

**HB**

**426**



# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB426CS(HES)-DHSS-DSDS-04-12-06  
 ( ) Publish Date: \_\_\_\_\_  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction): \_\_\_\_\_

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

RDU Senior and Disabilities Svcs

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						
<b>TOTAL OPERATING</b>	<b>( 83.1)</b>	<b>( 415.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>
<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**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)						
<b>TOTAL</b>	<b>( 83.1)</b>	<b>( 415.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>

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  
 Division: Senior and Disabilities Services  
 Approved by: Karleen Jackson, Commissioner  
 Agency: Department of Health and Social Services

Phone 465-3819  
 Date/Time 04/12/2006  
 Date 04/12/2006

**FISCAL NOTE**

**FN #**

**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

**FISCAL NOTE  
FN #**

**STATE OF ALASKA  
2006 LEGISLATIVE SESSION**

**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: \_\_\_\_\_  
 Bill Version: HB426CS(HES)-DHSS-DPA-04-12-06  
 ( ) Publish Date: \_\_\_\_\_  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction): \_\_\_\_\_

Title RELATING TO MEDICAL ASSISTANCE  
ELIGIBILITY AND COVERAGE FOR PERSONS RDU Public Assistance  
UNDER 21

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						
<b>TOTAL OPERATING</b>	<b>51.7</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES (0)</b>						
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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)						
<b>TOTAL</b>	<b>51.7</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>

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

FISCAL NOTE  
FN #

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

**FISCAL NOTE  
FN #**

**STATE OF ALASKA  
2006 LEGISLATIVE SESSION**

**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: \_\_\_\_\_  
 Bill Version: \_\_\_\_\_  
 ( ) Publish Date: HB426CS(HES)-DHSS-DBH-04-12-06  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction): \_\_\_\_\_

Title RELATING TO MEDICAL ASSISTANCE  
ELIGIBILITY AND COVERAGE FOR PERSONS RDU Behavioral Health  
UNDER 21  
 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						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**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)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

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 Wilier, 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: \_\_\_\_\_  
 Bill Version: HB426CS(HES)-DHSS-DHCS#1-04-12-06  
 ( ) Publish Date: \_\_\_\_\_  
 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  
 Component Medicaid Services

Sponsor COGHILL

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						
<b>TOTAL OPERATING</b>	<b>( 2,734.9)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>
<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**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)						
<b>TOTAL</b>	<b>( 2,734.9)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>

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 Peeples, Director  
 Division: Health Care Services  
 Approved by: Karleen Jackson, Commissioner  
 Agency: Department of Health and Social Services

Phone 465-5830  
 Date/Time 04/12/2006  
 Date 04/12/2006

FISCAL NOTE  
FN #

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 ' half 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

FISCAL NOTE  
FN #

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

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 x 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 x 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.

# FISCAL NOTE

**STATE OF ALASKA**  
**2006 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
Bill Version: HB426CS(HES)=DHSS-DHCS#2-04-12-06

( ) Publish Date: \_\_\_\_\_  
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction): \_\_\_\_\_  
Title: RELATING TO MEDICAL ASSISTANCE  
ELIGIBILITY AND COVERAGE FOR PERSONS  
UNDER 21

RDU: Health Care Services  
Component: Medical Assistance Admin.

Sponsor: COGHILL  
Requester: HOUSE (FIN)

Component No.: 242

**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	190.3	190.3	190.3	190.3	190.3	190.3
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES (0)</b>						
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts	95.2	95.2	95.2	95.2	95.2	95.2
1003 GF Match	95.1	95.1	95.1	95.1	95.1	95.1
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>

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.

The requirements contained in this bill will result in more subrogation cases and increased recoveries for the Medicaid program. This bill will increase the caseload for Department of Law employees working in the subrogation area.

Prepared by: Dwayne Peebles, Director  
Division: Health Care Services  
Approved by: Karleen Jackson, Commissioner  
Agency: Department of Health and Social Services

Phone 465-5830  
Date/Time 04/12/2006  
Date 04/12/2006

**FISCAL NOTE  
FN #**

**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 ; 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.

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE CISSNA

TO: CSHB 426( ), Draft Version "L"

1 Page 1, line 4, following "eligibility";

2 Insert "relating to home and community-based services;"

3

4 Page 7, following line 24:

5 Insert a new bill section to read:

6 "\* Sec. 8. AS 47.07 is amended by adding a new section to read:

7 **Sec. 47.07.045. Home and community-based services.** (a) A person who is  
8 eligible for medical assistance coverage may be paid for home and community-based  
9 services under a waiver approved by the federal government if the person is approved  
10 initially and at least once a year thereafter for the services by the department based on  
11 an assessment described in regulation that finds that the person meets a level of care  
12 necessary for admission to an intermediate care facility for the mentally retarded or to  
13 a nursing facility.

14 (b) The department may not terminate payment for approved home and  
15 community-based services unless, at any time,

16 (1) the recipient of the services scores below the eligibility standard on  
17 the assessment employed under (a) of this section; and

18 (2) the score is reviewed by an independent qualified health care  
19 professional who certifies that the recipient's condition has materially improved from  
20 the previous assessment.

21 (c) In this section,

22 (1) "independent qualified health care professional" means a

23 (A) registered nurse licensed under AS 08.68 who is qualified  
24 to assess children with complex medical conditions, older Alaskans, and adults

1 with physical disabilities for medical assistance waivers; and

2 (B) a person who is qualified under 42 CFR 483.430 as a  
3 mental retardation professional for the mental retardation and developmental  
4 disability waiver;

5 (2) "materially improved" means that the recipient has previously  
6 qualified for a waiver for

7 (A) children with complex medical conditions, no longer needs  
8 technical assistance for a life-threatening condition, and is expected to be  
9 placed in a skilled nursing facility for less than 30 days each year;

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

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

19

20 Renumber the following bill sections accordingly.

21

22 Page 8, line 21:

23 Delete "sec. 11"

24 Insert "sec. 12"



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.

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.

