%	20.3%
State Economic Characteristics		
Per capita income (2000)[c]	$29,612	$29,676
Percent change per capita income (1995–1999)[d]	7.3%	10.8%
Unemployment rate (2001)[e]	4.6%	4.5%
Family Profile		
Percent children in poverty (1998)[f]	11.8%	17.5%
Percent change children in poverty (1996–1998)[f]	–15.1%	–15.0%
Percent adults in poverty (1998)[f]	8.6%	11.2%
Percent change adults in poverty (1996–1998)[f]	–10.4%	–10.4%
Political		
Governor's affiliation (2001)[g]	Republican	NA
Party composition of senate (2001)[h]	15D-23R-2V	NA
Party composition of house (2001)[h]	52D-57R-1V	NA
Percent of Poor Children Covered by Welfare		
1996 (AFDC)[i]	98.2%	59.3%
1998 (TANF)[i]	78.6%	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)		
1996[j,k]	136%	124%
1998[j,l]	200%	178%
2000[j,m]	200%	205%

Table 1 notes begin on page 18.

cumstances of the state changed over the last several years? Second, how has the state changed its public or private health insurance coverage? Third, how have Medicaid managed care and other acute care issues changed? Fourth, how are states responding to pressures to expand home- and community-based services for persons with disabilities? Fifth, what other issues are prominent? Information contained in this Michigan site visit report comes from interviews conducted in the summer of 2001, a literature review, and reports available from the state; written sources are cited in endnotes.

Background

Michigan is a relatively populous state, with a population of about 10 million people in 2000.[2] Its per capita income and unemployment rate are similar to those of the nation (see table 1). A lower proportion of adults and children live in poverty in Michigan, and the state has proportionately fewer Hispanics and more blacks than the nation as a whole. However, at the time of the site visit, the economy was beginning to soften, a trend that was exacerbated by the terrorist attacks of September 11, 2001.

Employer-sponsored health insurance plays a larger role in health care coverage for Michigan's low-income population than in the rest of the country (see table 2). Over half of children and adults age 19 to 64 with incomes below 200 percent of FPL rely on such coverage, compared with about 40 percent of those nationally. About 90 percent of those under age 65 with incomes above 200 percent of FPL rely on employer-sponsored private health insurance coverage in Michigan. Publicly funded sources financed care for about one-third of the state's low-income children and about 15 percent of low-income adults. In

Michigan, only 7 percent of children and 11 percent of adults are uninsured; these rates are significantly lower than those of the nation.

Republicans set health policy in Michigan as they control both houses of the state legislature and the governor's office. Health care was not at first a notable priority for Governor Engler after his election in 1990. However, health has gained prominence over time, especially providing health care coverage to children and home and community services to the state's Medicaid population with disabilities.

Fiscal Circumstances and Budgetary Priorities

Between 1995 and 2000, average annual budgetary growth was 6 percent (see table 3). During this period, education and health were among the top budgetary priorities in Michigan, while the portion of the budget devoted to total cash assistance (AFDC/TANF) decreased from 4 percent in 1995 to 1 percent in 2000.

Three factors combined to keep Michigan's budget in the black during the latter half of the 1990s. First, although Governor Engler's drive to cut taxes resulted in substantially lower income and property tax rates, sales tax rates have increased. Second, Michigan's constitution limits the state's revenue to 9.49 percent of total state personal income and prohibits the state from spending current-year revenue in excess of this limit.[3] Third, Michigan's economy performed well during the latter half of the 1990s.

However, the budgetary situation began changing in state fiscal year (SFY) 2001. Although Michigan's reserves rose to $1.3 billion in SFY 2000 compared to a total budget (state and federal funds) of $35 billion,[4] the state had to begin considering budget cuts in the spring of 2001. The state's May 2001 revenue estimates were $592 million below levels forecast in January 2001, and state policymakers began considering such options as (1) finding sources of revenue to balance the budget, (2) restraining increases in spending by $325 million, (3) increasing short-term borrowing for capital improvements, and (4) accessing up to $282 million from the state's rainy day fund.[5] By the fall of 2001, the state's fiscal situation was considerably worse, with state policymakers considering a 5 percent across-the-board budget cut due to a projected budget shortfall of almost $1 billion.[6]

State finances continue to benefit from the November 1998 multistate tobacco settlement; Michigan's share is expected to amount to $8.2 billion over 25 years.[7] Total settlement payments through December 2000 amounted to $351.5 million. In 1999, the state committed 75 percent of the settlement funds to higher education scholarships and the remaining 25 percent to health care for older persons and health care research.[8] These funds were used in the SFY 2001 budget for the Department of Community Health to provide about $30 million in prescription drug coverage to older persons, $10 million for expansion of county indigent care programs, $10 million for long-term care innovations grants, and $5 million for respite care for older persons, among other programs.

Medicaid Trends

Total enrollment in Medicaid has remained stable over the past several years, while the composition of beneficiaries has changed. Medicaid expenditures have grown at about 5 percent a year, with the greatest increases for managed care, pharmaceutical, and long-term care services. Increases in spending on managed care were accompanied by decreases in spending for such services as physician and hospital care.

Of Michigan's 1.1 million average monthly beneficiaries in SFY 2000, 56 percent were children and 8 percent were age 65 and over; the remainder were disabled and nondisabled adults.[9] Between 1995 and 1998, the average number of adults and children receiving Medicaid because they received cash assistance declined dramatically, while the average monthly enrollment for adults and children receiving Medicaid via other avenues such as the medically needy program or Medicaid waivers grew rapidly (see table 4). In contrast, the average monthly enrollment for aged, blind, and disabled Medicaid beneficiaries grew slowly from 1995 to 1998.

