CHRT | Institute for Public Policy and Social Research MICHIGAN STATE UNIVERSITY

MICHIGAN HEALTH ENDOWMENT FUND

LEGISLATIVE BRIEF

Medicaid in Michigan

Medicaid is a jointly funded federal and state program that provides health insurance coverage for many low-income children and adults, making it an important and powerful tool for improving the health of Michiganders.

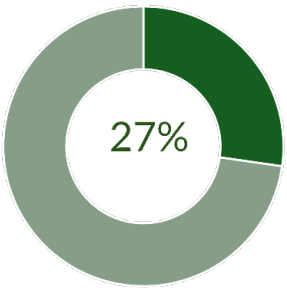
In June 2024, over 2.6 million of Michigan's 10 million residents were enrolled in Medicaid, 1.7 million adults and 946,314 children.[i] Most of Michigan's Medicaid costs —over 65 percent in 2024—are paid for by the federal government.[ii]

States have considerable power to tailor Medicaid policy, benefits, and services to address their residents' health and social needs. In Michigan, both traditional Medicaid and the Healthy Michigan Plan (HMP) cover Michiganders. HMP provides coverage for individuals who became eligible through the Michigan Medicaid expansion, implemented in 2014.

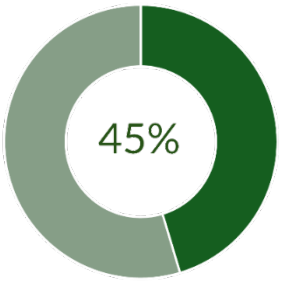
This primer provides key information about Medicaid in Michigan, including:

- Medicaid financing: The program is jointly funded by the state and federal government, with $18.5 billion in federal contributions in FY24.
- Eligibility and benefits: Michigan Medicaid covers people with incomes up to 138% of the Federal Poverty Level, providing a range of services like hospital visits, dentistry, behavioral health, and long-term care.
- Program challenges: Challenges that impact the program include costs and cost variation by beneficiary group, low provider reimbursement rates, and enrollment complexity.

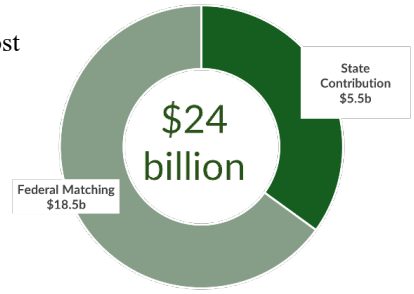
As of June 2024, more than one in every four Michiganders benefit from Medicaid coverage



As of June 2024, nearly half of all Michigan children benefit from Medicaid.



In FY24-25, The federal government pays two-thirds of the cost of Michigan Medicaid coverage.



Medicaid Program Overview

Annual spending

The largest spending category in the Michigan state budget is for the Michigan Department of Health and Human Services (MDHHS), which includes spending for Medicaid. At $37.7 billion, the MDHHS budget represents 45 percent of the total state budget in FY 2024-25. Within the MDHHS budget, the Medicaid program constitutes the largest category of annual spending, totaling approximately $24 billion. Of this, $18.5 billion is covered by the federal government, and $5.5 billion is state funding.[iii]

In FY 2025, the federal contribution to Michigan Medicaid, known as the Federal Medical Assistance Percentage (FMAP) or Medicaid matching rate, will cover 65.13 percent of the cost of coverage for traditional Medicaid, and 90 percent of the cost for those enrolled in the state's Medicaid expansion plan, the Healthy Michigan Plan (HMP).[1,iv] Michigan state Medicaid funds primarily come from General Fund/General Purpose (GF/GP) revenue.

[1] The FMAP is calculated using state per capita income. During the COVID-19 Public Health Emergency, the FMAP was increased 6.2 percentage points to provide additional support for states to continuously enroll individuals in Medicaid throughout the Public Health Emergency. This enhanced FMAP ended December 2023.

Medicaid eligibility

Medicaid provides health insurance coverage for those in Michigan with incomes up to 138 percent of the federal poverty level (FPL). In 2024, that is equivalent to an annual income of $20,783 per year for a single-person household and $35,632 per year for a family of three.[v] Certain individuals in special populations who earn more than the income limit may also qualify, including pregnant women, people with disabilities, and aging seniors receiving long-term services and supports (LTSS).[vi]

Prior to expanding Medicaid in Michigan, eligibility for Medicaid coverage for individuals making over 100 percent of the FPL was categorical. In other words, to qualify for Medicaid coverage, low-income Michigan residents earning more than the FPL had to fall into specific non-financial classifications (e.g., pregnant women; individuals with disabilities).[vii]

The relationship between poverty and health status is well documented; low-income individuals are more likely to have a higher burden of chronic disease and poorer health outcomes.[viii] A contributing factor to this disparity is access to healthcare, including health insurance coverage.[ix]

Flexibility

The federal government establishes certain eligibility and benefit requirements for Medicaid but leaves much flexibility to states to structure and implement their programs. [xi] This flexibility is available to states through Medicaid demonstration waivers or state plan amendments. With approval from the federal government, states that submit waivers and amendments can expand the scope of services offered through Medicaid as well as the populations they serve.[xii] Though these program levers are powerful tools, they are also complicated to design and implement, and require detailed reporting and evaluation.

