

HB

426

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FILE

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: CSHB 426(HES)
 (H) Publish Date: 4/12/06
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: RELATING TO MEDICAL ASSISTANCE ELIGIBILITY AND COVERAGE FOR PERSONS UNDER 21 RDU Behavioral Health
 Component: Behavioral Health Administration

Sponsor: COGHILL

Requester: HOUSE (FIN)

Component No. 2665

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: _____
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Section 11 of this bill requires the Department to prepare a report of recommendations for changes for residential psychiatric and substance abuse treatment programs that address reduction of medical assistance expenditures, enhancement of parental responsibility, and maximization of third-party resources.

This provision will have a zero fiscal cost under the assumption that the new Bring the Kids Home Project Manager position in the FY07 proposed budget is funded. The report would be written by the new position.

This is the only section of the bill that affects the Division of Behavioral Health. The eligibility groups affected (recipients of long-term care services and minors applying for themselves) by this bill generally do not use mental health services.

Prepared by: Christy Willer, Director Phone 269-3410
 Division: Behavioral Health Services Date/Time 04/12/2006
 Approved by: Karleen Jackson, Commissioner Date 04/12/2006
 Agency: Department of Health and Social Services

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 2
 Bill Version: CSHB 426(HES)
 (H) Publish Date: 4/12/06
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: RELATING TO MEDICAL ASSISTANCE
ELIGIBILITY AND COVERAGE FOR PERSONS
UNDER 21

RDU: Public Assistance

Component: Public Assistance Field Svcs

Sponsor: COGHILL

Requester: HOUSE (FIN)

Component No.: 236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	40.6	162.4	162.4	162.4	162.4	162.4
Travel						
Contractual	4.3	17.0	17.0	17.0	17.0	17.0
Supplies	6.8	5.0	5.0	5.0	5.0	5.0
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	51.7	184.4	184.4	184.4	184.4	184.4

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	25.9	92.2	92.2	92.2	92.2	92.2
1003 GF Match	25.8	92.2	92.2	92.2	92.2	92.2
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	51.7	184.4	184.4	184.4	184.4	184.4

Estimate of any current year (FY2006) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time	2	2	2	2	2	2
Part-time	1	1	1	1	1	1
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill contains provisions that change medical assistance eligibility in AS 47.07.020, which will increase the workload of Eligibility Technicians.

Section 7, subsection (j-k) limits who may apply for medical assistance for a person under 18 years of age.

Section 7, subsection (l) requires that persons applying for medical assistance must enroll for Medicare if eligible.

These provisions increase workload by requiring Eligibility Technicians to spend more time with applicants searching for legal guardians or parents of minors, and assisting eligible persons to enroll in Medicare.

Prepared by: Kitty Farnham, Director
 Division: Public Assistance
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone: 465-5835
 Date/Time: 04/12/2006
 Date: 04/12/2006

**STATE OF ALASKA
2006 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

MINORS APPLYING FOR MEDICAID

Currently, any adult may apply on behalf of a minor and minors may apply for themselves. Section 7, subsections (j) and (k) provide that only an adult who has a legal or vested interest may apply for Medicaid on behalf of a child under age 18. The department must make reasonable efforts to contact the parent or legal guardian before granting a waiver of consent. If a waiver of consent is granted, the department must document the reason for the waiver in the child's medical assistance record. Under this provision, Division staff will have to spend more time with applicants to contact and obtain consent of the parent or legal guardian or document a waiver.

Total Annual Costs = \$110.6 thousand for an additional 1.5 positions plus an extra \$4.4 thousand in FY07

Assumptions:

- ~Approximately 3800 minor children apply for Medicaid each year.
- ~An additional 45 minutes per application, on average, will be needed for eligibility staff to contact a minor applicant's parent(s) or legal guardian to obtain consent (or make a reasonable attempt to obtain consent) for the application, or to gather enough information needed to waive consent.
- ~3800 applications/per year x 45 minutes = 171,000 minutes per year or 2,850 hours
- ~Eligibility staff work 162 hours/month x 12 = 1944 hours/year
- ~2850 hours per year/1944 hours per technician = 1.5 workers
- ~Average personnel costs for an Eligibility Technician II is \$64,944/year
- ~One-time cost for computers and software in FY2007 = \$2,200/position
- ~Annual costs for office space, phones & supplies = \$8,800/position
- ~1 Eligibility Technician II full time = \$64,944 + 1 Eligibility Technician II part-time = \$32,472 = \$97,416/year
- ~Supplies & contractual costs for 1.5 positions = \$15,400 in FY07; \$13,200/year FY08 and beyond

ENROLLMENT IN MEDICARE

Currently, enrollment in Medicare is optional for medical assistance applicants. Section 7, subsection (l) requires that a person who is eligible must first enroll in the Medicare program before they are eligible to receive benefits through Medicaid. Under this provision Division staff will have to spend more time with applicants to evaluate Medicare eligibility and monitor their continued enrollment in Medicare.