# ALASKA STATE HOUSE OF REPRESENTATIVES



**Contact:**

Interim Address:  
3340 Badger Road  
North Pole, AK 99705  
(907)-488-5725  
Fax# (907)-488-4271

**Session**

(907)-465-3719  
FAX# (907)-465-3258  
State Capitol  
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.** 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 9.** 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 10.** 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 11.** 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 12.** The bill would have the effective date of July 1, 2006 or the date of federal approval of revised plan, which is later.

24-LS1602L  
Mischel  
3/24/06

**CS FOR HOUSE BILL NO. 426( )**

**IN THE LEGISLATURE OF THE STATE OF ALASKA**

**TWENTY-FOURTH LEGISLATURE - SECOND SESSION**

**BY**

**Offered:  
Referred:**

**Sponsor(s): REPRESENTATIVE COGHILL**

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act relating to cooperation of insurers with the Department of Health and Social**  
2 **Services; relating to subrogation, assignment, and lien rights and notices for medical**  
3 **assistance claims; relating to recovery of medical assistance overpayments; relating to**  
4 **asset transfers by medical assistance applicants; relating to medical assistance eligibility;**  
5 **relating to medical assistance coverage for persons under 21 years of age; requiring a**  
6 **report by the Department of Health and Social Services; and providing for an effective**  
7 **date."**

8 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

9 **\* Section 1. AS 21.09 is amended by adding a new section to read:**

10 **Sec. 21.09.240. Cooperation with the Department of Health and Social**  
11 **Services. An insurer, including a pharmacy benefits manager, shall coordinate benefits**  
12 **with medical assistance programs under AS 47.07, and shall cooperate with the**  
13 **Department of Health and Social Services by providing**

1 (1) requested information on an insured who is receiving public  
2 assistance and on claims made by the department as long as the department agrees to  
3 keep the information confidential;

4 (2) prompt verification of an assignment to and right of recovery for  
5 the department; and

6 (3) a claim period of at least 36 months from the date of service for  
7 eligible claims made by the department.

8 \* **Sec. 2.** AS 47.05.070(b) is amended to read:

9 (b) If the department provides or pays for medical assistance for injury or  
10 illness under this title, the department is subrogated to the rights of the recipient of that  
11 medical assistance for any claim arising from the injury or illness and to the proceeds  
12 of an insurance policy covering the injury or illness to the extent of the value of the  
13 medical assistance provided. [A RECIPIENT OF MEDICAL ASSISTANCE OR THE  
14 RECIPIENT'S ATTORNEY MUST NOTIFY THE DEPARTMENT IN WRITING  
15 OF ANY ACTION OR CLAIM AGAINST A THIRD-PARTY PAYOR IF  
16 MEDICAL ASSISTANCE WAS PROVIDED BY THE DEPARTMENT TO TREAT  
17 AN INJURY OR ILLNESS FOR WHICH THE THIRD PARTY MAY BE LIABLE.]  
18 Notwithstanding the assertion of any action or claim by the recipient of medical  
19 assistance, the department may bring an action in the superior court against an alleged  
20 third-party payor to recover an amount subrogated to the department for medical  
21 assistance provided on behalf of a recipient.

22 \* **Sec. 3.** AS 47.05 is amended by adding new sections to read:

23 **Sec. 47.05.071. Duty of a medical assistance recipient.** (a) A medical  
24 assistance recipient shall cooperate with and assist the department in identifying and  
25 providing information concerning third parties who may be liable to pay for care and  
26 services received by the recipient under the medical assistance program.

27 (b) A medical assistance recipient may not compromise or resolve an action or  
28 claim seeking payment for or related to an injury or illness for which care or services  
29 were provided or received under the medical assistance program against an insurer,  
30 entity, or other person without first providing notice to the attorney general's office of  
31 the facts and circumstances giving rise to the action or claim and the asserted basis for

1 supporting the action or claim.

2 (c) A medical assistance recipient may not receive payment from any source  
3 on account of or related to care or services for which medical assistance was received  
4 unless the recipient has received written consent of the attorney general's office and  
5 has paid the department reimbursement of the amount of medical assistance provided  
6 or paid.

7 (d) As a condition of medical assistance eligibility, a person who applies for  
8 medical assistance shall, at the time of application,

9 (1) assign to the department the applicant's rights of payment for care  
10 and services from any third party;

11 (2) cooperate with and assist the department in identifying and  
12 providing information concerning third parties who may be liable to pay for care and  
13 services received by the recipient under the medical assistance program;

14 (3) assign to the department the applicant's right to the applicant's  
15 permanent fund dividend and agree to sign a new assignment each year; the  
16 department shall use the assignment obtained under this paragraph to obtain  
17 reimbursement or enforce repayment when a recipient does not pay to the state  
18 reimbursement received from a third party for care or services provided or paid by the  
19 medical assistance program or fails to satisfy a lien perfected under AS 47.05.075; and

20 (4) agree to make application for all other available third-party  
21 resources that may be used to provide or pay for the cost of care or services received  
22 by the medical assistance recipient or that may be used to finance reimbursement to  
23 the state for the cost of care or services received by the medical assistance recipient.

24 **Sec. 47.05.072. Duty of attorney for medical assistance recipient.** (a) Before  
25 pursuing an action or claim on behalf of a medical assistance recipient for care or  
26 services for an injury or illness for which medical assistance was received, an attorney  
27 representing the medical assistance recipient shall notify the attorney general's office.

28 (b) The notice to the attorney general's office required under (a) of this section  
29 includes submission of the following:

30 (1) identification of the medical assistance recipient's name, last  
31 known address, and telephone number, and the date of the injury or illness giving rise

1 to the action or claim;

2 (2) copies of the pleadings and other papers related to the action or  
3 claim;

4 (3) the identification of each potentially liable third party, including  
5 that party's name, last known address, and telephone number;

6 (4) the identification of any insurance policy potentially responsive to  
7 the action or claim; and

8 (5) a description of the facts and circumstances supporting the action  
9 or claim.

10 (c) An attorney who represents a medical assistance recipient shall give the  
11 attorney general's office 30 days' notice before any judgment, award, or settlement  
12 may be satisfied in an action or claim by the medical assistance recipient to recover  
13 damages for an injury or illness that has resulted in the department's providing or  
14 paying for medical assistance.

