Health Policy for Low-Income People in Michigan

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This report is part of The Urban Institute's *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Project codirectors are Anna Kondratas and Alan Weil.

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About the Series

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility from the federal government to the states for health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments, along with changes in family well-being. The project aims to provide timely nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation's population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the

dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-recourse safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of *Assessing the New Federalism* will include studies of the variation in policy choices made by different states.

Contents

Highlights of the Report

Michigan has adopted a fairly standard mix of policies designed to address costs of and access to health care services for the low-income population. The four primary features of the Michigan approach are greater use of managed care in Medicaid, significant efforts to maximize receipt of federal funds, reorganization of state agencies, and the use of limited state and local programs to provide insurance for low-income children. The change in 1990 from Democratic control of the governor's office to Republican Governor John Engler may have affected how these policies were implemented. However, despite this political shift, health policy in Michigan is characterized more by incremental modifications of long-standing policies than by dramatic departures from the past.

Michigan is well situated to respond to changes in health care relative to many other states. A relatively low proportion of its population is without health insurance (10.4 percent versus the national average of 15.5 percent). This low rate is likely attributable to the strong union presence, which leads to a higher proportion of employees having coverage, and to the state's relatively broad eligibility standards for its Medicaid program. Per capita income in Michigan is above the national average and over the last five years has grown at a rate faster than the national average.

Rapid budget growth in the Medicaid program in the early 1990s, coupled with the election of Governor Engler, who has advocated tax cuts, has created pressure for significant Medicaid cost-containment efforts. Most notably, Medicaid spending per elderly enrollee is far above the national average and between 1992 and 1995 grew at a rate three times the national average. Medicaid cost growth has had such a negative effect on the state's ability to spend on other programs that the current administration has established a

3 percent annual growth target for Medicaid, which would prevent the program from consuming an ever-growing portion of the state's budget.

In April 1996, the state announced plans to move nearly all Medicaid beneficiaries into capitated managed care plans. The state's plan to increase its reliance on managed care in Medicaid is fairly typical. However, the plan reaches further than many states in its use of managed care for disabled populations and long-term care services and in the fairly rapid pace of expected implementation. The plan consists of five separate components, the largest of which is the "comprehensive plan," covering all Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) clients. Starting in 1997 in Southeast Michigan, clients enrolled in the state's Physician Sponsor Plan, a primary care case management program, will be expected to enroll in health maintenance organizations (HMOs) or other capitated plans. Enrollment for the four remaining components—services for children with special health care needs, long-term care services, behavioral health services, and services for people with developmental disabilities—is scheduled to commence in 1998.

Michigan has been quite aggressive in its efforts to receive federal matching funds through the Medicaid program. The primary vehicle for these efforts has been the disproportionate share hospital (DSH) program and provider payment adjustments with the state share financed with intergovernmental transfers. An indication of the scope of Michigan's effort is that, in 1996, more than one-third of the state appropriation for Medicaid consisted of intergovernmental transfers, rather than appropriations from the general fund. Through extensive use of DSH and related payment systems, the state has increased federal revenues for the state government and increased payments to health care providers.

In 1996, Michigan combined the three state agencies responsible for most health programs. The Medicaid program, the public health agency, and the administration of programs for developmental disabilities and mental health were placed in a single agency, the Department of Community Health. The objective of the consolidation was to help the state become a better purchaser—one that could command better quality and lower prices—for the populations it serves. Despite the consolidation, the three former agencies retain their status as separate divisions within the new department. It appears that it will take some time for the new agency to overcome the historical separation of its various functions.

The reorganization of state health-related agencies has accompanied changes in the state's public health activities. The state has made a significant investment in public health, largely with new revenues derived from an increased tobacco tax. New public health funding has been targeted toward population-based services and an incentive system that provides matching payments to counties for certain services such as well-child visits and immunizations.

Michigan has put into place limited programs to address the health care needs of the uninsured. The state administers the State Medical Program, which covers about 11,500 people who are enrolled in one of two state income assistance programs. Like some other states, Michigan has a Blue Cross/Blue Shield Caring Program for Children, which provides limited health benefits to 4,500 low-income children. Wayne County, the largest county in Michigan (which includes the city of Detroit), has also developed programs: PlusCare, which serves about 40,000 people, and HealthChoice, which covers 4,000 people using funding from employers, employees, and the county. Together, these programs reflect a quite modest effort to address the needs of a portion of the uninsured population.

In addition to these features of the Michigan health care system, two characteristics of the market set Michigan apart from most of the rest of the country. First, all acute care hospitals in the state are not-for-profit, and competition among hospitals seems less aggressive than in other states. Second, Blue Cross/Blue Shield of Michigan dominates the private health insurance market and has a sizable share of the HMO market as well. Michigan is also one of relatively few states that have not adopted significant reforms in the small-employer insurance market. These two facts are presumably related. Blue Cross/Blue Shield employs open enrollment periods and uses community-rated policies in the small-group and individual markets. Thus, its dominance of the market means that certain reforms adopted by other states to reduce risk-skimming behavior have limited relevance in Michigan.

Michigan has been aggressive in its approach to deinstitutionalizing its developmentally disabled and severely mentally ill population. However, the state has been quite cautious in the use of waivers to provide alternatives to institutional care for the elderly. In 1996, more than 10 times as many Medicaid elders were in nursing homes as were served through the state's home and community-based waiver program. The state plans to expand this program in the near future.

The route Michigan has taken in providing health care services to its low-income population raises three major challenges. First, there is some question as to whether the state will be able to realize its quality and cost objectives in Medicaid through its use of managed care. Michigan will likely face barriers that other states have experienced in its efforts to enroll people with disabilities in managed care. The state has established fairly optimistic assumptions about the savings that are likely to accrue from managed care competitive bidding. In addition, the state may face difficulties related to rapid enrollment of the Medicaid population into managed care. Given a 3 percent annual cost growth target, how will the state respond if any of these barriers prevent that target from being met?

Second, recent and future changes in the federal Medicaid law may affect Michigan's ability to continue its heavy reliance on federal funds. With general reductions in DSH, the state will be forced to allocate new state funds to the

program or adopt even greater cost-containment measures to meet its budget targets. At the same time, the repeal of the federal Boren amendment will allow the state to reduce hospital and nursing home payment rates. These federal Medicaid changes will likely have a significant effect in Michigan.

Third, many people in Michigan seem unsure of the likely effects of changes driven by welfare reform. The various state and county programs are very much in flux, reflecting changing political priorities and the possibilities created by welfare reform. For example, when the state eliminated its General Assistance cash program it also replaced the adjunct medical assistance program with a far more limited State Medical Program. At the same time, as part of its welfare reform plans, the Engler administration and many legislators support a proposal to extend Medicaid benefits to former welfare recipients. These changes suggest an effort to realign medical assistance around broader principles and objectives of welfare reform.

Safety net providers will need to adjust to the changes brought by Medicaid managed care. Federal policy changes in Medicaid will likely affect the state's ability to use intergovernmental transfers to obtain federal matching funds. At this point it is unclear if these changes in Michigan's health programs will reduce or increase the financial burden on safety net providers and access to care for the uninsured.

Overview of Michigan

Sociodemographic

In 1995, Michigan had a population of 9.6 million, which has been relatively stable since 1990. The state's population has grown at half the rate of the U.S. population in the 1990s (table 1), although this is faster than growth experienced in the 1980s, when the state population actually declined. One in seven people (13.9 percent) in the state has income below poverty, slightly less than in the nation (14.3 percent). Compared with the United States as a whole, Michigan has a higher proportion of African Americans but a lower concentration of other minorities (e.g., Asian, Hispanic). However, the Detroit area is home to the largest concentration of people of Arabic origin in the country. The majority of the state's population resides in the seven-county (Wayne, Oakland, Macomb, Washtenaw, St. Clair, Monroe, and Livingston) Southeast Michigan area. The state also has several other urban centers and large rural areas in the northern portion of the Lower Peninsula and most of the Upper Peninsula.

Economic

Michigan's economy has diversified over the past 15 to 20 years, but it still depends heavily on the "Big Three" automakers and their suppliers. Currently, Michigan's economy is strong. The unemployment rate is slightly less than that of the United States (4.9 percent in 1995 versus 5.4 percent for the nation), and the percentage of nonelderly people without health insurance is also relatively low (10.4 percent). AFDC rolls declined from about 225,000

Table 1 *State Characteristics*

	Michigan	United States
Sociodemographic		
Population (1994–95)[a] (in thousands)	9,555	260,202
Percent under 18 (1994–95)[a]	27.6%	26.8%
Percent 65+ (1994–95)[a]	12.4%	12.1%
Percent Hispanic (1994–95)[a]	1.7%	10.7%
Percent Non-Hispanic Black (1994–95)[a]	13.7%	12.5%
Percent Non-Hispanic White (1994–95)[a]	81.8%	72.6%
Percent Non-Hispanic Other (1994–95)[a]	2.7%	4.2%
Percent Noncitizen Immigrant (1996) *	2.3%	6.4%
Percent Nonmetropolitan (1994–95)[a]	16.1%	21.8%
Population Growth (1990–95)[b]	2.7%	5.6%
Economic		
Per Capita Income (1995)[c]	$23,915	$23,208
Percent Change in Per Capita Personal Income (1990–95)[c,d]	27.8%	21.2%
Percent Change in Personal Income (1990–95)[c,e]	31.1%	27.7%
Employment Rate (1996)[f,g]	63.1%	63.2%
Unemployment Rate (1996)[f]	4.9%	5.4%
Percent below Poverty (1994)[h]	13.9%	14.3%
Percent Children below Poverty (1994)[h]	22.0%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)[a]	10.4%	15.5%
Percent Medicaid—Nonelderly (1994–95)[a]	11.5%	12.2%
Percent Employer Sponsored—Nonelderly (1994–95)[a]	74.4%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)[a,i]	3.7%	6.2%
Smokers among Adult Population (1993)[j]	25.1%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)[k]	7.8%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)[l]	8.5	7.6
Premature Death Rate (Years Lost per 1,000) (1993)[m,n]	54.5	54.4
Violent Crimes per 100,000 (1995)[o]	687.8	684.6
AIDS Cases Reported per 100,000 (1995)[j]	12.6	27.8
Political		
Governor's Affiliation (1996)[p]	R	
Party Control of Senate (Upper) (1996)[p]	16D-22R	
Party Control of House (Lower) (1996)[p]	57D-52R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited by the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.

b. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1996* (116th edition). Washington, D.C., 1996. 1995 population as of July 1. 1990 population as of April 1.

c. *State Personal Income, 1969–1995.* CD-ROM. Washington, D.C.: Regional Economic Measurement Division (BE-55), Bureau of Economic Analysis, Economics and Statistics Administration, U.S. Department of Commerce, October 1996.

d. Computed using mid-year population estimates of the Bureau of the Census.

e. Personal contributions for social insurance are not included in personal income.

f. U.S. Department of Labor. *State and Regional Unemployment, 1996 Annual Averages.* USDL 97-88. Washington, D.C., March 18, 1997.

g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

h. CPS three-year average (March 1994–March 1996 where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.

i. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

j. Normandy Brangen, Danielle Holahan, Amanda H. McCloskey, and Evelyn Yee. *Reforming the Health Care System: State Profiles 1996.* Washington, D.C.: American Association of Retired Persons, 1996.

k. S.J. Ventura, J.A. Martin., T.J. Mathews, and S.C. Clarke, "Advance Report of Final Natality Statistics, 1994." *Monthly Vital Statistics Report*; vol. 44, no. 11, supp. Hyattsville, MD: National Center for Health Statistics, 1996.

l. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for 1995." *Monthly Vital Statistics Report*; vol. 44, no. 12. Hyattsville, MD: Public Health Service, 1996.

m. ReliaStar Financial Corporation. *The ReliaStar State Health Rankings: An Analysis of the Relative Healthiness of the Populations in All 50 States* , 1996 edition, Minneapolis, MN: ReliaStar, 1996.

n. Race-adjusted data, National Center for Health Statistics, 1993 data.

o. U.S. Department of Justice, FBI. *Crime in the United States, 1995.* October 13, 1996.

p. National Conference of State Legislatures. *1997 Partisan Composition, May 7 Update.* D indicates Democrat and R indicates Republican.

families in early 1995 to around 170,000 in late 1996, while Medicaid enrollment declined from 1.2 million individuals[1] in late 1994 to 1.1 million in late 1996. Per capita income ($23,915) is higher than the national average ($23,208) and grew more from 1990 to 1995 than in the nation overall (27.8 percent versus 21.2 percent). While these trends boost Michigan's revenues, they also reduce the federal Medicaid match rate—a cause of some concern to state budget officials.

