State Notes

TOPICS OF LEGISLATIVE INTEREST

Fall 2022

The Federal COVID-19 Public Health Emergency Declaration and Michigan's Medicaid Program
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Introduction

The July 2022 extension of the COVID-19 public health emergency (PHE) for an additional 90 days represented the 10th extension of the PHE after the initial declaration on January 31, 2020.[1] An ongoing PHE declaration is connected to several health care waivers, flexibilities, and other policies provided for by Federal statutes and rules. This article will discuss how the COVID-19 PHE declaration has affected Michigan's Medicaid program, specifically a change in the financing of the program, and how enrollment has been altered by Federal statutory changes.

Temporary Increase in the Federal Medical Assistance Percentage

On Friday, July 15, 2022, United States Secretary of Health and Human Services Xavier Becerra issued a "Renewal of Determination that a Public Health Emergency Exists Nationwide as the Result of the Continued Consequences of Coronavirus Disease 2019 (COVID-19) Pandemic".[2] While this determination is important for the continued public awareness of COVID-19, this declaration also is important for Michigan's budget as it triggers a continuation of lowering Michigan's share cost for the Medicaid program.[3]

Each state's Medicaid program has a Federal and state cost-sharing agreement with a varying percentage of costs that the Federal government will assume known as the Federal Medical Assistance Percentage (FMAP).[4] The FMAP is formula-based and is calculated annually based on the per capita incomes of each state relative to the national per capita income to reflect each state's ability to fund a Medicaid program from state revenue.[5] The Federal statutory minimum for cost-sharing is 50%-50% for states with high per capita incomes. For fiscal year (FY) 2021-22, Michigan's FMAP for the traditional Medicaid program is 65.48%, meaning that for every $1 spent on the traditional Medicaid program, the Federal government will provide $0.65, and State of Michigan-sourced revenue will provide the remaining $0.35. For the Healthy Michigan program and services provided under the Child Health Insurance Program, the Federal government will provide a greater share of program funding based on Federal statute.

COVID-19 Pandemic: Temporary FMAP Increase

Public Law 116-127, the Families First Coronavirus Response Act (FFCRA), went into effect on March 18, 2020, and allows an increase in FMAP for each state by 6.2 percentage points for each calendar quarter that includes a month during which the public health emergency is in effect.[6] The FFCRA requires that the temporary FMAP increase remain in effect until the last calendar day in the quarter for which an emergency declaration was in effect. Table 1 shows

the FMAP from FY 2017-18 through FY 2022-23 including the State Share under "regular" FMAP and under the temporary FMAP increase.

Table 1. Federal Medical Assistance Percentage (FMAP) for Fiscal Years 2017-18 through 2022-23

Fiscal Year	Regular FMAP Federal Share	Regular FMAP State Share	Temporary FMAP Federal Share	Temporary FMAP State Share
2017-18	64.78%	35.22%	N/A	N/A
2018-19	64.45%	35.55%	N/A	N/A
2019-20	64.06%	35.94%	70.26%	29.74%
2020-21	64.08%	35.92%	70.28%	29.72%
2021-22	65.48%	34.52%	71.68%	28.32%
2022-23*	64.71%	35.29%	70.91%	29.09%

**The PHE is scheduled to end October 15, 2022, but could end earlier. The FY 2022-23 budget assumes no temporary FMAP savings, but given the notice requirements, there will likely be some additional PHE temporary FMAP savings in FY 2022-23.*

