Michigan's Medicaid Program

August 2025

MDHHS
Michigan Department of Health & Human Services

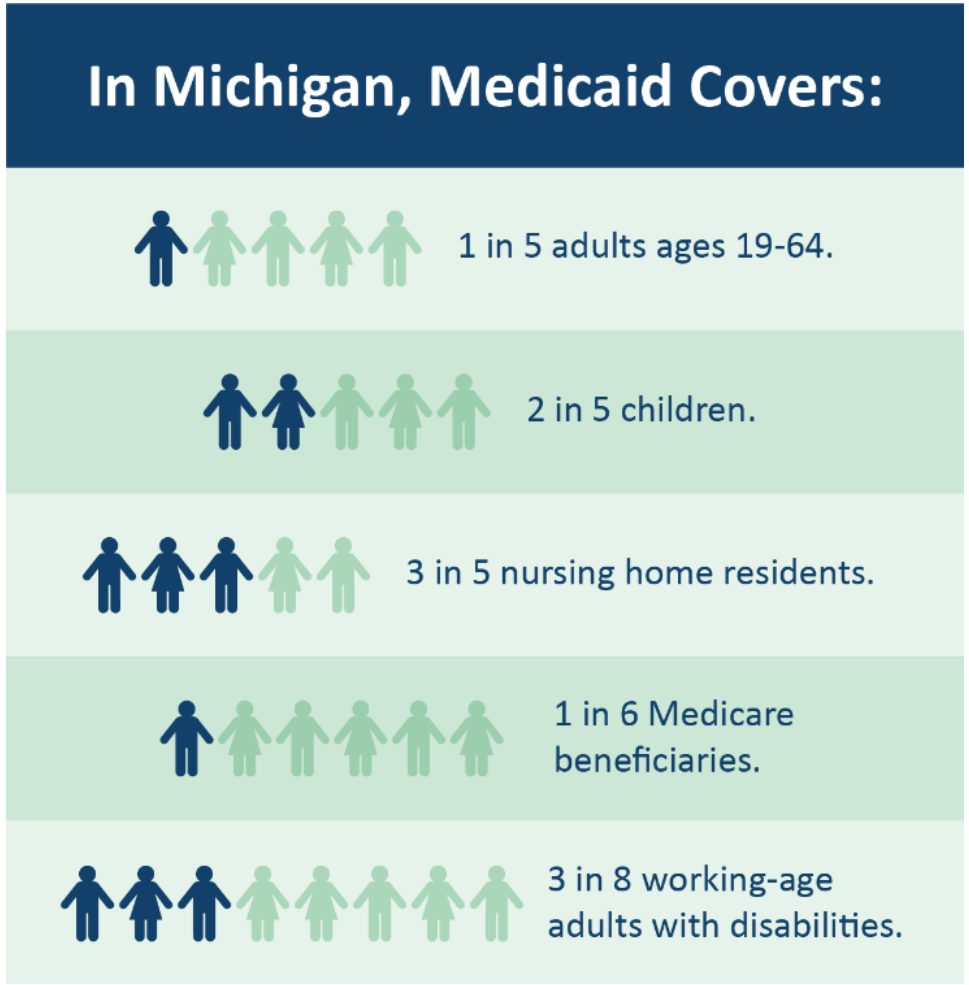
Michigan's Medicaid Program has a Vast Reach

Medicaid covers one in five individuals living in the U.S. In Michigan, the coverage rate is even higher – **one in four residents of Michigan**.

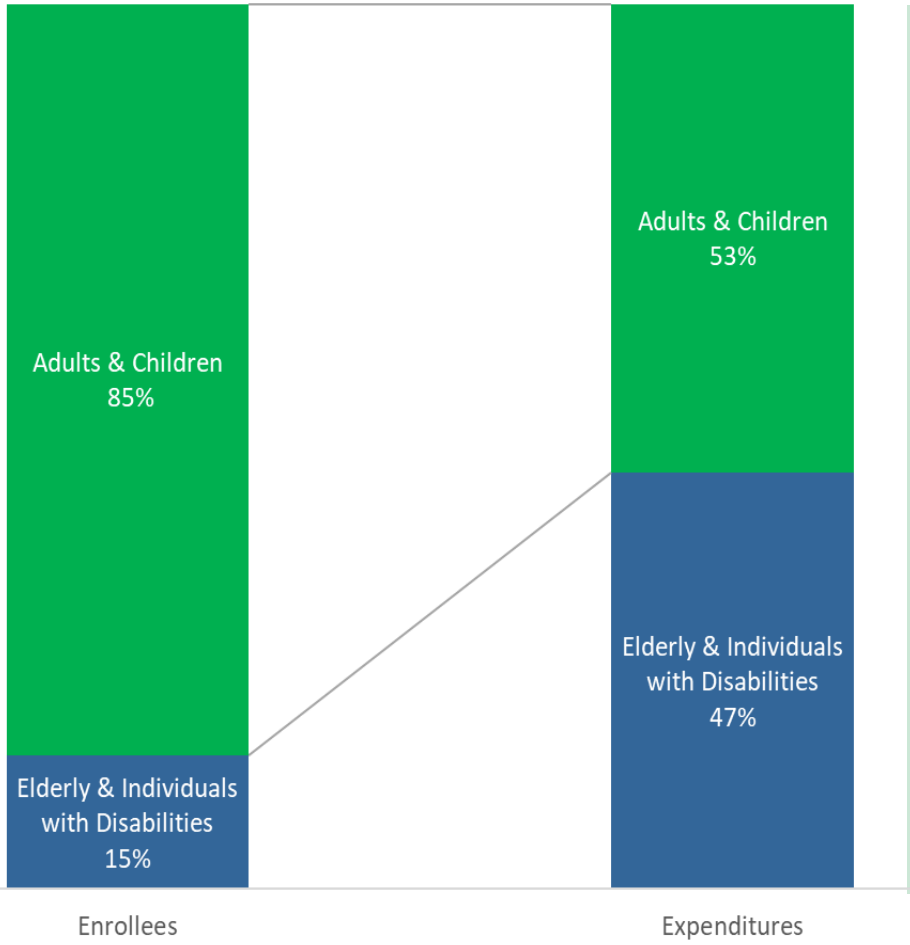
In FY24, Michigan's Medicaid program afforded health coverage to more than **2.6 million residents** each month, including:

- **1 million children**;
- **300,000 people** living with **disabilities**;
- **168,000 seniors**; and
- **750,000 adults** in **Healthy Michigan Plan (HMP)**.