Total Annual Costs = \$73.7 thousand for an additional 1 position plus an extra \$2.2 thousand in FY07

Assumptions:

- ~On average, 1800 individuals per month appear eligible for, and not enrolled in Medicare
- ~Eligibility for Medicare will be assessed at initial application and during the 6-month eligibility review
- ~Eligibility staff will need an additional 60 minutes per month to evaluate an individual's eligibility for Medicare, and to require and monitor enrollment as a condition of eligibility for Medicaid
- ~1800 individuals per month x 60 mins/case = 1800 hours/12 months = 150 hours/month

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ANALYSIS CONTINUATION

- ~Average personnel costs for an Eligibility Tech II is \$64,944/year
- ~One-time cost for computers and software in FY2007 = \$2,200/position
- ~Annual costs for office space, phones & supplies = \$8,800/position
- ~1 Eligibility Technician II full time = \$64,944/year
- ~Supplies & contractual costs for 1 position = \$15,400 in FY07; \$13,200/year FY08 and beyond

Other Assumptions:

- ~The bill takes effect July 1, 2006; however, implementation would be delayed until the 4th Quarter while waiting for approval of a Medicaid State Plan Amendment. For this reason, FY07 is 25% of a full year.
- ~The federal matching rate is 50%.
- ~The other sections of this bill will not substantially increase the workload and do not need a fiscal note in this component.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 3
 Bill Version: CSHB 426(HES)
 (H) Publish Date: 4/12/06
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: RELATING TO MEDICAL ASSISTANCE
ELIGIBILITY AND COVERAGE FOR PERSONS RDU Senior and Disabilities Svcs
UNDER 21
 Component: Senior/Disabilities Medicaid Svc

Sponsor: COGHILL

Requester: HOUSE (FIN) Component No. 2662

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	(83.1)	(415.0)	(500.0)	(500.0)	(500.0)	(500.0)
Miscellaneous						
TOTAL OPERATING	(83.1)	(415.0)	(500.0)	(500.0)	(500.0)	(500.0)
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	(47.8)	(220.9)	(252.2)	(250.0)	(250.0)	(250.0)
1003 GF Match	(35.3)	(194.1)	(247.8)	(250.0)	(250.0)	(250.0)
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	(83.1)	(415.0)	(500.0)	(500.0)	(500.0)	(500.0)

Estimate of any current year (FY2006) cost: _____
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill contains provisions that bring Alaska Statute into line with the deficit Reduction Act of 2005 including many mandatory rule changes related to determining financial eligibility for long-term-care related Medicaid.

Sec. 6 makes it more difficult to use an annuity to shelter assets when trying to qualify for Medicaid.

Sec. 7, subsection (m) allows the State to impose stricter penalties for transferring assets at below-market value.

Sec. 7, subsection (n) allows that a home valued over \$500,000 can be a resource in determining eligibility. Sec. 8 clarifies when a person on a home and community based waiver may be terminated from the waiver.

These provisions will reduce Medicaid costs by reducing the number of persons eligible for Medicaid, most of whom are eligible for the Older Alaskans waiver program.

Prepared by: Rod Moline, Director Phone: 465-3819
 Division: Senior and Disabilities Services Date/Time: 04/12/2006
 Approved by: Karleen Jackson, Commissioner Date: 04/12/2006
 Agency: Department of Health and Social Services

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

MEDICAID-QUALIFYING ANNUITIES

Currently, various kinds of trusts and annuities can be used to shelter assets when trying to qualify for Medicaid. The federal law cited in the bill places more restrictions on annuities used for Medicaid purposes than exist now. Section 6 limits the annuities that do not affect eligibility to only those that meet the requirements of the federal law. This bill also gives the State the right to recover the balance of an annuity should a recipient die before the annuity has fully paid out.

Annual savings: \$0. This provision will not have a fiscal impact as it is not included in the budget now.