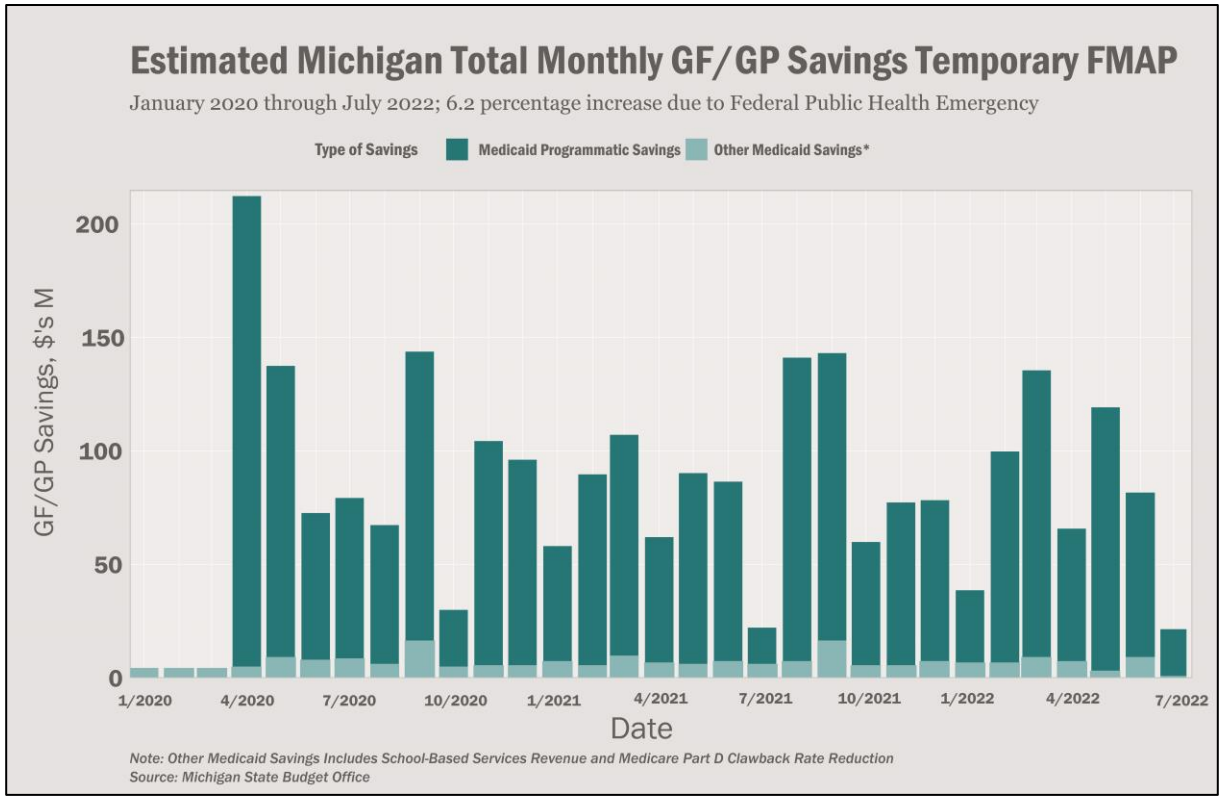
For FY 2020-21, the traditional Medicaid program's Gross cost was $14.9 billion. Michigan's state cost including Local, State Restricted, and General Fund was $4.4 billion or approximately 29.5% of the total program cost, which reflects the inclusion of the temporary increase in the FMAP.

In analyzing the overall fiscal picture that an enhanced FMAP has brought to Michigan, there are different variables under consideration with two ways to view the fiscal effects of the temporary decrease in the State's share of the Medicaid program. The first way is to view the monthly Medicaid expenditures eligible for the temporary FMAP increase under the regular FMAP and then apply a 6.2% factor to reduce the State's share of cost. For example, if Month A had $1.0 million in spending, under the regular FMAP (65% under this example), the State's share would be $350,000. If then there is an application of a 6.2% temporary FMAP increase, the State share would decrease to $288,000, $62,000 in reduced State costs.

