FISCAL FOCUS

Michigan's Medicaid Program

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EXECUTIVE SUMMARY

With the expansion of Michigan's Medicaid program under the Healthy Michigan Plan, the program provides health care benefits to over 20% of the state's nearly 10 million residents. The program now represents nearly one-third of Michigan's total state budget and nearly one-quarter of its General Fund budget.

The traditional Medicaid program is a joint federal-state health care program for low-income families and disabled individuals. A majority of the traditional Medicaid program's 1.7 million beneficiaries are children. The program's elderly, blind, and disabled beneficiaries, however, account for a much larger share of program expenditures.

Enrollment in the Healthy Michigan Plan, which is available to all non-elderly adults with family income up to 133% of the federal poverty level, has leveled off at just under 600,000 beneficiaries. Based on current HFA assumptions and estimates, state savings associated with expanding Medicaid will exceed increasing state match costs through Fiscal Year (FY) 2018-19. In subsequent years, the estimated net costs of continuing the Healthy Michigan Plan would be roughly $85 million per year.

Over 70% of total Medicaid beneficiaries are now enrolled in managed care health plans. Medicaid costs per beneficiary have grown at a rate below the level of general medical cost inflation over the last decade and a half.

In total, Michigan's Medicaid caseload has more than doubled since FY 2000-01 and expenditures for the program have tripled from $5.7 billion to $17.0 billion. State General Fund/General Purpose (GF/GP) support for the program, however, has effectively been held flat at about $2.0 billion per year over this period due to the use of provider assessments and other restricted funds, the federal match rate moving in the state's favor, and initial 100% federal funding for the Healthy Michigan Plan.

In order to maintain the state's Medicaid program at the current level of services for FY 2016-17 and beyond, additional GF/GP funds or other broad-based tax revenue will almost certainly be needed to address 5% state match costs for the Healthy Michigan Plan and replacement of temporary financing sources for the traditional program. The Governor's original Medicaid expansion proposal included the creation of a reserve fund to help pay for eventual Healthy Michigan Plan match costs; the Legislature, however, did not opt to establish such a reserve.

While options to reduce the state's Medicaid budget exist, they are constrained by federal program requirements and health policy considerations. Additionally, for each $1.00 in state savings from reductions to the Medicaid program, the state foregoes nearly $2.00 in federal funds.

The remainder of this report provides more detailed information on the traditional Medicaid program and its financing, describes Healthy Michigan Plan waiver requirements and financing, presents information on trends in total Medicaid expenditures, and discusses the FY 2016-17 budget outlook for the Medicaid program.

ACKNOWLEDGEMENTS

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ACRONYMS

DHHS	Department of Health and Human Services
DSH	Disproportionate Share Hospital
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FY	Fiscal Year
GF/GP	General Fund/General Purpose
GME	Graduate Medical Education
HFA	House Fiscal Agency
HICA	Health Insurance Claims Assessment
MCO	Managed Care Organization
PACE	Program of All-Inclusive Care for the Elderly
QAAP	Quality Assurance Assessment Program
SSI	Supplemental Security Income

THE TRADITIONAL MEDICAID PROGRAM

The traditional Medicaid program is a joint federal-state health care program for low-income families and disabled individuals. At the federal level, Congress enacted Medicaid in 1965 by adding Title XIX to the Social Security Act. Michigan's participation in Medicaid was authorized by 1966 legislation amending the state's Social Welfare Act.

Michigan's Medicaid program is administered by the state's Department of Health and Human Services (DHHS) and is governed through a combination of federal law and regulations, the Social Welfare Act, annual budget boilerplate language, and Michigan's Medicaid State Plan. Changes to the Medicaid State Plan must be approved by the federal Centers for Medicare and Medicaid Services. States may also request federal waivers for certain federal requirements: for example, to provide services through managed care, to provide home and community-based services (such as MI Choice), or to test new or existing approaches to financing and delivering services.

Federal law and regulations have established both mandatory and optional eligibility categories.[1] States have the flexibility to establish eligibility standards within those federal guidelines. Michigan's current net family income standards for the major eligibility groups, not including the expanded population under the Healthy Michigan Plan, are as follows:

- Families receiving Family Independence Program cash assistance: up to 49% of the federal poverty level (FPL)
- Aged, blind, and disabled individuals receiving Supplemental Security Income (SSI): up to 75% of FPL
- Elderly and disabled individuals: up to 100% of FPL
- Children under 18 in families: up to 160% of FPL
- Pregnant women and newborn children: up to 195% of FPL
- Individuals needing long-term care services: up to 225% of FPL (or 300% of SSI)
- Medically needy individuals with income or resources above regular financial eligibility levels[2]

[1] See this table on the federal Medicaid website for mandatory and optional eligibility categories and their legal citations: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf

[2] The medically needy population has income above Medicaid eligibility standards. To qualify for Medicaid coverage, a beneficiary in this population has to "spend down" monthly deductibles based on the person's excess income.

Individuals and families may be eligible for the program under more than one category; for example, those eligible under the first two categories listed above are also generally eligible under categories with higher income limits. Examples of income limits for major eligibility groups are presented in Table 1.

TABLE 1

2015 Federal Poverty Level Examples[3]

% of FPL	Eligibility Group	Individual	Family of 2	Family of 3	Family of 4
100%	Elderly/disabled	$11,770	$15,930	$20,090	$24,250
133%	Healthy Michigan Plan	15,654	21,187	26,720	32,253
160%	Children under 18	18,832	25,488	32,144	38,800
195%	Pregnant women/newborn children	22,952	31,064	39,176	47,288
225%	Individuals needing long-term care	26,600	36,002	45,403	54,805

Note: Does not reflect income disregards and asset tests, including 5% income disregard for Healthy Michigan Plan, children, and pregnant women.

Additionally, children in families with incomes above Medicaid eligibility levels but below 212% of FPL are eligible for the MIChild program. Expenditures for that program are matched at a higher rate by the federal government (98.92% for FY 2015-16) and are not included in the totals presented in this report.

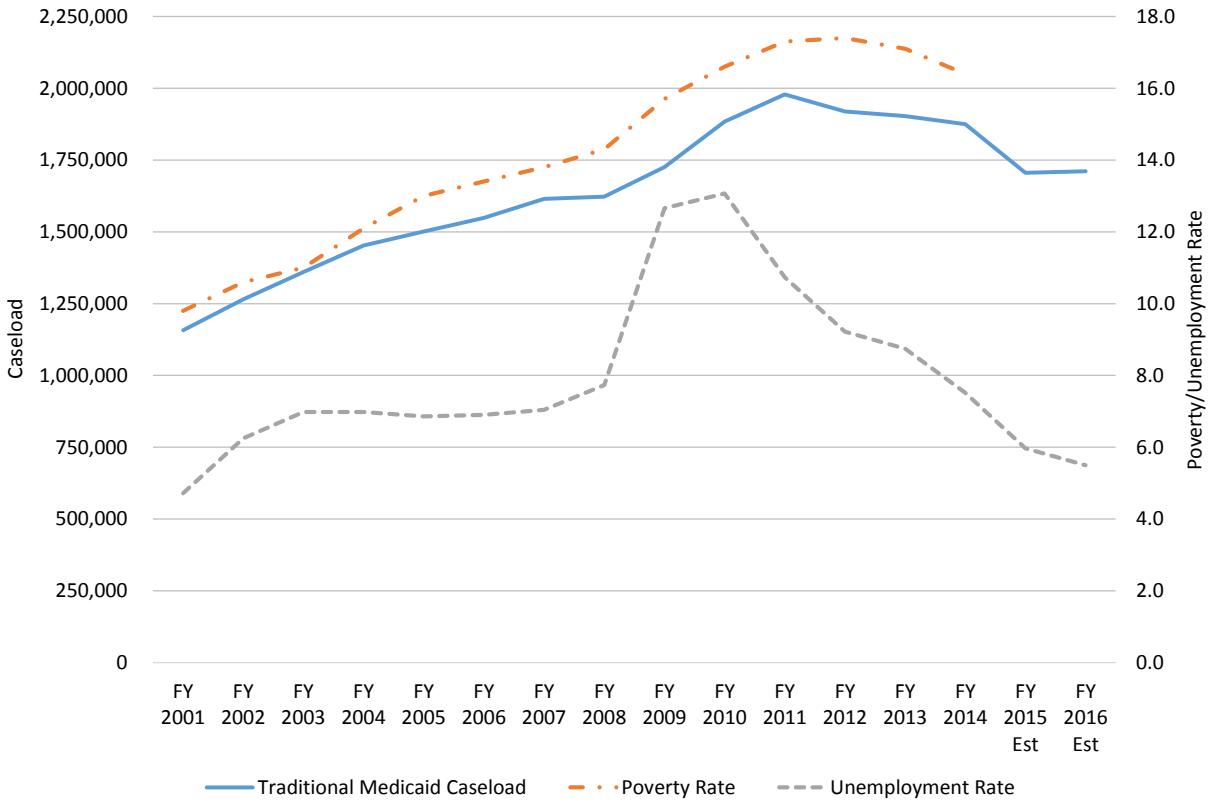
Generally, non-disabled, childless adults under the age of 65 were not eligible for the traditional Medicaid program prior to the expansion under the Healthy Michigan Plan. The exception was the Adult Benefits Waiver, which provided limited benefits to very low-income adults (35% of FPL or below); the program also had limited enrollment. The Adult Benefits Waiver was replaced by the Healthy Michigan Plan, which is described in more detail later in this report.