TRANSFER OF ASSETS AT BELOW-MARKET VALUE

Generally speaking, if a person applying for or receiving Medicaid benefits has transferred an asset at below-market value, that person may be subject to a period of ineligibility. Currently, the State can impose a penalty period beginning with the date of transfer. Section 7, subsection (m) allows the penalty period to begin with the date of application for Medicaid. This will eliminate almost all instances when an individual escapes serving a penalty period because the penalty period has already run its course before the Medicaid application is submitted. This would mostly affect applicant's seeking long-term care coverage including long-term care services under the Older Alaskans waiver program.

Annual savings to Medicaid = \$250.0 thousand

Assumptions:

- The number of applicants penalized in past 6 months = 6, which is 12 annually
- Average number of months penalized = 5
- Estimated total number of months eligibility is delayed annually due to penalties = 60
- Applicants would have been eligible for the OA waiver program
- Average annual cost per OA waiver recipient = \$50,000, which is \$4,167 per month
- The savings will ramp up over a 3-year period

HOMES AS A RESOURCE

Normally, a person's home is an exempt resource for Medicaid eligibility purposes. Section 7, subsection (n) puts a limit on the value of a home that would still qualify for this exemption. In effect, an individual will be ineligible for Medicaid if their home has an equity value for more than \$500,000, unless they sell it, borrowed against it, or take out a reverse mortgage to reduce the equity below \$500,000. This would mostly affect applicants seeking long-term care coverage including long-term care services under the OA Waiver program.

Annual savings to Medicaid = \$250.0 thousand

Assumptions:

- Currently number of long-term care recipients known to have a home valued over \$500,000 = 0
- Don't have any data on number of applicants with homes valued over \$500,000
- Estimated number of applicants per year with homes valued over \$500,000 who would now be ineligible = 5
- Applicants would have been eligible for the OA waiver program
- Average annual cost per OA waiver recipient = \$50,000

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ANALYSIS CONTINUATION

**TERMINATING WAIVER
SERVICES**

This section is in response to a class action lawsuit filed against the Division regarding how individuals from the Older Alaskans and Adults with Physical Disabilities waivers are assessed and terminated from the program. Prior to the litigation the Division only assessed individuals based on the current circumstances and level of client function. Section 8 says that a person who is eligible for a home and community based waiver may be terminated from the waiver only if the recipient scores below the eligibility standard on the assessment and an independent qualified health care professional certifies that the recipient's condition has materially improved from the previous assessment.

Annual savings: \$0. This provision will not have a fiscal impact as it is not included in the budget now. It will be a cost avoidance.

Other Assumptions:

~The bill takes effect July 1, 2006; however, implementation would be delayed until the 4th Quarter while waiting for approval of a Medicaid State Plan Amendment. For this reason, FY2007 is 25% of a full year.

~The federal matching rate is the estimated SFY quarterly average FMAP for the applicable year: FY07=57.58%, FY08=53.22%, FY09=50.44%; FY10 to FY12=50.00%.

~The other sections of this bill do not need a fiscal note in this component.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 4
 Bill Version: CSHB 426(HES)
 (H) Publish Date: 4/12/06
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title RELATING TO MEDICAL ASSISTANCE
ELIGIBILITY AND COVERAGE FOR PERSONS RDU Health Care Services
UNDER 21

Sponsor COGHILL Component Medicaid Services

Requester HOUSE (FIN) Component No. 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	(2,734.9)	(10,884.6)	(10,884.6)	(10,884.6)	(10,884.6)	(10,884.6)
Miscellaneous						
TOTAL OPERATING	(2,734.9)	(10,884.6)	(10,884.6)	(10,884.6)	(10,884.6)	(10,884.6)

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	(1,574.8)	(5,792.8)	(5,490.2)	(5,442.3)	(5,442.3)	(5,442.3)
1003 GF Match	(1,160.1)	(5,091.8)	(5,394.4)	(5,442.3)	(5,442.3)	(5,442.3)
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	(2,734.9)	(10,884.6)	(10,884.6)	(10,884.6)	(10,884.6)	(10,884.6)

Estimate of any current year (FY2006) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill contains provisions that would help to ensure repayment to the Medicaid program for cases involving Medicaid recipients receiving settlements or judgments from third party payers and would change medical assistance eligibility for minors and persons eligible for Medicare. These provisions will reduce Medicaid expenditures by increasing recoveries and reducing the number of persons eligible for Medicaid.

Sections 1-5 and 9-10 contain provisions that will result in more subrogation cases and increased recoveries for the Medicaid program.

Section 7, subsection (j-k) limits who may apply for medical assistance for a person under 18 years of age;

Section 7, subsection (l) requires that persons applying for medical assistance must enroll for Medicare if eligible.