As shown in Figure 1, the State of Michigan Budget Office (SBO) estimated the reduction in the State's share of the Medicaid program due to the temporary FMAP increase through July 2022 has allowed Michigan to avoid approximately $2.5 billion in State costs. Over the course of the 27 months after March 2020, the average monthly cost avoidance is $92.7 million, and the average quarterly cost avoidance is $278.3 million. Through three full fiscal quarters in FY 2021-22, the average quarterly cost avoidance has been $253.7 million. An additional $12.3 million of savings trail back to January 2020, as the FFCRA allowed for savings to occur for each calendar quarter that the PHE was in effect. Since the initial PHE was declared in January

2020, some costs from the first calendar quarter of 2020 were allowed to access the additional FMAP percentage.

Figure 1



One complication in labeling this reduced State share of costs as "savings" is that Medicaid is an entitlement program, meaning any person who is eligible can enroll in the program and receive benefits. Like other health insurance programs, Medicaid expenditures are driven by both the total number of enrollees and the underlying medical expenses that those enrollees incur. Since both enrollees and health care utilization change continuously, a static analysis of temporary FMAP increases applied to monthly expenditures will not capture underlying trends of utilization. To expand our $1.0 million example, if, in the following month, the costs increased to $2.5 million, under the 65% FMAP, the State's costs would increase from $350,000 to $875,000. If then we apply the temporary 6.2%, the State costs for that month would be $720,000. One could view the difference between the $875,000 and $720,000 as $155,000 in savings and that would be a sound way to view the changes. This type of analysis assumes the monthly change in expenditures as "fixed" and is a fair way to analyze the effect under a counterfactual situation: "If the 6.2% increase were not in effect, what would the State's costs have been?"

Another view is that calculating "savings" to Michigan under a temporary FMAP increase is somewhat of a moving target given that disenrolling individuals (as will be expanded upon in the next section) has not been allowed under the PHE and new individuals have continued to be enrolled in the program. "Savings" would have to be defined in terms of the change in overall Medicaid expenditures in light of the additional 6.2% FMAP increase.

Under a scenario with more enrollees, if overall Medicaid costs increase by a significant amount on a year-over-year basis, the presence of a temporary increase to the FMAP will not provide a net "savings" because the underlying trend of costs went up regardless of whether there was a reduction in the relative State share of those costs.

Table 2. Projected Traditional Medicaid Expenditures and Total Temporary FMAP Savings for Fiscal Years 2017-18 through 2022-23

Fiscal Year	Gross Traditional Medicaid Expenditures	Actual State Share Medicaid Expenditures	State Share Medicaid Expenditures No Temporary FMAP Inc.	Annual Change due to regular FMAP changes	Effect due to Temp. FMAP Changes	Utilization and Caseload changes
2017-18	$13,464,340,900	$4,631,701,300	$4,631,701,300	$ -	$-	$-
2018-19	14,687,253,400	5,102,062,800	5,102,062,800	-	-	-
2019-20	14,456,042,200	4,336,070,200	5,195,501,600	57,280,300	(522,826,900)	(83,097,300)
2020-21	14,946,911,700	4,430,384,100	5,368,930,700	(2,891,200)	(926,708,500)	176,320,300
2021-22*	16,906,166,900	4,830,804,400	5,836,008,800	(209,256,700)	(1,048,182,300)	676,334,900
2022-23*	17,323,119,100	5,901,918,800	5,901,918,800	-	-**	-
			Subtotal	($154,867,700)	($2,497,717,700)	$769,557,900
			State Share Savings Total ($1,883,027,500)			

**Estimated in May 2022 Consensus process*

***The PHE is scheduled to end October 15, 2022, but could end earlier. The FY 2022-23 budget assumes no temporary FMAP savings, but given the notice requirements, there will likely be some additional PHE temporary FMAP savings in FY 2022-23.*

Table 2 illustrates six fiscal years and total Medicaid expenditures. For three fiscal years the table shows changes due to: "regular" FMAP changes[1], temporary FMAP increase, and utilization/caseload changes. The estimated savings from the temporary FMAP of $2.5 billion, which is similar to the SBO estimated savings. There is an additional $154.9 million in State savings due to the "regular" FMAP's increasing in two out of the three years. Lastly, there is