15 (d) An attorney representing a medical assistance recipient who has received  
16 care or services for the injury or illness provided or paid for by the medical assistance  
17 program shall maintain all proceeds paid in connection with the action or claim in a  
18 trust account or deposit the proceeds into the registry of the court until any lien  
19 perfected by the department under AS 47.05.075 is satisfied or, if a lien has not been  
20 filed under AS 47.05.075, 60 days from the attorney's receipt of the proceeds.

21 (e) Notwithstanding AS 47.05.070(c), for pro rata reduction of the  
22 department's lien if an attorney fails to comply with this section.

23 (1) the department is entitled to and shall collect the full lien amount  
24 from the judgment, award, or settlement;

25 (2) if the attorney has already received payment for the attorney's  
26 services through the pro rata reduction as provided in AS 47.05.070(c), the attorney is  
27 civilly liable to the department for the amount of that payment.

28 (f) If a medical assistance recipient is handling the action or claim on a pro se  
29 basis, the provisions of this section apply as if the medical assistance recipient were an  
30 attorney representing the medical assistance recipient.

31 **Sec. 47.05.073. Judgment, award, or settlement of a medical assistance**

1           lien. (a) An action or claim brought by a medical assistance recipient or an attorney  
2           who represents the medical assistance recipient against a third party or insurer may not  
3           be compromised or discharged without the express written consent of the attorney  
4           general.

5           (b) A judgment, award, or settlement that requires or results in the  
6           compromise of a lien under AS 47.05.075 may not be entered into or granted by a  
7           court without the express written consent of the attorney general.

8           (c) A medical assistance recipient may not maintain any rights to payment as a  
9           result of a judgment, award, or settlement of an action or claim for which another  
10          person may be legally obligated to pay without first making full repayment to the  
11          department for costs of past medical assistance services provided to or paid for by the  
12          medical assistance recipient that relate to that action or claim.

13          (d) A medical assistance recipient may not place any payment as a result of a  
14          judgment, award, or settlement of an action or claim for which another person was  
15          legally obligated to pay because of injury or illness into any trust for the purpose of  
16          maintaining public assistance or medical assistance eligibility without first

17                  (1) making full repayment to the department for costs of past medical  
18          assistance services provided to the medical assistance recipient related to that action or  
19          claim; and

20                  (2) obtaining the express written consent of the attorney general.

21          (e) The department's recovery under a subrogation right, assignment, or  
22          enforcement of a lien shall be applied to the entire payment made in satisfaction of  
23          judgment, award, or settlement.

24          (f) The doctrine of equitable subrogation, the equitable made whole doctrine,  
25          or the common fund doctrine may not be applied to defeat, reduce, limit, or prorate  
26          any recovery by the department based upon its subrogation rights, assignment, or lien,  
27          or the medical assistance recipient's obligation of repayment.

28          (g) The attorney general may only discharge or give written consent related to  
29          a medical assistance lien under AS 47.05.075 if the discharge or consent complies  
30          with federal law.

31                  **Sec. 47.05.074. Conflict with federal requirements.** If any provision of this

1 chapter related to subrogation, assignment, or lien conflicts with federal law  
2 concerning the Medicaid program or receipt of federal money to finance the medical  
3 assistance program, the provision does not apply to the extent of the conflict.

4 \* Sec. 4. AS 47.05.075(d) is amended to read:

5 (d) A perfected lien under this section has priority over all other liens except  
6 tax liens and a lien perfected for attorney fees and costs [IMMEDIATELY AFTER  
7 A LIEN PERFECTED BY A HOSPITAL, NURSE, OR PHYSICIAN UNDER  
8 AS 34.35.450 - 34.35.480].

9 \* Sec. 5. AS 47.05.080(a) is amended to read:

10 (a) Benefit overpayments collected by the department in administering  
11 programs under AS 47.07 (medical assistance), AS 47.25.120 - 47.25.300 (general  
12 relief), AS 47.25.430 - 47.25.615 (adult public assistance), AS 47.25.975 - 47.25.990  
13 (food stamps), and 47.27 (Alaska temporary assistance program) shall be remitted to  
14 the Department of Revenue under AS 37.10.050(a), except for overpayments  
15 recovered under AS 47.07 that cover the value of services paid from federal  
16 sources.

17 \* Sec. 6. AS 47.07.020(f) is amended to read:

18 (f) A person may not be denied eligibility for medical assistance under this  
19 chapter on the basis of a diversion of income or transfer of assets, whether by  
20 assignment or after receipt of the income, into a Medicaid-qualifying trust or annuity  
21 that, according to a determination made by the department.

22 (1) has provisions that require that the state will receive all of the trust  
23 or annuity assets remaining at the death of the individual, subject to a maximum  
24 amount that equals the total medical assistance paid on behalf of the individual: and

25 (2) otherwise meets the requirements of 42 U.S.C. 1396p(d)(4) for a  
26 trust and 42 U.S.C. 1396p(c)(1)(F) and 42 U.S.C.1396p(e)(1) for an annuity.

27 \* Sec. 7. AS 47.07.020 is amended by adding new subsections to read:

28 (j) A person may not apply for medical assistance coverage on behalf of a  
29 child under 18 years of age who is not emancipated unless the person is the parent or  
30 legal guardian of the child or, if the parent or legal guardian can be contacted and  
31 consents to the application and the person is

1 (1) an adult caretaker relative who lives with the child and who is  
2 exercising care and control of the child; or

3 (2) an employee of the department who is applying on behalf of a child  
4 who is in the custody of the department.

5 (k) A child who is unemancipated may apply for medical assistance coverage  
6 on the child's own behalf if the parent or legal guardian of the child consents to the  
7 application. The department may waive consent under this section if the child  
8 expresses a reasonable fear of the child's parent or legal guardian or the department  
9 has been unable to contact the parent or legal guardian after the department has made  
10 reasonable efforts to do so. If a waiver of consent is granted, the department shall  
11 document the reason for the waiver in the child's medical assistance record.