From FY 2000-01 to the Medicaid caseload peak in FY 2010-11, Medicaid caseloads increased by over 70%–from 1.2 million beneficiaries to 2.0 million beneficiaries. Since the peak, caseloads for the traditional program have declined by nearly 15% to 1.7 million beneficiaries. Changes in caseloads can occur for a number of reasons, including policy changes. The primary driver of caseload changes during this time period, however, does appear to be economic. As shown in Figure 1, when the state's poverty rate and unemployment rate increases, so does the Medicaid caseload. And when the poverty rate and unemployment rate decline, which has occurred since FY 2010-11, Medicaid caseloads have also declined. The caseload decline since FY 2010-11 has not been as steep as the reduction in the state's unemployment rate, as caseload levels appear to track more closely with the state's poverty rate.

[3] For other FPL amounts, see the U.S. Department of Health & Human Services website: http://aspe.hhs.gov/poverty/15poverty.cfm.

FIGURE 1

Annual Medicaid Caseloads and Economic Trends



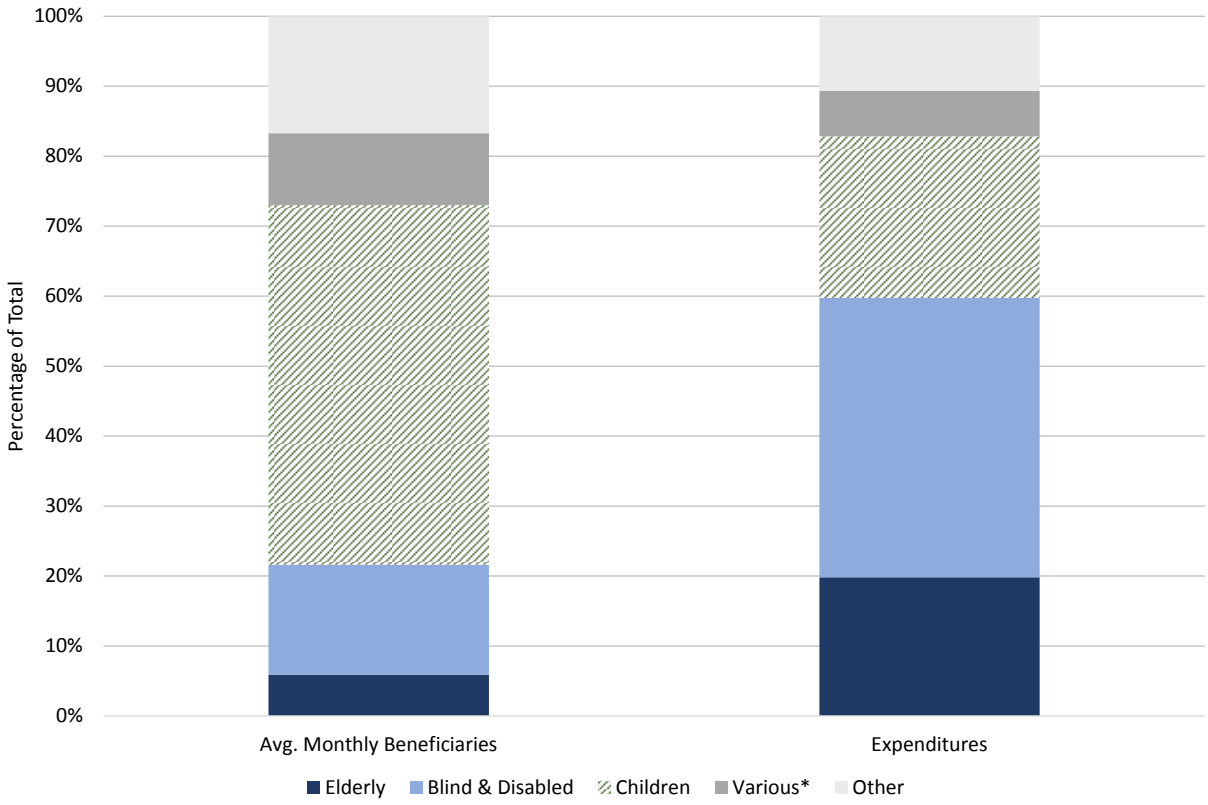
As shown in Figure 2, average costs per beneficiary vary widely among beneficiary groups. In FY 2012-13, the elderly, blind, and disabled represented 22% of beneficiaries, but accounted for 60% of expenditures. Conversely, children represented 51% of beneficiaries, but accounted for only 23% of expenditures.

Similar to Medicaid eligibility, federal law and regulations have established both mandatory and optional medical services that are covered by the program.[4] Mandatory Medicaid services include inpatient and outpatient hospital services, physician's services, nursing facility services, laboratory and x-ray services, emergency services, and pregnancy-related services. Optional Medicaid services covered under Michigan's Medicaid program include mental health services, home- and community-based services (including MI Choice and habilitation support waivers), pharmaceutical services, adult home help services, dental services (including the Healthy Kids Dental program), hospice services, and the Program of All-Inclusive Care for the Elderly (PACE), among others.

[4] For a list of all mandatory and optional services, see the federal Medicaid website: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Medicaid-and-CHIP-Benefits.pdf.
For information on which states provide individual services, see the Kaiser Family Foundation website: http://kff.org/state-category/medicaid-chip/medicaid-benefits/.

FIGURE 2

Comparison: FY 2012-13 Medicaid Beneficiaries and Expenditures



* Includes pregnant women, childless adults, foster care children and Plan First enrollees.

While mental health services are technically optional Medicaid services, a proposed federal rule, published April 10, 2015, would require Medicaid managed care organizations to comply with federal mental health parity requirements within the federal Public Health Services Act. The proposed federal rule also strongly encourages states to provide mental health services to their Medicaid fee-for-service beneficiaries.[5] Additionally, Chapter 35 of the Michigan Insurance Code requires managed care organizations to provide for not fewer than 20 outpatient mental health service visits.

States have the flexibility to establish Medicaid provider rates up to the various federal upper payment limits for hospital services, nursing facilities, clinic services, and practitioner services. These upper payment limits generally correspond to reimbursement rates for the federal Medicare program. Federal regulations also require that provider rates "be sufficient to enlist enough providers so that services under the [Medicaid state] plan are available to beneficiaries at least to the extent that those services are available to the general population."[6] Medicaid is considered the payer of last

[5] The full text of the proposed federal rule can be found here: https://www.federalregister.gov/articles/2015/04/10/2015-08135/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of.