[1] "Regular" FMAP adjustments occur annually and are calculated based on the changes to Michigan's per capita income with respect to changes that occurred nationwide.

an additional $769.6 million in State costs due to an increase in utilization and caseload, which is the main driver in the differing amounts in State savings amount between the SBO and SFA projections. The net effect of these changes is a total State savings of $1.9 billion. From FY 2017-18 through projected FY 2021-22, the average GF/GP portion of the State share of Medicaid costs has been 50.2% with the remainder of the State share being State Restricted funding. This means there is an estimated $941.5 million of GF/GP savings over the three fiscal years that have included a temporarily increased FMAP.

The currently enacted FY 2022-23 budget assumes no PHE in effect after July 2022, so no assumed savings are recognized in the first fiscal quarter of FY 2022-23. If the PHE had ended before October 1, 2022, there would be $0 in additional temporary PHE savings. Since PHE was still in effect as of October 1, 2022, there will be a $250 million reduction in the State share of the Medicaid program for the first fiscal quarter of FY 2022-23 with $125 million of GF/GP savings. Even if the PHE is ended earlier than October 15, 2022, those savings will still be recognized. It is unclear if there will be further extensions of the PHE, but the Federal government has stated that it would give states 60 days' notice before the end of the PHE. A 60 day notice would need to be provided to the states by November 1, 2022 to meet a December 31, 2022 PHE end date that would prevent the State from recognizing an additional quarter of temporary FMAP savings.

PHE and Medicaid Enrollment Requirements

Included in the FFCRA as one of the conditions for states to receive the 6.2 percentage point FMAP increase is a requirement that if an individual was enrolled for Medicaid benefits as of the date of the bill's enactment (March 18, 2022), those enrollees must be treated as eligible for Medicaid benefits until the end of the month in which the PHE ends unless the individual requests a voluntary termination or the individual ceases to be a resident of the state offering the program.[7] Any state receiving the temporary increase may not make eligibility standards, methodologies, or procedures under the Medicaid state plan that are more restrictive than what was in place on January 1, 2020. In addition, for a state to receive the 6.2 percentage point increase, the state may not increase premiums on Medicaid recipients and may not impose any cost-sharing requirements on COVID-19 vaccines, therapies, or specialized equipment.

Nationwide, it is estimated that 14 million individuals have been able to gain extended health insurance through the “continuous coverage” requirement. In Michigan, as of August 2022, there were 2,073,891 individuals on Traditional Medicaid and 1,017,887 on the Healthy Michigan Plan for a total enrollment of 3,091,778. This is a 28.7% increase over March 2020 levels with an additional 688,773 enrollees. Figure 2 shows the Medicaid enrollment from September 2019 through July 2022, noting the declaration of the PHE and the continuous enrollment requirements established in March of 2020 under the FFCRA. From March 2018, when there were 2,459,529 residents in combined Medicaid enrollment, through July 2022, there was an increase of 26.3% over that longer period of measurement.