As of July 2024, Michigan has 10 approved Medicaid waivers implemented through Section 1115 or Section 1915 authority of the Social Security Act. These waivers serve a variety of functions, including:

- expanding Medicaid eligibility to Michiganders impacted by the Flint water crisis,
- providing additional community-based services for individuals with behavioral health needs,
- providing guidance for Medicaid managed care programs, and
- supporting home and community-based services.[xiii]

These waivers are time-limited and are generally approved for up to five years. If a Medicaid program is successful under the waiver authority, states may submit requests for extensions to the Centers for Medicare & Medicaid Services (CMS). In addition, all waivers must be formally evaluated for impact.

Expansion of dental coverage for adults

Michigan significantly expanded dental coverage for adult Medicaid beneficiaries in April 2023. Increased access to dental services can help prevent and detect costly oral health diseases and related chronic conditions, reducing emergency room visits and lost work hours. These redesigned Medicaid dental benefits and increased provider payments cost $115.1 million in total state and federal funding for FY 23-24.[12]

Newly covered dental services include root canals and gum care, and the expansion significantly increased reimbursement rates for dental services to encourage more dentists to serve Medicaid patients. As of July 2024, however, long waitlists for dental care persist as there are still too few dentists accepting Medicaid patients.[x]

Benefits and services

Services covered by Medicaid can vary widely across states. However, federal guidelines do require all states to cover a minimum set of benefits and services.

Mandatory benefits

Mandatory benefits include but are not limited to inpatient and outpatient hospital care, laboratory services, ambulance services, family planning, and home health services. All children enrolled in Medicaid are eligible for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. EPSDT provides preventive care for children related to dental, mental health, and specialty services.[xiv]

Optional benefits

CMS also designates certain benefits as optional for states to cover.[xv] Michigan Medicaid covers many common optional benefits such as dental, vision, prescription drugs, and hospice care as well as less common benefits like chiropractic care and doula services.[xvi] In the wake of the COVID-19 pandemic, Michigan, along with many others states, are choosing to enact benefit expansions to address behavioral health, maternal infant health, and social needs, such as food insecurity.[xvii]

Long-Term Services and Supports

Michigan, like most states, is working to support beneficiaries who prefer to age in their homes rather than in costly nursing homes. Medicaid is the primary funder for long-term services and supports (LTSS), which provide enhanced program coverage for individuals who require additional assistance with activities of daily living such as eating, bathing, and managing medications, as well as those who need much higher levels of care.[xx]

Examples of LTSS programs in Michigan include:

- the Program of All-Inclusive Care for the Elderly (PACE),
- the MI Choice waiver,
- Home Health benefits,
- Community Transition Services (CTS),
- MI Health Link, and
- Home Help.[xxi]

Direct care workers in Michigan

Direct care workers (DCWs) provide long-term care services to vulnerable populations—largely older adults and people with disabilities—and often help keep people in their homes. Many Medicaid funded long-term care services are provided by DCWs. According to the 2024 Michigan Healthcare Workforce Index, Michigan's home health aides, personal care aides and nursing assistants have some of the highest shortage levels and turnover rates of all healthcare workers in the state.[xviii]

Strategies to support DCWs in other states include wage and benefit increases, employment benefits, recruitment and retention bonuses, and more. During the COVID-19 pandemic, the Michigan legislature enacted three wage increases for DCWs. This continued in FY24, resulting in a $3.20 per hour wage increase from October 1, 2023 to September 30, 2024.[xix]

Enrollment in managed care

Michigan is a national leader in enrolling Medicaid beneficiaries in managed care plans, first introducing managed care into the state's Medicaid program in 1996. In contrast to traditional fee-for-service models that pay providers for each service they deliver, managed care works to reduce health care costs and improve quality of care by paying providers a fixed amount per person (a "capitated" payment) for all of their care. This creates incentives for providers to reduce any unnecessary care and to keep patients as healthy as possible.[xxii] Two-thirds of Michigan Medicaid beneficiaries are enrolled in a managed care plan rather than receiving care on a fee-for-service basis.[2]

[2] CHRT calculation based on the total number of individuals enrolled in managed care in Michigan and total number of Medicaid enrollees for June 2024.