Political

Michigan historically had a strong Democratic tradition, and Detroit was for decades the state's center of political power. Both situations have changed significantly in the past several years. Republican Governor John Engler, the former majority leader in the State Senate, was elected in 1990, and his popularity grew as he championed tax cuts and devolution of power to local communities. He was re-elected in 1994 by a substantial majority. In 1994, Republicans also gained majority control of the House, with a slight majority of 56 members to 54 Democrats. Democrats regained control of the House in the 1996 elections; they now have 57 members to 52 Republicans. Republicans retained control over the Senate; in 1994, they held 22 seats to the Democrats' 16, and this lead remained the same after the 1996 elections.

At the time of the site visit, relations between Governor Engler and the majorities in the state legislature were very good. Engler enjoyed strong support from Republicans in both houses, many of whom rode his coattails to victory in 1994. There was some tension between the House and Senate, as many House members were expected to run for the Senate in the next election because of the recent passage of a term-limit law.

Governor Engler's priorities and interests have focused on welfare, job growth, tax cuts, and corrections. He has been one of the leading governors on national welfare reform, pushing for changes in federal law, and he has made a priority of implementing welfare reform in Michigan as well. His campaign platforms and subsequent legislative and budget priorities also emphasized economic and public safety issues. For example, despite significant reductions in growth in most budget categories in the 1990s, spending by the Department of Corrections rose by 41 percent from 1990 to 1995.[2]

In general, health policy issues have been a high priority of the governor and the legislature, because of the importance of health in the overall budget and because of the size and growth of the Medicaid program over time. During 1996, reorganization of state health agencies and Medicaid managed care initiatives were prominent because of their potential to keep the growth of health care costs in line and to prevent the need for higher taxes to support these programs.

The rapid growth of Michigan's total and general-fund expenditures in the first half of the decade—averaging 8.4 percent and 8.6 percent per year, respec-

Table 2 *Michigan Spending by Category, 1990 and 1995 ($ in Millions)*

Program	State General-Fund Expenditures [a] 1990	1995	Annual Growth	Total Expenditures [b] 1990	1995	Annual Growth
Total	$10,012	$15,099	8.6%	$17,529	$26,222	8.4%
Medicaid [c,d]	1,151	1,353	3.3	2,571	5,162	15.0
% of Total	(11.5)	(9.0)	—	(14.7)	(19.7)	—
Corrections	765	1,141	8.3	788	1,168	8.2
% of Total	(7.6)	(7.6)	—	(4.5)	(4.5)	—
K–12 Education [e]	2,995	7,963	21.6	3,527	8,649	19.6
% of Total	(29.9)	(52.7)	—	(20.1)	(33.0)	—
AFDC	543	377	(7.0)	1,289	1,025	(4.5)
% of Total	(5.4)	(2.5)	—	(7.4)	(3.9)	—
Higher Education	1,467	1,604	1.8	1,471	1,608	1.8
% of Total	(14.7)	(10.6)	—	(8.4)	(6.1)	—
Miscellaneous [f]	3,091	2,661	(3.0)	7,883	8,610	1.8
% of Total	(30.9)	(17.6)	—	(45.0)	(32.8)	—

Source: National Association of State Budget Officers, *1992 State Expenditure Report* (April 1993) and *1996 State Expenditure Report* (April 1997).

a. State spending refers to general-fund expenditures plus other state fund spending for K–12 education.

b. Total spending for each category includes the general fund, other state funds, 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., does get included in state spending because states cannot separate them. Michigan reported other state funds of $18 million in 1990 and $873 million in 1995.

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. In 1994, Michigan enacted a finance reform plan that shifted the majority of the education costs to the state and reduced local property taxes. Increased state expenditures were paid for by increases in sales tax and other taxes.

f. This category includes all remaining state expenditures (e.g., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.

tively—was a significant force shaping the current political climate (table 2). (A large share of this growth is attributed to increases in state expenditures on K–12 education due to a shift in financing away from local governments.) During this same period (1990–95), total Medicaid program spending grew at an average annual rate of 15.0 percent, accounting for 19.7 percent of total state spending by 1995 compared with 14.7 percent in 1990. However, it should be noted that the state's general-fund spending on Medicaid averaged only 3.3 percent growth per year during this period; most of the increases in program spending were thus due to growth in federal dollars (table 2).

The state's general-fund spending appears to have slowed in the second half of the decade. From FY 95 to FY 96, general-fund revenue grew by 4 percent overall.[3] In the near term, state revenue is expected to grow at about 3 percent per year, assuming that the state's recent high-growth economy continues and

there is no change in state fiscal policy. Department of Community Health and other administration officials use this 3 percent growth estimate as their target for Medicaid spending. This target would limit Medicaid spending growth to the level generated by the economy, with no further tax increases or spending shifts from other areas. In 1997 and 1998, the general fund will shrink because of a transfer of revenues to the school aid fund mandated by the 1994 overhaul of the state tax system.[4] This does not, however, affect the goal of a 3 percent cap on Medicaid growth.

State–local government relations are very important in Michigan. The 83 county governments, along with some of the major city governments, are responsible for managing many of the state's public health, mental health, and social service programs. Counties also share in the financing of some of these programs; for example, they pay 10 percent of the nonfederal share for Medicaid services delivered by county mental health agencies. In Michigan, responsibility for mental health and developmental disability programs has almost completely devolved to local jurisdictions—more so than any other government-administered health program in the state.

Tensions have long existed between Southeast Michigan, where the majority of the population lives, and "outstate"—all areas outside Southeast Michigan. As Detroit's population has shrunk, the political power base has also shifted. In recent years, the Republicans' rise to power in the state has been accompanied by a shift of power from Detroit/Southeast Michigan to outstate. For example, analysts and state officials noted that conservative officials loyal to Engler were brought in from western and central Michigan communities to run the state bureaucracies, sweeping out the old guard of Democratic officials sympathetic to Detroit interests.

Roadmap to This Report

The remainder of this report lays out the major issues, initiatives, and challenges in health care facing the state policymakers in the fall of 1996. Information was obtained during a site visit to the state in September and October 1996. Although some follow-up calls were placed after that time to obtain updated facts or data, the information is primarily based on what was known at the time of our visit. The report describes the state's current health care agenda and recent spending trends, describes the organizational structure of state health programs, and gives some sense of prevailing attitudes toward meeting the health care needs of the poor. It then delves into the specifics of Medicaid eligibility, managed care programs, provider reimbursement, and long-term care policy. The report describes how state policies are affecting the health care delivery system for poor people in Detroit and describes the long-term care delivery system for elderly and disabled individuals. It concludes with some predictions for how the situation might change in the future.

Setting the Policy Context

Overview of the State's Health Care Agenda

The most significant health care issue for the state, providers, and consumers at the time of our visit was an initiative to move nearly all Medicaid patients into capitated managed care plans (with limited exceptions) over the next three years. This initiative was slated to begin in May 1997 in five counties in Southeast Michigan and will then extend to the rest of the state in phases. The move to capitated managed care defines the parameters for almost every other state health program, and these programs (maternal and child health, mental health, long-term care) are trying to adapt to its models and expectations. The initiative's ramifications for the health care market are also enormous: Medicaid has become the biggest new market for managed care plans. The initiative also reflects the Engler administration's desire to privatize Medicaid and reduce the size of state government.

The plan to expand Medicaid managed care drove the recent reorganization of state government, which consolidated health agencies—Medicaid, public health, and mental health and developmental disabilities—into one umbrella agency called the Department of Community Health. The reorganization was accompanied by shifting power over Medicaid policy from the Department of Social Services (now called the Family Independence Agency) to the new Department of Community Health. The reorganization also signals a desire to devolve more responsibility for health care from the state to the community level, although how this will occur was not clearly articulated.

Among those interviewed, there was broad consensus that eligibility for Michigan's Medicaid program is generous, at least with respect to coverage for pregnant women and children. At the time of the site visit, Medicaid officials were unaware of the details in the new federal welfare reform law and did not know how they would decide on various state options regarding Medicaid eligibility. (Some decisions have since been made; see pp. 22–24.) They knew of some Medicaid-related eligibility changes proposed by the Family Independence Agency but supported only two of these changes: extending transitional Medicaid assistance and allowing former AFDC recipients whose transitional coverage expires to "buy in" (pay a premium) to continue Medicaid coverage. The latter proposal was the only Medicaid-related change requiring a federal waiver that was approved by the Health Care Financing Administration (HCFA).

Further expansion of Medicaid or other coverage to the uninsured in the state is unlikely. While administration officials have said that future savings from capitated Medicaid managed care would be applied to increasing coverage for the uninsured, funding was made contingent on federal Medicaid block grants, which Congress did not pass. If additional funds were available, the governor's FY 97 budget proposal suggests where it might go: $100 million was proposed to (1) expand coverage to children in families earning up to 185 percent of the federal poverty level (FPL), (2) provide more in-home assistance for the elderly, and (3) fund additional county indigent health programs.

State Health and Health Care Indicators

Michigan's uninsured rate of 10.4 percent (1994–95) is much lower than the national average of 15.5 percent (table 1). This may be attributable both to a strong union presence, which sets the standards for employer-provided health benefits, and to a relatively generous Medicaid program. Michigan has better-than-average scores for some health status indicators, such as AIDS cases per 100,000 (see table 1). However, it scores worse than the average on vaccinations for children under age two, heart disease death rates, and infant mortality. As a consequence, these problems have been priority issues for the state's public health system.

Medicaid Spending and Coverage

From the late 1980s until 1994, annual increases in total federal and state Medicaid expenditures were in the double digits. These increases were caused by the economic recession of the early 1990s that swelled AFDC and Medicaid rolls, the expansion of Medicaid eligibility, and the generous use of intergovernmental transfers to generate federal matching dollars for disproportionate share hospital (DSH) payments. Most of the DSH payments, however, were returned to the state to help finance the rapidly growing Medicaid budget (see

pp. 31–33), which constituted nearly 18 percent of the state's total budget in 1996, although only 8.6 percent of its general fund spending.

These budgetary pressures are the main forces driving the state's move toward capitated Medicaid managed care. Without substantial changes, budget officials projected that Medicaid would consume 30 percent of the budget by the year 2000. After failing to curtail cost growth by mandating enrollment in a primary care case management program, the state decided to enroll almost all beneficiaries into capitated plans. In addition to potentially lowering costs, capitation offers the benefit of improving the predictability of future spending.

Even before this plan is fully implemented, the growth rate for total Medicaid spending has dropped dramatically, from 10.5 percent average annual growth from 1992 to 1995 to 3.4 percent in 1996. There are several likely reasons for this decline: (1) the federal limits on the use of DSH payments; (2) an improvement in the economy and the state's welfare reform program, both of which may have helped to reduce AFDC and Medicaid rolls; (3) further enrollment of Medicaid beneficiaries into managed care plans, a shift that guarantees some savings to the state by virtue of the way the state caps payments to the plans; and (4) low inflation rates that moderated growth in provider payments. The Department of Community Health's target is to keep Medicaid growth to 3 percent annually, which would be consistent with projections for 3 percent annual increases in the state's general fund. As noted earlier, the latter is based on optimistic projections for rates of economic growth and no tax increases or cuts.

As shown in table 3, federal and state spending on Medicaid totaled $5.3 billion in 1995. (The state's federal Medicaid matching assistance percentage was 55.2 percent in FY 96.) Only about two-thirds of state spending on Medicaid comes from state general revenue. The remainder of the state portion includes funds generated from other sources, primarily intergovernmental transfers from local governments and state or other publicly owned hospitals. The overall annual growth rate of Michigan's combined state and federal Medicaid spending in the recent past (1992 to 1995) generally mirrored that at the national level (10.5 percent versus 9.9 percent) (table 3). Yet average growth from 1992 to 1995 in expenditures *per beneficiary* in Michigan (11.5 percent) was double that for the United States (5.5 percent), and the rate for the elderly was triple (14.1 percent in Michigan versus 5.0 percent for the United States) (table 4). Of total Medicaid spending on acute and long-term care benefits, Michigan spent 37 percent on long-term care, slightly less than the 40 percent spent on average in the United States in 1995.