Figure 2

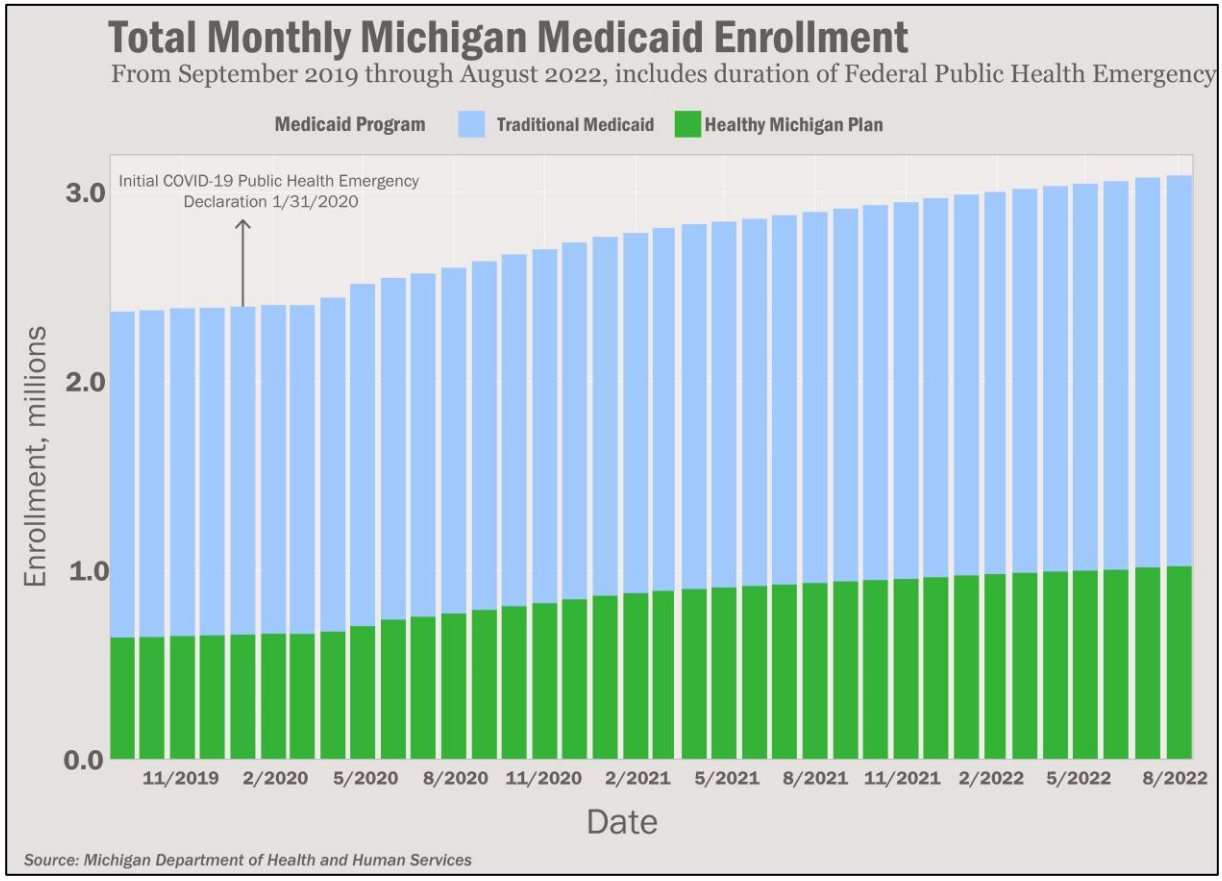
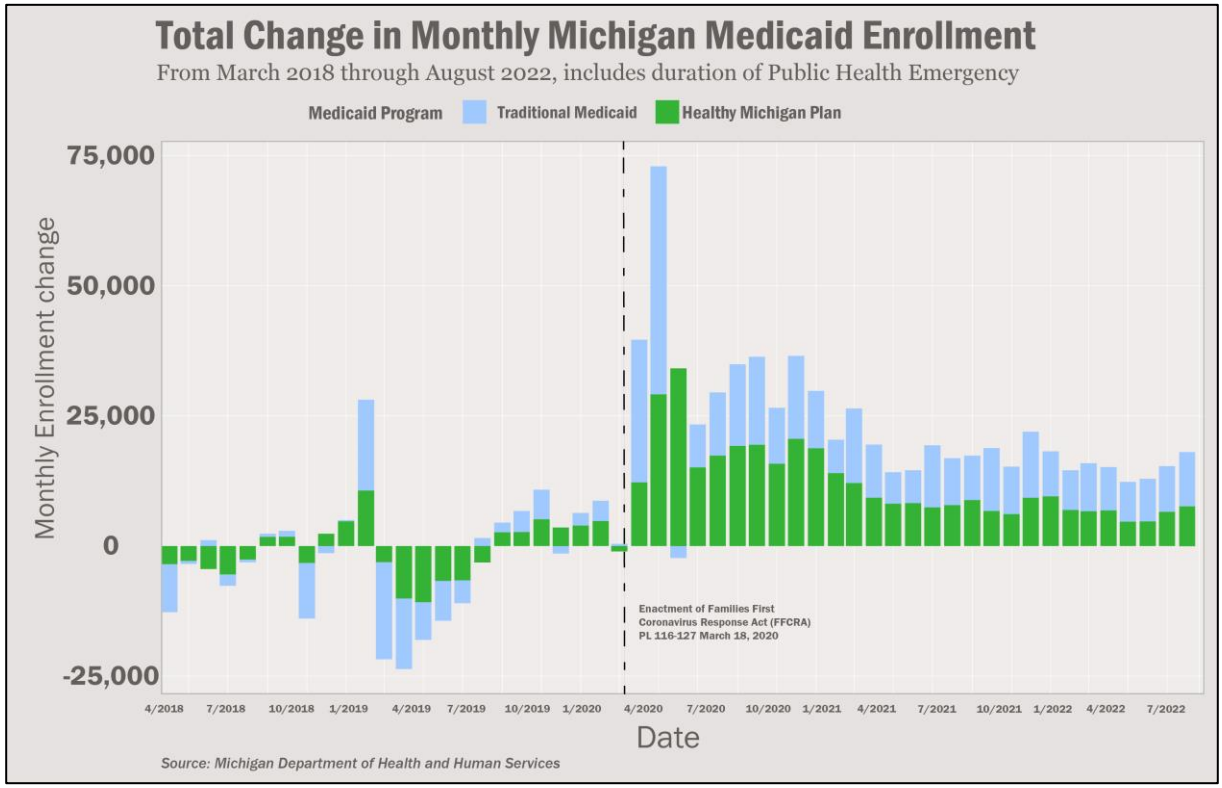