45% of births in Michigan are covered by Medicaid.



Medicaid Helps Seniors and Individuals with Disabilities



- Nationally, **Medicaid pays for more than half of spending on long-term care.**
- Michigan Medicaid covers seniors and individuals with disabilities paying more than $2,000 per month per person.
- Michigan Medicaid pays an average of $6,200 per month for an individual needing nursing home care.



How is Medicaid Funded and Where Do Medicaid Dollars Go?

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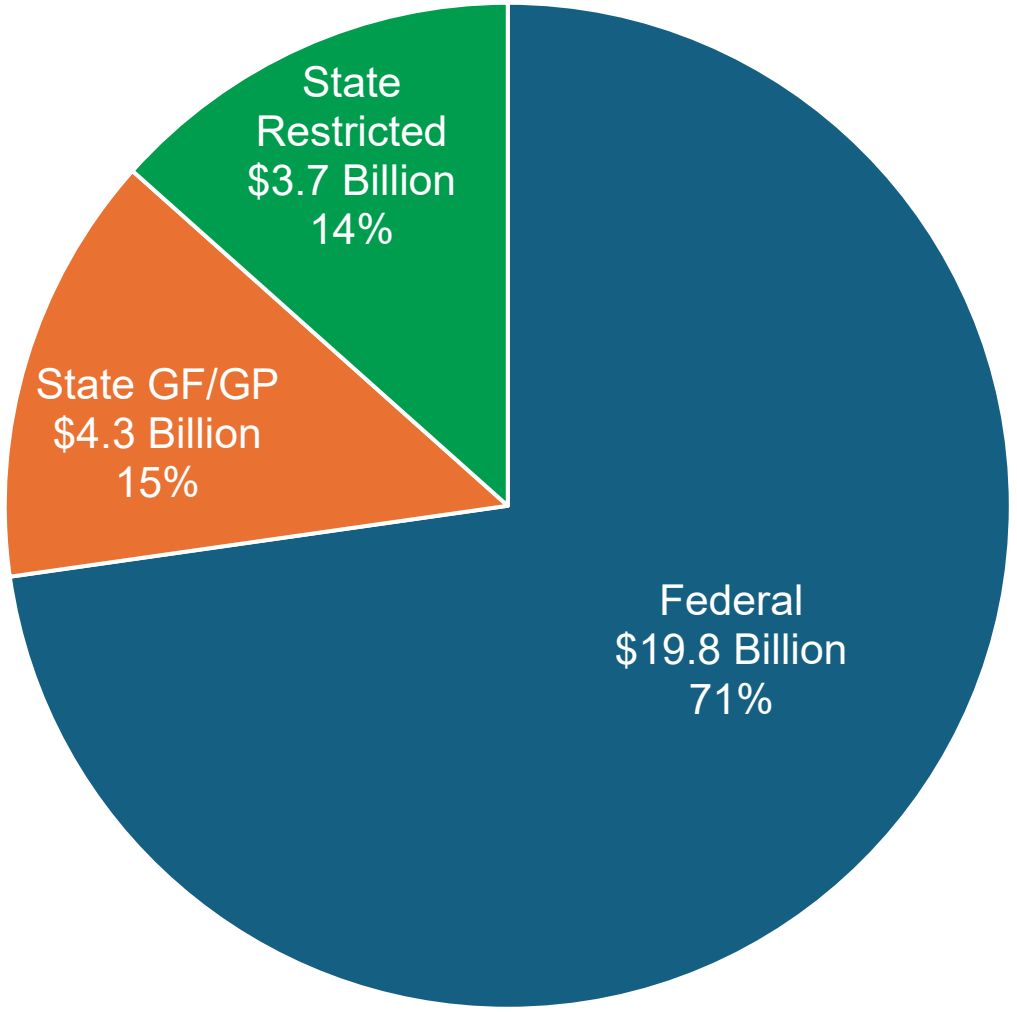
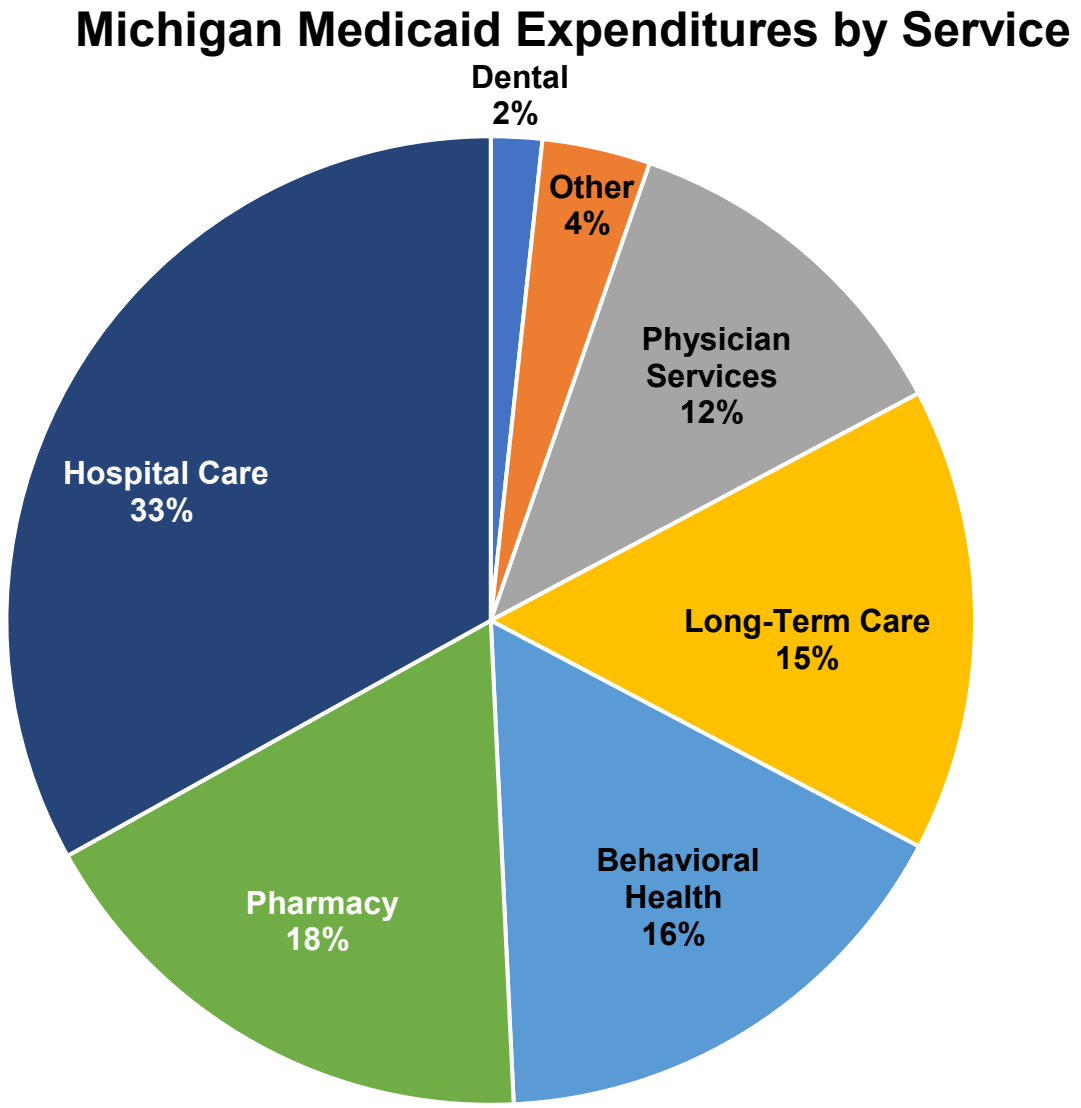
Michigan Medicaid Budget