Prepared by: Dwayne Peoples, Director Phone 465-5830
 Division: Health Care Services Date/Time 04/12/2006
 Approved by: Karleen Jackson, Commissioner Date 04/12/2006
 Agency: Department of Health and Social Services

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

SUBROGATION AND RECOVERIES

Sections 1-5 and 9-10 of this bill requires insurers to coordinate benefits with other insurers (including Medicaid); clarifies that the department may take the role of the recipient when the department has paid medical claims on behalf of the recipient and the recipient may be in a position to recover funds that are partially attributable to the injury and medical care received; clarifies that the Department may take the place of the recipient and pursue recovery if the recipient chooses not to pursue a liable 3rd party; and requires that the state be notified of cases and settlements from third party payers. Section 5 provides the state the ability to attach Permanent Fund dividends of recipients in cases where the state is not notified of a Medicaid recipient's recovery and has no other recourse to recover amounts paid. Currently the Department is authorized to garnish a recipient's PFD to recover General Relief, Adult Public Assistance, food stamps and Alaska Temporary Assistance Program overpayments, but not Medicaid. The department needs the same authority to recoup overpayments from Medicaid recipients who have received Medicaid coverage but shouldn't have, including those who choose to receive continued Medicaid benefits pending a fair hearing, but who ultimately lose the fair hearing. One of the most efficient and least intrusive recovery methods has been to garnish the recipient's PFD.

Annual savings to Medicaid: \$1,010.2

Assumptions:

- Additional staff resources from Department of Law applied to subrogation cases
- Annual subrogation recoveries of \$1M are doubled
- Increased amount of subrogation recoveries = \$1,000,0
- Number of cases with a successful garnishment of PFD annually = 12
- Average amount collected by garnishing PFD = \$850
- Annual amount collected by garnishing PFD = \$10.2

MINORS APPLYING FOR MEDICAID

Currently, any adult may apply on behalf of a minor and minors may apply for themselves. Section 7, subsections (j) and (k) provide that only an adult who has a legal or vested interest may apply for Medicaid on behalf of a child under age 18. The department must make reasonable efforts to contact the parent or legal guardian before granting a waiver of consent. If a waiver of consent is granted, the department must document the reason for the waiver in the child's medical assistance record. Under this provision, some applicants will not be eligible because either the adult refuses to enroll the minor or the additional income makes the minor ineligible.

Annual savings to Medicaid: \$334.4

Assumptions:

- Number of minor children who apply themselves for Medicaid each year = 3800
- 1% would be ineligible because the parent/guardian refuses to enroll = 38 minors
- 1% would be ineligible because the parent/guardian's income exceeds the income limits = 38 minors
- Average annual cost per minor = \$4,400

STATE OF ALASKA
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ANALYSIS CONTINUATION

ENROLLMENT IN MEDICARE

Currently, enrollment in Medicare is optional for medical assistance applicants. Section 7, subsection (1) requires that a person who is eligible must first enroll in the Medicare program before they are eligible to receive benefits through Medicaid. In June, 2005, the Centers for Medicare and Medicaid Services (CMS) informally revised its policy and now allows states to require Medicare enrollment as a condition of eligibility for those who qualify for it. Most, but not all, seniors have enrolled in Medicare and adding this requirement would help the department maximize the 100% federal dollars available from Medicare for all Medicare eligible recipients. Medicare Part A would pay for some of the most expensive individual cases, including those with end-stage renal disease. Medicaid would continue to pay the premiums and co-payments for the lowest income Medicare recipients.

Annual savings to Medicaid: \$9,540.0

Assumptions:

- On average, 1800 individuals per year appear eligible for, and not enrolled in Medicare
- Total Average annual Medicaid benefits costs avoided per Medicare enrollee = \$6,500.00
- Annual amount of Medicaid benefit costs saved by requiring Medicare enrollment = \$11,700.0
($\$6,500 \times 1,800$)
- Savings are offset somewhat by the additional cost of premiums for Medicare recipients
- Weighted average monthly premium amount for Medicare = \$100 or \$1,200.00 p/year
- Increased annual costs for premium buy-in of persons required to enroll in Medicare = \$2,160.0
($\$1,200.00 \times 1800$)

Other Assumptions:

-The bill takes effect July 1, 2006; however, implementation would be delayed until the 4th Quarter while waiting for approval of a Medicaid State Plan Amendment. For this reason FY2007 is 25% of a full year's costs.

-The federal matching rate is the estimated SFY quarterly average FMAP for the applicable year: FY07 = 57.58%, FY08 = 53.22%, FY09 = 50.44%; FY10 to FY12 = 50.00%.