Figure 3 shows the average monthly change in Medicaid enrollment between March 2018 through March 2020, and the data can be divided into two clear periods: before the COVID-19 PHE and post-March 2020 with the "continuous coverage" requirement. From March 2018 through March 2020, the average monthly change in traditional Medicaid was a decrease of 1,543 eligible individuals, and a decrease of 812 eligible individuals in the Healthy Michigan Plan. Since March 2020, the average monthly enrollment in traditional Medicaid has increased by 11,564 individuals and increased by 12,186 in the Healthy Michigan Plan. The largest single month of enrollment increases was in May 2020 with a monthly enrollment of 72,966 recipients (43,817 traditional Medicaid and 29,149 Healthy Michigan Plan).

Michigan has not completed income, age, or disability eligibility checks (also called eligibility redeterminations) on current recipients of Medicaid since June 1, 2020. After initial qualification during the PHE or enrollment before the PHE, those individuals were deemed eligible for Medicaid until the end of the month in which the PHE ends. With no annual redetermination since March 2020, all individuals enrolled in Medicaid will need their cases reviewed to verify that they are Medicaid-eligible after the PHE ends.

Figure 3



Implications for the Ending of the Public Health Emergency

With about 600,000 additional cases enrolled since the beginning of the PHE, the Michigan Department of Health and Human Services (DHHS) has a large administrative burden ahead of the end of the PHE. Though there was $20.9 million Gross appropriated in the FY 2021-22, budget to assist DHHS with Medicaid redetermination, none of those funds have been spent as the PHE has been extended through the end of the fiscal year. It is possible that these funds could be put into a work project request from the SBO for use during the "unwinding" of the PHE. For FY 2022-23, $10.0 million was appropriated to assist with the cessation of the PHE and to resume regular Medicaid eligibility processes.