[6] 42 Code of Federal Regulations 447.204.

resort, meaning all other financial resources such as commercial insurance, Medicare, workers compensation, or no-fault automobile insurance are utilized prior to Medicaid reimbursement.

Finally, state Medicaid programs are required to participate in Medicare savings programs, which help low-income Medicare-eligible individuals pay premiums for Medicare coverage. There are four Medicare savings programs. Each has a different income eligibility requirement and may provide different coverages:

- For Medicare-eligible individuals up to 100% of FPL, the Qualified Medicare Beneficiaries program pays Medicare Part A (inpatient services) premiums, Medicare Part B (outpatient services) premiums, deductibles, and coinsurances.
- For Medicare-eligible individuals between 100% and 120% of FPL, the Special Low-Income Medicare Beneficiaries program pays Part B premiums.
- For Medicare-eligible individuals between 120% and 135% of FPL, the Qualifying Individuals program pays Part B premiums.
- For Medicare-eligible individuals up to 200% of FPL, the Qualified Disabled Working Individual program pays Part A premiums.

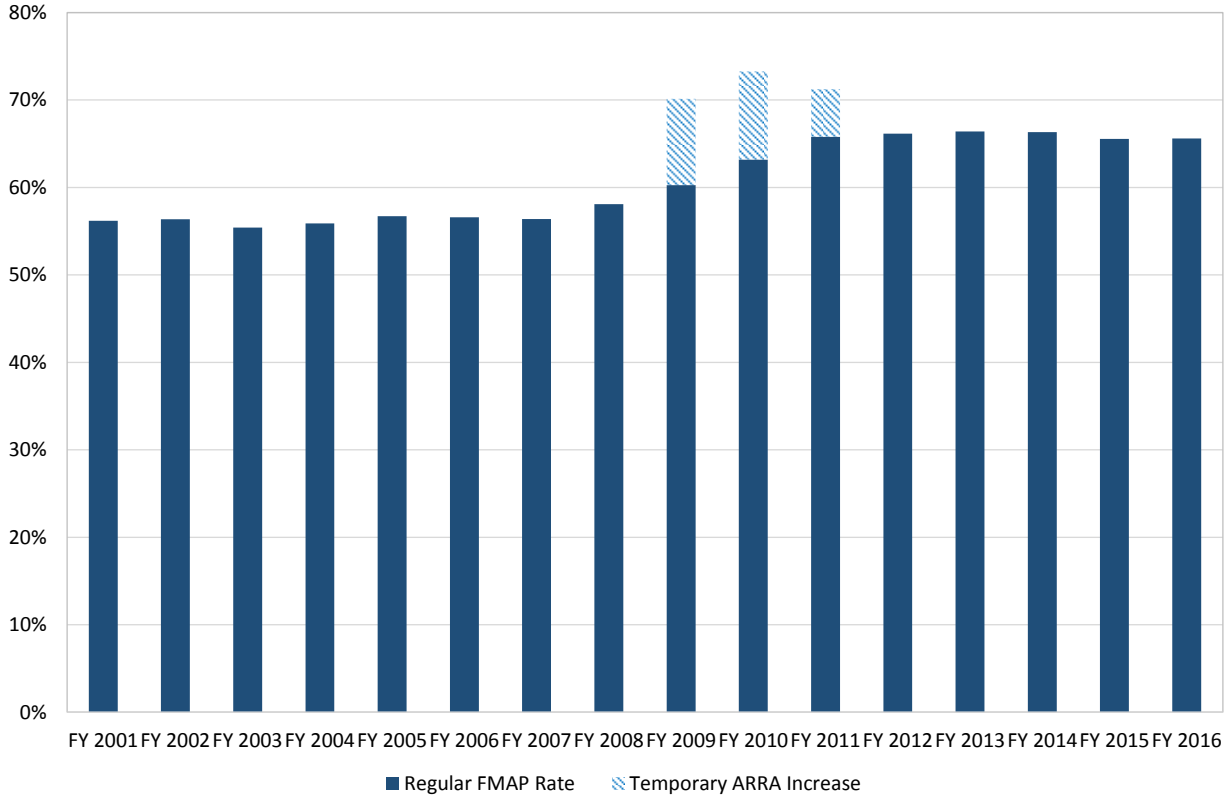
Michigan recently implemented a new program for individuals receiving full Medicare and full Medicaid coverage (known as "dual eligibles") called MI Health Link. This program is a three-way partnership between the state, the federal government, and managed care health plans to provide a single, integrated health plan for all health services regardless of whether Medicare or Medicaid is the primary payer. MI Health Link is currently available in Southwest Michigan, the Upper Peninsula, Macomb County, and Wayne County. Enrollment is voluntary, but if a person does not opt out he or she is passively enrolled into MI Health Link.

TRADITIONAL MEDICAID FINANCING

Medicaid expenditures are jointly financed by the federal and state governments. For most expenditures the portion financed by the federal government is determined utilizing the Federal Medical Assistance Percentage (FMAP) rate.[7] This rate is adjusted annually based on a comparison of a given state's average personal income to the average national personal income utilizing a three-year average. For FY 2015-16, Michigan's FMAP rate is 65.60%: the federal government finances 65.60% of Medicaid expenditures, and the state finances the remaining 34.40%. In other words, for each $1.00 of state funds Michigan allocates for the Medicaid program, the federal government provides $1.91.

Nationally, FMAP rates for individual states range from a floor of 50% to 74%.[8] The average FMAP rate is set at 57%.

FIGURE 3
Michigan's FMAP Rate



[7] Some exceptions include administrative costs, information technology services, family planning services, and Indian health services.

[8] A complete list of FMAP rates is available on the U.S. Department of Health and Human Services website: http://aspe.hhs.gov/health/reports/2015/FMAP2016/fmap16.cfm.

Figure 3 shows Michigan's FMAP rate over the last 16 years. Michigan's regular FMAP rate increased by 10 percentage points, from 56.38% to 66.14%, during the period of FY 2006-07 to FY 2011-12 as the state's personal income grew at a much lower rate than the nation as a whole during the economic downturn of 2008 and 2009. This reduced the need for state matching funds. Additionally, state FMAP rates were temporarily increased for the period of FY 2008-09 to FY 2010-11 under the American Recovery and Reinvestment Act.

Since FY 2011-12, the state's match rate has been relatively flat, as Michigan's personal income growth has roughly tracked the nation's personal income growth in recent years.

For FY 2015-16, $4.3 billion in state funds are appropriated as the state match portion of $12.9 billion in total projected traditional Medicaid expenditures. The largest source of state match funds is General Fund/General Purpose (GF/GP) revenue, at $2.4 billion. Over the last 15 years, the state has increasingly relied on state restricted funds to reduce the need for GF/GP funds as state match, with $1.9 billion in state restricted funds appropriated for FY 2015-16.