-The other sections of this bill do not need a fiscal note in this component.

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ANALYSIS CONTINUATION

SUBROGATION AND RECOVERIES

Sections 1-5 and 9-10 of this bill requires insurers to coordinate benefits with other insurers (including Medicaid); clarifies that the department may take the role of the recipient when the department has paid medical claims on behalf of the recipient and the recipient may be in a position to recover funds that are partially attributable to the injury and medical care received; clarifies that the Department may take the place of the recipient and pursue recovery if the recipient chooses not to pursue a liable 3rd party ; requires that the state be notified of cases and settlements from third party payers; and provides the state the ability to attach Permanent Fund dividends of recipients in cases where the state is not notified of a Medicaid recipient's recovery and has no other recourse to recover amounts paid.

These provisions will increase the caseload for Department of Law employees working in the subrogation area. Health Care Services currently has an RSA with the Department of Law for subrogation work. Health Care Services would expand the RSA by \$190.3 for additional Department of Law staff of 1 FTE attorney and 1 FTE law office assistant. With the additional staff, the Department of Law estimates subrogation recoveries could easily double.

Assumptions:

~Subrogation caseload doubles from \$1M per year to \$2M

~The bill takes effect July 1, 2006. The Department of Law intends to staff the new positions in July.

~The federal matching rate is 50%.

~The other sections of this bill will not substantially increase the workload and do not need a fiscal note in this component.

ALASKA STATE HOUSE OF REPRESENTATIVES



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Session

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Room 204

REPRESENTATIVE JOHN COGHILL

HB 426 Medical Assistance Eligibility

Sectional for Version I

Section 1: This section requires insurers to coordinate benefits, provide information on their covered population, and provide for a three-year timely filing limit for the Medicaid program.

Medicaid often bills other insurance for claims paid by the program when other insurance is found to exist for the recipient. A common problem has been short timely filing requirements by other insurance, which has resulted in a failure to recover the claim.

Section 2: This section clarifies that if the department has paid medical claims on behalf of the recipient and the recipient may be in position to recover funds which are partially attributable to the injury and medical care received, the Department can act on behalf of the recipient to recover funds even when the recipients does not pursue a liable third-party.

Section 3: A common problem has been that settlements will occur without the department's knowledge and recovery against recipients or their attorney after the fact is near impossible. This section requires not only the recipient, but also the recipient's attorney, to notify the department of any case or action, which may involve the recovery of payments made, by the department on behalf of the recipient.

It also provides for remedies when the law is not followed. A lawyer will be held civilly liable for not notifying the department of recovery actions.

Another provision of this section requires the Attorney General to sign off on any settlement that involves a recipient of medical assistance requiring past medical expenses paid by the department in a case that results in a settlement to be reimbursed.

Finally, AS 47.05.07 is a provision, which disqualifies any new provision of the law related to subrogation, assignment, or lien conflicts, that is contrary to federal law.

Section 4. This section creates a priority for liens that places the State's claims from Medicaid reimbursements over all other liens except tax liens and attorneys fees and costs. This gives a preference to the Medicaid claims over health care providers who would otherwise collect from Medicaid and leave it to the State to get reimbursement.

Section 5. Benefit overpayments occur under several circumstances. One situation would be someone is found guilty of program abuse or fraud. The department would seek repayment. Another would be a person's coverage is discontinued and that person requests a fair hearing. Benefits continue until the fair hearing occurs. If the fair hearing finds in favor of the State, the department can seek repayment of those benefits provided during the period of time between notice of discontinuance and the fair hearing.

This section adds medical assistance to the list of programs for which the department may garnish a recipient's PFD in order to secure reimbursement for an overpayment. The state paid portion of the overpayment goes to the Dept. of Revenue, the federal portion to the federal government.

Section 6. The section brings Alaska Statute in line with the Deficit Reduction Act of 2005 in regards to transfer of assets and annuities. It allows person to transfer assets into a Miller Trust and treats annuities like a Miller Trust. This allows them to qualify for medical assistance without having to sell resources or gives them the option of selling large resources and invest the proceeds in an annuity. The income from the annuity is counted as income in determining eligibility, but the annuity is not counted as a resource. When assets are transferred or an annuity is established, the applicant agrees to grant the State a claim to the assets remaining at the death of the individual to reimburse the total medical assistance paid on behalf of the individual.

Section 7. Subsection (j) limits who may apply for Medicaid coverage for a person under 18 years of age. Only a parent or legal guardian, an adult caretaker relative who lives with the child, or an employee of the department who is applying for a child in state custody can apply for Medicaid coverage for the child.