Michigan's Medicaid program is fairly generous compared with those of other states. Michigan is one of 28 states that cover pregnant women up to 185 percent of FPL and is among the top 10 states in providing coverage to low-income children (up to 150 percent of FPL for children up to age 16). Benefits are also quite generous; there are no restrictions on hospital days covered, and virtually all benefits available to the categorically needy are also covered for the

Table 3 *Medicaid Expenditures by Eligibility Group and Type of Service, Michigan and United States ($ in Millions)*

	Michigan					United States				
	Expenditures			Average Annual Growth		Expenditures			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	$2,767.0	$3,953.6	$5,338.6	19.5%	10.5%	$73,662.2	$118,926.0	$157,872.5	27.1%	9.9%
Benefits										
Benefits by Service	$2,563.3	$3,243.3	$4,676.4	12.5%	13.0%	$69,168.7	$97,602.4	$133,434.6	18.8%	11.0%
Acute Care	1,624.5	2,151.9	2,942.1	15.1%	11.0%	36,904.5	55,059.9	79,438.5	22.1%	13.0%
Long-Term Care	938.7	1,091.4	1,734.3	7.8%	16.7%	32,264.2	42,542.5	53,996.1	14.8%	8.3%
Benefits by Group	$2,563.3	$3,243.3	$4,676.4	12.5%	13.0%	$69,168.7	$97,602.4	$133,434.6	18.8%	11.0%
Elderly	$547.9	$757.7	$1,131.5	17.6%	14.3%	$23,334.3	$31,757.9	$40,087.4	16.7%	8.1%
Acute Care	110.8	185.8	196.5	29.5%	1.9%	4,925.4	6,911.5	9,673.7	18.5%	11.9%
Long-Term Care	437.1	571.9	935.0	14.4%	17.8%	18,408.9	24,846.4	30,413.7	16.2%	7.0%
Blind and Disabled	$1,032.2	$1,344.5	$1,939.0	14.1%	13.0%	$25,771.6	$35,684.6	$51,379.4	17.7%	12.9%
Acute Care	621.1	885.0	1,256.3	19.4%	12.4%	12,929.2	19,483.6	29,760.7	22.8%	15.2%
Long-Term Care	411.1	459.5	682.7	5.7%	14.1%	12,842.4	16,201.0	21,618.7	12.3%	10.1%
Adults	$427.0	$522.2	$622.6	10.6%	6.0%	$8,765.0	$12,710.1	$16,556.9	20.4%	9.2%
Children	$556.2	$618.9	$983.3	5.5%	16.7%	$11,297.8	$17,449.8	$25,410.9	24.3%	13.3%
DSH	$54.4	$544.3	$438.0	216.3%	–7.0%	$1,340.9	$17,525.6	$18,988.4	261.5%	2.7%
Administration	$149.4	$166.1	$224.1	5.4%	10.5%	$3,152.6	$3,797.9	$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Table 4 *Medicaid Expenditures per Enrollee by Eligibility Group, Michigan and United States*

	Michigan					United States				
	Spending per Enrollee			Average Annual Growth		Spending per Enrollee			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	$2,185	$2,383	$3,303	4.4%	11.5%	$2,397	$2,729	$3,202	6.7%	5.5%
By Group										
Elderly	$6,534	$8,295	$12,326	12.7%	14.1%	$6,839	$8,422	$9,738	11.0%	5.0%
Cash	3,305	4,063	4,674	10.9%	4.8%	3,329	4,017	4,818	9.8%	6.2%
Noncash	8,192	10,277	15,526	12.0%	14.7%	10,377	12,192	13,521	8.4%	3.5%
Blind and Disabled	$7,325	$7,338	$7,841	0.1%	2.2%	$6,378	$7,320	$8,022	7.1%	3.1%
Cash	6,254	6,671	7,085	3.3%	2.0%	4,969	5,927	6,686	9.2%	4.1%
Noncash	11,255	9,382	10,454	–8.7%	3.7%	12,047	12,574	12,660	2.2%	0.2%
Adults	$1,323	$1,424	$1,744	3.7%	7.0%	$1,301	$1,518	$1,728	8.0%	4.4%
Children	$889	$860	$1,366	–1.6%	16.7%	$770	$931	$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

medically needy. Furthermore, reimbursement to providers is high. A Boren amendment lawsuit was brought by the nursing home association in 1990, resulting in average state payments to nursing homes of about $71 per day versus $83 per day for the United States in 1994. In addition, as a result of a class action Boren amendment lawsuit brought by the state hospital association, Medicaid hospital payments as a share of hospitals' Medicaid-related service costs are around 90 percent (including DSH payments), close to the national average of 93 percent. DSH and DSH-related payments are quite high, totaling over $900 million in 1996. However, only about $350 million of this amount counts as federal DSH payments, which explains why the state is a "low-DSH state"; the rest of the funds are payment enhancements targeted to government-owned facilities that provide a high volume of indigent care. In any case, federally defined DSH payments by the state that are not tied to intergovernmental transfers represent just $45 million of the total $900 million.[5]

Organizational Structure of State Health Programs

Before 1996, Michigan's Medicaid program was situated within the Department of Social Services, while the Department of Public Health and the Department of Mental Health were separate agencies, each with cabinet-level chiefs. Some health oversight authority also resided (and continues to reside) within other departments, including the Aging, Environmental Quality, and Commerce Departments. This structure created a number of problems: (1) fragmentation of health programs and functions in more than 8 of 20 state departments; (2) lack of uniformity in state health policy; (3) overlapping responsibility for Medicaid programs and expenditures; and (4) public confusion surrounding a complex, fragmented, state-supported health care system.

On the basis of the recommendations of a gubernatorial task force, a reorganization was announced by the governor in January 1996. The most important change was the consolidation of Medicaid, public health, and mental health into one department, called the Department of Community Health. One of the goals of this reorganization was to bring together policy, programs, and resources to "enable the state to become a better value purchaser of health care services for low-income persons and other vulnerable population groups." By consolidating the populations served by the former departments, the state believed it could acquire "dollar volume and market clout to demand higher quality services at lower rates." At the same time, the Department of Social Services was renamed the Family Independence Agency, which has responsibility for implementing the state's welfare reform plan.

Within the Department of Community Health, there are three major agencies or divisions: the Medical Services Administration (Medicaid), the Community

Public Health Agency, and the Behavioral Health Agency, which includes services to the mentally ill and developmentally disabled. Because these three divisions correspond almost directly to the agencies as they were constituted previously and because few staff have been physically moved from their previous locations, the sense of departmental consolidation was not particularly apparent at the time of the site visit in the fall of 1996. In April 1997, the department took the next step in its reorganization plan to further integrate functions across the department.

Assessing the New Federalism: Potential State Responses to Additional Flexibility and Reduced Funding

General State Philosophy toward the Poor

The governor has been a leader in federal welfare reform efforts, having run on campaign pledges to reduce welfare rolls within the state. The state's policy is that no able-bodied adult should receive cash assistance without having to work. Early in the Engler administration, the state eliminated the General Assistance program for this population, terminating coverage for more than 80,000 individuals and replacing it with a much smaller and more limited assistance program. Yet, most legislators and executive agency officials believe that access to basic health care is important to keep individuals in the workforce and that funding such care can be cost-effective if it reduces unnecessary emergency room admissions. In addition, many legislators support the administration's plan to extend Medicaid benefits to former welfare recipients, many of whom will be working in low-wage jobs that do not provide health insurance. Moreover, Republican legislators and top Department of Community Health officials repeatedly stressed that efforts to contain Medicaid spending growth do not represent an attempt to cut the Medicaid program and thus do not represent a reduced commitment to provide health care to the poor. Despite the Medicaid program's relative generosity, there was little concern about attracting out-of-state, low-income residents. Fear of becoming a "welfare magnet" does not appear to influence state policy.

The state's commitment to covering medical care for low-income people is primarily limited to Medicaid. When it eliminated the General Assistance program for able-bodied adults, for example, the state replaced the former General Assistance medical component with a State Medical Program for non-AFDC families and disabled adults. But this program covers just a small number of those who previously qualified for General Assistance, and the State Medical Program's budget is significantly smaller than that of the former General Assistance medical program. Several observers expressed doubts that the state would raise taxes in the foreseeable future to expand health benefits for poor people.

Medicaid-Specific Issues

During the block-grant debate of 1995, Michigan state officials pushed for as much flexibility as they could gain from the federal government, because they believed that federal regulations often act as a barrier to cost-effective management approaches. Most Medicaid officials claim that relief from Boren amendment–related requirements on provider reimbursement would be the most important benefit from gaining more flexibility from the federal government, either under a block grant or through other vehicles. They also would appreciate not having to return to the federal government for approval of their various waiver programs every few years, especially since they have repeatedly demonstrated savings and effectiveness. With greater flexibility, administration officials claim they might be able to expand Medicaid eligibility or services with the savings achieved, though it is not clear exactly how these savings would be produced.

Michigan officials acknowledge that they are out of compliance with a federal law requiring states to establish estate recovery programs, because the legislature will not pass authorizing legislation. The state also proposes an unusual approach to implement a rule requiring states with 1915(b) managed care waivers to pay federally qualified health centers (FQHCs) at cost-based reimbursement rates. In its pending 1915(b) waiver request, the state has proposed to regard the rates negotiated by contracting managed care plans and any FQHC or rural health clinic subcontractors as full cost, if the FQHC or rural health clinic agrees. This would remove the state's responsibility to make extra payments to these clinics to ensure they receive cost-based reimbursement. Though HCFA has indicated on a preliminary basis that this would comply with federal rules, a final decision has not been issued yet.

Providing Health Coverage for Low-Income People

Medicaid Eligibility

Michigan is slightly more generous in its eligibility standards for Medicaid than the average state; in 1994, 54 percent of the low-income population (below 150 percent of FPL) had Medicaid coverage compared with 51 percent nationally. The maximum income allowed for AFDC eligibility is 75 percent of FPL, compared with 67 percent nationally. Michigan extends Medicaid coverage to pregnant women and infants up to 185 percent of FPL, and since July 1994, it has covered children up to age 16 from 133 percent to 150 percent of FPL. Only eight states have higher maximum income levels for children.

In January 1995, the state also extended coverage under an optional category for aged and disabled people with incomes up to 100 percent of FPL; the state now provides such individuals with full Medicaid benefits, rather than coverage just for Medicare copayments, deductibles, and premiums. Since March 1992, the state has also extended Medicaid eligibility to elderly and disabled individuals with incomes up to 300 percent of the Supplemental Security Income (SSI) maximum income level for those who are nursing-home eligible and seek to qualify for home and community-based services under a waiver program.

Many perceive that services for the elderly have "stepchild" status in the Medicaid agency, since they account for only 24 percent of long-term and

acute care expenditures compared with 30 percent for the nation as a whole. Though children have traditionally been the priority for Medicaid, increasing attention is focused on the aged and disabled, a trend that may be hastened as welfare reform potentially reduces the number of children who are eligible.

The improved economy and the state's welfare reform program may be contributing to a decline in the AFDC caseload. The welfare reform program, begun in October 1992, encourages parents to remain together by eliminating "marriage penalties"; disregards earned income of $200 plus 20 percent of each month's income (formerly $30 and 33 percent); increases child care funding substantially; and enhances child-support enforcement tools. AFDC recipients eligible for Medicaid dropped from 540,669 in December 1995 to 506,481 in July 1996. Total Medicaid enrollment also dropped, from approximately 1,191,000 in October 1994 to 1,102,000 in October 1996. See table 5 for additional enrollment data.[6]

A state law passed in December 1995 modified the state's welfare program, requiring further changes to the state's waiver. In April 1996, the Family Independence Agency submitted an application for a Section 1115 welfare reform waiver that proposed 16 changes to Medicaid eligibility policies. The stated intent of the waiver request was to simplify the Medicaid eligibility determination process, but some of the proposed changes appeared designed to expand or reduce eligibility. A Department of Community Health official believed that the Family Independence Agency's proposal would have eliminated certain groups of Medicaid eligibles, including children of disabled adults, certain low-income Medicare recipients, and certain groups who qualify as medically needy. Thus, the waiver's Medicaid provisions caused great concern among advocates.

Of Michigan's 16 Medicaid-related waiver requests, HCFA approved only one: allowing AFDC/Family Independence Agency participants whose transitional Medicaid assistance has expired and who have no employer-based coverage to pay a premium to continue Medicaid coverage. Premiums were to be pegged to cover the state general fund's costs. This buy-in program has been implemented on a pilot basis in six areas of the state that are targeted by Project Zero, which seeks to reduce the number of AFDC households without earned income and ultimately achieve 100 percent employment for those clients. The state has since revised its waiver proposal to ensure that none of the proposals would reduce Medicaid eligibility.