- Michigan's FY25 Medicaid budget is approximately $27.8 billion and 34% of the state's overall budget.
- **More than 70% of the Medicaid budget comes from federal funding.**
- Federal match rates are higher for states with lower per-capita income.
  - Michigan's federal match rate is ~65%.
  - **For every dollar Michigan spends, the federal government contributes an additional $1.87.**
  - For every dollar Michigan cuts, $2.87 is lost for people and providers.



Medicaid is a Major Payor in the Health Care System

- Nationally, Medicaid accounts for one-fifth of all health care spending.
- It is the **largest payor of mental health services, long-term care services and births.**
- As such, it plays a critical role in assuring the sustainability of hospitals, community health centers, physicians and nursing homes.



Medicaid Helps Providers



- Michigan's **hospitals receive nearly $9 billion** in Medicaid funding annually, which accounts for almost one-fifth of the state's hospitals' net patient revenue.
- Medicaid supports the local **Community Mental Health system with nearly $3.5 billion** annually.
- Michigan's **nursing homes receive more than $3 billion** in Medicaid annually.
- Home- and Community-Based Services (HCBS) providers support **vulnerable seniors and persons with disabilities living in the community with more than $1.5 billion** in Medicaid dollars each year.
- Michigan's **safety net health centers receive $483 million** from Medicaid each year, accounting for 63% of their patient services-related revenue.
- In the 2023 school year, Michigan **schools received $160.5 million** from Medicaid for services to students.
- Michigan's **Emergency Medical Services providers receive $130.5 million** from Medicaid annually to support lifesaving emergency services.
- More than **200,000** Medicaid-enrolled providers across Michigan communities deliver essential care.

Key Medicaid Provisions in the OBBBA Eligibility

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Major Eligibility Changes

New Work Requirements

- Applies to many HMP enrollees ages 19–64.
- Must work, train or volunteer at least 80 hours/month.
- Non-compliance will lead to loss of coverage.

Effective Date:
January 1, 2027

Six-Month Redeterminations

- Eligibility checks for HMP now every six months (instead of annually).
- Increased risk of coverage interruptions due to paperwork gaps.

Effective Date:
January 1, 2027

Retroactive Eligibility Limited

- No more 90-day retroactive coverage.
- HMP: One month prior to application.
- Other Medicaid enrollees: Two months prior to application.

Effective Date:
January 1, 2027

Limits on Non-Citizen Eligibility

- Fewer pathways to coverage for lawfully present non-citizens.
- Affected individuals will lose full coverage → Moving to Emergency Services Only (ESO) coverage.

Effective Date:
October 1, 2026

Medicaid Work Requirements Key Dates

June 1, 2026:

Federal government required to release regulatory guidance.

September 30, 2026:

States required to begin outreach about new requirements.

January 1, 2027:

Work Requirements required to go into effect.

Medicaid Work Requirements Overview



Beginning **January 2027**, certain HMP will be subject to new work requirements to keep their Medicaid benefits.



Eighty hours per month of approved activities required for non-exempt individuals.



Verified at application and renewal.

Medicaid Work Requirements Qualifying Activities and Exemptions

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Qualifying Activities

80 hours per month of:

- Work.
- Community service.
- Participation in a "work program“.

- Half time+ enrollment in an education.
- Any combination of the above totaling 80 hours per month.
- Monthly income equal to minimum wage × 80 hours.
- Seasonal workers with a 6-month average monthly income equal to minimum wage × 80 hours.

Exemptions

Parent, guardian, or caretaker of:

- Dependent children under age 13.
- Disabled individuals.

- Pregnant or postpartum individuals.
- Foster youth or former foster youth under age 26.
- Medically frail.
- Participating in a substance use disorder (SUD) program.
- Meeting SNAP/TANF work requirements.
- American Indians and Alaska Natives.
- Disabled veterans.
- Incarcerated or released from incarceration within the past 90 days.

