

Summary of Medicaid Requirements Included in PPACA

Following is a preliminary summary of each PPACA provision identified in an initial review as having or potentially having an impact on the State of Alaska Medicaid program. Identification of all provisions that may impact Alaska’s Medicaid program is not yet complete, and the descriptions presented here are preliminary pending additional guidance from the federal government.

Provision Title	Section # Citation	Effective Date	Explanation
Mandatory Coverage of Certain Populations, Including Federal Funding (FMAP) Changes			
Maintenance of Effort Requirement	2001	3/23/2010	This provision requires the State to maintain eligibility standards, methodologies and procedures at a level that is at, or less restrictive than, the levels in place on the date of enactment of PPACA. This provision in PPACA following on the one in ARRA essentially means there are many changes States will not be able to make to their Medicaid programs between July 1, 2008 and January 1, 2014 (out to October 1, 2019 for children under age 19); therefore, Alaska’s ability to take cost-saving actions in these areas is limited for a five-year period (11 years for children). This provision in ARRA was a condition of accepting additional federal funds through the enhanced Federal Medical Assistance Percentage (FMAP) rate, but the PPACA requirement is not accompanied by additional federal support
Mandated Expansion to 133% (138%) FPL with Enhanced FMAP	2001; 10201	1/1/2014	<p>This provision expands the Medicaid program beginning in 2014 by creating a new, mandatory category of Medicaid eligibility for legal residents under the age of 65 with income no greater than 133% of the federal poverty level (FPL). A provision in Sec. 2002 requires States to apply a mandatory 5% income disregard, effectively raising the eligibility level to 138% FPL. Sec. 2001 also stipulates that the benefits be provided as defined in the Benchmark Benefits Package, and requires mental health service parity for that package. The federal government will fully fund the expansion through FFY 2016, then States will be required to cover 5% of the cost in 2017, increasing to 10% in FFY 2020 and beyond. A State option to expand eligibility to this new group early is included in this provision as well, but the expansion would be funded at the State’s current FMAP rate (about 50%).</p> <p>Most people who are eligible for Alaska’s Chronic and Acute Medical Assistance Program (CAMA), which is fully funded with State general funds, will fall into this new Medicaid eligibility group. Many individuals who receive substance abuse or mental health services funded with State general fund grants will also fall within this group. As a result, while the</p>

			required expansion will cost Alaska State general fund dollars, the increased cost may be offset by State general fund savings.
Medicaid Mandatory Coverage of Children Ages 6-19 under 133% FPL	2001	1/1/2014	This provision means that some, probably a small proportion, of current Denali KidCare enrollees will now be eligible under Medicaid. No new person is added to Medicaid eligibility by this provision, but would only move from one program to another with the same benefits and services. The administrative workload may include computer systems changes to recognize this different eligibility grouping, which also translates to the loss of the enhanced CHIP match rate.
Mandatory Coverage of Foster Care Children Up to Age 26	2004; 10201	1/1/2014	This will be a new mandatory group different from the larger mandatory Medicaid expansion up to 133% FPL. This group will be composed of those persons enrolled in Medicaid on the date they aged out of foster care. This group will receive the full Medicaid benefit array, not the Benchmark Benefits of the newly eligible; and at the usual FMAP, not the enhanced FMAP for the newly eligible. It appears this eligibility is retroactive for anyone meeting the requirements, not just those aging in after 1/1/2014. DHSS must begin looking at records to identify those with future eligibility for this benefit, possibly notifying them to maintain contact information or looking at the PFD records for whereabouts. Federal regulations should address identification issues for those that reside in states other than where they were in foster care. This has the potential to be administratively difficult for the retroactively eligible group and for those that move from state to state.
CHIP Program Authorization Extended until FFY 15; 23% Increase in CHIP FMAP FFY 16 thru FFY 19	2101; 10203	2/4/2009 CHIP Exten. 10/1/2015 CHIP FMAP Increase	This Children's Health Insurance Program (CHIP) reauthorization extends funding through 9/30/2014, permitting continued federal funding of Denali KidCare (DKC), but PPACA also seems to assume that Congress will do a further program extension, given there is a corresponding 23% FMAP boost to the already enhanced CHIP FMAP starting in FFY 16. As a result of this the FMAP for Alaska DKC would increase from about 66% to 89%. The 23% increase in CHIP FMAP will be in affect from 10/1/2015 to 9/30/2019.
New Eligibility Determination Requirements			
Mandatory Use of Modified Adjusted Gross Income (MAGI) for Eligibility Determination; Required 5% Disregard (effectively increasing upper limit to 138% FPL); and, Prohibited Use of Resource or Asset Test When Determining	2002; HCERA 1004	1/1/2014	The provisions in this section of PPACA will require fundamental changes to the State's current eligibility process and procedures. Under these provisions States are required to change the methodology for determining income eligibility for Medicaid to the use of "modified adjusted gross income" (MAGI) and household income as defined for federal tax purposes. States are also prohibited from using income or expense disregards, but are required to disregard the difference between the monetary equivalent of the upper income eligibility limit and the upper income limit increased by 5% - in effect increasing the upper income eligibility limit from 133% to 138% FPL. States will also be prohibited from applying any assets or resources tests for purposes of determining eligibility (with certain exceptions). Current Alaska policies likely meet the new asset test requirements.