12 (l) Notwithstanding the eligibility provisions under (a) and (b) of this section,  
13 a person may not receive medical assistance under this section unless the person first  
14 enrolls in the Medicare program under 42 U.S.C. 1395 to the extent that the person is  
15 eligible to receive benefits and services under the program.

16 (m) Except as provided in (g) of this section, the department shall impose a  
17 penalty period of ineligibility for the transfer of an asset for less than fair market value  
18 by an applicant or an applicant's spouse consistent with 42 U.S.C. 1396p(c)(1).

19 (n) Except as provided under 42 U.S.C. 1396p(f) and 42 U.S.C. 1396u-1, the  
20 department shall include as an asset for eligibility purposes the value of an applicant's  
21 home if the equity value in the home exceeds \$500,000 at the time the application is  
22 completed. Nothing in this subsection prohibits an applicant from reducing the equity  
23 value in the applicant's home by selling the home or by taking out a loan that affects  
24 the equity.

25 \* **Sec. 8.** AS 47.05.070(e) is repealed.

26 \* **Sec. 9.** The uncodified law of the State of Alaska is amended by adding a new section to  
27 read:

28 **APPLICABILITY.** Sections 2 - 4 of this Act apply to a cause of action related to a  
29 subrogation, assignment, or lien by the Department of Health and Social Services that accrues  
30 on or after the effective date of this Act.

31 \* **Sec. 10.** The uncodified law of the State of Alaska is amended by adding a new section to

1 read:

2 REPORT. The Department of Health and Social Services shall prepare a report and  
3 deliver the report to the legislature not later than the first day of the First Regular Session of  
4 the Twenty-Fifth Alaska State Legislature. The report must include recommendations for  
5 statutory, regulatory, and systematic changes that will

6 (1) assist the department in reducing medical assistance expenditures for  
7 services received in residential psychiatric treatment centers and substance abuse treatment  
8 facilities;

9 (2) enhance and clarify parental financial responsibility for children receiving  
10 residential psychiatric treatment center and substance abuse treatment facilities services; and

11 (3) maximize all third-party resources available to pay for the cost of  
12 residential psychiatric treatment center and substance abuse treatment facilities services  
13 before a provider seeks reimbursement under AS 47.07.

14 \* Sec. 11. The uncodified law of the State of Alaska is amended by adding a new section to  
15 read:

16 STATE PLAN. (a) The Department of Health and Social Services shall immediately  
17 apply for federal approval of a revised state plan to implement the changes to the medical  
18 assistance program made under this Act.

19 (b) The commissioner of health and social services shall notify the revisor of statutes  
20 of the date of the federal approval of the revised state plan submitted under (a) of this section.

21 \* Sec. 12. This Act takes effect July 1, 2006, or on the date of notification under sec. 11 of  
22 this Act of federal approval of a revised state plan for medical assistance coverage  
23 incorporating the changes made by this Act, whichever is later.

A M E N D M E N T

OFFERED IN THE HOUSE

BY REPRESENTATIVE COGHILL

TO: CSHB 426( ), Draft Version "I"

1 Page 1, line 4, following "eligibility";

2 Insert "relating to home and community-based services;"

3

4 Page 8, following line 12:

5 Insert a new bill section to read:

6 **"\* Sec. 9.** AS 47.07 is amended by adding a new section to read:

7 **Sec. 47.07.045. Home and community-based services.** (a) A person who is  
8 eligible for medical assistance coverage may be paid for home and community-based  
9 services under a waiver approved by the federal government if the person is approved  
10 initially and at least once a year thereafter for the services by the department based on  
11 an assessment described in regulation that finds that the person meets a level of care  
12 necessary for admission to an intermediate care facility for the mentally retarded or to  
13 a nursing facility.

14 (b) The department may not terminate payment for approved home and  
15 community-based services unless, at any time,

16 (1) the recipient of the services scores below the eligibility standard on  
17 the assessment employed under (a) of this section; and

18 (2) the score is reviewed by an independent qualified health care  
19 professional who certifies that the recipient's condition has materially improved from  
20 the previous assessment.

21 (c) In this section,

22 (1) "independent qualified health care professional" means a

23 (A) registered nurse licensed under AS 08.68 who is qualified

1 to assess children with complex medical conditions, older Alaskans, and adults  
2 with physical disabilities for medical assistance waivers; and

3 (B) a person who is qualified under 42 C.F.R. 483.430 as a  
4 mental retardation professional for the mental retardation and developmental  
5 disability waiver;

6 (2) "materially improved" means that the recipient has previously  
7 qualified for a waiver for

8 (A) children with complex medical conditions, no longer needs  
9 technical assistance for a life-threatening condition, and is expected to be  
10 placed in a skilled nursing facility for less than 30 days each year;

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

16 (C) older Alaskans or adults with physical disabilities, no  
17 longer has a functional limitation or cognitive impairment that would result in  
18 the need for nursing home placement."  
19

20 Renumber the following bill sections accordingly.

21

22 Page 9, line 9:

23 Delete "sec. 12"

24 Insert "sec. 13"

By Prof. [unclear]  
Hond [unclear]  
Hond

(2) "materially improved" means that the recipient has previously qualified for a waiver for

(A) children with complex medical conditions, no longer needs technical assistance for a life-threatening condition, and is expected to be placed in a skilled nursing facility for less than 30 days each year;

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

(C) older Alaskan or adults with physical disabilities, no longer has a functional limitation or cognitive impairment that would result in the need for nursing home placement, and the recipient [department?] is able to demonstrate that recipient has, without the need for waiver services,

- (i) the ability to independently function in a home setting for the next twelve month period;
- (ii) the ability to independently maintain the recipient's current level of functional and cognitive functioning for the next twelve month period; and
- (iii) the ability to independently maintain the recipient's current health status level for the next twelve month period;



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 decide policy for providing for the public health. To better provide medical assistance to the truly needy, some eligibility requirements need to be changed.

First, under existing law, a stepparent's income is not counted as household income if that income would disqualify a child for medical assistance. House Bill 426 would provide that medical assistance eligibility follow the same guidelines as other public assistance programs.

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.

At the request of the department we have drafted a CS to add provisions to comply with federal law when dealing with transfer of assets and home equity value for Medicaid qualifications.