As of June 2024, nine Medicaid Health Plans (MHPs) provide managed care for nearly 1.8 million Medicaid enrollees across the state (none of the MHPs serve the entire state). MHPs receive a capitated payment for each enrolled beneficiary, assuming full financial risk for care and services provided for their enrollees.[xxiii] This arrangement can save Medicaid program costs for the state and incentivize MHPs to provide appropriate, preventive, high-quality care for beneficiaries. It also encourages MHPs to cover additional evidence-based benefits and services beyond what the state and CMS require.[xxiv]

Behavioral health

Michigan is one of seven state Medicaid programs that "carves out" behavioral health (BH) benefits for beneficiaries with moderate to severe BH needs, and for those with intellectual or developmental disabilities (I/DD).[xxvi] Most of those with mild to moderate BH conditions receive BH coverage under the same Medicaid managed care benefit that covers all their physical care services. Those with moderate to severe BH conditions and those with I/DD, however, receive coverage through a separate funding mechanism for more specialized BH services. This separate mechanism is administered through 10 prepaid inpatient health plans (PIHPs) across the state that fund the mental health, substance use, and disability services for the "carve out" population through a capitated funding arrangement. In recent years there have been unsuccessful efforts to "carve in" the Medicaid benefit for those with moderate to severe BH needs, [xxvii] with Medicaid health plans generally favoring a "carve in" and behavioral health advocates generally opposed to the change.[xxviii]

Michigan's Behavioral Health Landscape

About six million Michiganders live in Mental Health Professional Shortage Areas, with areas of Northern Lower Michigan and the Upper Peninsula particularly impacted. The state would require an estimated 249 more psychiatrists to alleviate these shortage designations. Provider shortages are particularly acute for children: rates of child behavioral health (BH) conditions are rising while suicide rates fluctuate. Many of those seeking BH services endure long waits for outpatient appointments and in emergency departments ("ED boarding"). Options for improving access to behavioral health care in Michigan include supporting reimbursement for BH telehealth in Medicaid, Medicare, and private insurance, BH provider loan repayment programs, and streamlined licensure processes through interstate licensing contracts.[xxv]

Impact of the Affordable Care Act

In 2014, Michigan expanded Medicaid coverage in the state through the 2010 Affordable Care Act (ACA). The expansion, known as the Healthy Michigan Plan (HMP), was made possible through a Section 1115 Medicaid demonstration waiver, Medicaid state plan amendment, and Michigan Public Act 107 of 2013.[xxix] A Supreme Court ruling in 2012 provided states with the option to expand their Medicaid coverage rather than requiring states to expand as a condition for receiving federal funding.[xxx] Michigan was one of the national leaders in Medicaid expansion, implementing the expansion just three months after the authority began. As of June 2024, 41 states including the District of Columbia have expanded Medicaid coverage.

Healthy Michigan Plan

The Healthy Michigan Plan changed income eligibility requirements for Medicaid in Michigan. Instead of limiting coverage to individuals at or below the federal poverty level (FPL) or those that meet categorical requirements (e.g., pregnant women), Michiganders became eligible for HMP through the ACA expansion if their income was at or below 138 percent of the FPL. As a result of expanded eligibility, Medicaid enrollment in the state increased by 22 percent in the first year, with HMP enrollment alone exceeding 400,000 in the first six months and 600,000 after the first year.[xxxiv]

When the HMP section 1115 waiver was renewed in 2018, new requirements were added for HMP beneficiaries, including cost-sharing and completion of a Health Risk Assessment.[xxxv] In December 2023, the HMP 1115 demonstration waiver expired along with the cost-sharing and health risk assessment requirements. All beneficiaries who were eligible for Medicaid through the expansion have been reassigned to the Michigan Comprehensive Health Care Program (CHCP), but the state still refers to this beneficiary population as HMP.[xxxvi] This reassignment has had no impact on beneficiary eligibility. [xxxvii] As of June 2024, nearly 1.8 million Michiganders are enrolled in HMP Medicaid coverage; the federal government pays 90 percent of the cost for this population.

Healthy Michigan Plan Evaluation

The Section 1115 waiver that established the Healthy Michigan Plan required the state to conduct an independent evaluation of the program. The Institute for Healthcare Policy and Innovation (IHPI) at the University of Michigan was selected by MDHHS to lead the evaluation work.[xxxi] The evaluation report from the first five years of the HMP Medicaid expansion, submitted to CMS in 2020, found multiple improvements for beneficiaries and for systems, such as improved physical, mental, and oral health and reduced uncompensated care costs for hospitals. In 2022, an interim evaluation showed similar findings and focused on findings related to key provisions unique to HMP, including the Healthy Behaviors Incentive Program and cost-sharing requirements for some beneficiaries. The final evaluation report for the second five years of HMP (through 2023) is expected to be submitted to CMS in late 2024.