Without interim redeterminations during the PHE, it is not known how many individuals enrolled in Medicaid no longer would meet program eligibility. Another uncertainty is how many individuals have gained health coverage from other payors such as employer-based health insurance. If a person has gained employer-based health coverage but has not voluntarily notified the DHHS or has moved out of Michigan and notified the DHHS, these individuals would be carried on the enrollment figures even though their health coverage is being paid by a non-Medicaid payor. If there are Medicaid recipients who are "enrolled" and in a health plan but not using services, these $0 cost experience health plan members could cause uncertainty in the process for determining the actuarial soundness of the health plan rates. As these

enrollees with low utilization could move off the Medicaid rolls, there could be some volatility in various rate categories depending on the degree to which the low utilization plan members have provided additional revenue to health plans. An analysis done on the Medicaid health plan industry noted that the revenue and underwriting gains in calendar year 2021 were the highest composite totals observed in the history of that annual report[8].

The Federal Centers for Medicare & Medicaid Services (CMS) has issued guidance to states that provides flexibility for states in adopting a redetermination processing strategy.[9] The CMS has stated that states will have 12 months to initiate all renewals and other eligibility issues with two additional months to complete all pending actions that were initiated in the 12-month unwinding period.

The four strategies allowed by CMS include a time-based approach (simply starting with cases with the oldest renewal dates), a population-based approach (basing renewals on a population type or Medicaid eligibility group), a hybrid approach that incorporates features of time-based and population-based approaches, and a state-developed approach (states can develop a strategy that best fits their needs that does not fit in three other options). The DHHS has chosen the state-developed strategy that "…initiates regular renewals for all individuals by month as they come due following the end of the PHE, without regard to year or how long the renewal is overdue."

Figure 4

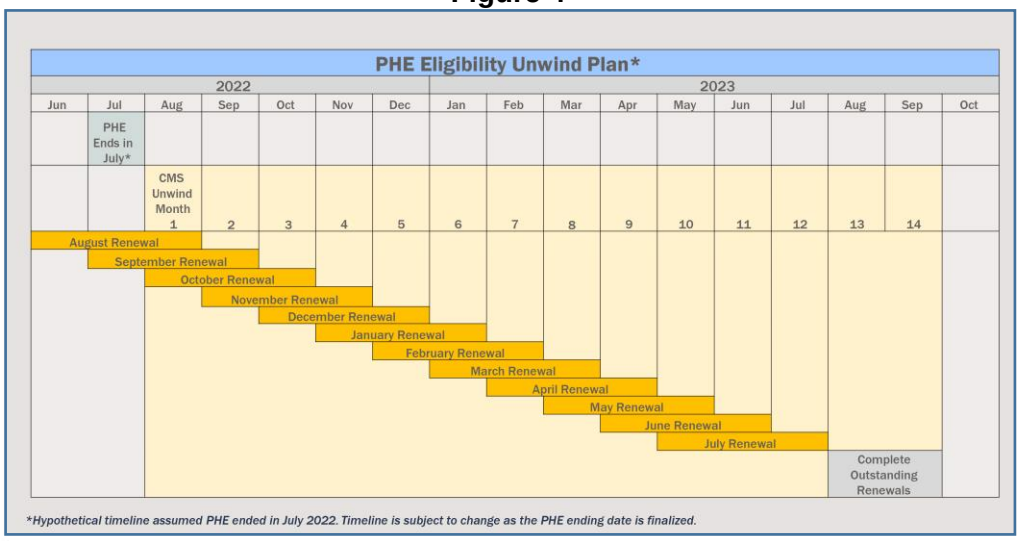


Figure 4 is a draft "PHE Eligibility Unwind Plan" from the DHHS issued in June 2022 that shows the Medicaid eligibility processing schedule. This draft plan was completed with the assumption that the PHE would end in July 2022. When the PHE is ended, this plan for eligibility processing will follow the same manner as in Figure 4.