Eligibility			<p>States are required to submit for approval by CMS a transition plan for changing methodologies and procedures for income eligibility determination.</p> <p>Until federal regulations and guidance are issued on these provisions it is not possible to determine the full impact, other than to conclude there will be a multitude of changes. For example, it is unclear whether we will be required to maintain current eligibility processes for some eligibility groups and create this new process for others; whether we will be required to apply both processes to insure we meet the maintenance of effort requirements; whether we will have to connect with the IRS to gather MAGI determination information, or if the IRS will determine MAGI for those who have filed income tax returns; etc.</p>
Presumptive Eligibility by Hospitals	2202	1/1/2014	<p>It is unclear whether this provision creates a State option to permit hospitals to make a presumptive eligibility determination for any individual potentially eligible for Medicaid, or if it in fact allows hospitals to make the determination regardless of State choice. If federal clarification indicates that the provision may be implemented at each hospital's discretion, then this provision creates an issue for all States. One concern is the State workload associated with training hospital staff on new eligibility processes and maintaining the training over time. In addition, permitting hospitals to use a separate process to assure their claims are paid due to presumption of eligibility would not be consistent with the Insurance Exchange approach that is to be up and running by this date. Individuals will be able to access the web portal at the hospital and apply for subsidized coverage for Medicaid at the time of service, though the hospital would not be guaranteed payment for the immediate service. If the Exchanges work as envisioned then there should no longer be need for presumptive eligibility or any other special eligibility determination and enrollment processes.</p>
Protection Against Spousal Impoverishment	2404	1/1/2014	<p>Sec 2404 is a 5-year language substitution that removes 'at the option of the State' and replaces it with a broad description of all sections of the law by which a person could access home and community-based services. Alaska already takes a broad and expansive approach to avoid spousal impoverishment (State Plan Amendment Supplement 13 to Attachment 2.6-A), so it is unlikely that this provision will have any impact, but potential impact cannot be fully determined until after federal regulations implementing this provision have been promulgated.</p>
New Enrollment Requirements			
Health Insurance Administrative Simplification	1104; 10109	7/1/2011	<p>This provision requires the U.S. DHHS to adopt a uniform set of rules for electronic transactions between health care providers and health plans for actions such as health plan eligibility, claim status, and electronic funds transfer. These standards will apply to all health care providers and health plans governed by HIPAA, and therefore these provisions</p>