Hardship Exceptions

Individuals who were in:

- Inpatient hospital.
- Nursing facility.
- Intermediate care facility.
- Inpatient psychiatric hospital.

- Individuals who reside in a county with:
  - A federally-declared emergency or disaster.
  - High unemployment (above 8% or 1.5× national rate.
- Individuals who traveled outside their community for extended medical care (for self or dependent).

Six-Month Renewals and Retroactive Coverage Limits

Six-Month Renewals

- Beginning **January 2027**, people covered through HMP will need to renew their health coverage every six months, instead of annually.
- All other Medicaid beneficiaries continue to have their eligibility renewed every 12 months.

Retroactive Coverage Limits

- Also starting **January 2027**, individuals who apply for Medicaid or forget to turn in a piece of paperwork and have a gap in coverage will see a change in how far coverage can go back (called retroactive coverage).
  - ❖ HMP: Will cover one month back instead of three months.
  - ❖ Other Medicaid programs: Will cover two months back instead of three months.

Non-Citizen Eligibility

- Beginning **October 2026**, some people who are legally residing in the U.S., but are not citizens, will not qualify for full Medicaid coverage.

Remain Eligible	No Longer Eligible
• Lawful permanent residents (generally subject to a five-year waiting period). • Cuban/Haitian Entrants. • Compact of Free Association (COFA) migrants.	• Refugees. • Humanitarian parolees. • Asylum grantees. • Certain abused spouses and children. • Victims of human trafficking.

Impact of Eligibility Provisions

What's at stake for Michigan:

- Significant new administrative costs to support implementation needs, including system upgrades, staffing and compliance efforts.
- Potential loss of coverage for more than **500,000** individuals.

Significance of these changes:

Administrative Burden = Coverage Loss
Many enrollees meet requirements, but may lose coverage due to complex paperwork and red tape.

Higher Churn Rates → Delayed Care
Frequent churn caused by paperwork issues disrupts care continuity, hinders access and leaves individuals vulnerable during medical emergencies.

Rising Uninsured Rates
Parallel Affordable Care Act changes limiting Marketplace access could leave many individuals without access to coverage, driving up the uninsured rate across the state.

Increased Uncompensated Care and Medical Debt
Hospitals and local safety nets will be forced to absorb the costs of caring for those who have lost coverage, while patients face unaffordable bills and medical debt.

Key Medicaid Provisions in the OBBBA Financing

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Provider Tax Changes

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What Happened

- The law changes how provider taxes—used by 49 states to fund Medicaid—can be structured, making at least one Michigan provider tax impermissible.
- These changes will require the eventual discontinuation of the Insurance Provider Assessment (IPA), which replaced the Health Insurance Claims Assessment (HICA) in 2018.
- Today, the IPA brings $475 million in federal dollars to offset General Fund/Base Medicaid costs.



Where we are Today

- The Secretary of Health and Human Services (HHS) is permitted to set a transition period of up to three fiscal years and allow provider taxes that are prohibited outside of the transition.
- Michigan submitted formal public comments to HHS in July requesting a three-year transition period and the ability to secure federal approval for a budget-neutral replacement tax during the transition period.



What's Next

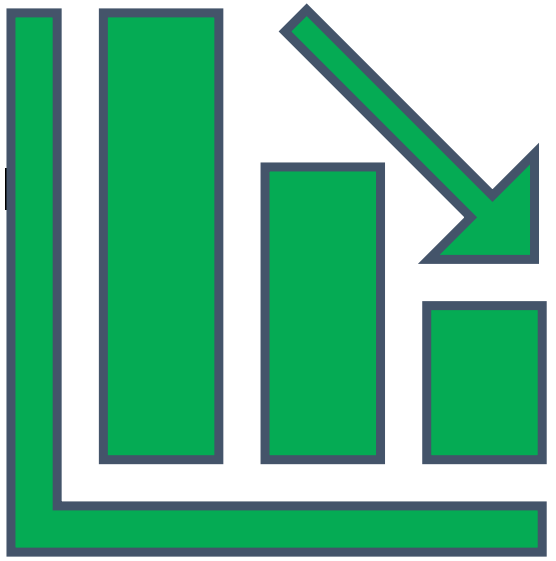
- Michigan will need to work with the federal government on what the IPA is being transitioned to.
- Transitioning to a budget-neutral replacement tax will require statutory changes.
- This collaboration will need to move quickly. Options are more limited in the future because OBBBA prohibits new provider taxes beyond the transition period Michigan requested.

Provider Tax and State Directed Payment (SDP) Limits

Provider Tax Cap Reduction:

New Tax Limits for Medicaid Expansion States like Michigan

- Gradual reduction of provider tax cap from 6% to 3.5%.
  - 2028 – 2032; 0.5 percentage points per year.
- Michigan will need to significantly reduce hospital taxes to comply.
- Further restricts ability to raise any provider tax beyond current level



State Directed Payment (SDP) Limitations:

New Medicare-Based Cap for Medicaid Expansion States

- SDPs to providers cannot exceed Medicare payment levels.
- Replaces previous cap based on average commercial rates.
- Michigan SDPs impacted:
  - $5.07 billion Hospital Rate Adjustment (HRA) – supports hospital access.
  - $610 million Specialty Network Access Fee (SNAF) – supports physician access.

Additional Financing-Related Provisions

Disproportional Share Hospital (DSH) Reduction

- Unless Congress intervenes, Medicaid DSH payments to states are scheduled to be reduced by $8 billion in FY26.
- This will impact Michigan's State Psych DSH claim creating an $87 million gap in funding starting in FY26.

Audit-Related Financial Penalties

- Beginning in 2030, CMS will be required to recoup funds from states with audit-related error rates of 3% or higher.
- The full federal share of erroneous payments above this threshold will be assessed in penalties after this date.

Federal Match Reduction for Emergency Services Only (ESO) Coverage

- Beginning October 2026, the federal match rate for all ESO coverage will be reduced to the state's traditional Medicaid match rate (~65% in Michigan).
- Restricts states from drawing higher match rates for expansion or CHIP enrollees.