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.

24-LS1602V  
Mischel  
3/14/06

**CS FOR HOUSE BILL NO. 426( )**

**IN THE LEGISLATURE OF THE STATE OF ALASKA**

**TWENTY-FOURTH LEGISLATURE - SECOND SESSION**

**BY**

**Offered:  
Referred:**

**Sponsor(s): REPRESENTATIVE COGILL**

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act relating to cooperation of insurers with the Department of Health and Social**  
2 **Services; relating to subrogation, assignment, and lien rights and notices for medical**  
3 **assistance claims; relating to recovery of medical assistance overpayments; relating to**  
4 **asset transfers by medical assistance applicants; relating to medical assistance eligibility;**  
5 **relating to medical assistance coverage for persons under 21 years of age; requiring a**  
6 **report by the Department of Health and Social Services; and providing for an effective**  
7 **date."**

8 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

9 **\* Section 1.** AS 21.09 is amended by adding a new section to read:

10 **Sec. 21.09.240. Cooperation with the Department of Health and Social**  
11 **Services.** An insurer, including a pharmacy benefits manager, shall coordinate benefits  
12 with medical assistance programs under AS 47.07, and shall cooperate with the  
13 Department of Health and Social Services by providing

1 (1) requested information on an insured who is receiving public  
2 assistance and on claims made by the department as long as the department agrees to  
3 keep the information confidential;

4 (2) prompt verification of an assignment to and right of recovery for  
5 the department; and

6 (3) a claim period of at least 36 months from the date of service for  
7 eligible claims made by the department.

8 \* **Sec. 2.** AS 47.05.070(b) is amended to read:

9 (b) If the department provides or pays for medical assistance for injury or  
10 illness under this title, the department is subrogated to the rights of the recipient of that  
11 medical assistance for any claim arising from the injury or illness and to the proceeds  
12 of an insurance policy covering the injury or illness to the extent of the value of the  
13 medical assistance provided. [A RECIPIENT OF MEDICAL ASSISTANCE OR THE  
14 RECIPIENT'S ATTORNEY MUST NOTIFY THE DEPARTMENT IN WRITING  
15 OF ANY ACTION OR CLAIM AGAINST A THIRD-PARTY PAYOR IF  
16 MEDICAL ASSISTANCE WAS PROVIDED BY THE DEPARTMENT TO TREAT  
17 AN INJURY OR ILLNESS FOR WHICH THE THIRD PARTY MAY BE LIABLE.]  
18 Notwithstanding the assertion of any action or claim by the recipient of medical  
19 assistance, the department may bring an action in the superior court against an alleged  
20 third-party payor to recover an amount subrogated to the department for medical  
21 assistance provided on behalf of a recipient.

22 \* **Sec. 3.** AS 47.05 is amended by adding new sections to read:

23 **Sec. 47.05.071. Duty of a medical assistance recipient.** (a) A medical  
24 assistance recipient shall cooperate with and assist the department in identifying and  
25 providing information concerning third parties who may be liable to pay for care and  
26 services received by the recipient under the medical assistance program.

27 (b) A medical assistance recipient may not compromise or resolve an action or  
28 claim seeking payment for or related to an injury or illness for which care or services  
29 were provided or received under the medical assistance program against an insurer,  
30 entity, or other person without first providing notice to the attorney general's office of  
31 the facts and circumstances giving rise to the action or claim and the asserted basis for

1 supporting the action or claim.

2 (c) A medical assistance recipient may not receive payment from any source  
3 on account of or related to care or services for which medical assistance was received  
4 unless the recipient has received written consent of the attorney general's office and  
5 has paid the department reimbursement of the amount of medical assistance provided  
6 or paid.

7 (d) As a condition of medical assistance eligibility, a person who applies for  
8 medical assistance shall, at the time of application,

9 (1) assign to the department the applicant's rights of payment for care  
10 and services from any third party;

11 (2) cooperate with and assist the department in identifying and  
12 providing information concerning third parties who may be liable to pay for care and  
13 services received by the recipient under the medical assistance program;

14 (3) assign to the department the applicant's right to the applicant's  
15 permanent fund dividend and agree to sign a new assignment each year; the  
16 department shall use the assignment obtained under this paragraph to obtain  
17 reimbursement or enforce repayment when a recipient does not pay to the state  
18 reimbursement received from a third party for care or services provided or paid by the  
19 medical assistance program or fails to satisfy a lien perfected under AS 47.05.075; and

20 (4) agree to make application for all other available third-party  
21 resources that may be used to provide or pay for the cost of care or services received  
22 by the medical assistance recipient or that may be used to finance reimbursement to  
23 the state for the cost of care or services received by the medical assistance recipient.

24 **Sec. 47.05.072. Duty of attorney for medical assistance recipient.** (a) Before  
25 pursuing an action or claim on behalf of a medical assistance recipient for care or  
26 services for an injury or illness for which medical assistance was received, an attorney  
27 representing the medical assistance recipient shall notify the attorney general's office.

28 (b) The notice to the attorney general's office required under (a) of this section  
29 includes submission of the following:

30 (1) identification of the medical assistance recipient's name, last  
31 known address, and telephone number, and the date of the injury or illness giving rise

1 to the action or claim;

2 (2) copies of the pleadings and other papers related to the action or  
3 claim;

4 (3) the identification of each potentially liable third party, including  
5 that party's name, last known address, and telephone number;

6 (4) the identification of any insurance policy potentially responsive to  
7 the action or claim; and

8 (5) a description of the facts and circumstances supporting the action  
9 or claim.

10 (c) An attorney who represents a medical assistance recipient shall give the  
11 attorney general's office 30 days' notice before any judgment, award, or settlement  
12 may be satisfied in an action or claim by the medical assistance recipient to recover  
13 damages for an injury or illness that has resulted in the department's providing or  
14 paying for medical assistance.

15 (d) An attorney representing a medical assistance recipient who has received  
16 care or services for the injury or illness provided or paid for by the medical assistance  
17 program shall maintain all proceeds paid in connection with the action or claim in a  
18 trust account or deposit the proceeds into the registry of the court until any lien  
19 perfected by the department under AS 47.05.075 is satisfied or, if a lien has not been  
20 filed under AS 47.05.075, 60 days from the attorney's receipt of the proceeds.