Challenges in Medicaid

Due to the size and complexity of the Medicaid program, there are several challenges that have financial and operational implications for states and providers.

Cost

Including state and federal spending, Medicaid is the largest individual budget item for the state.[xxxviii] Medicaid is "countercyclical" by nature, meaning that when the state's economy is in a downturn, more residents will qualify for Medicaid coverage because more people will meet low-income designations. This type of increased enrollment in Medicaid can present major challenges for state budgets.

Variations in cost by beneficiary group

Individuals who qualify for both Medicare and Medicaid coverage, or "dual eligibles," are particularly high cost.[xxxix] These individuals tend to have complex medical and social needs, often requiring greater care and support. Children tend to be the lowest cost Medicaid beneficiaries.[xl]

Reimbursement rates

Medicaid reimbursement rates for providers are generally very low compared to commercial insurance payments and to Medicare reimbursement. For example, in Michigan, the Medicare-to-Medicaid fee index for opioid use disorder services was 58% compared to a national average of 64% as of 2021.[xli] Low reimbursement rates impact the number of providers willing to serve Medicaid beneficiaries. As a result, low-income residents across the state have greater difficulty accessing care. MDHHS increased reimbursement rates for some providers and services for

the two most recent budget periods (FY 23-24 and FY 24-25), including for home health agency services, ground ambulance services, dental care, and behavioral healthcare.[xlii]

LTSS "rebalancing"

Medicaid long-term services and supports (LTSS) programs encompass a broad range of care for older adults, those with disabilities, and individuals who otherwise need assistance with activities of daily living. Most people in need of LTSS prefer to receive care in their homes instead of in nursing homes or other institutions. When delivered at home, LTSS are generally less costly than care provided in an institutional healthcare setting.[xliii]

As the primary payer of LTSS, Medicaid plays an important role in "rebalancing" the proportion of services delivered in home and community-based settings versus in institutional settings.[xliv] Rebalancing LTSS has been a federal and state priority for at least the last two decades.[xlv] In 2023, 29.4% of Medicaid LTSS spending in Michigan went towards home and community-based services (HCBS), compared to the national average of 53.3% of LTSS spending.[xlvi] MDHHS provides some incentives for HCBS, and Michigan has participated in Medicaid demonstration pilots to expand HCBS through waiver authority.[xlvii] American Rescue Plan Act funds were also approved to enhance HCBS in Michigan.[xlviii] Strategies to improve rebalancing of LTSS services include strategic infrastructure investments, enhancing the LTSS workforce (including direct care workers and family caregivers), and expanding services to at-risk populations who are not eligible for full Medicaid benefits. [xlix]

Enrollment complexity

High proportions of Medicaid beneficiaries frequently enroll and disenroll from Medicaid coverage. This enrollment "churn" results in increased administrative burden for beneficiaries and for program enrollment specialists. Churning may be caused by monthly income fluctuations, job instability, switching enrollment between MHPs, and changes in pregnancy or disability status, as well as by frequent administrative redetermination of eligibility.[liii] Churning can result in periods of uninsurance, leading to delayed care, increased emergency room visits, as well as increased program administration costs.[liv]

Reducing Enrollment Churn

Common state strategies to minimize enrollment churn: 1) policies that allow for longer periods of eligibility, and 2) increases in automatic (called ex-parte) renewals based on other data sources, thereby eliminating the requirement for renewal applications.[l]
Michigan uses both strategies and offered 12-month continuous eligibility for children before it was mandated in the 2023 Federal Consolidated Appropriations Act.[li] Five states have active Section 1115 waiver demonstrations that implement 12-month continuous Medicaid eligibility for certain adult populations, and three more states have such waiver applications pending. [lii]

The COVID-19 Public Health Emergency (PHE) of 2020 required states to enact continuous Medicaid enrollment, thereby not disenrolling anyone enrolled in Medicaid during the PHE. In return, states received a temporary 6.2 percentage point increase in their FMAP to help with emergency-related increases in program costs. Once the PHE ended and states began redeterminations for Medicaid eligibility, millions lost Medicaid coverage nationally. As of July 2024, 979,900 Michiganders have lost Medicaid coverage due to the redetermination processes. Some have higher incomes and no longer qualify for coverage; others are still eligible but have not been able to enroll for procedural reasons. [lv]

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