What these changes mean for Michigan

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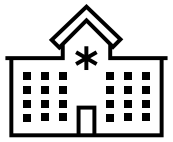
State Budget Impact:

- Loss of critical state flexibility to finance Medicaid without relying on the General Fund (GF).
- Annual loss of **$635 million** in revenue previously used to offset GF/core program costs.
- Risk to the state's ability to respond to future economic downturns and unforeseen events that increase demand for safety-net services.

Provider Impact:



- Lower provider tax and SDP limits ultimately result in:
  - Hospital payment reductions totaling upward of **$2.5 billion** annually.*
  - Physician payment reductions of **$309 million** annually.
- Cost pressures will force providers to make difficult decisions, including cutting services, reducing staff or opting out of the Medicaid program altogether.

Individual Impact:



- Reduced funding and declining coverage rates will limit access to care across the state.
- Rural and underserved areas—where provider margins are already thin—face the greatest risk.
- Rising costs, longer wait times and ripple effects like higher insurance premiums and the need to travel farther for essential services will be felt by statewide.

** Total includes lost supplemental payments and reductions in base payments supported by lost provider tax revenue.*

Questions & Discussion

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Appendix

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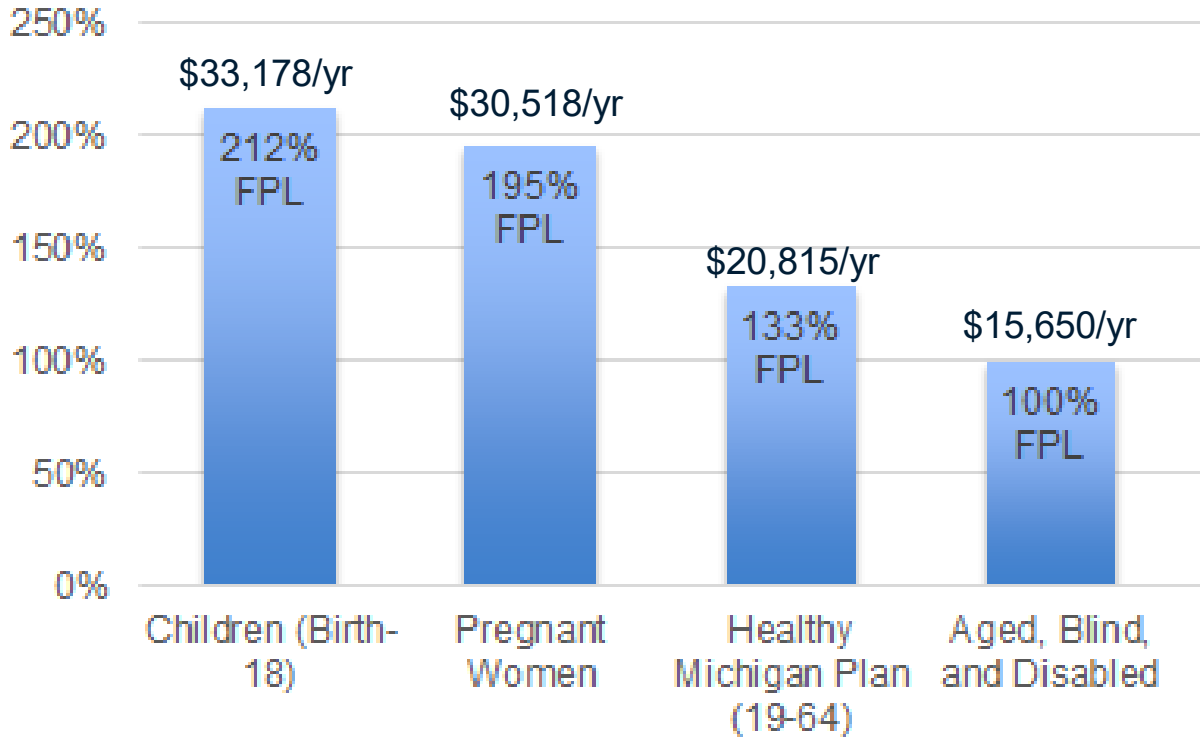
Medicaid Program Background