			will also apply to Medicaid. This primarily pertains to Health Information Technology/Health Information Exchange standards and formats and standardization of claims forms. The new operating rules are to be determined by 7/1/2011 with implementation no later than 1/1/2016.
Health Information Technology (HIT) Enrollment Standards and Protocols	1561	9/23/2010	This provision directs the U. S. DHHS to develop interoperable and secure standards and protocols that facilitate electronic enrollment of individuals in Federal and State health and human services programs. It also directs HHS to award grants to States to develop new and adapt existing technology systems to implement the new HIT (Health Information Technology) enrollment standards and protocols, but it does not include an appropriation or specific authorization for this grant program.
End of CHIP Enrollment Performance Bonus	2101	10/1/2013	This year Alaska received a bonus payment of almost \$800,000 based on performance measures. There is no way to project future eligibility for this award, thus no way to determine any impacts, positive or negative, to the ending of the bonus program.
Medicaid and CHIP Enrollment Simplification	2201	1/1/2014	This provision requires States to set up a website where people can compare the benefits and costs of subsidized coverage through the Health Insurance Exchange and Medicaid, and also apply for or renew Medicaid enrollment. This website must link to the Exchange. The State Medicaid program must accept eligibility determinations made by the Exchange. The State must enroll people into health plans under the Exchange and establish premium assistance amounts when they are determined not to be eligible for Medicaid or CHIP. The State must coordinate medical assistance for those also eligible for coverage provided through the Exchange. In addition the State must conduct outreach and enrollment efforts to multiple broadly defined vulnerable populations. All of these requirements will require significant additional resources to comply with the law.
Mandatory Coverage of Certain Services and Changes in Service Definitions and Requirements			
Freestanding Birth Centers	2301	3/23/2010	Alaska already covers these birthing centers under Medicaid; however the new requirement under PPACA to cover these services appears to require we pay the facility fee separate from the practitioner fees. When CMS approved our current Medicaid State Plan Amendment (SPA) they insisted the facility fee be combined with the practitioner fee. To comply with PPACA we will need to commit staff and resources to develop and submit to CMS for approval a new SPA, promulgate new regulations, develop a facility fee separate from the practitioner fee, and make computer system changes to implement the new reimbursement methodology.
Medical Assistance Definition Expanded	2304	3/23/2010	Previous court cases upheld the definition of “medical assistance” under the Medicaid Act to be payment for part or all of the service. PPACA expands the definition to include “or the care and services themselves, or both,” meaning States are not just liable for paying

			for health benefits for Medicaid recipients, but also for ensuring provision of the care and services. This is characterized as a “clarifying,” “technical” change, but could increase lawsuits against States by enrollees claiming delays or other access to and problems in delivery of services.
Comprehensive Tobacco Cessation Services for Pregnant Women	4107	10/1/10	The law requires Medicaid to cover counseling and pharmacotherapy for cessation of tobacco use by pregnant women, and prohibits a co-pay associated with these services. Alaska currently covers tobacco cessation products and counseling by physicians, mid-level providers and pharmacists.
Barbiturates, Benzodiazepines, and Tobacco Cessation Products	2502	1/1/2014	Certain classes of drugs are excluded from mandatory Medicaid coverage, leaving inclusion as a State option. PPACA removes barbiturates, benzodiazepines, and smoking and tobacco cessation agents from the excludable drug list. This provision has no effect on Alaska as our Medicaid program already covers these drugs.
Home and Community Based Services under the State Plan	2402	3/23/2010	Most provisions under Sec. 2402 are optional for States, but 2402(a) requires the Secretary to issue regs requiring States to ensure long term care service systems are allocated to meet the changing needs of beneficiaries and to maximize independence; provide support and coordination to design an individualized, self-directed, community-supported life; and improve coordination and regulation of providers. Until the regs are issued the State impact cannot be determined. Given the statutory language for this provision and based on experience with the recent CMS HCBS review, we can anticipate that CMS will provide very detailed instructions on how States operate such programs in the future.
Reimbursement and Payment Structure Changes			
Prohibit Medicaid Payments to States for Services Related to Health Care Acquired Conditions	2702; 10303	7/1/2011	This provision intends to reduce avoidable death, disability and health care costs through imposition of a financial penalty for health care services that must be provided as the result of a medical error or infection acquired during the provision of a medical service. The Secretary of HHS must promulgate regulations by 7/1/2011 that will prohibit federal payment to State Medicaid programs for any amounts expended for medical assistance required as the result of a health care-acquired condition. Unlike a number of other states, Alaska does not have a health care acquired infections or conditions reporting requirement, though the Alaska Division of Public Health recently launched a Health Care Associated Infections Prevention Program.
Medicaid Reduction of Disproportionate Share Hospital (DSH) Payments	HCERA 1203	1/1/2012	Assuming current Alaska spending patterns continue for hospital DSH payments this provision will have no impact. Federal DSH funds are capped for each state based on federal statute. Alaska historically has not had sufficient GF to fully expend the federal allotment, thus reducing the federal allotment should not negatively impact Alaska, though it may limit future possibilities for expanded use of these funds.
Fraud, Waste and Abuse Provisions			