TABLE 2. *Health Insurance Coverage, by Family Income and Type of Insurance, Michigan and the United States, 1999*

	Children (Ages 0–18)[a] (%)		Adults (Ages 19–64)[b] (%)	
	Michigan	United States	Michigan	United States
Below 200% FPL				
Employer-sponsored	**50.4**	38.7	**51.2**	41.7
Medicaid/SCHIP/state	**31.6**	35.2	15.3	14.7
Other coverage	3.6	3.8	7.5	8.8
Uninsured	**14.4**	22.4	**26.0**	34.9
Above 200% FPL				
Employer-sponsored	**89.8**	85.3	**88.1**	83.7
Medicaid/SCHIP/state	**2.6**	3.8	0.9	1.1
Other coverage	4.2	4.9	**4.4**	5.8
Uninsured	**3.4**	6.0	**6.6**	9.4
All Incomes				
Employer-sponsored	**76.4**	66.7	**79.5**	72.3
Medicaid/SCHIP/state	**12.5**	16.4	4.3	4.8
Other coverage	4.0	4.5	**5.1**	6.6
Uninsured	**7.2**	12.5	**11.1**	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families.* Washington, D.C.: The Urban Institute.
b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families.* Washington, D.C.: The Urban Institute.
Note: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.
FPL = federal poverty level
SCHIP = State Children's Health Insurance Program

Michigan's total spending (including federal sources) on Medicaid in SFY 2000 was estimated to reach $6.5 billion, or 18 percent of the state's $35 billion budget (see table 3). Total Medicaid spending in Michigan grew at an average annual rate of 5 percent from SFY 1995 to SFY 2000. Michigan spent an average of $4,926 per enrollee in federal fiscal year (FFY) 1998, and spending per enrollee grew by an average of 6.7 percent from 1995 through 1998, compared with 6.1 percent for the rest of the country (see table 4). Average yearly expenditure growth per beneficiary was highest at 10.4 percent a year for adults who received cash assistance followed by growth in average expenditures for the blind and disabled at 5.6 percent a year.

Michigan spent $6.1 billion in federal and state funds on Medicaid in FFY 1998, including $3.2 billion for acute care services, $2.2 billion for long-term care services, and $319 million for disproportionate share hospital payments.[10] From 1995 to 1998, the most recent year for which comparative data are available, Michigan's total Medicaid expenditures grew at an average annual rate of 4.7 percent compared with 3.9 percent in the nation. Long-term care expenditures grew fastest during this time period at an average annual rate of 7.8 percent, while acute services grew at a rate of 2.5 percent and DSH expenditures declined 10 percent a year on average.

Other Public Sources of Health Care Coverage

Although Medicaid is the primary source of publicly funded health care coverage, the federal State Children's Health Insurance Program, which Michigan implemented in 1998, is a new source of coverage for children. The state does not anticipate extending coverage to the parents of these children. In addition, some counties have undertaken other, smaller coverage initiatives for families.

State Children's Health Insurance Program

SCHIP provides states with grants to help create and expand insurance programs for low-income children through age 18. Michigan uses SCHIP funds to expand Medicaid coverage for children and to implement MIChild, a new children's health insurance program. Michigan's state matching rate for SCHIP is about 32 percent.

Prior to federal enactment of SCHIP, Michigan provided Medicaid coverage to children through age 15 in families with income up to 150 percent of FPL, with lower income eligibility thresholds for older children. Under SCHIP, the state expanded Medicaid to include children age 16 through 18 in families with incomes up to 150 percent of FPL, and MIChild began serving children through age 18 with family incomes between 150 and 200 percent of FPL. Medicaid was not the major focus of expansion under SCHIP because policymakers wanted to provide children with access to a program resembling mainstream insurance and avoid creating a new entitlement.

For children enrolled in MIChild, the benefit package is based on the state health employees' benefit plan, plus some additional benefits. For example, MIChild's vision and dental benefits are more generous than those offered in almost any other private plan. The MIChild program requires families with incomes exceeding 150 percent of FPL to pay premiums of $5 a month.

Although the Department of Community Health is responsible for administering both Medicaid and MIChild, the delivery systems for the two programs differ. Medicaid beneficiaries enroll in one of 19 HMOs, whereas three-quarters of MIChild participants enroll in the Blue Cross/Blue Shield PPO network and the remaining one-quarter enroll in one of a dozen HMOs. The Blue Cross network includes about 90 percent of the providers in the state.

SCHIP enrollment and expenditures were initially lower than anticipated but have grown over time. In December 1998, total SCHIP enrollment was 10,949.[11] According to state officials, by June 2001, 21,691 children were enrolled in MIChild and 29,626 in the SCHIP Medicaid expansion. This increase is due, in part, to the state's outreach efforts.

State efforts to increase outreach and enrollment have included major media campaigns, grants to local agencies, and the involvement of numerous state agencies. On the private side, the Blue Cross Blue Shield of Michigan (BCBSM) Foundation introduced an initiative called Seek-Find-Enroll: Reducing the Number of Uninsured Children in Michigan, which awarded grants to community coalitions to conduct outreach activities, identify and reduce barriers to enrollment, and enroll eligible children in Medicaid and MIChild. In addition, three Michigan communities—Detroit/Wayne County, Muskegon County, and the Upper Peninsula—benefit from a $1 million grant from the Robert Wood Johnson Foundation to help fund outreach.