At the time of the site visit, Medicaid policy officials had not yet decided what they would do with various options under the federal welfare reform law enacted in August 1996 (the Personal Responsibility and Work Opportunity Reconciliation Act). In a follow-up call in early March 1997, we learned that the state Medicaid agency was seeking to maintain Medicaid enrollment for as many people as possible. For example, the agency is trying to keep Medicaid

Table 5 *Medicaid Enrollment by Eligibility Group, Michigan and United States (Enrollment in Thousands)*

	Michigan					United States				
	Enrollment			Average Annual Growth		Enrollment			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	1,173.4	1,361.0	1,416.0	7.7%	1.3%	28,856.7	35,765.1	41,672.0	11.3%	5.2%
By Group										
Elderly	83.9	91.3	91.8	4.4%	0.2%	3,412.2	3,771.0	4,116.6	5.1%	3.0%
Cash	28.5	29.1	27.1	1.2%	–2.4%	1,713.1	1,739.2	1,789.2	0.8%	1.0%
Noncash	55.4	62.2	64.7	6.0%	1.3%	1,699.1	2,031.8	2,327.3	9.4%	4.6%
Blind and Disabled	140.9	183.2	247.3	14.0%	10.5%	4,040.9	4,875.1	6,405.2	9.8%	9.5%
Cash	110.7	138.2	191.8	11.7%	11.5%	3,236.8	3,853.4	4,973.5	9.1%	8.9%
Noncash	30.2	45.1	55.5	22.2%	7.2%	804.1	1,021.7	1,431.7	12.7%	11.9%
Adults	322.7	366.7	357.0	6.6%	–0.9%	6,738.7	8,373.3	9,584.2	11.5%	4.6%
Cash	271.7	281.1	230.5	1.7%	–6.4%	4,651.6	5,342.5	5,441.4	7.2%	0.6%
Noncash	50.9	85.6	126.6	29.6%	13.9%	2,087.2	3,030.9	4,142.8	20.5%	11.0%
Children	625.9	719.7	719.9	7.2%	0.0%	14,664.9	18,745.7	21,566.0	13.1%	4.8%
Cash	507.8	524.9	462.1	1.7%	–4.2%	9,946.2	11,281.8	11,314.6	6.5%	0.1%
Noncash	118.1	194.9	257.8	28.4%	9.8%	4,718.7	7,463.9	10,251.4	25.8%	11.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 data.

eligibility and Temporary Assistance to Needy Families (TANF) cash assistance eligibility linked by using the same application form. The Department of Community Health also plans to submit a state plan amendment to use less restrictive rules for Medicaid than the state's TANF program, such as a larger deduction for child care expenses. Medicaid projects that most of the approximately 15,000 children losing SSI[7] as a result of federal welfare reform will be eligible under the state's income maximum for children (below 150 percent of FPL for children up to age 16).

PRWORA barred new immigrants from receiving Medicaid during their first five years in the United States and gave states new options to determine legal immigrants' eligibility for Medicaid. Michigan has opted to continue Medicaid coverage of legal immigrants where federal matching funds are available: to legal immigrants in the United States as of August 22, 1996 and to legal immigrants entering after that date following the five-year bar. Michigan will not provide state-funded Medicaid to legal immigrants during the five-year bar.

Another recent change in federal law that will seriously affect Michigan is the denial of SSI coverage to those who qualify because of substance abuse. It was estimated that 16,000 people in Michigan would lose coverage. While some may qualify under other criteria, some state officials believe at least half will not, and many of those who remain eligible will drop off the rolls because they will fail to complete the reapplication process.

Other Public Financing Programs

Responsibility for financing health care for the poor who are ineligible for Medicaid is shared by the state and counties, at least in theory. By law, every county must have a Resident County Hospital program that covers inpatient hospital care for those who are uninsured and cannot afford it; however, the state does not impose any minimum funding requirements on the counties, nor does it enforce this law. As a result, hospitals in many counties are largely uncompensated for the care delivered to indigent patients. Outpatient care for the indigent is covered to a limited extent by the State Medical Program, described below. A few other programs for the uninsured exist, including one unique to Wayne County (Detroit area) called PlusCare and a Blue Cross/Blue Shield of Michigan Caring Program for Children.

State Medical Program

General Assistance and its associated medical program were terminated by the state in 1991. Approximately 82,000 people were estimated to have lost cash and medical benefits as a result of this action. A small residual State Medical Program was established covering very limited ambulatory care and emergency services for those who qualify for the State Disability Assistance and State Family Assistance programs, which provide small cash welfare benefits to

certain poor, disabled individuals or families with children ineligible for SSI or AFDC. Some aliens are also covered by the program without receiving cash assistance. For the fiscal year ending in October 1995, there were approximately 11,500 cases statewide between the two programs. The state currently contributes $20 million to the State Medical Program. Counties are also supposed to contribute to the State Medical Program but do so only minimally.

PlusCare

Wayne County operates an indigent health care program that is distinct from programs in other counties in the state. Called PlusCare, it provides comprehensive coverage on a capitated basis to eligible individuals. The program began as County Care in 1988, with $44 million from the state and additional county monies that had funded Wayne County Hospital before it closed. At the time, 57,000 General Assistance recipients were enrolled in the program. When the General Assistance program was terminated, so was state funding for County Care.

The county responded by devising a creative financing arrangement to maintain the program, unveiling the "new" program in 1992 as PlusCare, which is designed to serve very poor, unemployed people whose monthly income is under $250. The program is funded by $15 million in county funds and $4 million in state funds; this $19 million is matched with federal Medicaid funds for a total of $44 million. These funds are allocated to seven hospitals in Wayne County as DSH payments. The hospitals turn the money over to PlusCare, a nonprofit private organization, since the county cannot be the direct recipient of a federal match to its own funds. PlusCare, in turn, uses the funds to contract with provider networks to deliver care to enrollees, and it contracts with the county to manage and set policy for the program. The program currently contracts with three networks at a rate of $83 per member per month, which is lower than the average Medicaid rate ($117) because PlusCare does not cover prenatal and obstetric care. (It refers pregnant women to Medicaid for these services.) As of 1996, approximately 39,000 persons were enrolled in the program. The state set a cap of 40,000, but it may be increased somewhat to permit individuals removed from SSI rolls by federal welfare reform—estimated at 3,000 to 5,000 in Wayne County—to enroll in the program. It is uncertain whether the state will contribute a corresponding amount of funds.

HealthChoice

In 1994, Wayne County instituted HealthChoice, a capitated health insurance program that covers the working poor with financial support from their employers. Firms at which at least 50 percent of the employees earn less than $10 per hour are eligible if at least five employees enroll. The employer, employee, and county each pay one-third of the premium (although about one-third of employers choose to cover their employees' share). The county's cur-

rent spending on the program is $4.5 million annually. As of fall 1996, 4,000 individuals in 375 businesses were participating. The county has budgeted to expand the program to 12,000 persons in 600 companies over the next two years.

To date, no other counties have established a program similar to PlusCare, but programs using the HealthChoice one-third-share model were established in two counties, supported by grants under the Robert Wood Johnson Foundation's Health Care for the Uninsured program.

Blue Cross/Blue Shield Caring Program for Children

In 1990, Michigan received a federal Medicaid demonstration grant to provide health coverage to low-income children in conjunction with Blue Cross/Blue Shield of Michigan. Benefits are limited to outpatient primary and preventive care; inpatient care and emergency room visits prior to admission are not covered. The federal grant ended in 1995, but the Caring Program for Children continues under private sponsorship and an annual grant from the state. In 1995, the state contributed $1.5 million of the program's total budget of around $2 million; in 1996, the state's contribution dropped to $1 million. Eligibility criteria have changed to conform to changes in Medicaid eligibility standards for children. Currently, the program targets children aged 1 to 18 in families earning below 185 percent of FPL, but 1- to 15-year-olds in families with incomes under 150 percent of FPL are Medicaid-eligible and therefore ineligible for the Caring Program. Enrollment dropped from 7,000 in July 1994 to 4,500 in October 1996.

Insurance Reforms

Compared to most other states, Michigan has not been active in insurance reform. Michigan is one of just four states that does not impose rating restrictions in the *small-group* market, one of five states that did not impose preexisting condition limitations before the Health Insurance Portability and Accountability Act of 1996, and one of six states that does not guarantee either the issuance or renewal of insurance for small groups. Nor has Michigan made any attempt to reform the *individual* market, but about half of the other states have not done so either. The state has no laws on rate restrictions, preexisting condition exclusions, or issue or renewal in the individual market. Such reforms could help to make health insurance more available to small employers, which are more likely not to offer insurance to their workers or, if they do, face higher rates.

Those who regulate insurance in the state argue that their particular circumstances have made such reforms less necessary than elsewhere. In Michigan, employer-based coverage is dominated by large-group contracts with the United Auto Workers, rather than small groups as is the case in other states. Blue Cross/Blue Shield of Michigan, which dominates the small-group and

individual markets and controls about half of the overall market through its fee-for-service plans, is required by state law to write policies for all small groups and for individuals. It uses community rating for these group policies, and rates are generally considered to be reasonable. Small-group reform would be more likely if other insurers that are not bound by these rules were to gain more market share and practice more "skimming"—that is, insuring good risks at lower rates, leaving the higher risk groups to Blue Cross/Blue Shield. Legislation introduced in 1996 would have instituted some small-group reforms to preclude such activity, but it did not pass.

Financing and Delivery System

In general, the competitiveness of Michigan's health care market is more benign than in other markets. The dominance of nonprofit hospitals means that, even when they compete, they do so in ways that to some extent take into account community interests and needs. While managed care has made some inroads here, it tends to be in less restrictive forms than in other markets, and insurer intrusion into medical practice is not as harsh. While large self-insured employers are pushing plans and providers to cut costs and improve efficiency, they too tend to do so in a way that maintains their commitment to the entire community rather than their bottom line alone. This emphasis on community interests is partly due to the strong influence of unions in the region.

Managed Care

Michigan's HMO enrollment grew from 1.2 million members in 1986 to 2.1 million members in 1996; the HMO penetration rate for the state now stands at 22 percent, the same as the national average. Michigan's private HMO market has not grown as large as that in other states because of the dominance of Blue Cross/Blue Shield's fee-for-service business and because of labor unions, which have resisted the introduction of strict forms of managed care for their members.

As of 1996, there were 21 licensed HMOs in the state—an increase from 17 in 1995. While the number of HMOs serving the Michigan market has increased, new HMOs have not successfully challenged the dominance of cur-

rent leaders in the HMO market—Henry Ford Health System's Health Alliance Plan and Blue Cross/Blue Shield's four regional HMOs. No HMOs operating in Michigan are members of national chains. All are "home grown," which may reflect a state law requiring HMOs to be Michigan-registered corporations. The number of health plans serving the state, and particularly the Medicaid populations of Southeast Michigan, may increase in the short term as provider-sponsored networks are formed and compete with HMOs for contracts. However, consolidation or mergers are expected to occur over time as some plans outperform and/or underbid others.

The state does not have significant barriers to HMO licensure. State law requires HMOs to start out with a net worth of $100,000 and an additional $250,000 in working capital. Within five years, HMOs are required to have a net worth of $500,000, excluding physical plant. In addition, HMOs are required to start out with $100,000 on deposit with the state and maintain a deposit of 5 percent of annual income up to $500,000. Any provider-sponsored networks will have to meet state HMO licensing requirements by 1998. The state invited nonlicensed managed care organizations, presumably those created by providers, to bid on the Medicaid request for proposals (RFP) to increase managed care options in rural areas and to lessen the resistance of physicians and the state medical society to capitated Medicaid managed care. However, the state is expected to increase the financial reserve requirements for all HMOs and provider-sponsored networks, including those that contract with Medicaid.

Observers generally agree that the quality of care provided by Michigan's private HMOs is high. Health Alliance Plan and Blue Cross/Blue Shield's four HMO subsidiaries, which together account for 50 percent of Michigan's private HMO market, are regarded as model citizens of the managed care community. However, some analysts have expressed concern that Michigan may suffer from the "Jekyll and Hyde" HMO phenomenon, in which some HMOs manage care effectively and others focus primarily on financial success. To reduce the potential for abuses by HMOs, the Medicaid managed care RFP called for specific quality assurance measures.

Mergers and For-Profit Conversions

All acute care hospitals in Michigan are currently not-for-profit, although some specialty hospitals, including psychiatric and rehabilitation hospitals, are for-profit. Recent budgetary pressures on providers related to the impending expansion of capitated Medicaid managed care and employers' demands to reduce health care costs are beginning to spur acquisitions, mergers, and some closures among hospitals. As a result, the hospital services market in Southeast Michigan has become more concentrated.