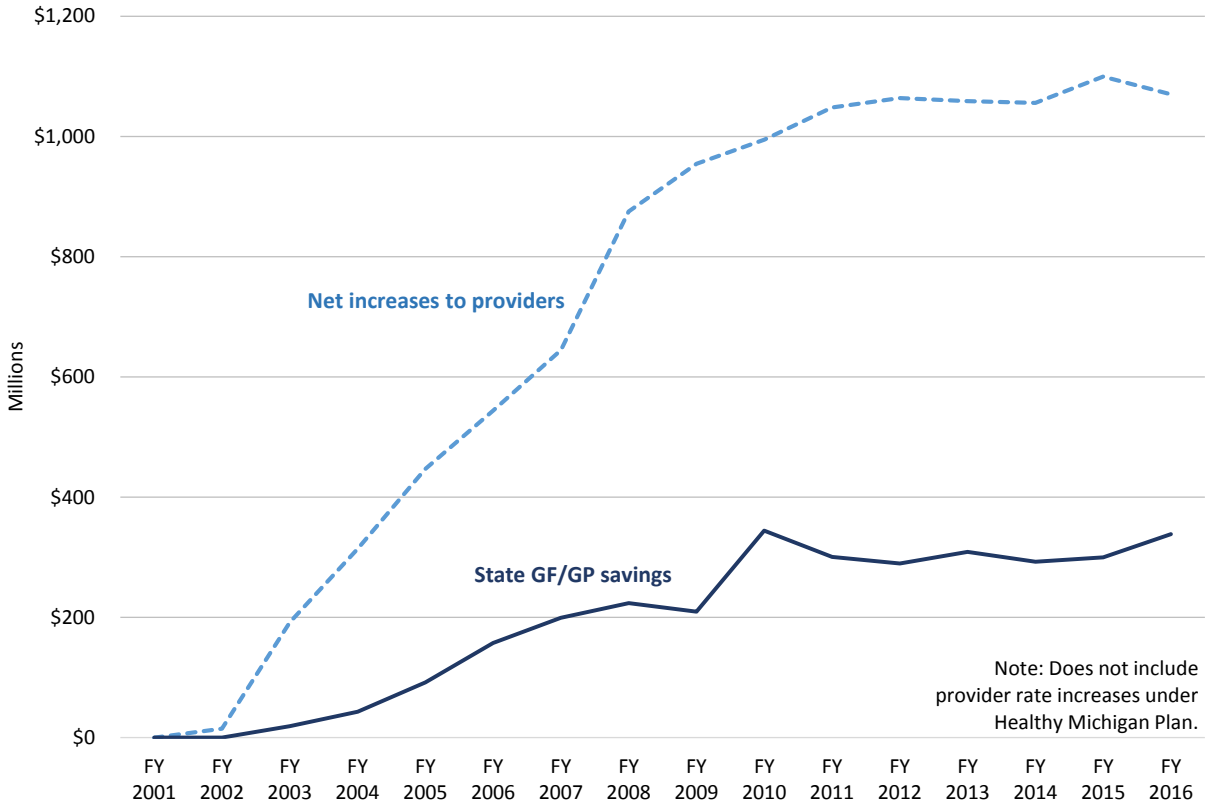
These restricted sources include provider assessments (capped at a 6% rate) levied against hospital, nursing home, and ambulance provider receipts under the state's Quality Assurance Assessment Program (QAAP). Those assessments are utilized both to boost provider reimbursement rates and to realize GF/GP savings, as shown in Figure 4. State savings (also known as a state retainer) are calculated through a statutory formula based on 13.2% of the federal funds the assessments can generate. While the assessments reduce the need for GF/GP funds, they increase gross Medicaid expenditures. In FY 2015-16, the QAAP program provides an estimated net provider benefit of $1.1 billion, with GF/GP retainer savings of $338 million.

Other major restricted fund sources utilized for state match funds in FY 2015-16 include the following:

- The Medicaid Benefits Trust Fund, which receives revenue primarily from cigarette tax revenue: $324 million.
- The Health Insurance Claims Assessment, which is assessed against most health insurance claims in the state: $210 million.
- Special financing funds claimed against contributions from public and university hospitals: $186 million.
- The Merit Award Trust Fund, which receives revenue from the state's share of tobacco settlement revenue: $64 million.

FIGURE 4

Quality Assurance Assessment Program: Estimated Provider Increases and State GF/GP Savings



Additionally, the state will collect roughly $600 million in FY 2015-16 by levying its Use Tax on Medicaid Managed Care Organizations (MCO). Two-thirds of this revenue accrues to the state's General Fund and the remaining one-third accrues to the School Aid Fund. The General Fund portion of that revenue is effectively used as a Medicaid match source (within the appropriated total of GF/GP funds for Medicaid).

THE HEALTHY MICHIGAN PLAN

The federal Patient Protection and Affordable Care Act, enacted in 2010, required states to expand their Medicaid programs to include all individuals with net income up to 133% of FPL (plus a 5% income disregard). The target population for the expansion is adults, as children in families with incomes of 133% or lower were already eligible for Medicaid. A subsequent Supreme Court decision, in the case of *National Federation of Independent Business v. Sebelius*, made expansion optional for each state. As of September 1, 2015, 30 states and the District of Columbia had adopted the expansion.[9]

The Michigan Legislature expanded Medicaid to include adults with income up to 133% of FPL via Public Act 107 of 2013 (House Bill 4714) which amended the Social Welfare Act to create the Healthy Michigan Plan. Public Act 107 required that an initial waiver be submitted by Michigan and approved by the federal government in order for the Healthy Michigan Plan to take effect. That waiver, which was approved on December 30, 2013, made a number of modifications from the state's traditional Medicaid program, including health savings accounts, co-pays and other cost sharing (up to 5% of income for individuals with income of 100% of FPL or higher), and certain incentives for healthy behavior. A second waiver is also required under the law, as described in the next section of this report.

The Healthy Michigan Plan took effect on April 1, 2014.[10] As shown in Figure 5, enrollment grew very quickly, reaching over 240,000 individuals in the first two months and then increasing by an average of over 30,000 individuals per month from May 2014 to March 2015. Enrollment has now plateaued at a little under 600,000 individuals.[11] Of that total, roughly 100,000 have income between 100% and 133% of FPL and are therefore subject to the program modifications of the waiver that created the Healthy Michigan Plan. Total expenditures for the Healthy Michigan Plan are estimated to be $4.1 billion for FY 2015-16.

Section 1902(k) of the Social Security Act requires that Healthy Michigan Plan beneficiaries be provided access to the federal essential health benefits provided under the Affordable Care Act. Those benefits include: outpatient, emergency, inpatient, maternity and newborn, mental health and addiction treatment, prescription drugs, rehabilitative, laboratory, preventative, and pediatric services.

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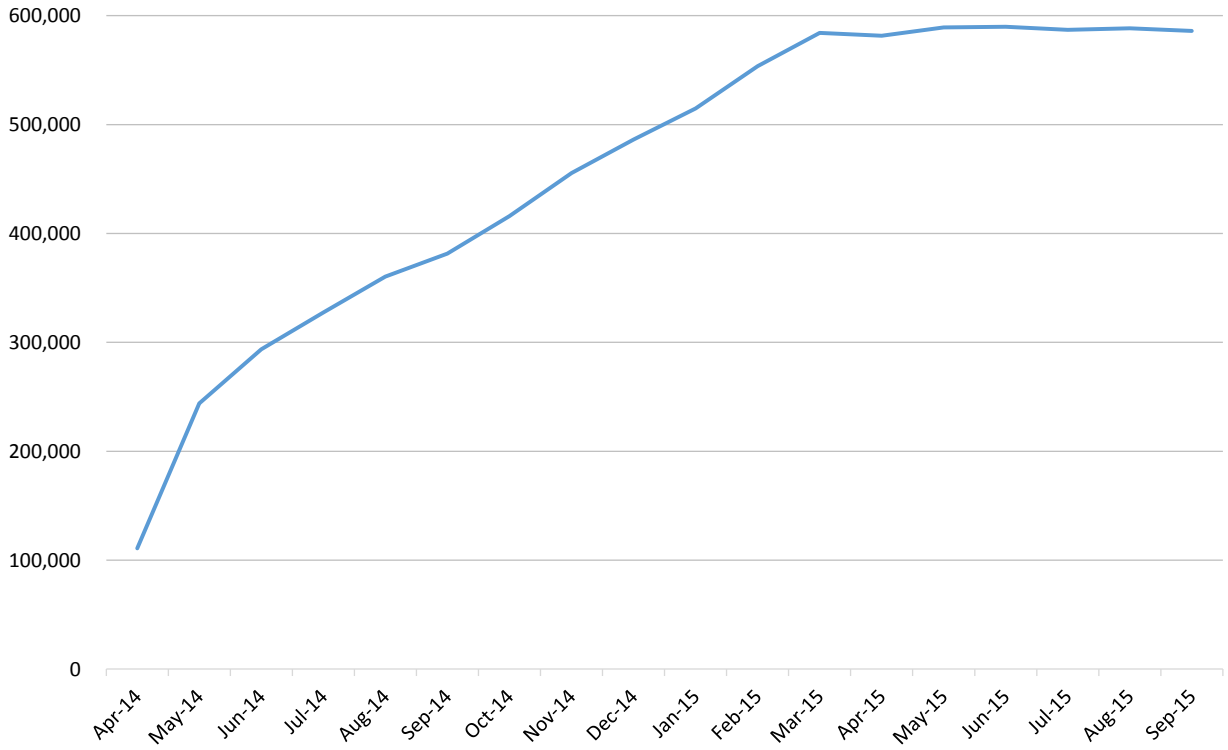
[9] See the following map produced by the Kaiser Family Foundation: http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/.