Other Health Coverage Initiatives

There are several local initiatives within the state that provide health care coverage. Two notable ones exist in Wayne and Ingham Counties.

Wayne County (Detroit). Wayne County has two health programs for low-income residents: PlusCare and HealthChoice. Both programs receive a mix of Medicaid DSH, state, and county funds. PlusCare, which began in 1992, provides health care coverage to Wayne County residents ages 21 through 64 with incomes below $250 per month. Coverage includes physician services, inpatient and outpatient hospital care, and dental care. In 2000, approximately 30,000 individuals were enrolled.[12]

HealthChoice, which began in 1994, provides comprehensive care to uninsured workers. The program is available to Wayne County employers who have not offered coverage in the preceding 12 months, have at least five employees eligible for coverage, and employ a workforce where over half the employees receive less than $10 per hour. In 2000, approximately 20,000 individuals were enrolled.[13] The HealthChoice program requires that the employee and employer each pay one-third of the program's cost.

TABLE 3. Michigan Spending by Category, 1995 and 2000 ($ in Millions)

	State General-Fund Expenditures[a]				Total Expenditures[b]			
	Actual	Estimated	Annual Growth (%)		Actual	Estimated	Annual Growth (%)	
Program	1995	2000	MI	U.S.	1995	2000	MI	U.S.
Total	$7,840	$9,230	3	5	$26,226	$34,915	6	6
Medicaid[c,d]	$1,353	$1,863	7	5	$5,162	$6,449	5	4
% of Total	17%	20%			20%	18%		
K–12 Education	$704	$458	–8	7	$8,649	$11,160	5	7
% of Total	9%	5%			33%	32%		
Higher Education	$1,604	$2,014	5	5	$1,608	$2,255	7	5
% of Total	20%	22%			6%	6%		
Public Assistance	$500	$325	–8	–6	$1,158	$470	–17	–5
% of Total	6%	4%			4%	1%		
AFDC/TANF	*$377*	*$212*	*–11*	*–9*	*$1,025*	*$349*	*–19*	*–7*
% of Total	*5%*	*2%*			*4%*	*1%*		
Corrections	$1,141	$1,541	6	6	$1,168	$1,782	9	6
% of Total	15%	17%			4%	5%		
Transportation	–	$20	–	5	$1,916	$2,850	8	6
% of Total	0%	<.01%			7%	8%		
All Other[e]	$2,538	$3,010	3	5	$6,565	$9,953	9	8
% of Total	32%	9%			25%	29%		

Source: National Association of State Budget Officers 1997. *1996 State Expenditure Report.* and 2000. *1999 State Expenditure Report*.
a. State general-fund expenditures exclude other state funds and bond expenditures.
b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.
c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them.
d. Total Medicaid spending will differ from data reported on the HCFA-64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA-64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA-64.
e. This category could include spending for the State Children's Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.

Note: Figures may not add to totals due to rounding.

Ingham County (Lansing). In 1998, the Ingham County Health Department created the Ingham Health Plan (IHP), which provides outpatient hospital care and, as of October 2000, a pharmacy benefit to county residents with incomes below 250 percent of FPL. Care for residents with incomes below 100 percent of FPL is free, while care for those with higher incomes requires copayments. In 2000, the plan enrolled about 11,500 individuals.[14] Funding is provided through a mix of Medicaid DSH funds, state and county funds, and some funds from private foundations.

Acute Care Issues

Michigan has taken a number of steps to change its delivery of acute care services, including increasing reliance on Medicaid managed care, continued use of Medicaid disproportionate share hospital funding, and replacement of its existing pharmaceutical assistance programs with a more generous program. The state is also facing the outcome of a lawsuit related to services for children that could have implications for Medicaid programs nationwide.

The lawsuit—*Westside Mothers v. Haveman*—was brought by a group of mothers who wanted to force the state to provide Medicaid early and periodic screening, diagnosis, and

treatment (EPSDT) services as required by federal law.[15] A U.S. district judge sided with state officials by saying that Medicaid is a contract between the federal and state governments and that beneficiaries have no grounds to sue for delivery of benefits. The Westside Mothers have appealed this ruling to the U.S. Sixth Circuit Court of Appeals. If the district judge's ruling is upheld, Medicaid beneficiaries in Michigan would not be able to sue the state for provision of program benefits.

Medicaid Managed Care

About 70 percent of Medicaid beneficiaries are enrolled in managed care, with expenditures totaling $1.3 billion in SFY 2001. Michigan received a Medicaid freedom of choice waiver in 1997 that required Medicaid beneficiaries, except nursing home residents, those dually eligible for Medicare and Medicaid, and the medically needy, to enroll in HMOs. However, if there is not more than one HMO in a county, enrollment in HMOs is voluntary.

The selection of participating HMOs was initially controversial after the state held its competitive bidding process and recommended that only 13 of 24 bidding HMOs receive contracts. The state received appeals from 11 unsuccessful bidders and one plan filed suit complaining of a flawed bidding process. As a result, in 1998, the Department of Community Health recommended that 23 HMOs in nine regions of the state receive Medicaid contracts.

In large part due to managed care, Medicaid's annual cost increases shrank from 14 percent in 1994 to about 3 percent in 1999, and the state claims that it saved $110 million in 1998.[16] A majority of the state's HMOs lost money in 1998, which they blamed on low state Medicaid payments. State officials assert that those losses stemmed from a combination of commercial and Medicaid business.