21 (e) Notwithstanding AS 47.05.070(c), for pro rata reduction of the  
22 department's lien if an attorney fails to comply with this section.

23 (1) the department is entitled to and shall collect the full lien amount  
24 from the judgment, award, or settlement;

25 (2) if the attorney has already received payment for the attorney's  
26 services through the pro rata reduction as provided in AS 47.05.070(c), the attorney is  
27 civilly liable to the department for the amount of that payment.

28 (f) If a medical assistance recipient is handling the action or claim on a pro se  
29 basis, the provisions of this section apply as if the medical assistance recipient were an  
30 attorney representing the medical assistance recipient.

31 **Sec. 47.05.073. Judgment, award, or settlement of a medical assistance**

1        **lien.** (a) An action or claim brought by a medical assistance recipient or an attorney  
2        who represents the medical assistance recipient against a third party or insurer may not  
3        be compromised or discharged without the express written consent of the attorney  
4        general.

5                (b) A judgment, award, or settlement that requires or results in the  
6        compromise of a lien under AS 47.05.075 may not be entered into or granted by a  
7        court without the express written consent of the attorney general.

8                (c) A medical assistance recipient may not maintain any rights to payment as a  
9        result of a judgment, award, or settlement of an action or claim for which another  
10       person may be legally obligated to pay without first making full repayment to the  
11       department for costs of past medical assistance services provided to or paid for by the  
12       medical assistance recipient that relate to that action or claim.

13               (d) A medical assistance recipient may not place any payment as a result of a  
14       judgment, award, or settlement of an action or claim for which another person was  
15       legally obligated to pay because of injury or illness into any trust for the purpose of  
16       maintaining public assistance or medical assistance eligibility without first

17                        (1) making full repayment to the department for costs of past medical  
18       assistance service provided to the medical assistance recipient related to that action or  
19       claim; and

20                        (2) obtaining the express written consent of the attorney general.

21                (e) The department's recovery under a subrogation right, assignment, or  
22       enforcement of a lien shall be applied to the entire payment made in satisfaction of  
23       judgment, award, or settlement.

24                (f) The doctrine of equitable subrogation, the equitable made whole doctrine,  
25       or the common fund doctrine may not be applied to defeat, reduce, limit, or prorate  
26       any recovery by the department based upon its subrogation rights, assignment, or lien,  
27       or the medical assistance recipient's obligation of repayment.

28                (g) The attorney general may only discharge or give written consent related to  
29       a medical assistance lien under AS 47.05.075 if the discharge or consent complies  
30       with federal law.

31                **Sec. 47.05.074. Conflict with federal requirements.** If any provision of this

1 chapter related to subrogation, assignment, or lien conflicts with federal law  
2 concerning the Medicaid program or receipt of federal money to finance the medical  
3 assistance program, the provision does not apply to the extent of the conflict.

4 \* Sec. 4. AS 47.05.075(d) is amended to read:

5 (d) A perfected lien under this section has priority over all other liens except  
6 tax liens and a lien perfected for attorney fees and costs [IMMEDIATELY AFTER  
7 A LIEN PERFECTED BY A HOSPITAL, NURSE, OR PHYSICIAN UNDER  
8 AS 34.35.450 - 34.35.480].

9 \* Sec. 5. AS 47.05.080(a) is amended to read:

10 (a) Benefit overpayments collected by the department in administering  
11 programs under AS 47.07 (medical assistance), AS 47.25.120 - 47.25.300 (general  
12 relief), AS 47.25.430 - 47.25.615 (adult public assistance), AS 47.25.975 - 47.25.990  
13 (food stamps), and 47.27 (Alaska temporary assistance program) shall be remitted to  
14 the Department of Revenue under AS 37.10.050(a), except for overpayments  
15 recovered under AS 47.07 that cover the value of services paid from federal  
16 sources.

17 \* Sec. 6. AS 47.07.020(b)(14) is amended to read:

18 (14) pregnant women who are not covered under (a) of this section if  
19 (A) the pregnant woman's [AND WHOSE] household  
20 income does not exceed

21 (i) [(A)] \$2,208 a month if the household consists of  
22 two persons;

23 (ii) [(B)] \$2,782 a month if the household consists of  
24 three persons;

25 (iii) [(C)] \$3,355 a month if the household consists of  
26 four persons;

27 (iv) [(D)] \$3,928 a month if the household consists of  
28 five persons;

29 (v) [(E)] \$4,501 a month if the household consists of six  
30 persons;

31 (vi) [(F)] \$5,074 a month if the household consists of

1 seven persons:

2 (vii) [(G)] \$5,647 a month if the household consists of  
3 eight persons:

4 (viii) [(H)] \$5,647 a month, plus an additional \$574 a  
5 month for each extra person above eight persons who is in the  
6 household if the household consists of nine persons or more:

7 (B) the pregnant woman has identified the putative father  
8 of the fetus: and

9 (C) the putative father's household income and resources,  
10 as defined by the department, each do not exceed \$50,000 annually, as  
11 determined on the first day of the month in which the application for  
12 assistance was received:

13 \* Sec. 7. AS 47.07.020(f) is amended to read:

14 (f) A person may not be denied eligibility for medical assistance under this  
15 chapter on the basis of a diversion of income or transfer of assets, whether by  
16 assignment or after receipt of the income, into a Medicaid-qualifying trust or annuity  
17 that, according to a determination made by the department,

18 (1) has provisions that require that the state will receive all of the trust  
19 or annuity assets remaining at the death of the individual, subject to a maximum  
20 amount that equals the total medical assistance paid on behalf of the individual; and

21 (2) otherwise meets the requirements of 42 U.S.C. 1396p(d)(4) for a  
22 trust and 42 U.S.C. 1396p(c)(1)(F) and 42 U.S.C.1396p(e)(1) for an annuity.