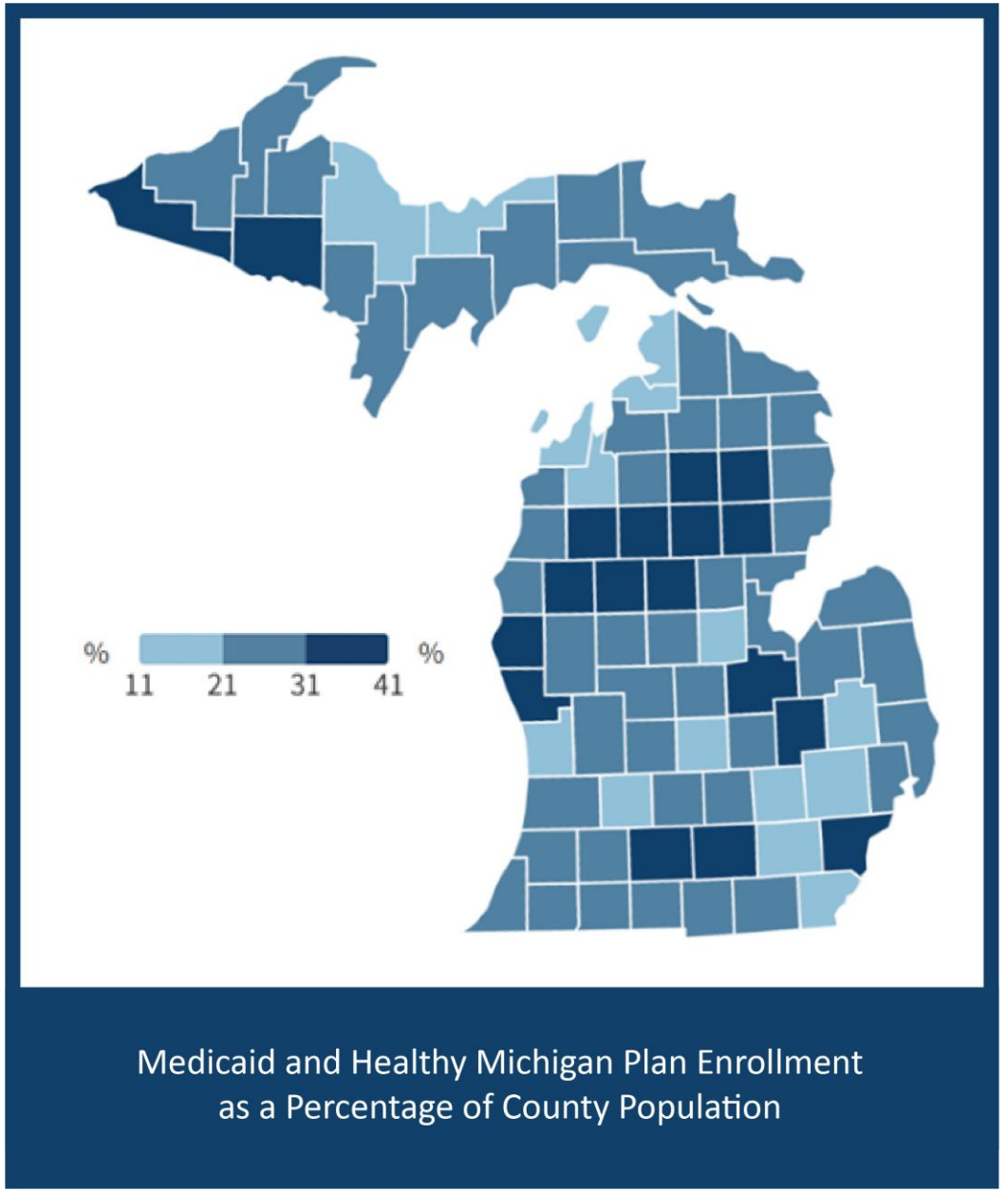
- Medicaid is the **largest health insurance program** in the U.S.
- A means-tested entitlement program providing **comprehensive health coverage for eligible populations**, including:
  - Low-income children and families.
  - Elderly and disabled individuals.
  - Pregnant women.

Medicaid Income Limit by Population



Medicaid Enrollment

Percentage of County Population



Medicaid and Healthy Michigan Plan Enrollment
as a Percentage of County Population

Medicaid Helps Rural Communities

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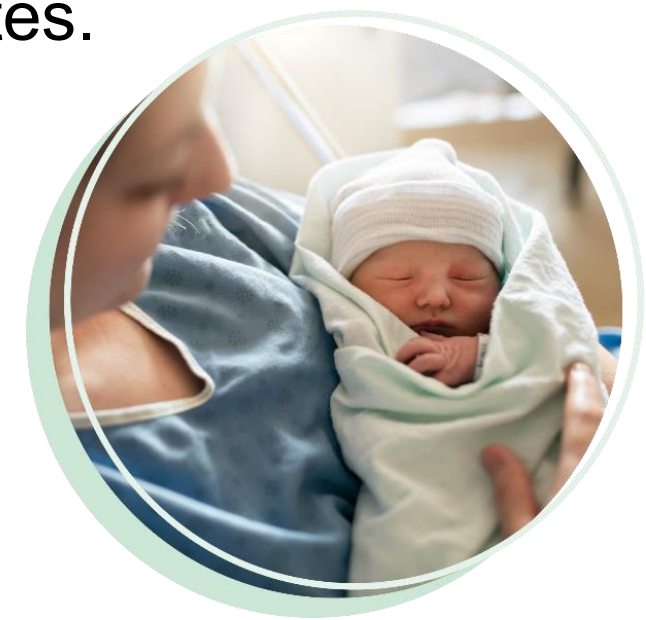
- **More than one-third of small town and rural** Michiganders are covered by Medicaid.
- States that did not expand Medicaid experienced **more hospital closures, especially in rural communities**. Hospitals are six times more likely to close in non-expansion states.
- Rural hospitals will struggle to keep **labor and delivery** open if Medicaid payments are reduced.
- The local hospital is often the **largest employer in many Michigan rural communities.**



Medicaid is good for our future

Medicaid Kids → High Earners

- Medicaid enrollment for children has been shown to:
  - Increase **positive health outcomes**.
  - Increase **educational attainment**.
  - Increase **wages** in adulthood.
  - Increase **future tax revenue** from increased earnings.



- Increasing the proportion of low-income pregnant women on Medicaid improved the **economic mobility outcomes** of their children in adulthood.
- The Congressional Budget Office estimates that **long-term** fiscal effects of Medicaid spending on children could **offset half or more** of the program's upfront costs.

Proven Healthy Michigan Plan Successes

In 2014, Michigan expanded Medicaid and launched Healthy Michigan Plan (HMP). Today, HMP covers nearly 750,000 Michigan residents.

HMP underwent extensive assessment to measure its impact. A University of Michigan evaluation found:

- Michigan's **uninsured rate went down**. Michigan's uninsured rate is one of the best in the nation — currently right around 5.4%. Prior to states being able to expand Medicaid, the national uninsured rate was more than 17%.
- Hospital **uncompensated care decreased by more than 50%.** Uninsured people don't stop getting sick, they wait until they are sicker to receive more expensive care. When they cannot afford to pay the bill the costs for everyone else at that facility increase – making check-ups, procedures and insurance more expensive for everyone.
- More people **accessed primary care**. By providing access to timely, effective care, individuals were able to better control chronic conditions and **avoid more expensive visits to emergency departments**.
- **Higher financial well-being** because beneficiaries can access medical care without taking away money for grocery bills and housing or without being forced into expensive medical debt. Positive effects were demonstrated on employment as some beneficiaries reporting gaining access to medical treatments that allowed them to begin or continue working.