During the second round of bidding for Medicaid HMO contracts in 2000, the state imposed data-reporting requirements on the plans, required new solvency protections, and is phasing in new quality standards. The Department of Community Health set a floor for bids and then the Michigan Insurance Bureau (now the Office of Financial and Insurance Services) determined whether the HMOs' bids were financially sound. The state's goal with the revisions to the bidding process is to have an adequate number of financially sound plans with sufficient capacity to provide quality care to beneficiaries. Nineteen HMOs received contracts, all but three of which serve predominantly Medicaid beneficiaries.

In response to health plan complaints and those of other providers, the state increased HMO rates by 4 percent in SFY 2000, by 11.7 percent in SFY 2001, and eliminated the requirement that plans be financially responsible for the cost of psychotropic medications.[17] As a result of these changes, plans are expected to show a profit on their Medicaid contracts in SFY 2001.

The state has used its role as a purchaser of services to improve its quality assurance for HMOs. Plans must report Health Employment Data Information Set (HEDIS) quality data and must have certification from either the National Committee on Quality Assurance or the Joint Commission on the Accreditation of Health Care Organizations by the summer of 2002. According to state officials, Medicaid-only plans are experiencing the most difficulty with these requirements because of the inherent complexity and lack of prior experience with this type of reporting. However, these HMOs are now engaging in more quality assurance activities.

Since 1999, the state has produced reports on HMO performance, which show generally good levels of consumer satisfaction but substantial variation among plans related to certain service delivery issues such as customer service, disabled beneficiaries' access to specialists, and provision of well-child services.[18]

The state encourages HMOs to use established clinical standards for treatment of diabetic, AIDS, cardiac, and asthma patients, among others. State officials reported that one of the Medicaid HMOs tried to implement disease management but found that two-thirds of

beneficiaries targeted had no phones, which are necessary for the periodic telephone contact that such management requires.

The key issues the state faces in dealing with managed care are relating payment rates to quality of HMOs' service delivery, ensuring adequate payment to HMOs, and determining how to provide prescription drugs without large cost increases. The state in particular is interested in performance-based contracting strategies.

Medicaid DSH and UPL Strategies[19]

Medicaid DSH and UPL strategies payments are a significant source of funds for publicly funded health care programs in Michigan. When using the Medicaid DSH strategy, states make lump-sum Medicaid payments to providers, obtain federal matching payments, and finance the state share with intergovernmental fund transfers. Because the payments are not based on actual services rendered, either the state or the provider can earn large net increases in federal funding, which they can use to provide health care to indigent persons. When using the UPL approach, states increase provider payment rates, generally to hospitals and nursing homes, collect federal matching payments on the higher rates, and finance the state's share with intergovernmental transfers. The federal UPL provisions prohibit aggregate payments to providers from exceeding payment that would have been made under Medicare's reimbursement policies. Despite these limits, the Medicaid rates are generally higher than costs, and funds are usually returned to the state.

Michigan has three DSH or UPL programs: (1) Disproportionate Share Payments to Public Hospitals (DSH); (2) Long-Term Care Adjuster Payments to County Medical Facilities and Hospital Long-Term Care Units (UPL); and (3) Outpatient Adjuster Payments to Public Hospitals (UPL). Disproportionate Share Payments to Public Hospitals are primarily payments to hospitals that serve high numbers of people with low incomes. These payments also help finance indigent care programs such as those described above in Ingham and Wayne counties. Payments to public hospitals, both state and locally owned, have been decreasing since federal restrictions on payments were imposed as part of the Balanced Budget Act of 1997. In SFY 2001 $258.6 million was appropriated to the Disproportionate Share Payments to Public Hospitals program. About $80 million was spent on DSH-funded indigent care programs that Wayne, Ingham, and Muskegon counties operated in SFY 2000. Long-Term Care Adjustor Payments are payments made to nursing facility units—county-owned medical care facilities and hospital chronic care units. In SFY 2001 $350.0 million was appropriated for these payments. Outpatient Hospital Adjustor payments are made to Hurley Hospital, one of the state's largest public hospitals. The payment is based on the difference between what Medicaid pays and what Medicare would have paid for the same outpatient services. In FY 2000–2001 $280.7 million was appropriated for these payments. The state calculates that it saved more than $484 million in state funds through the use of these three DSH and UPL strategies.

Prescription Drug Coverage for Medicaid and Medicare Beneficiaries

Michigan provides prescription drug coverage through its Medicaid program and a new pharmaceutical assistance program for aged Medicare beneficiaries. The primary concern about the Medicaid benefit is expected future growth in pharmaceutical expenditures, which currently absorb 15 percent of the Medicaid budget and are increasing more rapidly than any other service category, at 14 to 18 percent a year. The state estimates that drug expenditures will total $550 million in the fee-for-service sector in SFY 2001 and will rise to $720 million in SFY 2002. The state estimates that 20 percent of the $1.2 billion in Medicaid managed care expenditures is devoted to prescription drugs.