Extended Period for Collection of Overpayments	6506	3/23/2010	<i>Analysis pending</i>
Provider Screening & Enrollment Requirements	6401	3/23/2011	The State will be required to assure compliance with new requirements for medical providers and suppliers included in this section. The HHS Secretary is to establish regulations within 180 days to impose new Medicaid (and Medicare) provider screening procedures that must include a licensure check, and may include a criminal background check, fingerprinting, random site visits, database checks, and/or other measures determined appropriate based on the risk of fraud, waste and abuse. The screening requirements will be imposed for new enrollees beginning 3/23/2011; 3/23/2012 for providers who were already enrolled 3/23/2010. Other enrollment requirements include certain disclosures, and participation in compliance programs. The State will also be required to participate in a national system for reporting criminal and civil convictions and negative licensure actions. The State conducts many of these activities now, but without federal regulations, it is not possible to determine the new level of effort.
Face-to-Face Encounter Required for Home Health Services and DME Eligibility Certification	6407; 10605	?	This provision requires physicians or mid-level practitioners to have a face-to-face encounter with Medicaid (and Medicare) clients prior to certifying eligibility for home health services, durable medical equipment, or other items or services as required by the HHS Secretary.
Medicare Recovery Audit Contractor (RAC) Program Expanded to Medicaid	6411	12/31/2010	<i>Analysis pending</i>
Termination of Provider Participation in Medicaid if Terminated under Medicare	6501	1/1/2011	<i>Analysis pending</i>
States Mandated to Use National Correct Coding Initiative	6507	1/1/2011	<i>Analysis pending</i>
Other Medicaid Provisions and Potential Issues			
Prescription Drug Rebate Change	2501	1/1/2010	<i>Analysis pending</i>
Medicare Part D “Donut Hole” Closure	3315; HCERA 1101	1/1/2010	No direct impact, however, since State Medicare Part-D “clawback” payments to the federal government subsidize the increased premium payments for coverage of the doughnut hole for seniors who are dually-eligible under Medicare and Medicaid. Since the