[10] The original assumed effective date was January 1, 2014, but the lack of an affirmative immediate effect vote in the Michigan Senate delayed the effective date.

[11] The original projections for the program expansion include lower enrollment numbers: about 400,000 in FY 2014-15, eventually growing to closer to 500,000. See the following HFA memorandum on the Governor's original expansion proposal: http://www.house.mi.gov/hfa/PDF/CommunityHealth/MedicaidExpansionMemo_Mar2013.pdf. The HFA analysis of Public Act 107 is available here: http://www.house.mi.gov/hfa/PDF/CommunityHealth/13h4714s6_medicaid_expansion.pdf.

FIGURE 5

Healthy Michigan Plan: Average Monthly Eligible Individuals



HEALTHY MICHIGAN PLAN FINANCING

Initially, federal funds support 100% of costs associated with the Healthy Michigan Plan. That federal match rate will phase down to 90% over the next five years: 95% for calendar year 2017, 94% for 2018, 93% for 2019, and then 90% for 2020 and subsequent years. Based on current HFA projections, state matching costs for the Healthy Michigan Plan will be about $150 million in FY 2016-17 (for three-quarters of a year), growing to roughly $450 million in FY 2020-21 (when the state match rate will be 10% for a full fiscal year).

Not all of the state matching costs, however, will require additional GF/GP funds. Provider assessments and special financing contributions will be used to support the special Medicaid reimbursements within the Healthy Michigan Plan. HFA projects GF/GP state match costs of $117 million in FY 2016-17, growing to $331 million in FY 2020-21, as shown in Table 2 (page 16). The state is also spending approximately $20 million GF/GP per year on administrative costs associated with the Healthy Michigan Plan.

Implementing the Healthy Michigan Plan has also resulted in state savings, as various health care costs previously funded either partially or wholly through state GF/GP revenue have been shifted to 100% federal funding. Full-year GF/GP appropriation reductions are as follows:

- $168 million for non-Medicaid mental health funding (originally $204 million, with $36 million subsequently restored).
- $47 million for the discontinued Adult Benefits Waiver program (including $12 million in restricted Medicaid Benefits Trust Fund savings that had offset GF/GP).
- $19 million for prisoner health care costs in the Department of Corrections budget (originally $32 million, with $13 million subsequently restored).
- $1 million for smaller health care programs.

In sum, the state's ongoing GF/GP budget has been reduced by $235 million as a result of the Healthy Michigan Plan. Additionally, the state has realized additional revenue from the Health Insurance Claims Assessment (HICA) and the Use Tax on Medicaid MCOs as a result of increased health care activities driven by the Healthy Michigan Plan. These additional revenues have offset regular GF/GP funds.

Long-term HICA and Use Tax revenue projections from the Healthy Michigan Plan are uncertain. The federal government has indicated that because the Use Tax on Medicaid MCOs is not broad based in nature, the tax will no longer be permitted as a state matching fund source for Medicaid beyond December 31, 2016. At that time, the Use Tax on Medicaid MCOs will be eliminated and HICA will

revert back to 1.0%. HICA is then scheduled to sunset on January 1, 2018.[12] If HICA is extended and stays at 1.0%, the state would realize about $30 million in ongoing annual HICA revenue due to the Healthy Michigan Plan.

Public Act 107 includes two provisions, which if not met, will discontinue the Healthy Michigan Plan:

- First, Public Act 107 requires the submission of a second Medicaid waiver by September 1, 2015 (which has been accomplished) and the receipt of federal government approval by December 31, 2015 in order for the Healthy Michigan Plan to continue. If this waiver is not approved by the federal government on time, the Healthy Michigan Plan would be discontinued on April 30, 2016.

  Under this waiver, individuals enrolled in the program for more than 48 months with income of 100% of FPL or higher would either shift to a health insurance plan purchased on the health insurance exchange created under the Affordable Care Act (utilizing federal subsidies for purchasing health insurance rather than Medicaid funding) or remain on the Healthy Michigan Plan with higher cost-sharing requirements of up to 7% of income. As indicated earlier in this report, the population with income between 100% and 133% of FPL that would be subject to these provisions represents about one-sixth of the total Healthy Michigan Plan population, not all of whom would reach the 48-month limit.

- Second, Public Act 107 would also sunset the Healthy Michigan Plan whenever the net costs of the program exceed the savings, as determined by DHHS.

If either of these two provisions to discontinue the expanded program were triggered, the Legislature would need to restore the $235 million in annualized GF/GP funds removed from the budget when the Healthy Michigan Plan was adopted ($118 million for half the year in FY 2015-16), or reduce health care services provided by the state from the levels in place prior to the Healthy Michigan Plan. Additional regular GF/GP funds would also be needed to offset the loss of restricted revenue received from HICA and the Use Tax on Medicaid MCOs.

Based on current HFA assumptions and estimates, as outlined in Table 2 (page 16), the Healthy Michigan Plan will move from being a net savings to a net cost starting in FY 2019-20 (when the 10% match begins). From that point forward the net costs if state statute were amended to continue to cover 600,000 Healthy Michigan Plan beneficiaries would be roughly $85 million per year.

There are a number of variables that could affect the net cost calculation and the timing of when state costs begin to exceed state savings. Most notably, the state retainer savings under the hospital provider assessment will need to be defined in statute for the Healthy Michigan Plan once state match costs begin, as the current statutory formula doesn't work mathematically. The Legislature could set those savings at a higher level than assumed in the estimates presented here. Additionally, these estimates do not account for savings from anticipated reductions in uncompensated care,

[12] For additional background information on the Use Tax on Medicaid MCOs and HICA, see this HFA memorandum: http://www.house.mi.gov/hfa/PDF/CommunityHealth/HICA_Memo_Feb2015.pdf.

which will result in reductions to Disproportionate Share Hospital (DSH) payments under the statutory provisions that created the Healthy Michigan Plan.

Ultimately, DHHS, with approval of the State Budget Office, is statutorily charged with calculating the precise costs and savings associated with the Healthy Michigan Plan in order to determine at what point the program no longer creates a net financial savings to the state. The estimates presented here are focused on currently known state-level costs and savings and should be considered preliminary in nature.

Savings amounts presented in this report are relative to the state budget prior to adoption of the Healthy Michigan Plan. Those savings have now been fully incorporated into the ongoing budget, whereas costs will increase on a year-over-year basis. The Governor's original proposal for the Healthy Michigan Plan included the creation of a reserve fund with half of the net savings from the expansion of the Medicaid program deposited into a reserve fund in order to pay future state match costs. Ultimately, the Legislature did not utilize the savings to establish a reserve, so there are no state funds specifically set aside for future Healthy Michigan Plan costs.