Michigan will contain pharmaceutical costs and improve quality assurance using several methods. Michigan's 2001 legislature asked the Department of Community Health to devise a pharmaceutical cost containment plan that will involve (1) negotiating the lowest possible prices from pharmaceutical companies, (2) creating of a list of recommended prescription drugs, and (3) requiring patients who want a prescription drug that is not on

TABLE 4. Medicaid Enrollment and Expenditures in Michigan, 1998

	Michigan, 1998			Average Annual Growth (%), 1995–1998					
				Total Annual Expenditures		Avg. Monthly Enrollment		Expenditures per Enrollee	
	Total Annual Expenditures (in millions)	Avg. Monthly Enrollment (in thousands)	Avg. Annual Expenditures per Enrollee	Michigan	United States	Michigan	United States	Michigan	United States
Total Expenditures	**$6,123**	**–**	**–**	**4.7**	**3.9**	**–**	**–**	**–**	**–**
Medical Services									
By Eligible Group	**$5,343**	**1,085**	**$4,926**	**4.5**	**5.1**	**–2.0**	**–1.0**	**6.7**	**6.1**
Elderly	$1,296	81	$15,990	4.5	4.3	1.9	0.1	2.5	4.2
Blind and disabled	$2,665	247	$10,769	8.7	8.5	3.0	3.6	5.6	4.7
Adults	**$617**	**205**	$3,011	–4.3	–1.4	–9.2	–4.4	5.4	3.1
Cash assistance	$340	99	$3,444	–11.3	–10.4	–19.7	–14.9	10.4	5.3
Other enrollees	$277	106	$2,608	8.7	7.8	8.6	9.3	0.1	–1.4
Children	**$766**	**551**	$1,389	0.1	2.7	–1.5	–1.5	1.5	4.3
Cash assistance	$300	210	$1,428	–15.9	–8.8	–19.0	–12.2	3.8	3.9
Other enrollees	$466	342	$1,365	21.4	12.4	23.4	9.8	–1.6	2.4
By Type of Service	**$5,343**	**–**	**–**	**4.5**	**5.1**	**–**	**–**	**–**	**–**
Acute care	$3,170	–	–	2.5	4.0	–	–	–	–
Long-term care	$2,174	–	–	7.8	6.5	–	–	–	–
DSH	**$319**	**–**	**–**	**–10.0**	**–7.3**	**–**	**–**	**–**	**–**
Administration	**$461**	**–**	**–**	**27.2**	**8.5**	**–**	**–**	**–**	**–**

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Notes: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. "Cash assistance" refers to enrollees who receive AFDC/TANF or SSI, or who are eligible under Section 1931 provisions. "Other enrollees" include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. "Acute care" services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to managed care organizations (MCOs), and payments to Medicare. "Long-term care" services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. "DSH" stands for disproportionate share hospital payments.

Figures may not add to totals due to rounding.

the list to obtain approval from a pharmaceutical benefit management company. The state estimates that it could save $60 to $100 million annually using this plan, which was implemented in 2002. In addition, the state will focus on using the least expensive therapeutically equivalent drugs and promoting use of effective medications, some of which are underused. For example, state officials say that certain communities do not make optimum use of psychiatric medications and may, as a result, experience high rates of inpatient psychiatric hospitalization.

In 1999, Michigan established the Elder Prescription Insurance Coverage program to provide coverage to aged Medicare beneficiaries. This program, which began enrollment in October 2001, provides pharmaceutical assistance to persons age 65 and older with incomes below 200 percent of FPL. Beneficiaries pay a sliding scale premium to enroll in EPIC. The state held a competitive bidding process and awarded the enrollment and pharmacy benefit management contract to First Health, which performs some of the same administrative functions for Medicaid.

EPIC replaces Michigan's two very limited, preexisting pharmaceutical assistance programs, which enrolled less than 1 percent of Medicare beneficiaries in 1999.[20] One program provided vouchers for purchase of prescription drugs to those with incomes below 150 percent of FPL who were spending 10 percent or more of their income on prescription drugs. The second program provided a tax credit to people with incomes below 150 percent of FPL who spent 5 percent or more of their income on prescription drugs.

The new EPIC program is more comprehensive than the two old programs and is being phased in by enrolling participants in the preexisting programs first. EPIC has an open formulary but does not cover cosmetic or lifestyle drugs; use of generic drugs is encouraged because this type of drug does not require a copayment. People are able to enroll by mail and can receive assistance in doing so from workers staffing a toll-free telephone number. Income is self-declared. EPIC cross-checks its enrollment with Medicaid files to avoid dual enrollment but does not require EPIC enrollees to apply for Medicaid. First Health negotiates rebates for the state and conducts prospective and retrospective drug utilization reviews. EPIC's funding for SFY 2001 comes from the two programs it replaces ($26 million) and tobacco funds ($30 million).

Issues in Long-Term Care for Older People and Younger Persons with Disabilities

Overview

Although institutions play a significant role in Michigan's long-term care system, the state has a large Medicaid home and community services waiver, a large Medicaid personal care program, and several much smaller state-funded programs. These programs for aged and disabled Medicaid beneficiaries are under the state's new Long-Term Care Initiative, which is intended to lead to a more coordinated system of services that will rely on capitated funding. The state has increased the number of state surveyors and implemented new quality assurance programs to address reports of poor quality care in nursing homes. Long-term care providers complain that they are experiencing difficulty recruiting and retaining workers, and the governor commissioned a study of the issue.

In 1998, Michigan began using a Medicaid waiver to establish a statewide Medicaid managed care program for long-term recipients of mental health, substance abuse, and developmental disability services. Local Community Mental Health Service Programs (CMHSPs) provide services under a prepaid, shared-risk arrangement.

