Michigan Department of Community Health

MDCH

Exchanges, Medicaid and Affordable Care Act Compliance

Michigan Patient Accounting Association

Mt. Pleasant, Michigan

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State Exchange: Where are we Now?

- The legislature did not appropriate the $31 Million federal grant to establish a State Partnership Exchange.
- Michigan will have to enter into the Federally Facilitated Exchange.
- This means that the federal government will handle all Exchange functions.

Shopping at the Federal Marketplace

- The Marketplace in each state is designed so that individuals and families can easily compare the health plans available to them.
- Those shopping on the exchange will also be able to apply for Advanced Payments of the Premium Tax Credit (APTC) to help them cover the costs of their selected plan.
  - Families up to 400% of the federal poverty level (FPL) will be eligible for APTC.
- Each plan option will be assigned a “medal level” based on the actuarial value of the plan.

Actuarial Value and Medal Levels

- Actuarial value (AV) is a measurement of the percentage of expected health care costs a health plan will cover. The higher the AV the more health costs a plan will cover.
- Each of the plans available at the Marketplace is assigned a medal level which corresponds to its actuarial value:

Medicaid and the Marketplace

- Michigan is an “assessment state.” This means that those who apply for help paying the costs of their selected health plan will be screened for Medicaid eligibility by the Marketplace.
- Those who are assessed as eligible will be transferred to the State for a final determination.
- The transfer between the federal and state governments will happen electronically for a seamless customer experience.

Medicaid and the ACA Compliance

- Modified Adjusted Gross Income
- Provider Pay Rate Increase
- Essential Health Benefits
- Streamlining Medicaid Determinations
- Healthy Michigan

Modified Adjusted Gross Income

- MAGI, or modified adjusted gross income, is the method the ACA identifies to be used in order to determine an individual's income.
- The only groups exempt from MAGI eligibility are those receiving SSI benefits, those over 64, the medically needy, and those eligible for Medicare cost-sharing.
- The State must convert its current Medicaid standards to a new MAGI standard.
- The MAGI standard creates four simplified groups that all new eligible individuals will be placed into. They are parent/caretakers, children, childless adults, and pregnant women.
- MAGI methodology uses no asset or resource tests.
- MAGI applies a singular 5% disregard to all applicants' income. This applies to all old Medicaid eligibility groups as well as the optional expansion population.

Medicaid Program Streamlining

- Applicants will be able to get eligibility determinations for any Medicaid program using a single application.
- In 2014 there will be “no wrong door.” Individuals will be able to apply through the online federal portal, at their local DHS office, or by sending in a paper application.
- Eligibility determinations are required to be made in “real time.”
- In January of 2015 all notices are required to be coordinated with the state exchange in order to cut down on multiple, and possibly confusing, notices being sent to applicants.
- Yearly redeterminations will now be made with information the Medicaid agency already has (only if it already has all the appropriate and necessary information) without requiring a response from the beneficiary.