The most publicized merger activity came in June 1996 when Columbia/ HCA attempted to form a joint venture with Michigan Affiliated Healthcare System, Inc., a nonprofit hospital in Lansing. Because Columbia/ HCA intended

to use the latter's assets to deliver hospital services for a profit, the attorney general successfully filed suit to block the venture. Michigan's Non-Profit Corporations Act precludes the assets of a nonprofit from being used for private gain. A gubernatorial aide said the charitable trust statute is outdated and may be amended in the future to facilitate the entry of for-profits into the hospital market. A Republican health policy leader in the state legislature is developing a plan to protect community assets when nonprofit conversions occur.

Medicaid Provider Reimbursement

Since 1985, Michigan has used prospective payment systems to compensate hospital inpatient care and nursing home care. The formulas and rules currently used to compensate hospitals and nursing homes have been in place since 1990, when Boren amendment lawsuits brought by the two industries were settled with the state. Inpatient hospital payment is based on diagnosis-related groups (DRGs) and follows hospital-specific rates that are periodically rebased, with ceilings and floors and an inflation index. As a result of this system, payment-to-cost ratios are fairly high (90 percent). Payment adjustments are made separately for DSH payments.

Although the state does not tax providers to pay for DSH or other Medicaid expenses, it makes extensive use of intergovernmental transfers (IGTs) to help finance the Medicaid program overall. The state spends over $900 million on DSH or DSH-related payments, and the majority of these funds come from federal Medicaid matching funds and IGTs from state mental hospitals, city- or county-owned hospitals, and other local units of government. There are two DSH programs in Michigan that qualify for federal matching funds: (1) Indigent Volume Adjustors, known in the state as "real or regular DSH" payments, which are allocated to hospitals based on their relative volume of inpatient care provided to Medicaid and low-income patients; and (2) Public Hospital Special DSH Payments, under which publicly owned hospitals, including state psychiatric hospitals, receive payments that include federal matching funds but transfer most of the money back to the state through IGTs. Spending from these two programs is reported to HCFA as the state's DSH spending. Another DSH-related program is called Other Indigent Volume and Adjustor Payments and features another series of IGTs by certain publicly owned hospitals, public long-term care facilities, mental health agencies, and schools. However, since these payments include coverage for nonhospital inpatient care, HCFA does not count them as DSH payments, though they still qualify for federal Medicaid matching funds. Much (perhaps most, though it is not certain in all cases) of the funds transferred to the state through IGTs by these institutions is returned to them through the payment adjustors.

The funds allocated through each of these three DSH or DSH-related categories for FY 94 to FY 96 (with estimates for FY 97) are shown in table 6. The numbers illustrate how the state has had to change its DSH allocations in response to the Omnibus Budget Reconciliation Act of 1993 rules that limited

Table 6. *Michigan's DSH and Related Payments, FY 94–97 ($ in millions)*

Type	FY 94	FY 95	FY 96	Est. FY 97
Indigent Volume Adjustors ("Real DSH")	$45.0	$45.0	$45.0	$45.0
a. Hospitals Using Diagnosis-Related Groups	$37.5	$37.5	$37.5	$37.5
b. Per Diem Hospitals (Mostly Psychiatric)	$7.0	$7.0	$7.0	$7.0
c. Distinct-Part Rehabilitation Units	$0.5	$0.5	$0.5	$0.5
Public Hospital Special DSH (Intergovernmental Transfers)	$572.7	$390.8	$302.5	$288.1
a. University of Michigan Hospitals	$570.7	$53.2	$42.7	$40.0
b. Hurley Hospital (Flint)		$25.0	$8.6	$7.0
c. State Psychiatric Hospitals	$2.0	$304.8	$241.0	$231.1
d. Small Public Hospitals		$7.8	$10.2	$10.0
Total DSH	$617.7	$435.8	$347.5	$333.1
% Change from Previous Year		–29.45%	–20.26%	–4.14%
Other Indigent Volume and Adjustor Payments[a]				
a. Outpatient Hospital Adjustors	$104.3	$104.6	$256.7	$248.7
Wayne County	$51.0	$51.0	$44.0	$44.0
Hurley Hospital (Flint)	$53.3	$53.3	$212.0	$204.0
Children's Hospital		$0.3	$0.7	$0.7
b. Long-Term Care Adjustor	$277.1	$262.0	$292.0	$262.0
c. Mental Health Adjustors	$6.4	$102.1	$44.6	$40.0
Community Mental Health Boards	$6.4	$102.1	$41.8	$40.0
Department of Mental Health			$2.8	
d. School-Based Services		$25.6	$38.6	$50.0
Total Other Payments	$387.8	$494.3	$631.9	$600.7
Total DSH and Other Payments	$1,005.5	$930.1	$979.4	$933.8
% Change from Previous Year		–7.50%	5.30%	–4.66%

Source: Michigan Department of Community Health, Medicaid Agency.
a. Michigan's reported DSH payments to HCFA do not include these other indigent volume and adjustor payments.

DSH payments. For example, Michigan's DSH payments to the University of Michigan Hospital, described in a General Accounting Office (GAO) report,[8] declined significantly, from $570.7 million in FY 94 to $42.7 million in FY 96. To maintain the level of federal funds, the state turned to other state-owned facilities, especially state mental institutions and city- or county-owned hospitals, to serve as pass-throughs for funds in the form of "special DSH payments." The net result is that IGTs from public institutions helped to raise nearly $900 million in FY 96, or 36 percent of total Medicaid spending in Michigan, without the state having to spend more general revenue funds than it did before 1990.[9] This amount is expected to remain about the same in FY 97, although the legislature authorized as much as $400 million more in case the agency comes up with any other qualifying institutions, or avenues, for IGTs.

The state's heavy dependence on IGT funds poses two liabilities to the state. First, it could complicate the state's plans to move Medicaid recipients into

capitated contracts. Contracts with private organizations would interfere with the state's system of transferring monies between state- or local-government-owned facilities. Indeed, some officials indicated that they may not want the expansion of Medicaid managed care to move as quickly as some others have proposed, until they iron out how capitated contracts will affect these financing arrangements. Second, if overall state Medicaid spending were capped by the federal government, Michigan could be hurt if DSH spending were excluded from the base.

With regard to Medicaid payments to physicians, rates were last increased in January 1992, after a brief period when voluntary contributions to Medicaid from hospitals resulted in an infusion of funds. At that time, the state also converted from physician fee screens to a modified resource-based, relative-value system, in which the state uses Medicare relative-value units but a lower conversion factor to determine physician rates. The state also made some upward adjustments for prenatal care and delivery, inpatient hospital care, and primary care evaluation and management procedures.

In 1997, Michigan's Medicaid reimbursement levels are estimated to be about 37 percent of charges, or about 84 percent of the national average Medicaid fee. Office visits are paid on average at $21, half the Medicare level. Primary care visits are reimbursed at 54 percent of Medicare levels, surgery at 49 percent, and diagnostic services at 51 percent. As a result, many physicians do not accept Medicaid patients. Fee-for-service Medicaid, however, appears to be a better payer than Medicaid HMOs. In Southeast Michigan, Medicaid HMOs are paying about $12 for an office visit; and as more Medicaid patients are enrolled in capitated plans, doctors may face increased financial pressure.

Medicaid Managed Care

Michigan's history with Medicaid managed care dates back to the early 1980s. In 1982, the state was one of the first to implement a primary care case management program, called the Physician Sponsor Plan, which it operated under a 1915(b) waiver. This program was initially restricted to Wayne County but is now implemented statewide. Under the program, primary care physicians are paid a $3-per-month case management fee per enrolled patient, in addition to regular fee-for-service rates.

In 1983, the state implemented the Clinic Plan, a partially capitated program that allows Medicaid clients to join participating clinics and group practices that provide comprehensive ambulatory and physician care. Under this program, providers receive capitated payments based on 100 percent of estimated fee-for-service costs for ambulatory services, and the state pays for inpatient hospital services through its normal DRG system. In 1993, the state received federal approval to mandate statewide enrollment in HMOs, prepaid health plans, the Clinic Plan, or the Physician Sponsor Plan through another 1915(b) waiver.

In April 1996, the Department of Community Health announced its plans to enroll virtually all Medicaid populations and services (with certain exceptions to be worked out as the plans are developed and implemented) into *capitated* managed care plans over the next three years. This new Medicaid managed care plan consists of five separate components, the largest of which is the "comprehensive plan," covering all AFDC and SSI clients currently enrolled in the Physician Sponsor Plan. Since 1993, enrollment for AFDC and SSI clients in the program has been mandatory statewide for beneficiaries not already enrolled in an HMO. Starting in 1997 in Southeast Michigan, clients enrolled in the Physician Sponsor Plan will be expected to enroll in HMOs or other capitated plans. Enrollment for the four remaining components—children with special health care needs, long-term care, behavioral health, and developmental disabilities—is planned to start in 1998.

State's Motivation for Medicaid Managed Care

Strong budgetary pressures are driving Michigan's move toward capitated Medicaid managed care. After failing to curtail cost growth by implementing and expanding the Physician Sponsor Plan, which relied on a fee-for-service model, the state decided to expand enrollment in capitated managed care plans. Concerned about the increasing level of Medicaid expenditures, legislators and administration officials also believed the change to prepaid capitated payments would help improve the predictability of future spending.

Projected savings from enrolling nearly all Medicaid clients into capitated managed care plans are substantial; however, projections vary somewhat both within the Department of Community Health and within state government more broadly. Most estimates fall within a wide range of a 5 to 15 percent savings *per capita* from enrolling beneficiaries in capitated contracts. Most analysts inside and outside government conceded that revenue estimates should be regarded as preliminary until terms of the proposals and contracts have been analyzed.

Enrollment, Expenditures, and Services Covered

Michigan's Medicaid managed care enrollment has grown rapidly in the past five years. In 1991, 243,000 (22 percent) of Medicaid beneficiaries were enrolled in some form of managed care: HMOs, the Physician Sponsor Plan, or the Clinic Plan. By 1996, the number was 814,000 (74 percent). During this period, enrollment in Medicaid HMOs increased from 142,000 to 292,000—an average annual growth rate of 15 percent. Enrollment in the Physician Sponsor Plan increased at an even faster pace, growing from 94,000 in 1991 to 470,000 in 1996—an average annual growth rate of 38 percent.

Under the current 1915(b) waiver, all Medicaid beneficiaries are required to enroll in some Medicaid managed care program, except those in institutions or receiving long-term care services, Medicare beneficiaries, spend-down clients,[10] and children in foster care. Children with special health care needs

and recipients of State Disability Assistance and State Family Assistance are not required to enroll in a managed care plan but may participate in the Physician Sponsor Plan if they choose.

Michigan's Medicaid managed care program covers all Medicaid services; however, HMOs and prepaid health plans are not expected to provide mental health care, long-term care, and dental services; and the Clinic Plan does not provide inpatient care, long-term care, dental services, or community mental health services. In the new Medicaid managed care initiative, the long-term care population and children with special health care needs will eventually be enrolled in separate managed care plans. The state's long-term vision, however, is for the comprehensive-plan HMOs to provide all services, including mental health. In the short term, however, behavioral health and developmental disability services will be provided through two "carve-out" plans.

To implement the state's new Medicaid managed care plan, in November 1996 the Department of Community Health released an RFP for health plans willing to accept prepaid capitated payments to participate in the comprehensive plan for five counties in Southeast Michigan (Wayne, Oakland, Macomb, Washtenaw, and Genesee counties). Enrollment was expected to begin in mid-1997. An RFP was to be released for the rest of the state in the ensuing months, with bids due later in 1997 and enrollment targeted for 1998. It is expected that it will take longer to move Medicaid clients outside the five-county area into capitated plans because these other counties have less experience with Medicaid HMOs. The state may start these areas with partial-risk contracts so that providers have time to build integrated networks. The state appears willing to slow the process somewhat to "bring outstate along" and avoid market entry by national health care chains.

Contracting Issues

Michigan's private and Medicaid HMO markets are fairly distinct. More than 75 percent of Medicaid HMO members are enrolled in three HMOs: the Wellness Plan (47 percent), OmniCare (17 percent), and Total Health Care (13 percent). Nine out of 10 Wellness Plan members and two out of three Total Health Care members are Medicaid beneficiaries. Medicaid clients represent an insignificant share (less than 10 percent) of enrollment in all other HMOs in Michigan. Department of Community Health officials expressed a desire to see these two markets converge by enrolling Medicaid clients in leading private HMOs.