Michigan has not developed a formal plan in response to the Supreme Court's *Olmstead* decision, which creates a limited right to home and community services for people with disabilities under certain circumstances. The state believes that it is already proactive in placing people with disabilities in the home and community.

Provider Supply

Michigan has a lower-than-average supply of nursing home beds and a substantial number of home health agencies.[21] In 1998, the state had 42.5 nursing facility beds per 1,000 persons age 65 and over, compared with a national average of 52.5.[22] According to the Health Care Association of Michigan, the nursing home census has remained at approximately 50,000 residents for the past 20 years. Michigan has experienced growth in the number of assisted living facilities, which are not subject to certificate-of-need or a moratorium on new construction. In 1998, Michigan had 37.8 nonresidential facility beds per 1,000 persons age 65 and over compared with the national average of 25.5.[23] The state does not track how many unlicensed assisted living facilities are operating. In 1998, Michigan had 251 certified home health agencies.[24]

Michigan's Medicaid spending on long-term care is dominated by institutions, with expenditures on nursing facilities consuming 52 percent of the long-term care budget and intermediate care facilities for the mentally retarded another 11 percent.[25] Medicaid expenditures on both types of facilities increased faster in Michigan from 1995 to 1998 than in the nation as a whole, but the state is increasing the resources it devotes to home and community services.[26]

Home and Community Services[27]

Michigan has several home and community services programs that serve aged and disabled Medicaid beneficiaries. The MI Choice Waiver for the Elderly and Disabled, which started on a pilot basis in 1992, provides a range of home care agency–based services to about 14,000 people who would otherwise be eligible for nursing home care at a cost of $101 million in SFY 2000. The Medicaid Home Help program (an optional personal care service), which began in the 1970s, covers personal care services using a consumer-directed model, where most beneficiaries hire and fire individual workers. For Home Help, beneficiaries do not need to be functionally eligible for nursing home services. The program had an average monthly census of 37,200 people and cost $157.7 million in SFY 2000.

In 2001, the Michigan Department of Community Health (MDCH) created the Long-Term Care Initiative that has administrative responsibility for all long-term care programs serving older persons and younger adults with physical disabilities, including the Medicaid MI Choice waiver and the Home Help program. The Long-Term Care Initiative is also responsible for developing and implementing a new, comprehensive long-term care system based on reforms recommended by the Long-Term Care Work Group in July 2000. The Work Group, which was composed of key stakeholders in the state's long-term care system, developed four service coordination models that the state plans to test in selected regions.[28] These models are designed to offer more choice to beneficiaries and to contain costs by managing the full range of long-term care services in return for capitated payment. The Long-Term Care Reform Plan's ultimate objective is to integrate Medicare and Medicaid funding for dual eligibles with disabilities and to deliver services through a statewide integrated managed long-term care system that is capitated and at risk.

The Long-Term Care Initiative has funded innovative projects designed to lead to the integrated system it envisions; among the projects funded are some that are targeted to worker development and training initiatives. These projects were funded in response to concerns about the difficulties that providers report they are having in recruiting and retaining workers.

Nursing Homes

While implementing the Work Group's recommendations, the state is changing its current long-term care system in several respects. The state is redesigning its nursing home level of care criteria; the existing criteria, which are used to determine whether nursing home residents qualify for Medicaid coverage, are considered too vague. Nursing homes will begin operating under a Medicaid case-mix reimbursement system, which relates payment

to the care needs of residents. The state also applied for and received nursing home transition grants designed to help nursing home residents move to the community.

Quality of care in Michigan's 450 nursing homes is the subject of both federal and state scrutiny. In response to increased federal oversight,[29] Michigan conducted its own review of state survey and certification and found that loss of state inspectors helped lead to a large backlog of complaints. The Senate Fiscal Agency found that from 1994 through 1998 Michigan placed in the top five states in terms of the average number of deficiencies per facility,[30] which could indicate either poor quality care or vigorous inspection efforts.

In response to these reports, the state has taken a number of steps to increase its quality assurance activities for certified nursing facilities.[31] Michigan created additional inspector positions and worked to fill existing vacancies, implemented an early review process to detect problems at facilities between surveys, hired a contractor to consult with homes that are not in compliance with quality standards, created a Quality Improvement Nurse Program, where nurses provide technical assistance to borderline facilities, and established awards for innovative quality improvement projects in nursing homes.

Twelve nursing homes closed between 1998 and 2000, and the explanations about why vary, depending on the viewpoint of the observer.[32] Critics of the nursing home industry say that homes have had financial problems due to poor management and that they failed to meet quality assurance standards. The industry claims that the closures occurred because of tough state and federal inspections, low Medicaid and Medicare reimbursement rates, and an increased availability of alternatives to nursing homes. A report from the Michigan senate shed light on the reimbursement issues by showing that Medicaid nursing home payments have increased nearly twice as fast as the nursing home inflation index, and in the FY 2001 state budget homes receive an additional $52 million, a 5.4 percent increase over the prior year.[33]

Developmental Disability and Mental Health Services

In 1998, Michigan instituted major reforms to its service systems for people with developmental disabilities or mental health conditions. In June 1998, Michigan received federal approval for a freedom of choice waiver to establish a statewide Medicaid managed care program for long-term recipients of mental health, substance abuse, and developmental disability services. Under the two-year waiver, the Department of Community Health contracted with CMHSPs to manage and provide Medicaid mental health, substance abuse, and developmental disability services and supports under a prepaid, shared-risk arrangement.