			doughnut hole will be reduced each year over the next several years until it no longer exists starting in 2020 for all Medicare beneficiaries, state clawback obligations should be reassessed.
Community Living Assistance Services & Supports (CLASS) Act	8002	1/1/2011	This provision creates a new national voluntary long term care insurance program, and it includes an obligation for State Medicaid programs to conduct by 1/1/2013 a needs assessment of public and non-profit long term care service providers' ability to serve as fiscal agents, employers and providers of long term care services for CLASS beneficiaries; designate or create such entities, including in rural and underserved areas; and ensure that these additional requirements do not impede current capacity for self-directed home and community-based service delivery.
New Medicaid Reporting Requirements	2001; 10201	1/1/2015	This provision adds to the annual reporting requirements new requirements for reporting total enrollment, newly enrolled, and yet to be determined sub classifications of enrollees. It also adds a new requirement for reporting on outreach and enrollment processes, and whatever else the Secretary might deem necessary.
Community Health Center Expansion	10503; HCERA 2303	10/1/2010	PPACA appropriates \$9.5 billion for FFYs 2011 through 2015 to increase operational support for federally funded community health centers (CHCs). An additional \$1.5 billion is appropriated to expand funding for construction and renovation. Expansion of the National Health Service Corps under PPACA will also partially support enhancement of CHC staffing. The community health center system in Alaska expanded significantly over the past 15 years, and currently includes 26 grantees operating 142 clinic delivery sites. Approximately half of the grantees are tribal health organizations. Medicaid services provided to AI/AN patients in tribal health organization facilities are reimbursed by the federal government at 100% FMAP. Addition or expansion of tribal health organization CHCs will enhance federal support of the Medicaid program. Addition or expansion of non-tribal CHCs will increase workload for the Office of Rate Review in AK DHSS/Division of Health Care Services associated with establishing and maintaining cost-based encounter rates.

State Medicaid Options & Demonstration Projects

PPACA includes numerous Medicaid program options and demonstration projects intended to:

- Expand eligibility further to serve more people under Medicaid (e.g., early expansion option, increase to 200% FPL)
- Support expansion of certain services (e.g., family planning, preventive services)
- Test payment reform methodologies (e.g., hospital bundled payment)
- Support home and community-based services over institutional care (e.g., Community 1st Choice, incentives for non-institutional LTC services)
- Test new delivery system models (e.g., health homes, accountable care organizations)

The Medicaid options and demonstration projects available to States under PPACA are listed below in chronological order by effective date.

Medicaid Options & Demonstration Projects	Section	Effective Date
Demonstration of Global Capitated Payment to Safety Net Hospitals	2705	10/1/2009
Option to Provide Family Planning Services to Low-Income Individuals	2303	3/23/2010
Option to Provide CHIP Coverage to Children of State Employees	2101	3/23/2010
Early Expansion Option	2001; 10201	4/1/2010
Money Follows the Person Rebalancing Demonstration Project	2403	4/22/2010
Demonstration Project to Allow Payment to Private Institutions for Mental Diseases	2707	10/1/2010
Option to Provide Health Homes to Enrollees with Chronic Conditions	2703	1/1/2011
Grants to States to Provide Chronic Disease Prevention Incentives to Medicaid Beneficiaries	4108	1/1/2011
Incentive Payments to States to Increase the Percentage of Long Term Care Spending on Non-Institutional Services	10201	10/1/2011
Option to Offer Home & Community Based Services Under Sec. 1915(k) (Community First Choice)	2401; HCRA 1205	10/1/2011
Hospital Bundled Payment Demonstration Project	2704	1/1/2012
Demonstration Project to Allow Pediatric Medical Providers to Organize as Accountable Care Organizations	2706	1/1/2012
FMAP Increase of 1% if Preventive Services are Covered with No Cost-Sharing Requirements	4106	1/1/2013
Option to Increase Eligibility to 200% FPL for Individuals Otherwise Eligible for the Exchange	2001	1/1/2014
Grant Hospitals Permission to Make Presumptive Eligibility Determinations for all Medicaid Eligible Populations (<i>or mandatory?</i>)	2202	1/1/2014
Premium Assistance Program for all Medicaid Eligibles (including Cost Effectiveness Test)	2003; 10203	1/1/2014

State of Alaska Medicaid Budget Impact Analysis

	Projected Change in State General Fund Expenditures (in thousands)						
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
Medicaid Expansion to 138% FPL	0	0	0	3,878.9	8,814.1	11,039.5	15,351.6
Absorb CAMA into Medicaid	(953.0)	(1,963.4)	(2,081.5)	(2,150.4)	(2,211.2)	(2,319.1)	(2,406.1)
CHIP FMAP Increase by 23%	0	0	(6,245.7)	(8,855.9)	(9,417.7)	(10,015.2)	(2,662.6)
Drug Rebate Shift to Fed Gov	7,500.0	7,500.0	7,500.0	7,500.0	7,500.0	7,500.0	7,500.0
Net "Cost" to State of Alaska	6,547.0	5,536.6	(827.4)	372.6	4,685.2	6,205.2	17,782.9