Medicaid Helps Hospitals

- Because Medicaid covers a quarter of the state's population, Michigan's **uninsured rate** continues to improve and is now **among the best in the country** (5.4% in Michigan compared to 8.2% nationally).
- Since the launch of Medicaid expansion in 2014, **hospital uncompensated care** has fallen dramatically – **decreasing by more than 50%.**
- Michigan's hospitals receive **nearly $9 billion** in Medicaid funding annually, which accounts for **almost one-fifth of the state's hospitals' net patient revenue.**

Medicaid Helps the Economy

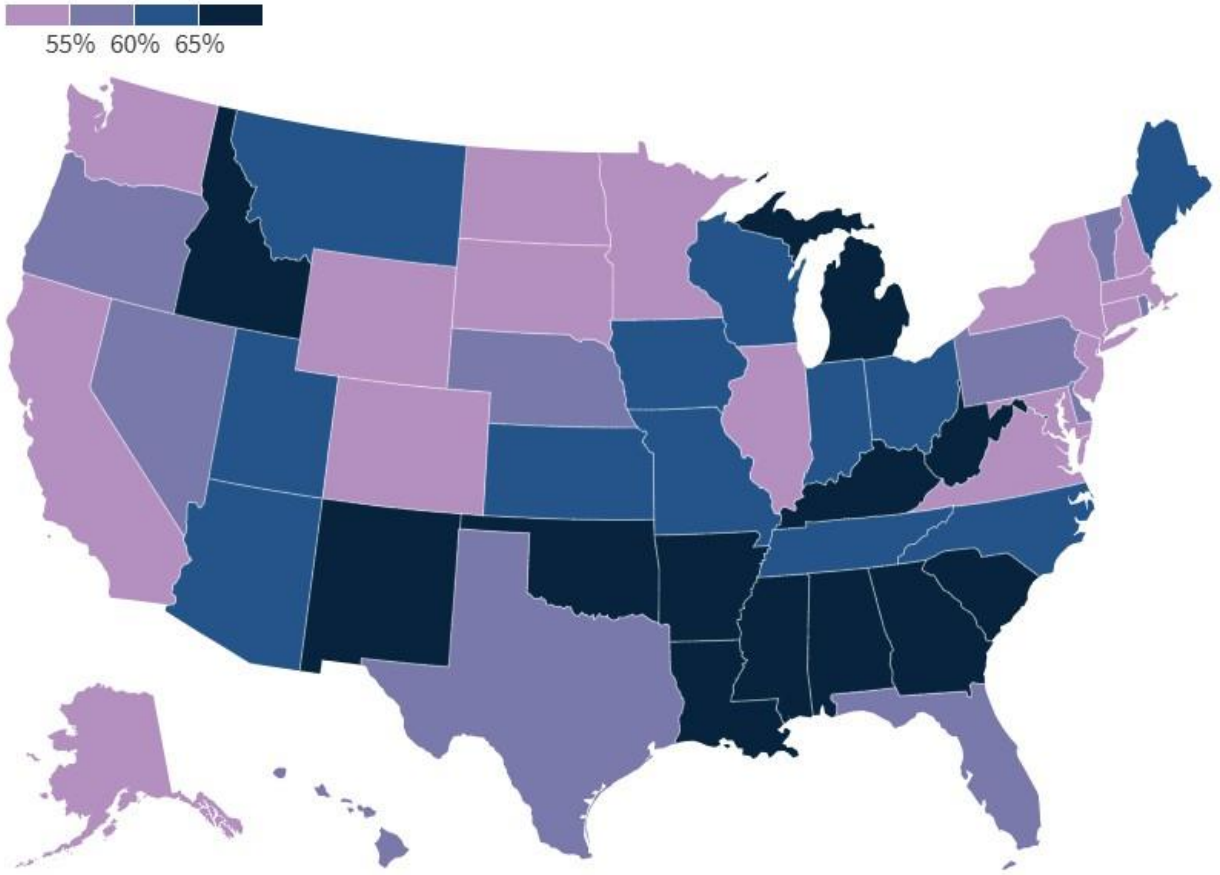
- According to the Michigan Health and Hospital Association, Michigan's health care industry has a total economic impact of **$77 billion** per year – **greater than any other industry in the state**.
- A University of Michigan study found that Medicaid expansion alone sparked the creation of **more than 30,000 new jobs every year**.
  - One-third in health care and 85% in the private sector.
- These jobs boost the **personal spending power** for Michigan residents by about **$2.3 billion each year** and result in an additional **~$150 million in tax revenue annually.**

How Michigan Medicaid is Financed

- Medicaid is **jointly funded** by the state and federal governments.
- The federal match rates for most Medicaid enrollees vary by state following a federal formula that provides a **higher federal match rate for states with lower per capita income**.
  - Michigan's FY25 **federal match rate is ~65%**.
  - The remaining **~35% is covered by the state** through a combination of state appropriations, provider taxes and local revenue.
- **HMP**, Michigan's Medicaid expansion program, qualifies for **90% federal match**.
- Medicaid **administrative expenditures** are covered by the federal government at **50%, 75% or 90%, depending on the type of expenditure**.

States With Lower Per Capita Incomes Have a Higher Federal Matching Rate for Medicaid

Federal Medicaid Assistance Percentages (FMAPs) for Traditional Medicaid Spending Effective for FFY 2026