The priority populations for the CMHSPs are those with the most serious disabilities. The programs also have responsibility for preadmission screening for people entering inpatient psychiatric facilities. The programs provide limited services to people who are not Medicaid-eligible in return for income-based fees. The CMHSPs have separate clinical directors and contractual requirements for the programs serving people with mental illness and developmental disabilities.

In SFY 2000, about 200,000 of the state's 1.1 million Medicaid enrollees received mental health services, about 23,000 received developmental disability services, and over 80,000 received substance abuse services from 49 CMHSPs. The total budget for these services under the two-year waiver is $1.9 billion.[34] The capitation rates the programs receive are based on previous fee-for-service experience, and rates are adjusted by age, disability, and a developmental disability—but not a mental illness—intensity factor.

Quality assurance for CMHSPs involves a number of different mechanisms. Most programs are certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Rehabilitation Accreditation Commission. In addition, the programs' contracts require them to identify their competencies and infrastructure available to carry them out, and to demonstrate the ability to assume risk for delivering services. The programs have performance objectives and quality indicators related to access to services, efficiency, and outcomes for participants. Every year a site review team visits each CMHSP

and identifies areas for improvement, and the programs develop plans of correction if necessary. The state also provides technical assistance to help programs develop and implement their correction plans. The programs conduct consumer satisfaction surveys of a random sample of users of services. Response rates to the mail survey are 30 percent among those with developmental disabilities and 20 percent for those with mental health conditions. The state is trying to work with disability organizations to improve the response rate.

Under the 1998 waiver, the state contracted with CMHSPs without using a competitive bidding process, but during negotiations with the federal Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) over renewal of the 1998 waiver, the state had to agree to implement a competitive bidding process for the new contracts. The state is giving CMHSPs the first opportunity to meet the capitated contractual requirements and, if a program cannot meet these requirements, then the bidding will be opened to private competitors. The new conditions include requiring programs to have service areas with at least 20,000 Medicaid beneficiaries, meet the needs of beneficiaries who have limited English proficiency, provide EPSDT for children, have an appeals process and grievance procedures, engage in more quality assurance activities, submit more outcome data, and set up jail diversion programs. Local programs are affiliating with one another to submit bids; some of the smaller boards are specializing in service delivery and the larger ones are specializing in administrative services.

Regarding mental health, the state closed 12 state mental health institutions between 1990 and 1998.[35] A report by the Michigan Mental Health Association found that many previously institutionalized people did not receive proper treatment for their illness and, as a result, committed crimes and were jailed.[36] The report also stresses that there are not enough inpatient beds for people who need hospitalization for 90 days or longer and that there are not enough programs in the community to fill the void. According to the Association, part of the problem is inadequate funding; in 1998, 41 percent of the $1.5 billion spent on community mental health programs went to people with mental illnesses, which is $3,900 per adult and $2,600 per child, much less than the cost of one year's worth of some psychiatric medications.

Other Issues

The health care industry has overtaken the motor vehicle manufacturing industry as the largest private contributor to the state's employment base,[37] and the number of HMOs has increased in recent years. These plans have experienced financial difficulties, which has led to more oversight on the part of state regulators. And providers complain of loss of revenue due to publicly funded health programs' cost containment measures.

Insurance Market Developments and State Regulation

Michigan's insurance market is unique because of the influence of the big three automakers—General Motors, Ford, and Chrysler—and the dominance of Blue Cross Blue Shield of Michigan (BCBSM). General Motors alone provides coverage for over one million employees, retirees, and their families, while BCBSM covers over half of the state's insured population. The big three automakers actively influence the health care delivery system in Michigan. Historically, the automakers focused on cost, but now there is an increased emphasis on quality and satisfaction with services.[38]

In 2000, HMO penetration was about 27 percent, or 2.7 million enrollees.[39] Between 1993 and 1998, HMO enrollment growth averaged 8 percent per year; it was 5 percent between 1998 and 1999 and declined between 1999 and 2000.[40]

As of March 2001, there were 29 HMOs, up from 19 at the end of 1999. The increase comes from a number of Medicaid health plans converting to licensed HMOs and HMOs setting up separate regional health care plans. HMOs in Michigan are primarily local. Only the Blue Cross Blue Care Network provides coverage in most counties.[41] Partly as a result, HMO penetration varies by region.

Developments in the state's insurance market, including HMOs' financial losses, have prompted renewed state oversight. Between 1997 and 1999, the states' HMOs, as a whole, lost money. In 1999 alone, 21 HMOs lost money, but the losses were smaller than in the previous year. Losses were due to HMOs offering low premiums in the competition to gain market share. Plans responded to earlier losses, in part, by raising premiums. In 2000, HMO finances began to improve, with most plans making a profit or reducing their debt.[42]

During the past few years, Michigan has enacted numerous patient protection laws, which can affect HMO finances and operations. For example, in October 1997, four patient protection laws took effect, which were revised somewhat in June 2000. Known together as the Patient Bill of Rights, the bills require insurers, HMOs, and BCBSM to provide information on covered services, physicians' professional credentials and disciplinary records, and financial relationships between the health plans and physicians. Each plan must also offer a toll-free insurance question hotline and consumer grievance procedures with a state-set resolution timeline. Grievance procedures grant enrollees the opportunity to appeal claim denials or make complaints within the health plan. Grievances must be settled in 35 days for most patients and 3 days for the severely ill.[43] In addition, Governor Engler signed into law five bills governing HMOs in 2000.[44] The laws codify HMO appeals processes and create an independent external review process, increase financial reserves, and require the production of a consumer guide to HMOs. The bills also limit HMOs' ability to offer providers financial incentives to limit care.