Table 2

Healthy Michigan Plan: Preliminary Estimated State Costs and Savings

Millions of $

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Average monthly beneficiaries	286,311	545,593	600,000	600,000	600,000	600,000	600,000	600,000	600,000
State match rate (1)	0%	0%	0%	5%	6%	7%	10%	10%	10%
State Costs									
State GF/GP match costs (2)	$0	$0	$0	$117	$182	$217	$302	$331	$336
Administration and IT	20	20	20	20	20	20	20	20	20
Total Costs	**$20**	**$20**	**$20**	**$137**	**$202**	**$237**	**$322**	**$351**	**$356**
Budget Savings (3)									
Non-Medicaid Mental Health	($77)	($168)	($168)	($168)	($168)	($168)	($168)	($168)	($168)
Adult Benefits Waiver (4)	(12)	(47)	(47)	(47)	(47)	(47)	(47)	(47)	(47)
Corrections health care	(10)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)
Other health programs	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Subtotal: Budget Savings	**($100)**	**($235)**	**($235)**	**($235)**	**($235)**	**($235)**	**($235)**	**($235)**	**($235)**
Savings from Revenue Impacts									
Additional HICA revenue (5)	($7)	($22)	($25)	($30)	($32)	($32)	($32)	($32)	($32)
Additional Use Tax revenue (6)	(40)	(172)	(195)	(50)	0	0	0	0	0
Total Savings With Revenue Impacts	**($147)**	**($429)**	**($455)**	**($315)**	**($267)**	**($267)**	**($267)**	**($267)**	**($267)**
Net Costs/(Savings)	**($127)**	**($409)**	**($435)**	**($178)**	**($65)**	**($30)**	**$55**	**$84**	**$89**

Notes

(1) Presented on calendar year basis; match cost estimates are based on January 1 match rate changes.

(2) Assumes QAAP retainer based on current QAAP-to-state-match ratio for traditional Medicaid. State retainer savings could be established at higher level.

(3) Assumes no inflationary increase in previous state costs shifted to Healthy Michigan Plan.

(4) Includes $12 million in Medicaid Benefits Trust Fund revenue appropriated for the program.

(5) Net of actuarial soundness costs once state match begins. Assumes HICA rate reverts to 1.0% on 1/1/17 and is extended at that rate beyond 1/1/18.

(6) Assumes Use Tax on Medicaid Managed Care Organizations is discontinued effective 1/1/17; portion of revenue accrues to School Aid Fund.

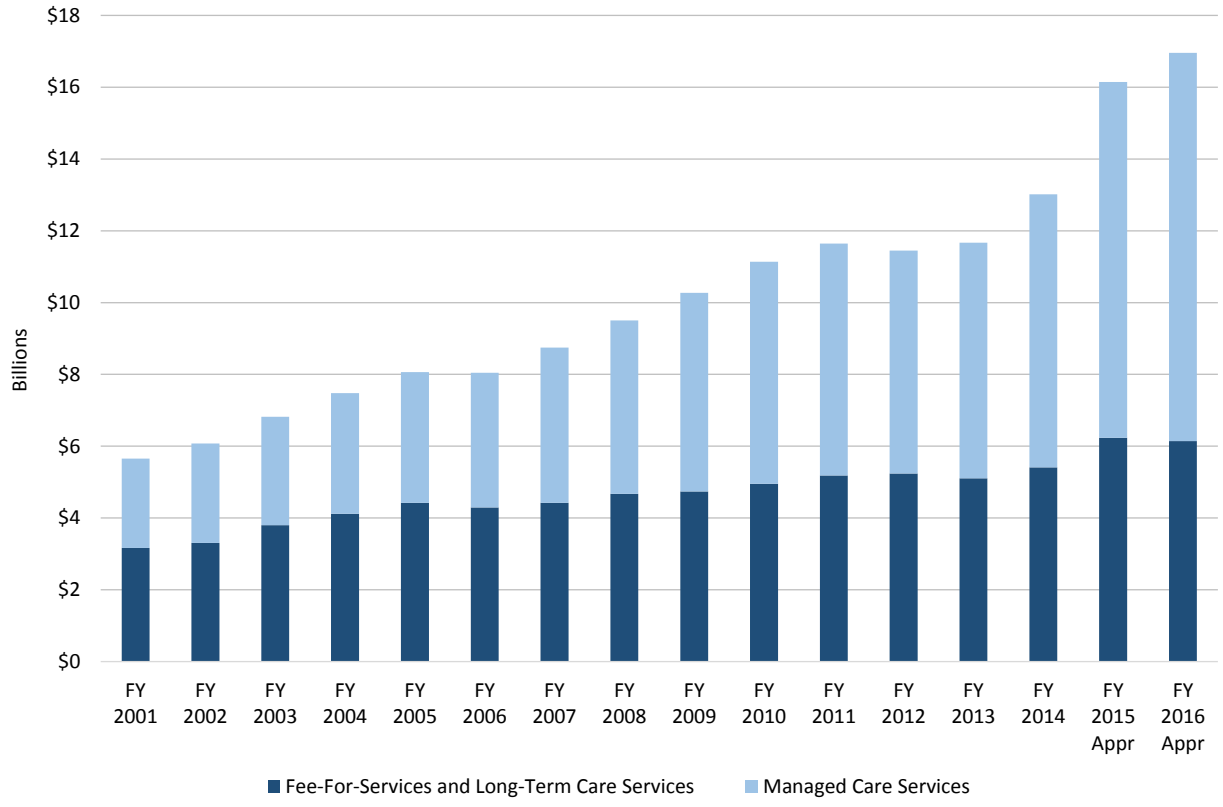
General Note: Does not reflect local savings or reductions in uncompensated care (which will result in reductions to Disproportionate Share Hospital payments under Healthy Michigan Plan statutory provisions).

TOTAL MEDICAID EXPENDITURES

As both traditional Medicaid and Healthy Michigan Plan caseloads have increased, so have Medicaid expenditures. Since FY 2000-01, total Medicaid expenditures have tripled, increasing from $5.7 billion to $17.0 billion. As shown in Figure 6, expenditures for both Medicaid fee-for-service and Medicaid managed care services have increased. Expenditures through managed care services have increased more rapidly, though, as an increasing percentage of Medicaid beneficiaries have been enrolled into managed care health plans. Managed care services now provide coverage for 71% of Medicaid beneficiaries and represent 64% of Medicaid expenditures.