Comprehensive-plan contracts will be awarded to managed care organizations through a competitive bidding process. The state will accept bids from nonlicensed provider organizations as well as HMOs. Nonlicensed providers whose bids are successful will have between 12 and 18 months to apply for and obtain an HMO license. To receive a new contract, health plans must accept full risk for enrolled Medicaid populations, agree to provide a comprehensive list of medical services, implement a system to comply with the state's data-reporting requirements, and agree to employ only subcontractors approved by the state.

The state hopes to use the bidding process to ensure selection of HMOs or managed care organizations that will provide quality care. The RFP lists several quality measurement requirements, such as providing management oversight, reporting encounter data, and tracking performance indicators. In their narrative proposals, HMOs must detail plans for complying with quality measurement criteria. Only if a bid's quality assurance system meets the RFP's criteria will the price bid envelope be opened. The state retains the right to impose sanctions on HMOs that fail to comply with quality measurement standards after contracts are awarded.

Medicaid HMOs and prepaid health plans currently receive capitated payments within the range of 90 percent to 98 percent of estimated fee-for-service costs. In the new competitive bidding system, plans will submit their bid prices. If the bid price falls within state-determined bid corridors[11] (which are not made known to bidders), health plans will receive contracts at the bid price. If the bid price falls below the bid corridor, health plans will be awarded contracts at the low end of the bid corridor. Health plans that score the highest on their narrative proposals will receive the highest shares of assigned clients (i.e., those who do not select a plan on their own).

Enrollment Issues

In 1994, Michigan's Medicaid managed care system began an automated enrollment process. Medicaid clients covered by the mandatory enrollment waiver who are not already enrolled in an HMO are notified by mail that they must choose a managed care option within 10 days or be assigned to a physician in the Physician Sponsor Plan. The program matches those who do not choose plans or doctors to a physician according to the clients' Zip codes. Even if clients have been seeing a provider regularly, there is no attempt to match the clients to their current doctors. Officials and analysts agree that letters sent to recipients are not easily understandable, contributing to high auto-assignment rates. (The state does not have exact figures.)

A 1996 state law prohibits managed care plans from marketing directly to Medicaid clients. The law was passed in response to abuses by plans, including forgeries of enrollment forms and promises of incentives unrelated to health care, such as free long-distance calling cards and Thanksgiving turkeys. Previously, plans could establish enrollment booths and undertake direct mailings; now they are limited to indirect marketing options including billboards, magazines, and other mass media. The Department of Community Health plans to improve the process of educating clients on their enrollment options through the use of an enrollment broker (an RFP was in development at the time of the site visit) and ombudsman programs.

Managed Care for the Elderly and Disabled

Capitation of patients who need long-term care or who are enrolled in state behavioral health or developmental disability programs is a key component of

the state's Medicaid reform initiative. The long-term care plan is slated for implementation in 1998, and competitive selection of one managed care organization per region is envisioned. For the dually eligible (Medicare and Medicaid), the state initially will capitate only long-term care, with the goal of eventually integrating acute and long-term care for these beneficiaries. Obtaining a Medicare waiver to do so is viewed as a challenge; yet without the waiver, dual eligibles will be encouraged to voluntarily enroll in integrated plans. Currently, 10,000 dual eligibles are voluntarily enrolled in HMOs for acute care services.

The organizational infrastructure to support capitated long-term care and integrated plans is in its infancy. There are few Medicare-risk HMOs (partly because of the low capitation rate outstate), and no organization now offers the full range of long-term care services. One barrier to the creation of such entities is the tension that exists among long-term care "competitors"—nursing homes, home health agencies, and Area Agencies on Aging. Moreover, not-for-profit organizations may not have the capital required to bear risk. Despite initial efforts of locally based organizations to ready themselves, an out-of-state company could enter and bid on the regional contracts, a scenario the state hopes to avoid to protect "community identity."

With gradual implementation scheduled for 1997–98, behavioral health and developmentally disabled services will be carved out from the comprehensive managed care plan. Community mental health boards (county-based entities, described later) will be capitated for outpatient, inpatient, and residential behavioral health and developmental disability services, while acute care needs (including 20 mental health outpatient visits per year and psychiatric drugs) will be met through the comprehensive plans. The carve-outs were predicated on fears and anecdotal evidence that behavioral health services would be shortchanged if rolled into the comprehensive plan. The state's long-term goal, however, is to integrate both carve-outs into the comprehensive health plan, particularly because of concerns that coordination between the community mental health boards and managed care organizations will pose difficulties. In the interim, the state may also allow organizations other than the boards to competitively bid on the carve-outs.

Delivering Health Care to the Uninsured Population

State Public Health Programs

Michigan's public health system is in the early stages of transformation, especially since the former Department of Public Health was merged into the newly created Department of Community Health. Two themes that run through discussions of transforming public health are (1) a return to population-oriented services, and (2) devolution of responsibility to local communities.

One of the objectives set forth at the creation of the Department of Community Health was to return public health to its traditional mission and strengthen its core activities such as health assessment, prevention, and health promotion. The Department's Community Public Health Agency, like many public health agencies around the nation, is grappling with whether it should support the delivery of primary care services in local health departments over the long term. Those local health departments that provide substantial direct services reimbursed by Medicaid are faced with the decision of whether to subcontract with managed care plans or focus on their traditional role. If they stop providing direct services, the uninsured could be adversely affected, since they often rely on the local health department for care. In an effort not to disrupt effective systems of health care delivery, the state is granting "preference points" to plans bidding for Medicaid contracts that subcontract with local health departments.

The former Department of Public Health received a substantial hike in funding from FY 94 to FY 95, with a large portion of the increase coming from a newly established tobacco tax fund. In 1994, Michigan voters approved a ballot initiative increasing the tax on cigarettes from 25 cents to 75 cents per pack—the biggest increase for any state at that time. Most of the $313 million in revenue raised from the tax was allocated to education, but $50 million was given to the department, and it received another $67 million in other new funds. Both the cigarette tax and the boost in funds for the department were due primarily to the leadership of the former public health director. Within the department, most of the additional funds have been used to support smoking cessation and prevention programs, but they have also been used to fund existing and new maternal and child health (MCH) programs.

MCH programs have been credited with some of the steep decline in Michigan's infant mortality rate (8.5 per 1,000 in 1995 compared with 11.0 per 1,000 in 1986–88). Before the availability of cigarette tax funds, a variety of state MCH investments were made in the late 1980s and early 1990s. However, Michigan's healthy economy also may have helped to reduce infant mortality, as income is strongly associated with infant mortality.

Local Government's Role in Providing Health Care to Low-Income People

Counties currently play a large role in carrying out the core public health activities of the state. Local health departments—which are primarily county-based—receive funds and direction from the state, but staff are officially county or city employees. As of 1991, there were 35 county health departments with jurisdiction over a single county, 13 multicounty health departments, and 1 city health department (Detroit). Coordination of public health activities with other programs (e.g., mental health) is often difficult because jurisdiction across programs is not consistent. State officials would prefer to have more coordination among organizations, and even consolidation in some cases.

Expenditures on public health by state and local governments present evidence of decentralization to localities. As of 1992, localities controlled 57 percent of combined government expenditures on public health (non-Medicaid, nonhospital services), compared with the national average of 47 percent.[12] This suggests that more federal and state dollars are sent to local governments in Michigan than in many other states. In addition, a few cities and nearly every county allocate funds to the local or regional health department, and counties pay 10 percent of the nonfederal share of Medicaid services delivered by community mental health boards.

Recent developments may have increased the percentage of public health dollars controlled by local health departments. The state has started to provide a financial incentive for local health departments to deliver core public

health services, reviving an initiative established in 1978. Nine services, including well-child care, immunizations, and sanitation, now qualify for a 50 percent match from the state. The initiative has resulted in an influx of $17 million per year to local health departments. In return, local health departments are expected to meet certain performance standards, though sanctions for failure to meet the criteria have not yet been made clear. Current plans call for transferring even more funds and responsibility to localities. While state officials support the concept of community-based decisionmaking, others question whether county governments, as opposed to other community-based entities, are the appropriate vehicles for such attempts.

Very few counties or cities have public hospitals. The one major exception is Hurley Hospital, owned by the city of Flint. There also are about a dozen public hospitals in rural counties or small towns throughout the state. Both Wayne County and the city of Detroit closed or sold their public hospitals in the mid- to late 1980s.

Impact of Government Policies and Market Changes on Safety Net Providers in Detroit

The state's plan to switch nearly all Medicaid beneficiaries into capitated managed care plans starting in 1997 will affect the entire health care system and has especially important implications for safety net providers. Total Medicaid revenues to providers are likely to be reduced as a result, posing a threat to certain providers' ability to provide uncompensated care.

Detroit, which was selected as the local area for study, may be less affected by the transformation to capitated managed care than others because nearly 60 percent of all Wayne County Medicaid beneficiaries are already enrolled in HMOs. Yet, at the time of the site visit, the plan to switch enrollees into capitated plans was still the most important state policy development affecting the local market. For example, there were reports of increasing competition for Medicaid patients and new alliances forming to compete for capitated contracts from the state; but this is occurring within the context of larger competitive market forces.

The large safety net hospitals in Detroit (Detroit Medical Center, Henry Ford Hospital, Mercy Hospital of Detroit) are responding to competition and pressure from purchasers (i.e., employers and insurers) to control costs by (1) reorganizing, improving information systems, and streamlining internal operations; (2) expanding primary care capacity; and (3) developing other techniques to manage the care of Medicaid patients. Each of the hospitals visited was pursuing these improvements or facing unique challenges. For example, Henry Ford Health System, which owns the Health Alliance Plan (the biggest commercial HMO), sees Medicaid managed care as an opportunity for growth and will likely try to increase Medicaid enrollment. To manage these patients' care and

stay within competitively bid rates, however, Health Alliance Plan will need to improve case management and increase primary care sites in certain neighborhoods, and it might buy a Medicaid HMO to enhance its expertise in serving this population. Mercy Hospital, which contracts with several HMOs, cites its biggest challenge as learning how to manage care for the SSI population, which has largely been served through the Physician Sponsor Plan.

The Detroit Medical Center, which is the largest safety net provider and includes seven hospitals, 40 ambulatory care clinics, two nursing homes, a home health agency, and a durable medical equipment supply company, is undergoing tremendous changes in response to market forces and capitated Medicaid managed care. Over the past two years, it has consolidated its governing boards, created a new management structure, started a physician-hospital organization that will be able to submit its own bid for a Medicaid managed care contract, invested heavily in information systems, and developed both a management services organization and an independent practice association to support physicians aligned with the Detroit Medical Center. In October 1996, corporation officials announced that they would close two hospitals (Hutzel and the Rehabilitation Institute) and cut 2,500 jobs over the next three years. These cuts, in combination with management changes, are designed to save nearly $250 million and reduce costs by 20 percent over the next three years. Detroit Medical Center officials insist that access will not be harmed by these cuts, because all critical services (e.g., the obstetrics/gynecology services of Hutzel) will be moved elsewhere within the system. They also assert that most jobs will be cut through attrition. They describe these changes as a "long-term growth strategy rather than a short-term crisis strategy." Nonetheless, the changes will likely have an important economic impact on Detroit because the Detroit Medical Center is the largest private employer in the city, and the changes could undercut the level of service to the uninsured if downsizing is not managed carefully.

The Detroit Health Department's response to the state's new Medicaid managed care initiative was based on an assessment of its strengths and weaknesses. The city health department, which has six primary care clinics, had considered developing its own Medicaid HMO. The department decided not to do so because the city cannot or does not want to assume financial risk and its infrastructure and bureaucracy are not nimble enough to make the changes needed.[13] Instead, the health department plans to join its current hospital partners in submitting bids for capitated Medicaid managed care contracts to the state. Patients in four participating health department clinics would enroll in their system partner's HMO (e.g., Herman Kiefer clinic patients would join Henry Ford Hospital's health plan). In general, city health officials believed that greater enrollment in capitated plans would reduce the department's Medicaid revenues, but they say they are not driven only by the need to obtain third-party reimbursements. They are fortunate to have other funding from city, state, and federal grants. While it is trying to emphasize its traditional public health functions, the city health department believes it must continue providing direct services primarily to serve those (insured and uninsured) who have nowhere else to go.