Provider Rate Increase

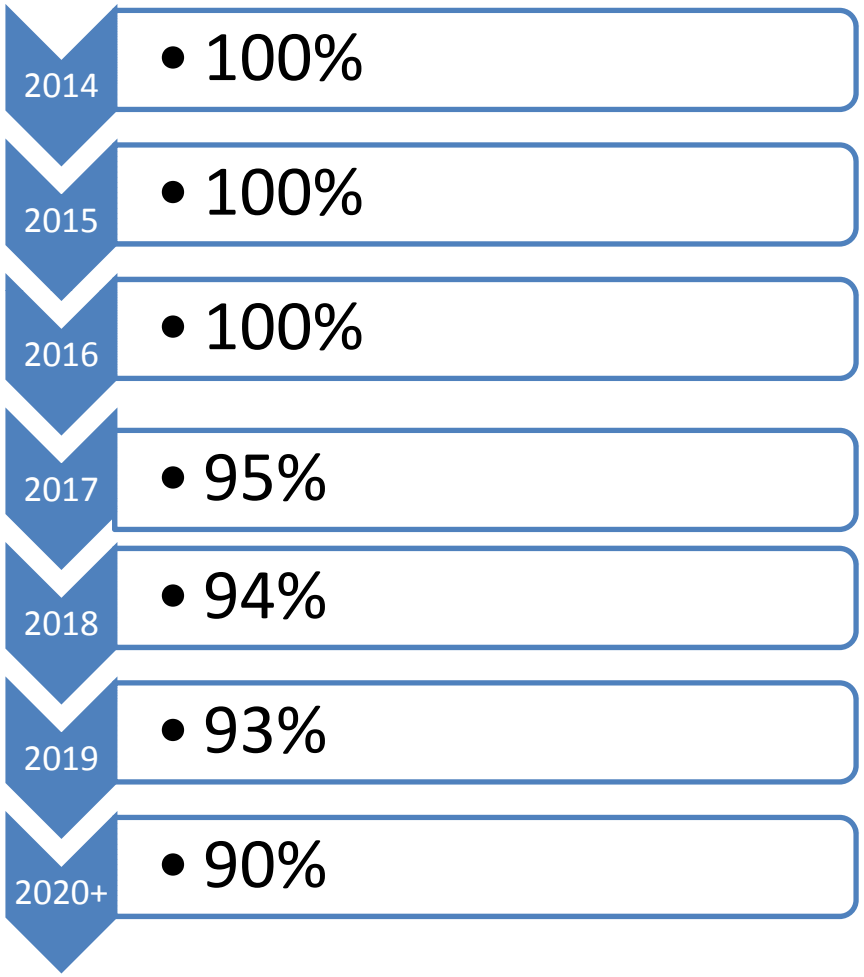
- Increases the Medicaid rates paid to physicians “with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine” up to Medicare levels.
- Rate increase starts in 2013 and lasts through 2014 with the state option to continue past the federal participation end date.
- This rate increase will likely encourage physicians to begin participating in the Medicaid program or increase the number of patients they see. These new providers will help to increase Medicaid’s overall capacity.

Essential Health Benefits (EHB)

- Essential health benefits are ten categories that must be covered by qualified health plans with limited cost sharing.
- Medicaid programs must comply with EHB regulations.
- The ten essential categories are:
  1. Ambulatory services
  2. Emergency services
  3. Hospitalization
  4. Maternity and newborn care
  5. Mental health and substance use disorder services (provided at parity with physical health benefits)
  6. Prescription drugs
  7. Rehabilitative and habilitative services and devices
  8. Laboratory services
  9. Preventive and wellness services and chronic disease management
  10. Pediatric services – including oral and vision care

Medicaid Expansion

- Medicaid expansion under the ACA is optional.
- The expansion would qualify individuals for Medicaid up to 138% of federal poverty level (FPL). Between 138% and 400% applicants will be eligible for tax credits on the exchange.
- The expansion will increase access to coverage for the childless adult population(Michigan currently only covers this group up to 37.5% of FPL).
- The federal government has pledged to pay 100% for newly eligible individuals through 2016 when they will begin to slowly scale back payments ending in 2020 with a 90% match. (See adjacent chart)
- MAINTANENCE OF EFFORT: States must maintain their current eligible population until the exchange in their state is operational. Regardless of the exchange's status states must maintain eligibility for children until 2019.



Healthy Michigan Plan

- The Healthy Michigan legislation raises the Medicaid income limit to 133% of the federal poverty level.
  - Cost sharing for this group is limited to no more than 5% of their annual income.
  - Cost sharing can be further reduced by meeting certain benchmarks to improve health (ex: quitting smoking)
- Those enrolled in Michigan Medicaid with incomes between 100% and 133% FPL will be put into health plans that provide a health savings account.
  - Money can be deposited into this account from several sources such as the enrollee's provider.
  - The enrollee will be responsible for depositing their average monthly co-pay, as determined by the Department of Community Health, into this account.

Healthy Michigan Plan cont'd

- Those between 100% and 133% of the FPL will be limited to 48 cumulative months of Medicaid coverage. At this point enrollees have two options:

- Continue with Medicaid but increase cost sharing up to 7% of income OR
- Leave Medicaid and be considered for Advanced Premium Tax Credits at the Federal Marketplace.