23 \* Sec. 8. AS 47.07.020 is amended by adding new subsections to read:

24 (j) A person may not apply for medical assistance coverage for a child under  
25 18 years of age who is not emancipated unless the person is

26 (1) an adult and the parent or legal guardian of the child;

27 (2) an adult caretaker relative who lives with the child and who is  
28 exercising care and control of the child; or

29 (3) an employee of the department who is applying on behalf of a child  
30 who is in the custody of the department.

31 (k) Notwithstanding the eligibility provisions under (a) and (b) of this section.

1 a person may not receive medical assistance under this section unless the person first  
2 enrolls in the Medicare program under 42 U.S.C. 1395 to the extent that the person is  
3 eligible to receive benefits and services under the program.

4 (l) Except as provided in (g) of this section, the department shall impose a  
5 penalty period of ineligibility for the transfer of an asset for less than fair market value  
6 by an applicant or an applicant's spouse consistent with 42 U.S.C. 1396p(c)(1).

7 (m) Except as provided under 42 U.S.C. 1396p(f) and 42 U.S.C. 1396u-1, the  
8 department shall include as an asset for eligibility purposes the value of an applicant's  
9 home if the equity value in the home exceeds \$500,000 at the time the application is  
10 completed. Nothing in this subsection prohibits an applicant from reducing the equity  
11 value in the applicant's home by selling the home or by taking out a loan that affects  
12 the equity.

13 \* Sec. 9. AS 47.05.070(e) is repealed.

14 \* Sec. 10. The uncodified law of the State of Alaska is amended by adding a new section to  
15 read:

16 APPLICABILITY. Sections 2 - 4 of this Act apply to a cause of action related to a  
17 subrogation, assignment, or lien by the Department of Health and Social Services that accrues  
18 on or after the effective date of this Act.

19 \* Sec. 11. The uncodified law of the State of Alaska is amended by adding a new section to  
20 read:

21 REPORT. The Department of Health and Social Services shall prepare a report and  
22 deliver the report to the legislature not later than the first day of the First Regular Session of  
23 the Twenty-Fifth Alaska State Legislature. The report must include recommendations for  
24 statutory, regulatory, and systematic changes that will

25 (1) assist the department in reducing medical assistance expenditures for  
26 services received in residential psychiatric treatment centers and substance abuse treatment  
27 facilities:

28 (2) enhance and clarify parental financial responsibility for children receiving  
29 residential psychiatric treatment center and substance abuse treatment facilities services; and

30 (3) maximize all third-party resources available to pay for the cost of  
31 residential psychiatric treatment center and substance abuse treatment facilities services

1 before a provider seeks reimbursement under AS 47.07.

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

4 STATE PLAN. (a) The Department of Health and Social Services shall immediately  
5 apply for federal approval of a revised state plan to implement the changes to the medical  
6 assistance program made under this Act.

7 (b) The commissioner of health and social services shall notify the revisor of statutes  
8 of the date of the federal approval of the revised state plan submitted under (a) of this section.

9 \* Sec. 13. This Act takes effect July 1, 2006, or on the date of notification under sec. 12 of  
10 this Act of federal approval of a revised state plan for medical assistance coverage  
11 incorporating the changes made by this Act, whichever is later.

# STATE OF ALASKA

## DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

FRANK H. MURKOWSKI, GOVERNOR

P.O. BOX 110601  
JUNEAU, ALASKA 99811-0601  
PHONE: (907) 465-3030  
FAX: (907) 465-3068

### MEMORANDUM

DATE: February 22, 2006

TO: Honorable John Coghill  
Alaska House of Representatives

THRU: Karleen K. Jackson, Ph. D.  
Commissioner

FROM: Kevin D. Henderson  
Medical Assistant Administrator III

RE: Suggestions for HB 426.

On February 13, 2006 you met with Sherry Hill, Ellie Fitzjarrald, and me to discuss HB 426 dealing with the Medicaid program. Thank you for that opportunity. Even though we expressed reservations about our legal ability to implement the original provisions of HB 426, we share your conviction that those who are able to contribute to their health care should do so and that Medicaid be reserved for those who cannot. You stated it was not your desire to make major reductions in Medicaid eligibility, but that you did want to find "low hanging fruit" that would help address your concerns. At the conclusion of that meeting, we promised to provide you with suggestions.

The following ideas are the result of department brain storming and the opportune timing of the federal Deficit Reduction Act of 2005. We offer them to you as suggestions for amendments to HB 426, in lieu of the original provisions of HB 426.

1. **Require Medicare Enrollment:** 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. 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.

An amendment to HB 426 could require the department to make Medicare enrollment a condition of Medicaid eligibility for the elderly or disabled who are eligible to receive Medicare.

2. **Authority to Garnish PFD:** AS 47.05.080 currently authorizes the department to garnish a recipient's PFD to recover General Relief, Adult Public Assistance, food stamps and Alaska Temporary Assistance Program overpayments. 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. Existing regulation 7 AAC 43.1800 explains this policy. Realistically, however, recipients rarely have the will or the means to arrange for repayment. One of the most efficient and least intrusive recovery methods has been to garnish the recipient's PFD.

HB 426 is an appropriate vehicle to amend AS 47.05.080 so medical assistance programs are included.

3. **Study Parental Contributions for Extended Medical Care Away from Home:** In some situations, a child who is outside the home receiving extended medical care for 30 days or more is eligible for Medicaid based only on the child's own income and resources. The department would benefit from investigating strategies other states are using to require financial contributions from parents under these circumstances. Minnesota, for example, has a plan that requires parents to pay "parental fees" when their child is residing in a residential psychiatric treatment facility or a substance abuse treatment facility. In some situations, the State of Washington considers a child receiving inpatient mental health treatment to still be in the parent's household unless the child is found to require treatment for more than 90 days.

We believe there is value in the department studying alternative policies in other states to determine what might work best in Alaska. Before trying to implement any cost-containment strategies in this area we need to better understand how these other programs are implemented, the legal challenges they faced, and which ones have been effective. This is more than we can do during the session, but we see an opportunity for you direct such a study through HB 426.

4. **Asset Test for Pregnant Women Eligibility:** The poverty-level pregnant woman Medicaid eligibility category is the only group where the income and resources of the unmarried father of an unborn child are not counted.