In addition to the large safety net hospitals and the Detroit Health Department, Detroit's safety net providers include five federally qualified health centers (FQHCs) and nearly a dozen school-based clinics. They, too, are concerned about the transition to capitated managed care. Over the past several years, FQHCs have been paid well by Medicaid under cost-based reimbursement, and these enhanced Medicaid payments have increased health centers' capacities to serve the uninsured. In the new plan for capitated managed care contracts, however, the state Medicaid agency proposes that HMOs or other qualified health plans negotiate with FQHCs over rates. If they agree that the negotiated rates are full cost, the state is freed from having to pay extra to FQHCs and rural health clinics to ensure cost-based reimbursement. Although HCFA had yet to make a final decision on this proposal, the FQHCs were concerned about the possible effects of this policy.

The two FQHCs visited were at very different stages in their preparations for the impending changes in Medicaid managed care. One clinic was well into efforts designed to expand and improve its facilities and was seeking contracts with as many health plans as possible to increase its chances to be part of the plans that receive Medicaid managed care contracts. The other was still struggling to determine with whom to ally and trying to keep all options open until it decides.

Besides the switch to capitated Medicaid managed care, other forces could affect the ability of safety net providers in Detroit to provide the same level of uncompensated care as they have in the past. These include state budget cuts in social services, welfare reform, and the state's economy, which could change the level or extent of Medicaid coverage and the numbers of uninsured that safety net providers would have to serve. In fact, some community clinics already believe that they are seeing more uninsured and that small businesses are dropping coverage. As Medicaid patients have easier access to private physicians and hospitals through HMOs, Medicaid patients may decline as a proportion of the clinics' total patients. If clinics see a higher percentage of uninsured among their patients as a result, they may perceive this as indicative of a decline in insurance coverage.

The consensus among interviewees was that access for Medicaid patients had improved considerably over the last several years, but competition for Medicaid patients had not extended to extremely vulnerable populations such as the homeless or those with AIDS. According to community clinic administrators, the uninsured, underinsured, and very high-risk populations still face considerable access problems. Unfortunately, our interviews did not reveal whether Medicaid recipients were aware of the changes they will have to make in response to the new system.

Long-Term Care for the Elderly and Persons with Disabilities

Brief Overview of Supply, Expenditures, and Utilization

Michigan has forged a long-term care strategy for its elderly and disabled populations that emphasizes managed care and home and community-based care, with the objective of reducing dependence on costly residential facilities. Long-term care in Michigan, as in all states, is heavily financed by Medicaid and accounts for a large share of the total Medicaid budget. In 1995, the state spent 32 percent of its Medicaid budget on long-term care—the majority of which was for nursing homes (tables 3 and 7). The growth of expenditures for long-term care has outpaced overall Medicaid growth since 1992 (table 3). Michigan's spending on long-term care and acute care per elderly recipient surpassed the U.S. average in 1995; long-term and acute care expenditures per disabled recipient, in contrast, were slightly lower than the U.S. average (table 4).

Nursing homes in Michigan numbered 453 in 1995 and contained 51,203 beds, down slightly from 51,813 beds in 1989. Approximately 33,000 of these are filled with Medicaid recipients at any given time. With 43.4 beds per 1,000 elderly in 1994, compared with 53.3 per 1,000 nationally, the state has one of the tightest bed supplies in the country. Bed growth over the 1980–95 period was 10.1 percent—less than a third of the national rate (33.5 percent).

Table 7 *Medicaid Long-Term Care Expenditures by Eligibility Group, Michigan and United States ($ in Millions)*

	Michigan					United States				
	Long-Term Care Expenditures			Average Annual Growth		Long-Term Care Expenditures			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	$938.7	$1,091.4	$1,734.3	7.8%	16.7%	$32,264.2	$42,542.5	$53,996.1	14.8%	8.3%
Elderly	$437.1	$571.9	$935.0	14.4%	17.8%	$18,408.9	$24,846.4	$30,413.7	16.2%	7.0%
Nursing Home Care	370.6	509.4	840.6	17.2%	18.2%	15,131.3	20,542.9	25,571.5	16.5%	7.6%
ICFs/MR[a]	4.7	5.4	13.1	7.4%	34.4%	348.9	452.0	615.8	13.8%	10.9%
Mental Health	22.2	24.4	44.0	4.8%	21.7%	973.0	1,286.0	1,107.3	15.0%	–4.9%
Home Care	39.5	32.6	37.3	–9.2%	4.6%	1,955.7	2,565.6	3,119.1	14.5%	6.7%
Blind and Disabled	$411.1	$459.5	$682.7	5.7%	14.1%	$12,842.4	$16,201.0	$21,618.7	12.3%	10.1%
Nursing Home Care	78.8	102.0	137.8	13.8%	10.6%	3,161.3	3,968.0	4,813.3	12.0%	6.6%
ICFs/MR[a]	208.0	175.0	206.5	–8.3%	5.7%	7,241.3	8,380.4	9,321.1	7.6%	3.6%
Mental Health	35.7	27.4	63.3	–12.4%	32.2%	457.9	682.1	881.3	22.1%	8.9%
Home Care	88.5	155.1	275.1	32.4%	21.0%	1,982.0	3,170.5	6,603.0	26.5%	27.7%
Adults and Children	$90.6	$60.0	$116.6	–18.6%	24.8%	$1,012.9	$1,495.1	$1,963.7	21.5%	9.5%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
a. Intermediate care facilities for the mentally retarded.

Michigan's declining reliance on institutional care extends in more striking proportions to the mentally ill and developmentally disabled populations. The census in state psychiatric hospitals has fallen dramatically, from 19,059 in 1960 to 1,650 in 1995. In 1990, the state operated nine psychiatric hospitals; by 1994, three of these had closed. As for intermediate care facilities for the mentally retarded (ICFs/MR), the state currently operates only three, with a total census of 392. This represents a substantial decline from the peak census of 12,694 in 1967. In 1994, there were 2,244 private residential settings for the developmentally disabled population, of which 494 were certified ICFs/MR. About 95 percent of developmentally disabled clients receiving residential services lived in smaller (fewer than seven beds) homes, compared with a national average of 47 percent.

Long-Term Care for the Elderly

Michigan, like many states, has stepped up its efforts to encourage long-term care delivery in home and community settings. Yet spending on home health for the elderly under Medicaid increased less rapidly than nursing home spending over the 1990–95 period (table 7). The state's Certificate of Need (CoN) program, which authorizes new facilities or beds, is credited with some containment of nursing home costs; however, because CoN determinations are linked to demographic changes, the state will eventually have to allow additional beds to be built. At present, the statewide occupancy rate stands at 90 percent, the same as the national average. Yet concerns have been raised regarding access to nursing homes, since some are approaching full occupancy and, according to advocates' reports, some applicants who qualify for Medicaid are being turned away, particularly in Southeast Michigan.

The expansion of other residential care settings, such as homes for the aged (21 or more beds) and adult foster care (20 beds or fewer), has further contributed to curtailing growth in nursing homes. In 1995, there were 4,760 of these licensed facilities with 44,793 beds, the majority of which were adult foster care residences. Compared with the national average, Michigan has nearly twice the concentration of residential care beds—37.9 versus 21.1 per 1,000 elderly. SSI pays approximately $600 per month for eligible residents in both settings, while Medicaid pays for some personal care expenses. The majority of residents in these settings, however, are not eligible for SSI or Medicaid.

Long-term care delivery changes have in part been spurred by Michigan's home and community-based waiver. Michigan lagged most states in the development of a waiver program for the elderly and physically disabled, primarily owing to concern that it would create new demand and increase costs. Initiated in 1992, the waiver program is relatively small, operating in 19 of 83 counties and capped at 3,000 slots for FY 96. The program's budget was $30 million in that year. Of the state's Medicaid spending on home and community-based care in 1993, less than one-third was directed at waiver services, while nearly 60 percent was spent for personal care services, which assist disabled persons

with activities of daily living (bathing, feeding, etc.). This compares with 42 percent and 37 percent, respectively, for the United States overall. The state's composition of home and community-based services may shift, as the state plans to extend the waiver program statewide by the end of the decade.

The waiver program for the elderly and physically disabled is jointly administered by the Office of Services to the Aging (in the Department on Aging) and the Medicaid program. The most commonly delivered services under the waiver are personal care, home-delivered meals, and personal emergency response. Other services include homemaker, respite, transportation, durable medical equipment, and private duty nursing. A care manager authorizes provision of the services. Nonwaiver counties apply a similar case management strategy to coordinate home and community-based care for those at risk of nursing home entry. Yet the state currently has no objective criteria to determine nursing home eligibility, nor a universal approach to direct individuals in need of long-term care to the appropriate service. A pre-admission screening tool is now under development for all nursing home applicants.

It is not known how much savings can be gained from expanding home and community-based services because such services are not necessarily direct substitutes for nursing home care. Based on recent data, the average net cost per day for waiver clients in Michigan is $39 compared with $61 for nursing home residents; yet these costs are not case-mix adjusted. Though waiver participants must be eligible for nursing home care, it is likely that they are less frail than nursing home residents. For example, 30 percent of waiver participants are reported to have cognitive impairments, versus 60 percent of nursing home residents.

It is expected that capitating Medicaid long-term care services will add to the Medicaid population receiving home and community-based services. Moreover, capitation will relieve the state of paying relatively high nursing home rates that have arisen in part from a successful Boren amendment suit by the industry in 1989–90. The state has also been generous in building costs of compliance with the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) quality standards into its rates. Due to these two forces, Medicaid payment rates to nursing homes increased 65 percent between 1989 and 1994. By capitating long-term care services, the state hopes to be no longer bound by the Boren amendment and will perhaps pass some of its responsibility for quality standards to the managed care organizations. The nursing home industry fears that quality of care will suffer as a result. The Medicaid program has recently turned more attention to the issue of quality of nursing home care and has implemented a number of measures, including establishment of a database to track quality and an incentive program to improve quality of life in nursing homes. Despite these efforts, the office of the state long-term care ombudsman, having received 5,286 complaints about long-term care facilities in 1995 (about 10 percent of all patients), is concerned that minimum standards are not being met. Understaffing in facilities appears to be a significant and growing problem.

In addition to capitating long-term care, the state seeks to lower Medicaid costs by encouraging the purchase of long-term care insurance. The legislature passed the Insurance Partnership Act in 1995, which raises the asset level for Medicaid eligibility for those who buy a policy. The legislation is not yet operable because a waiver to redefine asset level requirements is needed from HCFA.

Unlike other states, Michigan does not have an estate recovery program to retroactively cover costs of nursing home care, so it is out of compliance with federal law. The legislature must pass a bill to initiate such a program, which it has chosen not to do, in part because of the high rate of home ownership in the state.

Long-Term Care for Younger Persons with Disabilities

Michigan has been very successful in moving mental (behavioral) health and developmentally disabled clients out of institutions. The state's efforts to capitate behavioral health and developmental disabilities under two carve-outs should further the deinstitutionalization of disabled populations. Much of the credit for deinstitutionalization is owed to the local jurisdictions, to whom the state has devolved almost complete responsibility for behavioral health and developmental disabilities. A 1974 law mandated the creation of community mental health boards (CMHBs) to assume primary authority for the direct provision of mental health services. There are now 52 CMHBs—34 single-county boards and 18 multicounty boards. The transfer of authority to the CMHBs has been furthered through the creation of the new Department of Community Health in January 1996, with its underlying emphasis on "community."

The new Behavioral Health Agency oversees programs that serve the severely mentally ill and developmentally disabled populations, contracting with local jurisdictions to administer outpatient and residential programs. The state retains control of the few public psychiatric hospitals and ICFs/MR that remain in operation. CMHBs provide a comprehensive range of outpatient services and serve as the single entry point for admissions to the public mental health system. They also contract for inpatient services for their clients, in both state hospitals and psychiatric units in community hospitals. In the area of developmental disabilities, CMHBs control admissions to ICFs/MR. CMHBs provide services directly, contract with private providers, or mix the two approaches. In large health care markets, boards are more likely to contract for services, because private providers are available. In very rural areas, CMHBs are often the only provider and thus directly deliver services to clients.

For FY 96, $1.2 billion was appropriated for CMHBs to serve a projected 188,000 children and adults. Of the budget, more than $800 million is allocated for developmental disabilities, though these clients make up only 15 percent of the agency's caseload. Boards receive their annual allocation from the state in the form of a grant, which includes an anticipated amount of federal Medicaid matching funds. The boards bill Medicaid throughout the year and transfer some of this amount back to the state.