Michigan Medicaid is Cost-Effective

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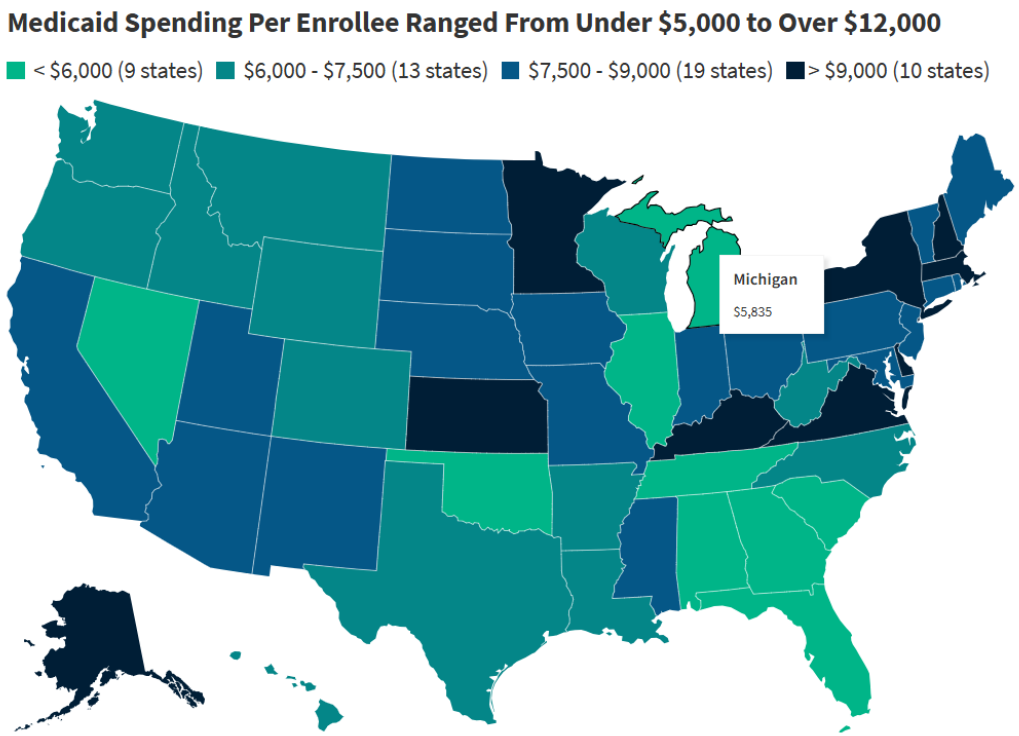
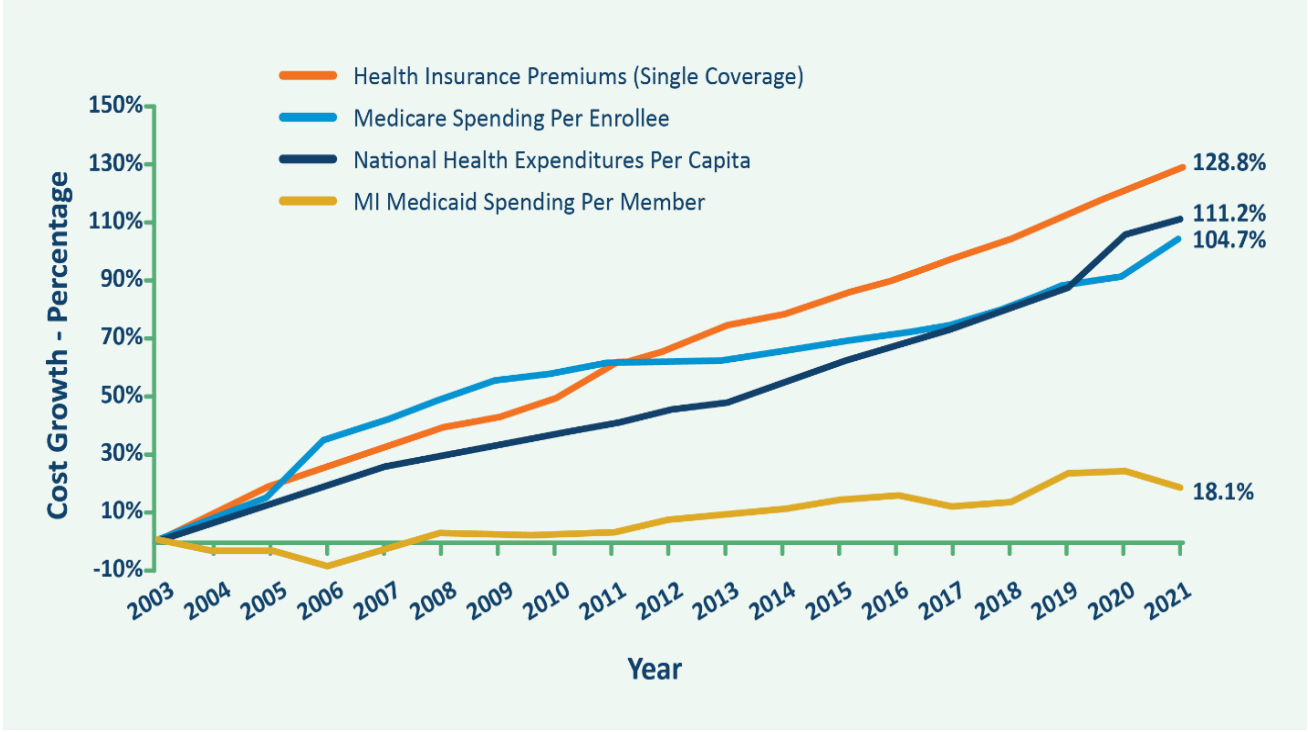
Michigan's Medicaid program has long been recognized for its cost-effectiveness, providing high-quality coverage to millions while maintaining per-enrollee spending below the national average. However, this efficiency means the program has less room to cut.





Medicaid's Required Coverage and Services

Who must be covered under federal law?

- Older adults (age 65 and older) who receive Medicare and also qualify for Medicaid.
- Individuals who are blind.
- Individuals with disabilities.
- Supplemental Security Income (SSI) recipients.
- Pregnant women.
- Children under age 1.
- Children in foster care.
- Very low-income families with children.
- Non-citizens for limited emergency services only.

What services must be covered under federal law?

- Inpatient and outpatient hospital services.
- Nursing facility services.
- Physician services.
- Lab and X-ray services.
- Home health services.
- Non-Emergency Medical Transportation (NEMT).
- Federally Qualified Health Centers & Rural Health Centers.
- Family planning services.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (under 21).
- Medication Assisted Treatment (MAT).

Federally Optional Medicaid Spending

- While federal law defines a core set of required Medicaid services, many "optional" benefits—like pharmacy and Home- and Community-Based Services (HCBS)—are essential to cost-effective, community-based care.
- Cutting these supports doesn't reduce waste—it removes critical tools that prevent hospitalizations, delay institutional care and stabilize individuals in their homes and communities.