(k) Provides that an unemancipated child may apply for Medicaid on the child's own behalf if the parent or legal guardian consents. The department may waive consent if the child expresses reasonable fear of the parent or guardian or if reasonable effort has been made to locate a parent or legal guardian but is unsuccessful in locating the parent or legal guardian.

(l) Requires Medicare enrollment for senior citizens and certain individuals with disabilities before they can qualify for benefits and services under the Medicaid program. The department believes this change will maximize the 100% federal dollars available from Medicare.

(m) When a person transfers an asset for less than fair market value, the State can impose a penalty period beginning only with the date of the less than fair market value transfer. This provision will allow the penalty period to start with the date of application for Medicaid.

(n) This covers another provision of the Deficit Reduction Act of 2005. Generally, a home is an exempt resource. The provision puts a limit on the value of a home that would still qualify for this exemption of \$500,000.

Section 8. This addresses a lawsuit filed against the state, which would require the State to determine the medical condition of a client on a Medicaid Waiver had "materially improved" before removing the client from the waiver. This section inserts the "materially improved" language into Alaska Statute.

Section 9. Repeals a subsection of AS 47.05.070 that allows the department to waive subrogation rights to all or part of the amount of medical assistance paid on behalf of a recipient of medical assistance in cases of undue hardship. The State would be mandated to pursue third party reimbursement.

Section 10. Sections 2 – 4 of HB 426 would apply to a cause of action related to subrogation, assignment, or lien by DHSS on or after the effective date.

Section 11. This section addresses concerns Representative Coghill has about the State paying for residential psychiatric treatment and substance abuse treatment for minors whose parents have medical insurance coverage. In discussing the issue with the department it became apparent the problem is not easily solved.

This section directs the department to review the authorization process with private insurance carriers and how they differ from the assessment process of the department. They are instructed to report back to the legislature no later than the first day of the next regular legislative session on how to maximize third-party coverage, enhance and clarify parental financial responsibility, and reduce medical assistance expenditures for residential psychiatric treatment and substance abuse treatment.

Section 12. Directs the department to, on enactment of HB 426, to apply for federal approval of a revised state plan reflecting the changes made in the bill.

Section 13. The bill would have the effective date of July 1, 2006 or the date of federal approval of revised plan, which is later.

adopted 4/18

24G-2
4/14/06
(1:57 PM)

A M E N D M E N T

OFFERED IN THE HOUSE FINANCE
COMMITTEE
TO: CSHB 426(HES)

BY Meyer by
Request

1 Page 7, line 26, through Page 8, line 30:

2 Delete all material and insert:

3 "Sec. 47.07.045. Home and community-based services. (a) The department
4 may provide home and community-based services under waivers in accordance with 42
5 U.S.C. 1396 - 1396p (Title XIX, Social Security Act), this chapter, and regulations
6 adopted under this chapter, if the department has received approval from the federal
7 government and the department has appropriations allocated for the purpose. To
8 supplement the standards in (b) of this section, the department shall establish in
9 regulation additional standards for eligibility and payment for the services.

10 (b) Before the department may terminate payment for services provided under (a)
11 of this section,

12 (1) the recipient must have had an annual assessment to determine
13 whether the recipient continues to meet the standards set in or under (a) of this section;

14 (2) the annual assessment must have been reviewed by an independent
15 qualified health care professional under contract with the department; for purposes of this
16 paragraph, "independent qualified health care professional" means

17 (A) for a waiver based on mental retardation or developmental
18 disability, a person who is qualified under 42 C.F.R. 483.430 as a mental
19 retardation professional;

20 (B) for other allowable waivers, a registered nurse licensed under
21 AS 08.68 who is qualified to assess children with complex medical conditions.

1 older Alaskans, or adults with physical disabilities, as applicable; and

2 (3) the annual assessment must find that the recipient's condition has
3 materially improved since the previous annual assessment; for purposes of this paragraph,
4 "materially improved" means that a recipient who previously qualified for a waiver for

5 (A) a child with complex medical conditions no longer requires
6 technology dependence or sustains life-threatening conditions, and is expected to
7 be treated in a skilled nursing facility for less than 30 days each year;

8 (B) mental retardation or developmental disability no longer needs
9 the level of care provided by an intermediate care facility for the mentally
10 retarded either because the qualifying diagnosis has changed or the recipient is
11 able to demonstrate the ability to function in a home setting without the need for
12 waiver services;