Table 8. *Funding History of Behavioral Health ($ in Thousands)*

	FY 90	FY 94	FY 95	FY 96
General Fund/General Purpose	$905,751.6	$967,232.8	$991,254.2	$1,018,855.1
All Funds	$1,246,380.4	$1,459,038.5	$1,494,447.5	$1,583,642.9
% Change—GF/GP			2.5%	2.8%
% Change—All Funds			2.4%	6.0%

Source: Executive Budget Proposal, FY 97.

The total behavioral health budget for the past several years is presented in table 8. It shows that 36 percent of funds for mental health and developmental disability programs are derived from sources outside the state general fund. Federal funds, including Medicaid matching funds, account for most of the balance. In 1995, about half of those served by the boards had Medicaid coverage, making Medicaid a significant source of revenue for mental health and developmental disability programs. Developmentally disabled clients are more likely to qualify for Medicaid than are mental health clients, because about 70 percent of funding for developmental disability services comes from Medicaid. Medicaid maximization of both programs may increase as a result of opportunities for coordination between Medicaid and the Behavioral Health Agency under the Department of Community Health umbrella. Federal revenues are further enhanced via matches on intergovernmental transfers made by state psychiatric hospitals, a fraction of which is returned as DSH payments.

The state requires counties to pay 10 percent of the nonfederal share for Medicaid services delivered by the CMHBs. However, if a board is successful in moving a person out of a psychiatric hospital, the state waives the 10 percent requirement for that client. County funds are also used to cover some of the costs of treating non-Medicaid clients. Local government contributions to mental health activities accounted for 3 percent of program revenues in 1993, compared with a national average of 1 percent.

CMHBs' efforts to deinstitutionalize clients have been effective: Michigan spends less than half—46 percent in 1993—of its mental health dollars on psychiatric hospitals, compared with a national average of 53 percent. Regarding developmental disability services, Michigan is ranked 48th among the states in its spending on institutions. The state instead emphasizes other residential care, supported employment, case management, family support, and assistive technology. CMHBs also run the state's home and community-based care waiver program, which makes available employment services, transportation, chore services, respite, personal care, and private duty nursing, among other services. The program began in 1988 with 616 clients and has grown to 3,200 participants. The program has capacity for 7,013, but the state does not have funds to fill substantially more slots.

Challenges for the Future

Michigan has a strong base of well-funded employer-sponsored insurance, reflecting the union presence, and fairly extensive Medicaid coverage. As a result, the state has a relatively low number of uninsured residents. Medicaid expenditures are quite high by national standards. Blue Cross/Blue Shield's dominance in the insurance market and its policies of open enrollment and community rating have generally provided access to health insurance for persons with higher health risks. Further, the state's health care system is not faced with the intense cost-cutting competition seen elsewhere. Because marketplace competition is less intense, nonprofit hospitals are under less pressure to seek efficiencies, and there is less of a threat to their ability to provide care for the uninsured than in many other states.

Nonetheless, the state faces numerous challenges. Medicaid rolls have fallen recently and could decline more as welfare reform is enacted; further, the state substantially reduced its medical care program for General Assistance recipients. There are reports that insurance coverage offered by small employers has been declining. As a result, the number of uninsured persons in the state may be increasing.

The state has been highly supportive of transitional health insurance coverage for those leaving welfare rolls. Michigan has received a federal waiver permitting former welfare recipients who have exhausted transitional benefits to buy into Medicaid if private insurance is not available. A key issue is the extent to which these individuals will take advantage of the offer of assistance easing the transition from welfare to work.

Another challenge is the movement of Medicaid recipients into capitated HMOs, a key component of the state's strategy of holding Medicaid expenditure

growth to 3 percent per year. In 1996, about 25 percent of Medicaid recipients were in managed care, with 75 percent of these enrolled in three commercial HMOs. The state wants to substantially increase the number of plans participating in Medicaid; at the same time, it seeks to save 5 to 15 percent of costs per enrollee. Clearly, this could be difficult. If the state is successful, capitated HMOs will have to control hospital rates and perhaps move many Medicaid patients away from safety net hospitals. Most of the safety net providers have formed or contracted with plans, but they will have to aggressively control costs to avoid losses on Medicaid beneficiaries. There will be a clear tension between attempting to survive under capitated managed care and at the same time continuing to provide uncompensated care to a possibly growing uninsured population.

Blue Cross/Blue Shield, as noted above, has dominated the private insurance market and has generally not aggressively pursued hospital discounts. All the state's major HMOs are nonprofit and Michigan-based. None of the more aggressive national chains have entered the state. All general acute care hospitals are also nonprofit; thus, the state has a combination of less-aggressive managed care and less competition in the hospital sector. All of this is expected to change eventually. The results are likely to be lower health care costs, but at the same time, reduced ability of the safety net providers to respond to the service needs of the Medicaid and uninsured populations.

The state may also face major challenges due to recent changes in federal law. One recent enactment is a cut in disproportionate share hospital (DSH) payments. The hospitals in Michigan that have benefited from DSH payments may be adversely affected by these reductions. DSH payments have also provided fiscal relief to the state. Federal DSH reductions may force the state to make other Medicaid cutbacks as well.

On the other hand, the recent repeal of the Boren amendment will allow the state to reduce hospital and nursing home rates. The amendment has been seen by state officials as a major impediment to cutting these rates in the past. Repeal may help the state's finances, but it could hurt hospitals' capacity to serve the low-income population and could threaten nursing home quality, an area where problems already appear to exist.

The next few years could also present major challenges for local governments. Local health departments are currently providers of many services to Medicaid clients. Capitated managed care could hurt health departments if HMOs do not contract with them. Managed care could reduce the funds that they receive from Medicaid—funds that in some cases help finance both public health services and services to the uninsured. Counties are not a major source of health care financing in Michigan. Unless the state responds, counties may have to do more in the future, and assume an expanded role for which they may not be prepared.

NOTES

1. State data. This figure is 200,000 less than the 1,416,000 enrollees in 1995 reported in the Urban Institute's analysis of Health Care Financing Administration 2082 data, which counts all of those enrolled at any time during the year.
2. Michigan League for Human Services, "Assessing the New Federalism Project: Background Paper," August 9, 1996, pp. 4–5. Note that this is a percentage change in state spending from state resources (not including federal, local, or private funds) and is adjusted by the state/local deflator with program transfers taken into consideration.
3. Michigan Department of Management and Budget, Office of Health and Human Services.
4. In FY 95, Michigan restructured the financing of its public school system, partially replacing about $4.5 billion in local property taxes with $3.1 billion in increases to the state sales, cigarette, and real estate transfer taxes, and with a new statewide property tax.
5. When a hospital or other governmental entity makes intergovernmental transfers to the state, the hospital receives little or no net increase in total Medicaid payments from the state.
6. These caseload figures are reported by the state and reflect average monthly caseloads or enrollees at a point in time. Data in table 5 are numbers of enrollees ever in the program during a given year.
7. Individuals losing SSI eligibility are automatically referred for notice of redetermination under Medicaid; their eligibility is maintained for at least two months after they lose SSI coverage, during which time they can try to requalify for Medicaid under another category.
8. U.S. General Accounting Office, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, GAO/HEHS-94-133, August 1994.
9. This occurs because the state makes DSH payments to public hospitals using state funds and federal matching payments, and the hospitals transfer back to the state most (and sometimes all) of the DSH payments. The result is that the state spends no additional state general revenue funds on Medicaid and *nets* the federal contribution. In the process, IGTs have increased the effective federal match rate for the state.
10. People may "spend down" to Medicaid eligibility because their medical expenses reduce their income and/or assets below an established threshold. This eligibility category is optional for states.
11. Corridors are determined based on state-targeted savings, the minimum amount needed to provide quality care, and expected changes in use.
12. U.S. Bureau of the Census. The Census regards public *expenditures,* regardless of the locus of control, as being composed of federal, state, and local *revenues.*
13. The Detroit Health Department also decided not to join the HMO sponsored by the FQHCs in the state (called Community Choices of Michigan) because it did not think the plan was a good risk.

APPENDIX

List of People Interviewed

LANSING

State Government

Department of Community Health

Robert Smedes	Karen Schrock	Carl Ramroth
Denise Holmes	Donald VeCasey	Karen Kerzak
Marilyn Hill	Judy Wilson	Jill Zakrajsek
Jane Finn	Linda McArdle	Robert Alexander
Dennis DuCap	Brenda Fazzette	Carl Gibson
Bonnie Barnes	Stan Barnhard	Patrick Berry
David Viele	Terri Wright	Mark Miller
Edmund Kemp	Janet Olszewski	Vernon Smith
Karen McCosky	Robert Stamply	

John Peterson	Department of Aging
Jean Carlson	Insurance Bureau, Department of Commerce
Fran Wallace	Insurance Bureau, Department of Commerce
Paul Reinhart	Department of Management and Budget
Frederick Hoffecker	Department of the Attorney General
Stephanie Comai-Page	Office of the Governor

State Legislators

Dale Shugars	Michigan State Senate
John Llewellyn	Michigan House of Representatives

Provider Associations

Charles Elstein	Michigan Health and Hospital Association
Kim Sibilsky	Michigan Primary Care Association
Christine Shearer	Michigan State Medical Society
Sandra Kilde	Michigan Association for Homes and Services to the Aging

Advocacy Groups

Paul Shaheen	Michigan Council for Maternal and Child Health
Hollis Turnham	Citizens for Better Care
Terry Hunt	United Cerebral Palsy Association of Michigan

Outside Experts

Jeffrey Taylor	Michigan Public Health Institute
Pamela Paul-Shaheen	Comprehensive Community Health Models of Michigan

DETROIT

Hospitals

Gail Warden	Henry Ford Health System
Brenita Crawford	Mercy Hospital
Robert Yellan	Detroit Medical Center
Robert Johnson	Detroit Medical Center

HMOs

Robert Jones	OmniCare
Isadore King	Wellness Plan

Community Health Centers

Ricardo Guzman	Community Health and Social Services Center, Inc. (CHASS)
Mary Ferris	Detroit Community Health Connection

City/County Officials

Cynthia Taueg	Detroit Health Department
Patty Kukula	Wayne County Patient Care Management

Others

James Kenney	Greater Detroit Area Health Council
Donald Softley	Village Development Corporation (a community development group)
John Waller, M.D.	Wayne State University

About the Authors

Debra J. Lipson, currently a health policy consultant in Geneva, Switzerland at the World Health Organization, continues her work on projects related to safety net providers. She was formerly associate director of the Alpha Center where she managed research studies on state and local health care reform, with an emphasis on the financing and organization of health services for the poor and uninsured.

Michael Birnbaum is an associate at the Alpha Center. He works on a number of Alpha Center programs and research projects and has written reports on state and federal health policy issues. Previously he worked as a consultant to several health policy organizations in Washington, D.C.

Susan Wall is a research associate in the Urban Institute's Health Policy Center. Previously she served as an analyst for the Physician Payment Review Commission. Her research has centered on access to care for low-income populations, including issues of health professional maldistribution, Medicaid managed care, and public health departments.

Marilyn Moon is a senior fellow with the Health Policy Center of the Urban Institute. She serves as one of two public trustees of the Social Security and Medicare trust funds. Dr. Moon has written and spoken extensively on health policy, policy for the elderly, entitlement issues, and income distribution. Prior to her position at the Urban Institute, she served as the founding Director of the Public Policy Institute of the American Association of Retired Persons.

Stephen Norton is a research associate at the Urban Institute's Health Policy Center, where he specializes in research on the Medicaid program, maternal and child health, and those institutions providing care to the medically indigent. He is the author of a number of articles on health care.

Errata

Several published *State Reports* and *Highlights* include an error in Table 1, "State Characteristics." Incorrect figures were included for noncitizen immigrants as a percentage of the population. Corrections were made on August 13, 1998 to both the HTML and PDF version of these reports on the *Assessing New Federalism* website.

Correct figures for 1996

	Noncitizens as a Percent of the Population
UNITED STATES	6.4%
Alabama	0.9%
California	18.8%
Colorado	5.1%
Florida	10.0%
Massachusetts	5.4%
Michigan	2.3%
Minnesota	3.0%
Mississippi	0.9%
New Jersey	8.8%
New York	11.9%
Oklahoma	1.5%
Texas	8.6%
Washington	4.3%
Wisconsin	2.1%

Source: Three-year average of the Current Population Survey (CPS) (March 1996-March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship.

The error appears in the following publications:

State Reports:
Health Policy: Alabama, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington

Income Support and Social Services: Alabama, California, Massachusetts, Michigan, Minnesota, Texas, Washington

Highlights:
Health Policy: Alabama, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Oklahoma, Texas, Washington

Income Support and Social Services: Minnesota, Texas

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