In June 2021, passive renewals (meaning the DHHS has enough current information on a case to determine eligibility without contacting the recipient) were restarted. This information is available only in a certain percentage for a subset of cases, about 18% of all Medicaid cases. The DHHS estimates that the remaining nonpassive renewals that must be manually processed are roughly 130,000 each month. Likely the most difficult group that will be affected by the end of the PHE is those individuals who are within the 138%-200% Federal poverty level guidelines, as these individuals could have incomes that vary monthly, which could result in eligibility churn depending on the month of an income eligibility review. This could lead to fluctuation between the Healthy Michigan Plan and marketplace insurance and increased caseworker review if the cases churn between the categories often.[10]

An analysis of the fiscal and enrollment implications of the PHE from May 2022 estimated that nationwide enrollment growth based on pre-pandemic trends was 4% from March 2020 through September 2022.[11] As mentioned previously in this paper, Michigan was experiencing a slight decline in Medicaid enrollment from March 2018 through March 2020 but, using a 4% growth factor on March 2020 enrollment data, the baseline Medicaid enrollment would be about 2.5 million enrollees. The estimate from this rough analysis is that there could be 575,000 currently eligible Medicaid beneficiaries who no longer will be eligible once the PHE ends.

A DHHS memo noted that there were significant increases in the months of July and August.[12] It is not clear if this reference to increases in cases in July and August was because of previous enrollment increases in past years or if this was a reference to an increased workload for caseworkers which would have been projected with a potential end of the PHE in summer of 2022.

Conclusion

The end of the PHE will signal a change in the overall management of the COVID-19 pandemic, but also will trigger changes in Michigan's Medicaid program that, because of Federal statute, are second-order to direct pandemic-related management. The PHE has allowed the State of Michigan to save around $2.0 billion in the State's share of the Medicaid program with an additional 600,000 individuals enrolled in health insurance. The potential "unwinding" of the PHE in Michigan's Medicaid system will require a resumption of the regular State share of costs and a large work effort to determine the continued eligibility of most Medicaid enrollees. If the PHE continues past January 1, 2023, there could be further savings in the State's Medicaid program.

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[1] Renewal of Determination that a Public Health Emergency Exists, US Department of Health and Human Services, Sec. Xavier Becerra, July 15, 2022.
[2] *Id*.

[3] Medicaid and CHIP Payment and Access Commission, Federal Match Rate Exceptions. Retrieved Aug. 15, 2022.
[4] Federal Register: Federal Financial Participation in State Assistance Expenditures FMAP for Medicaid, Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for 10/1/2021 – 9/30/2022, 85 FR 76586, Published Nov. 30, 2020
[5] Christie Provost Peters, "Medicaid Financing: How the FMAP Formula Works and Why It Falls Short", Issue Brief No. 828, National Health Policy Forum. Retrieved Aug. 22, 2022.
[6] PL 116-127, § 608
[7] Elizabeth Williams, *et al*., "Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends", Kaiser Family Foundation. Retrieved Aug. 15, 2022.
[8] Jeremy Palmer, *et al.*, "Milliman Research Report: Medicaid managed care financial results for 2021". Retrieved Sept. 1, 2022.
[9] State Health Official Guidance Letter #22-001, "RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency", Centers for Medicare and Medicaid Services.
[10] Michigan Department of Health and Human Services Post PHE Normalization: Medicaid and CHIP Renewals and Redeterminations. Retrieved Aug. 15, 2022.
[11] Elizabeth Williams, *et al*., "Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends", Kaiser Family Foundation. Retrieved Aug. 15, 2022; "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP", October 2021, Medicaid and CHIP Payment and Access Commission.
[12] Michigan Department of Health and Human Services Post PHE Normalization: Medicaid and CHIP Renewals and Redeterminations. Retrieved Aug. 15, 2022.