FIGURE 6

Medicaid Expenditures by Service Delivery



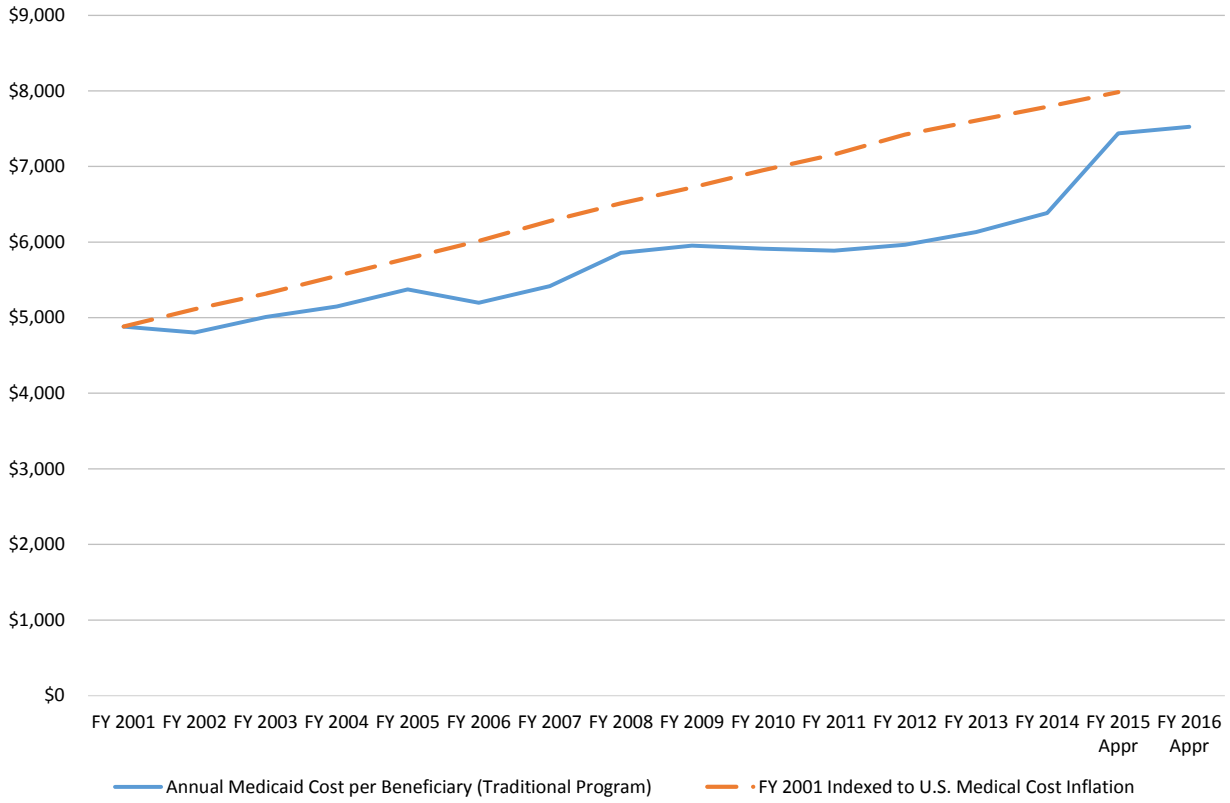
The use of managed care is intended to constrain costs by minimizing utilization of higher-cost services, emphasizing primary and preventative care, and negotiating and incentivizing lower reimbursement rates with providers. Managed care also creates more predictability for state budgeting. Managed care plans accept the risk of having to pay for high utilizers of health care by accepting a capitated per-member, per-month rate.

Traditional Medicaid beneficiaries have been increasingly moved to managed care over the last two decades. All Healthy Michigan Plan beneficiaries are required to enroll in a managed care plan, as long as there isn't a federal prohibition on the beneficiary's enrollment. Managed care enrollment is optional for some groups of Medicaid beneficiaries: migrants, Native Americans, and dual eligibles. Some groups are excluded from managed care enrollment: individuals without full Medicaid coverage, individuals residing in a psychiatric hospital or nursing facility, MI Choice and PACE beneficiaries, and individuals with commercial coverage.

Caseload increases are not the sole reason for the increase in Medicaid expenditures. Cost increases are also due to changes in utilization and inflation, as well as increases in special payments and provider assessments. The annual average cost per traditional Medicaid beneficiary has increased by a little over 50% since FY 2000-01, from approximately $4,900 to $7,500. (The average cost for a Healthy Michigan Plan beneficiary is somewhat lower at $6,300.) As shown in Figure 7, this increase is below the rate of general medical cost inflation across the country, as measured by the U.S. Bureau of Labor Statistics.

FIGURE 7

Annual Cost per Medicaid Beneficiary Compared to Medical Cost Inflation



As an additional comparison, during this same time period, Milliman's Medical Index on the cost for healthcare for a family of four with employer-sponsored health insurance has tripled.[13]

[13] Information on Milliman's medical index can be found here: http://www.milliman.com/mmi/.

Total Medicaid expenditures in FY 2015-16, as presented in the figures in this report, include approximately $3.3 billion in supplemental Medicaid payments. Those payments include DSH payments, enhanced practitioner payments, Graduate Medical Education (GME) payments, and special rural hospital payments, as well as QAAP supplement payments funded by provider assessments.

The large increase in expenditures per beneficiary from FY 2013-14 to FY 2014-15 shown in Figure 7 is the result of actuarial soundness payments made to managed care organizations due to the reimplementation of the Use Tax on those organizations, which results in an overall net benefit to the state GF/GP budget despite higher gross expenditure amounts.

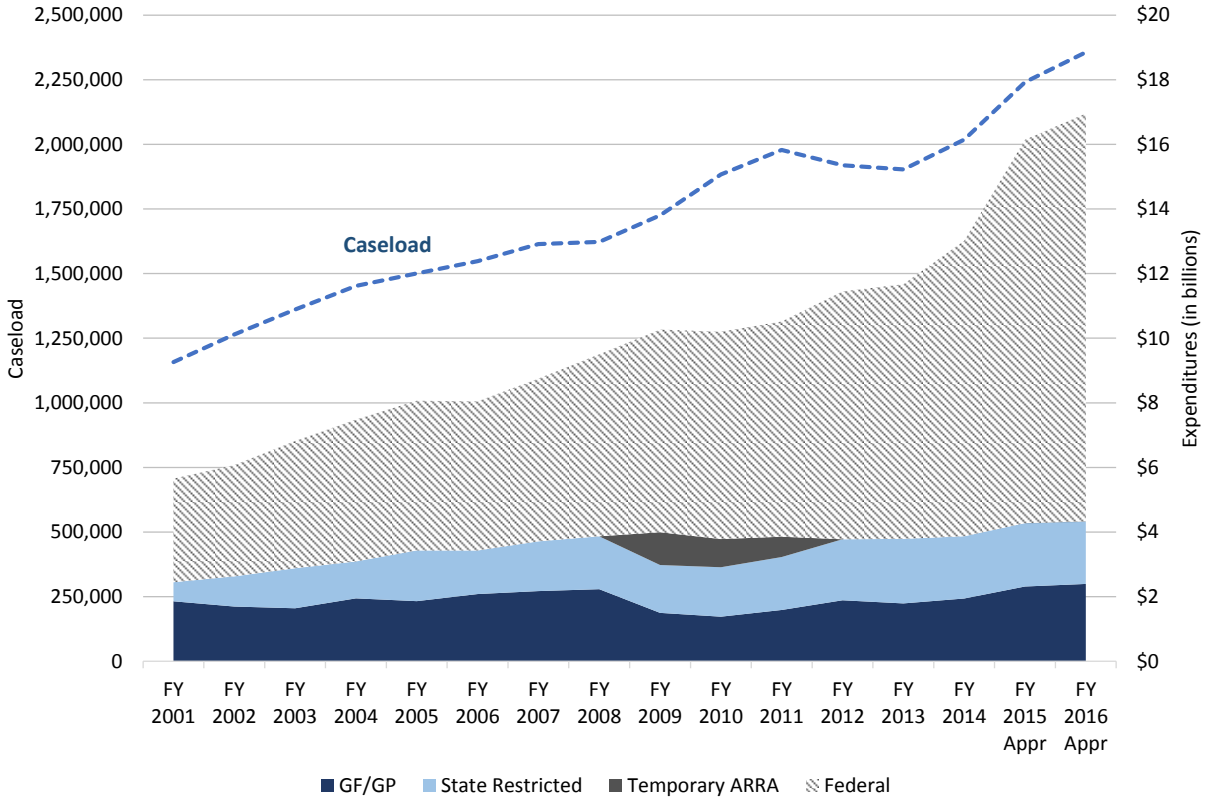
MEDICAID BUDGET OUTLOOK

As shown in Figure 8, between FY 2000-01 and FY 2015-16:

- The state's total Medicaid caseload has more than doubled, increasing from 1.1 million to 2.3 million, due to economic trends in the 2000s and the Medicaid expansion under the Healthy Michigan Plan that began in 2014.
- Total Medicaid expenditures have tripled, increasing from $5.7 billion to $17.0 billion, due to caseload growth and relatively modest per-beneficiary cost growth (driven in part by increased provider assessments).