Health Care Market Developments

In 1999 all of Michigan's 145 community hospitals were nonprofit.[45] The hospital market in Michigan has shrunk considerably since the mid-1980s, when the state had roughly two dozen more hospitals. The decrease in the number of hospitals in rural areas has been greater than in urban areas. Correspondingly, the number of staffed beds and admissions has also decreased. In recent years, the number of inpatient days decreased, while the number of outpatient visits has increased. The shift to outpatient care has occurred at a faster pace in Michigan than in the United States as a whole, but hospital occupancy has held steady at 64 percent.[46]

The Michigan Health & Hospital Association asserts that Medicare and Medicaid cost containment measures have resulted in $537 million of lost revenue between 1997 and 2000 across the 50 hospitals the association surveyed.[47] Hospitals have responded by reducing staff, terminating health plan contracts, eliminating services, and delaying technology and capital purchases. Two-thirds of the hospitals interviewed had eliminated or reduced patient programs since 1997. Hospitals are also sharing business functions. Unaffiliated hospitals do this by standardizing and reengineering major business processes, including customer management, finance, human resources, supply, and purchasing management and information systems.

Conclusion

Michigan is faced with a softening economy and a challenge in containing Medicaid costs, particularly those related to prescription drugs. The state has already undertaken a major effort to contain program costs through the use of HMOs. Although the implementation of this effort was controversial, the situation has stabilized with the state increasing payment rates and implementing requirements regarding payment to providers and protections for enrollees, which could adversely affect HMOs' costs.

Since the late 1990s, the state has implemented two major expansions of health care coverage—the State Children's Health Insurance Program and Elderly Prescription Insurance Coverage. The program for children experienced slow initial enrollment, but the state has tackled that issue with an increased outreach effort. However, the state has no plan to extend the program to the parents of enrolled children. The prescription drug program began in October 2001, and the program's experience with prescription drug cost

increases will be instructive given the recent rapid escalation of prescription drug use in the Medicaid program.

As in acute care, the Medicaid program has used managed care principles to reform its service delivery systems for persons with disabilities. The state is moving toward a capitated system to deliver long-term care services to aged and disabled Medicaid beneficiaries. People with mental health conditions or developmental disabilities already receive their services through a capitated managed care system. The effects on beneficiaries of this pronounced trend toward managed care under Medicaid will be a key issue for the state, as will managed care's effects on cost growth.

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h. The National Conference of State Legislatures. 2001. http://www.ncsl.org/ncsldb/elect98/partcomp.cfm?yearsel=2001. Note: D indicates Democrat, R indicates Republican, I indicates Independent, O indicates other, V indicates Vacant.

i. Two Urban Institute calculations: (1) Average monthly number of AFDC 1996 recipient children divided by number of children in poverty in 1996: U.S. Department of Health and Human Services. Administration for Children and Families. 1997. *Characteristics and Financial Circumstances of AFDC Recipients FY 1996.* Table 18. "Percent Distribution of AFDC Recipient Children by Age (October 1995–September 1996)"; (2) Average monthly number of TANF 1998 recipient children divided by number of children in poverty in 1998: U.S. Department of Health and Human Services. Administration for Children and Families. 1999. *Second Annual Report to Congress August 1999.* Table 9:22. "Percent Distribution of TANF Recipient Children by Age Group (October 1997–September 1998)." The numbers of children in poverty in 1996 and 1998 are Urban Institute calculations from the National Survey of America's Families II.

j. Based on three sources: (1) Urban Institute's TRIM [Transfer Income Model]; (2) Smith, Vernon K. 1999. "Enrollment Increases in State CHIP Programs: December 1998 to June 1999." Health Management Associates, July; (3) Urban Institute analysis of *1999 SCHIP [State Children's Health Insurance Program] Annual Report.* Rules for 1996 and 1998 are policies in place the majority of the year. Rules for 2000 represent plans approved as of January 1, 2000.

k. In 1996, the threshold represents the state Medicaid threshold for poverty-related eligibility or AFDC-related eligibility. Higher thresholds for separate state-financed programs (such as in New York) are not represented here.

l. The figure for 1998 represents the higher of the state threshold for Medicaid eligibility, or the state threshold for Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.

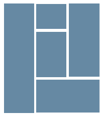
m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are only eligible through Medicaid.

About the Authors

Jane Tilly is a senior research associate in the Urban Institute's Health Policy Center with over 15 years of experience in public policy analysis and research. Her primary research interests are related to end-of-life care, long-term care, and prescription drugs. She has recently completed research on Medicaid and end-of-life care, Medicaid's role in state home- and community-based care systems, pharmaceutical assistance programs for older persons and people with disabilities, and health care workers. She also has prepared a long-term care chartbook for the Congressional Research Service and completed research on consumer-directed home and community services.

Frank C. Ullman at the time of this research was a research associate with the Urban Institute's Health Policy Center, where he focused on implementation of the State Children's Health Insurance Program.

Julie Chesky is a project associate in the Urban Institute's Health Policy Center. She provides project management and research support on a variety of health-related projects including Medicaid, Medicare, long-term care, managed care, and child health issues.



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2100 M Street, N.W.
Washington, D.C. 20037
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Phone: (202) 833-7200
Fax: (202) 728-0232
E-mail: pubs@ui.urban.org

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