Consider an amendment to HB 426 that would add a high asset test to the poverty-level pregnant women Medicaid eligibility group. The asset level might be something like \$20,000, or some other amount that was high enough for the state to assume the pregnant women had enough resources to pay for her own prenatal care and delivery. The asset level would have to be high enough that

- (a) truly needy pregnant women are still going to be eligible;
- (b) Division of Public Assistance caseworkers are able to use less intrusive verification policy when it was obvious that a pregnant woman does not have assets close to the limit; and
- (c) pregnant women who have enough assets to cover their own prenatal and delivery care, are required to pay for that care even though they may have limited income.

The federal **Deficit Reduction Act of 2005** (DRA 2005), signed into law February 8, 2006, includes many mandatory rule changes related to determining financial eligibility for long-term-care related Medicaid. Four of the changes are significantly more restrictive than current policy. You may be interested in using HB 426 to support the department's implementation of these new requirements, including a decision on #8 below. Addressing these rule changes in legislation will help get the word out that these new rules are coming and show the Legislature's interest in controlling Medicaid costs.

5. **Transfer of asset penalty period.** Instead of starting the penalty period beginning with the date of transfer, this new law requires the penalty period to start 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.
6. **Transfer of Assets:** The DRA 2005 also requires states to impose any partial months of ineligibility determined following a transfer of asset for less than fair market value. This means that many transfer of asset penalties will be one month longer than they would be under existing rules. More importantly, it eliminates the loop-hole that some exploit by purposely transferring assets piece meal so that they never amounted to a full month of long-term care costs and, therefore, they never have a penalty to serve. Over time these small transfers can add up to a significant asset being transferred.
7. **Annuities:** A restatement of the annuity changes in the DRA 2005 would support the department in our efforts to implement these changes. This is particularly true of the provision that requires the state of Alaska to be named as the remainder beneficiary in the first position for at least the total Medicaid paid on behalf of the annuitant. Prior to the passage of the DRA 2005, I included a similar provision in the proposed eligibility regulations. One of the public comments received included a threat of legal action if we went through with it. We now have the

benefit of the DRA 2005, but I would be helpful to have the explicit backing of the Legislature.

8. **Limit on the value of a home:** Normally, a person's home is an exempt resource for Medicaid eligibility purposes. The DRA 2005 actually 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. The DRA 2005 actually gives the state a more liberal option of increasing that equity value to \$750,000. Your bill could determine the equity amount that Alaska will recognize.
9. **Health insurers required to work with Medicaid:** Section 6036 of DRA 2005 includes a mandate that states have a law requiring health insurers to cooperate with the state by (1) providing requested information on individuals they insure, (2) accept the State's right of recovery and assignment of rights, (3) responding to inquiries about claims they have paid, and (4) not denying claims submitted to them by the State within 3 years. Legal review will be needed to determine exactly what kind of statutory amendment is needed, but HB 426 would be an appropriate vehicle to put this amendment forward. This change will improve the chances that health insurance is used to the fullest extent before Medicaid is used.

#### **DHSS Action Already in Progress**

Even though legislation is not required, you may be interested in what the department is already doing to address some of the issues around children in residential psychiatric treatment centers (RPTC) and other residential settings. The Division of Behavioral Health is currently evaluating and testing through pilot projects the InterQual Behavioral Health Decision Support Tool, which will help the department assess the degree of need for children and adolescents referred for treatment in an RPTC. Using this nationally-normed "decision tool" prior to authorizing any Medicaid payment for treatment services out-of-state will result in consistent clinical decision-making around levels of care and appropriateness for treatment. When applied during the prior authorization process, InterQual will result in placement decisions better able to meet the child's needs and will minimize inappropriate level of care placements. InterQual has demonstrated that it is especially useful at the top end of the spectrum: i.e., acute care, sub-acute care, partial hospitalization. The department anticipates full implementation of this tool in calendar year 2006.

Let us know what you think. We are available to discuss these recommendations with you.

cc: Sherry Hill  
Ellie Fitzjarrald  
Jerry Fuller

Testimony Re: House Bill 426  
Comments to CS for House Bill No. 426

My name is Clover Simon, I am a social worker. I am currently not practicing social work in the State of Alaska but have extensive experience working with high risk youth in Washington State, most of whom were not living with their parents.

The changes reflected in the CS version of HB 426 have greatly improved this bill and I appreciate all the work that has gone into making this bill something that will not create a barrier for youth getting the medical care they need.

The one remaining concern I have is with Section 7 letter (j) and (k). This section does insert exception language that would allow a minor to apply and receive medical benefits without parental consent, which I feel is important. The issue is that the exception is vague and leaves the decision up to the "department" I assume this would be the person reviewing the application. Whether or not a youth can get confidential services is then at the discretion of the "department". On one hand you may have an employee who is an advocate for youth and can recognize that a youth applying for benefits on their own must have compelling reasons. Or you could get an employee who doesn't believe that youth should ever do anything without parental consent regardless of the situation. This section appears to be very subjective and my worry is that the confidentiality of youth will not be protected.

In my experience, youth who do not involve their parents have very compelling reasons. Navigating the medical assistance system is not easy and most youth are not going to choose to follow through without a parent or guardian unless there are extenuating circumstances. The percentage of youth who will be affected by this bill is likely small, but chances are they are the most vulnerable youth of our communities and deserve to have access to medical care with or without parental participation. I don't feel that leaving it up to individuals in a department will adequately protect youth.

I fully support that parents should be involved and responsible for their children, however I have worked with enough high risk youth to recognize that there are unfortunately many parents out there who are not. Youth who live in these types of situations or live outside the home should be given the opportunity to care for themselves by applying for medical assistance. I am worried that the subjective nature of this exception will close the door for many youth who are in need of services.

I urge you to look at this section and allow youth to apply for medical assistance without parental consent. Or for other support systems to assist them without parental consent (section 7 letter j). Often youth have found other support systems to replace dysfunctional parents and these adults should be able to assist a youth in getting the medical assistance they need. Thank you for your consideration and your commitment to respect the ability of youth to make responsible choices.

Sincerely,  
Clover Simon, MSW  
Anchorage, AK  
240-6032