	Projected Increase in Federal Medicaid Spending (in thousands)						
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
Federal Spending for Expansion	74,114.3	152,695.8	161,899.6	167,722.4	173,061.6	181,773.4	189,030.2
Federal Spending for CHIP FMAP	0	0	6,245.7	8,855.9	9,417.7	10,015.2	2,662.6
New Federal Medicaid Spending	74,114.3	152,695.8	168,145.2	176,578.3	182,479.3	191,788.6	191,692.9

	Projected Number of New Medicaid Enrollees (does not include CAMA clients)						
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
	29,188	30,884	31,038	31,193	31,349	31,506	31,663

Medicaid Expansion, CHIP, & CAMA Projections developed by: AK DHSS/FMS Medicaid Budget Group

Assumptions & Data Sources for Medicaid and CAMA Projections

Data Source for uninsured up to 138% and privately insured up to 100% FPL: Current Population Survey
 Date Source for population and projected population growth: AK Department of Labor & Workforce Dev
 Assumptions:

- CHIP (Denali KidCare) eligibility remains at 175% FPL
- Expansion implemented January 1, 2014
- Expansion covers those up to 138% FPL (133% + mandatory 5% income disregard)
- 75% uninsured non-AI/AN Alaskans below 138% FPL will enroll
- 50% uninsured AI/AN below 138% will enroll
- 60% of AN/AI services/costs will be at tribal facilities at 100% FMAP
- Individuals on CAMA will be moved to Medicaid
- 50% of privately insured Alaskans <100% FPL will move to Medicaid
- Population growth for adults 0.5% per year (AK DOLWD)
- Population growth for children 0.8% per year (AK DOLWD)
- Per capita cost based on average 2009 FM&TM group spending
- Per capita cost growth is 5.5% per year
- Those previously on CAMA will cost more than other new enrollees

Medicaid Drug Rebate Revenue Loss Projections developed by:
The Alaska DHSS Medicaid Program Pharmacist

Assumptions for Medicaid Drug Rebate Revenue Loss Projections:

- Estimated drug rebate revenue for Alaska for this year is \$30 million.
- Projected revenue loss assumes a 25% share will now go to the federal government.

Other Potential State Costs not Included:

- **Costs for work needed to implement the expansion related to:**
 - Analysis & Planning
 - Administrative and Operational Changes
 - Data System Changes
 - Increased Enrollment
- **Costs associated with increased enrollment of those currently eligible but not enrolled**
 - The so-called “woodwork effect” – assumes those who are Medicaid eligible but currently chose not to enroll will choose to enroll when faced with paying a tax penalty otherwise.

Other Potential State Revenues and Savings not Included:

- **Medicare Part D Clawback** – Will the State’s payment to the federal government to cover Medicaid GF’s share of the Part D premium for dual-eligibles be reduced or eliminated with the closure of the doughnut hole?
 - Alaska’s annual Medicare Part D Clawback payment to the federal government for the past couple years has been approximately \$20.4 million
 - Due to the ARRA FMAP reduction Alaska is saving approximately \$4.7 million in SFY 10 and will save approximately \$2.5 million in SFY 11. That savings is not reflected here as it is not related to PPACA, and because other ARRA FMAP savings are not included.
- **State Behavioral Health & Substance Abuse Grants** – Will the State be able to significantly reduce or eliminate grants that currently subsidize these services as safety-net clients become covered under the Medicaid expansion or through the Insurance Exchange, and as the Mental Health Parity Act and mental health parity provisions under PPACA take effect?
- **Federal Grants** – New federal grant and contract programs authorized under PPACA will provide additional revenue opportunities for Alaska health programs both within and outside State government. Potential new grant revenues are not included in these projections.