13 (C) an older Alaskan or adult with physical disabilities no longer
14 has a functional limitation or cognitive impairment that would result in the need
15 for nursing home placement, and the recipient is able to demonstrate the ability to
16 function in a home setting without the need for waiver services."
17

18 Page 9, following line 19:

19 Insert a new bill section to read:

20 **** Sec. 12.** The uncodified law of the State of Alaska is amended by adding a new section to
21 read:

22 **TRANSITION FOR SEC. 8 OF THIS ACT: REGULATIONS FOR HOME AND**
23 **COMMUNITY-BASED SERVICES.** To the extent that regulations on home and community-
24 based services that are in effect on the effective date of sec. 8 of this Act are not inconsistent
25 with the language and purposes of sec. 8 of this Act, those regulations remain in effect as valid
26 regulations implementing sec. 8 of this Act."
27

28 Renumber the following bill sections accordingly.
29

30 Page 9, line 24, following "under":

31 Insert "secs. 1 - 7 and 9 of"

1 Page 9, following line 26:

2 Insert a new bill section to read:

3 **** Sec. 14.** Sections 8 and 12 of this Act take effect immediately under AS 01.10.070(c)."

4

5 Renumber the remaining bill section accordingly.

6

7 Page 9, line 27:

8 Delete "This"

9 Insert "Except as provided in sec. 14 of this Act, this"

10

11 Delete "sec. 12"

12 Insert "sec. 13"

13

14 Page 9, line 29, following "by":

15 Insert "secs. 1 - 7 and 9 of"



Representative John Coghill
State Capitol, Room 204
Juneau, AK 99801-1182

HB 426 Medical Assistance Eligibility
Sponsor Statement

In times when federal dollars are diminishing, the legislature will have to review policies for providing for the public health. To better provide medical assistance to the truly needy, some eligibility requirements need to be changed.

As the department has put it, we are trying to address the "low hanging apples" that drain millions of dollars a year from a program that is growing in astounding increments.

HB 426 puts best practices to use by increasing third-party reimbursement, reducing Medicaid abuse and fraud, setting home equity limits, and implementing new federal requirements on the State for asset transfers and treating annuities like a Miller's Trust.

This bill also requires a person applying for medical assistance for a minor to be that person's parent or legal guardian, unless the parent or legal guardian is a minor. If a child is in state custody, an employee of the department can apply for coverage. The HSS committee substitute provides a waiver for unemancipated children who express fear of a parent or guardian, or whose parent or legal guardian cannot be located after a reasonable effort to do so by the department.

Currently, the unmarried father's income and resources are not considered in determining the eligibility of a pregnant woman for Medicaid. While the new CS eliminates income guidelines for unmarried fathers, we are exploring other ways to make the unmarried father financially responsible for the medical costs of a child.

HB 426 legislation repeals a statute that allowed the department to waive subrogation rights to third party reimbursements in cases of undue hardship. The department will now be required to pursue all third party reimbursements.

Section 8 of the bill addresses a lawsuit filed against the state, which would require the State to determine the medical condition of a client on a Medicaid Waiver had "materially improved" before removing the client from the waiver. HB 426 adds that requirement to Alaska Statute.

Lastly, this bill directs the department to report back to the legislature no later than the first day of the Twenty-Fifth Legislature on ways to reduce medical assistance expenditures for services received in residential psychiatric treatment centers by enhancing parental financial responsibilities and maximizing third-party resources available. Under current law a child could be placed in residential treatment and qualify for medical assistance after being out of the family home for thirty days, even though one or both parents have medical insurance.

4-18-06
 attached

CS HB 426 Medical Assistance for Persons Under 21
 Fiscal Note Summary by Section

4/12/06 version "S"

		FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	Assumptions
<i>Dollars in thousands</i>	% Federal	57.58%	53.22%	50.44%	50.00%	50.00%	50.00%	Federal % is Title XIX SFY average FMAP.
Total All	Total	(\$2,575.9)	(\$10,924.9)	(\$11,009.9)	(\$11,009.9)	(\$11,009.9)	(\$11,009.9)	Effective date of bill is July 1, 2006. Savings begin FY07 Q4 waiting for new regulations and approved SPA, plus normal lag in billing delays except for Law RSA.
	Federal	(\$1,501.6)	(\$5,826.2)	(\$5,555.1)	(\$5,504.9)	(\$5,504.9)	(\$5,504.9)	
	GF Match	(\$1,074.2)	(\$5,098.7)	(\$5,454.8)	(\$5,505.0)	(\$5,505.0)	(\$5,505.0)	
Sections 1-4, 9-10.	Total	(\$59.7)	(\$809.7)	(\$809.7)	(\$809.7)	(\$809.7)	(\$809.7)	amt projected in 2005=\$2,00.0; 50% recoveries increase=\$1,000.0. HCS admin costs for Dept Law RSA=\$190.3 @ 50% FMAP.
Subrogation of medical assistance overpayments	Federal	(\$48.8)	(\$437.1)	(\$409.3)	(\$404.8)	(\$404.8)	(\$404.8)	
	GF Match	(\$10.9)	(\$372.7)	(\$400.5)	(\$404.9)	(\$404.9)	(\$404.9)	
Section 5.	Total	(\$2.6)	(\$10.2)	(\$10.2)	(\$10.2)	(\$10.2)	(\$10.2)	# cases garnish PFD=12; avg amt collected=\$850.
Garnish Permanent Fund Dividend	Federal	(\$1.5)	(\$5.4)	(\$5.1)	(\$5.1)	(\$5.1)	(\$5.1)	
	GF Match	(\$1.1)	(\$4.8)	(\$5.1)	(\$5.1)	(\$5.1)	(\$5.1)	
Section 6.	Total	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	cost avoidance: not budgeted so no fiscal impact
Medicaid-qualifying annuities and transfer of assets	Federal	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	
	GF Match	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	
Section 7, subsection (j-k).	Total	(\$52.5)	(\$223.7)	(\$223.7)	(\$223.7)	(\$223.7)	(\$223.7)	# self-enrolled < age 19=3800; 1% ineligible w/ parent's income=38; 1% parents refuse=38; avg annual cost per enrollee=\$4,400; DPA admin 1.5 FTE = \$110.6 @ 50% FMAP.
Parent or legal guardian must submit the application for a person under age 18	Federal	(\$32.6)	(\$122.7)	(\$113.4)	(\$111.9)	(\$111.9)	(\$111.9)	
	GF Match	(\$19.9)	(\$101.0)	(\$110.3)	(\$111.8)	(\$111.8)	(\$111.8)	
Section 7, subsection (l).	Total	(\$2,378.0)	(\$9,466.3)	(\$9,466.3)	(\$9,466.3)	(\$9,466.3)	(\$9,466.3)	est. 15.7% age 65+ eligible but not enrolled in Medicare=1800; avg annual cost avoided per enrollee=\$6,500; est wt avg mo premium for buy-in=\$100. DPA admin 1 FTE= \$73.7 @ 50% FMAP.
Must enroll in Medicare if eligible	Federal	(\$1,370.9)	(\$5,040.2)	(\$4,775.1)	(\$4,733.1)	(\$4,733.1)	(\$4,733.1)	
	GF Match	(\$1,007.1)	(\$4,426.1)	(\$4,691.2)	(\$4,733.2)	(\$4,733.2)	(\$4,733.2)	
Section 7, subsection (m).	Total	(\$20.6)	(\$165.0)	(\$250.0)	(\$250.0)	(\$250.0)	(\$250.0)	# penalties in past 6 mos=6; avg months penalized: 5; avg annual cost per OA waiver enrollee=\$50,000; ramp up savings over 3 years
Penalty period for transfer of assets at less than fair market value (DRA 2006)	Federal	(\$11.9)	(\$87.8)	(\$126.1)	(\$125.0)	(\$125.0)	(\$125.0)	
	GF Match	(\$8.7)	(\$77.2)	(\$123.9)	(\$125.0)	(\$125.0)	(\$125.0)	
Section 7, subsection (n).	Total	(\$62.5)	(\$250.0)	(\$250.0)	(\$250.0)	(\$250.0)	(\$250.0)	# LTC recipients with \$500K home=0; est # enrollees=5; avg annual cost per OA waiver enrollee=\$50,000
Homes exceeding \$500K are resource for Medicaid eligibility	Federal	(\$36.0)	(\$133.1)	(\$126.1)	(\$125.0)	(\$125.0)	(\$125.0)	
	GF Match	(\$26.5)	(\$117.0)	(\$123.9)	(\$125.0)	(\$125.0)	(\$125.0)	
Section 8	Total	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	cost avoidance: not budgeted so no fiscal impact
Terminating waiver services if "materially improved"	Federal	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	
	GF Match	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	
Section 11	Total	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	DBH admin costs for report=\$0 if BTKH Project Mgr is funded in SFY07 budget
Report on RPTC changes recommended by DHSS	Federal	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	
	GF Match	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	