FIGURE 8

Total Medicaid Caseload and Expenditures by Fund Source



Despite those increases, GF/GP funds appropriated for Medicaid are basically at the same level as FY 2000-01: roughly $2.0 billion. (GF/GP appropriated in FY 2000-01 was $1.9 billion. GF/GP appropriated in FY 2015-16 is $2.4 billion, but approximately $400 million of that is effectively revenue from the Use Tax on Medicaid MCOs.)

Three major factors have allowed GF/GP support for Medicaid to be held flat over this period of time:

- The increased use of provider assessments and other state restricted revenue sources as state match. Restricted funds have grown from $274 million to $1.9 billion.
- The federal FMAP rate moving in Michigan's favor as the state's economy lagged the national economy in the late 2000s. If Michigan's FMAP was still at the FY 2000-01 rate of 56.18% (instead of 65.60%), the state would need to identify $1.3 billion in additional state matching funds.
- Initial 100% federal funding for the Healthy Michigan Plan population.

These trends are unlikely to continue for the following reasons:

- A 2012 U.S. Government Accountability Office report indicates that Michigan is already among the most aggressive states in utilizing provider assessments.[14] Regular GF/GP funds (that is, excluding the Use Tax on Medicaid MCOs) now account for less than half of state match costs.
- Assuming Michigan's economy continues to grow at at least the same rate as the national economy, the state's federal match rate will be flat or will decline. For FY 2016-17, the state's FMAP rate is forecast to decline from 65.60% to 65.15%, which will increase state GF/GP costs by approximately $50 million.
- State match costs for the Healthy Michigan Plan will begin on January 1, 2017. This will result in projected GF/GP costs of $117 million for three-quarters of FY 2016-17, increasing to roughly $330 million per year in FY 2020-21. Alternately, discontinuing the expanded program and shifting mental health, prisoner health care, and other costs back to the state would cost $235 million per year, plus the GF/GP cost of offsetting lost HICA and Use Tax revenue. These costs would also be triggered if the Healthy Michigan Plan were automatically discontinued due to the failure of the federal government to approve the second waiver required under current state law.

In addition to the FMAP rate change and Healthy Michigan Plan match costs, there are two specific Medicaid financing issues for the traditional program that will potentially require additional GF/GP funds for FY 2016-17:

- Federal guidance indicates that the state's Use Tax on Medicaid MCOs must be discontinued by the end of 2016 (three-quarters of FY 2016-17 will be affected). This guidance is based on the fact that the tax is not broad based in nature; it applies only to Medicaid MCOs rather than all MCOs. Under current law, the elimination of the Use Tax on Medicaid MCOs will automatically cause the Health Insurance Claims Assessment rate to be restored from 0.75% to 1.0%. On net, this will leave a GF/GP budget shortfall of roughly $130 million per year ($100 million for FY 2016-17). It will also reduce School Aid Fund revenue by about $200 million per year ($150 million for FY 2016-17). Further, the Health Insurance Claims

[14] See GAO report, 14-627: http://www.gao.gov/assets/670/665077.pdf.

Assessment sunsets at the end of calendar year 2017. If the assessment isn't extended, this would create an additional budget shortfall of about $320 million per full year beginning in FY 2017-18.

- The state retainer from the provider assessment on hospitals was increased by $93 million on a one-time basis for FY 2015-16 in order to reduce the need for GF/GP funds. Either this increase will need to be extended statutorily, or additional GF/GP funds will be needed.

Absent additional GF/GP funds or other broad-based tax revenue being appropriated for Medicaid, reductions to the program would be needed. There are significant obstacles or policy considerations for each of the four major options to reduce Medicaid spending:

- **Reducing eligibility:** There are only a handful of eligibility groups that can be reduced. Under the Affordable Care Act, a state cannot reduce eligibility for children under 19 until October 1, 2019. Additionally, the higher federal match rate for the Healthy Michigan Plan is only available for individuals who would not be eligible for traditional Medicaid on the date of Affordable Care Act enactment, meaning any eligibility reductions below 133% of FPL for individuals between ages 19 and 64 would not generate GF/GP savings. These restrictions effectively leave only pregnant women, individuals needing long-term care services, and the medically needy population as eligibility groups that could be reduced.

- **Reducing provider rates:** While reimbursement rates for Medicaid providers can be reduced, reductions have already been made over the last 15 years to rates which are much lower than commercial rates. Data from the Kaiser Family Foundation indicates Michigan's Medicaid provider rates are already among the lowest in the country relative to Medicare rates.[15] Further rate reductions could affect access to care for Medicaid recipients if they cause providers to discontinue participation in the program. Additionally, federal law requires that reimbursement rates for health plans providing managed care services to Medicaid recipients be actuarially sound–that is, sufficient to ensure that the health plans can cover the costs of providing care to recipients. A 1.0% reduction in provider rates would yield approximately $30 million in GF/GP savings per year.

- **Reducing services:** States can eliminate optional services such as home- and community-based services, pharmaceutical services, adult home help services, dental services (including the Healthy Kids Dental program), hospice services, and the Program of All-Inclusive Care for the Elderly (PACE). Major funding amounts for optional services provided under Michigan's program are shown in Table 3. Many of those services, however, may not be considered optional from a medical perspective. For example, all 50 states provide pharmaceutical services, which are now considered an essential health benefit under the Affordable Care Act. Additionally, unaddressed beneficiary medical needs in one service area can result in medical problems in other areas, reducing or negating savings in the Medicaid program as a whole.[16]

[15] Source: http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/.

[16] For example, a recent DHHS report asserted: "Michigan has removed and reinstated adult dental benefits several times in the past and found there to be no cost-savings during times of rescinded adult dental benefits, but an increase in emergency room costs for dental-related problems." Source: http://www.michigan.gov/documents/mdhhs/Report_105d10-FINAL_502479_7.pdf.

- **Reducing GF/GP-funded special Medicaid payments:** A limited amount of GF/GP savings could be achieved by reducing certain special Medicaid payments. These payments represent a small percentage of overall Medicaid expenditures. A combined total of $81.2 million GF/GP is currently appropriated for GME, Special Rural Hospital, and DSH payments.[17]

TABLE 3
Optional Medical Services: FY 2015-16 Costs
Millions of $

Service (1)	Gross Amount	GF/GP Amount
Home- and Community-Based Services		
Habilitation Supports Waiver (2)	$450.0	$154.8
MI Choice	329.7	112.1
Children's Waiver	20.0	6.9
Serious Emotional Disturbance Waiver	12.6	3.3
Home Help/Personal Care Services	314.8	107.8
Pharmaceutical Services (3)	300.1	104.4
Dental Services (including Healthy Kids Dental)	233.7	81.0
Hospice Services (3)	107.8	37.1
Program of All-Inclusive Care for the Elderly (PACE)	65.9	22.7
Autism Services	36.4	12.5
Auxiliary Medical Services (Hearing/Speech/Vision) (3)	6.3	2.2

Notes:
(1) Excludes mental health services (see page 4).
(2) Amounts are estimates.
(3) Amounts do not include cost for services provided through managed care.

All reductions to the Medicaid program result in nearly $2.00 in foregone federal funding for each $1.00 in state savings. So any gross reduction to the Medicaid program would be nearly three times greater than the targeted GF/GP reduction.

The Medicaid financing issues discussed above are independent of ongoing changes in the program's caseload, utilization, and inflationary trends. If the state's economy continues to improve, reductions in Medicaid caseloads could reduce costs. The recent increase in available pharmaceutical treatments (including those for Hepatitis C), however, could increase Medicaid utilization and inflationary costs.

[17] The Executive Recommendation for the FY 2015-16 budget proposed to finance GME and Special Rural Hospital payments with increased provider QAAP revenue, which would have resulted in GF/GP savings of $74.9 million and $16.0 million, respectively. (GF/GP savings includes both offsetting $68.0 million GF/GP appropriated for GME and special rural hospital payments and $22.9 million GF/GP from the statutorily mandated 13.2% state retainer on federal funds generated by the provider QAAP.) The Legislature did not adopt this proposal.

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