MEDICAID IN ALASKA—A PRIMER

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Medicaid was established in 1965 by Title XIX of the Social Security Act (42 USC §1396, et seq.) to supply health coverage for people with low incomes. Federal law provides the underlying framework for the program but allows mechanisms for states to exercise a degree of flexibility in how their programs are administered and delivered. According to figures from the federal Center for Medicare and Medicaid Services (CMS), in July 2020 state Medicaid programs oversaw coverage for 76.5 million individuals, or a little over 23% of the U.S. population. At that time, Alaska Medicaid covered about 31% of the state's population at just over 230,000 participants. That figure marks an overall increase of roughly 88% since 2013.

A study commissioned by the State of Alaska and published in January 2020 provides historic and projected Medicaid enrollment and spending data. Results show that program participation increased dramatically in recent years, substantially exceeding long-term projections made in 2006, but is expected to grow considerably slower in the future. Despite more Alaskans being served than projected at that time, costs per recipient are much lower than originally foreseen due to policy-driven cost saving efforts. Nonetheless, state spending on Medicaid is expected to increase substantially over the next 20 years, primarily due to annual inflation of prices for healthcare services at about 4.5% annually, on average--roughly double the rate of expected overall inflation. If those projections prove correct, Medicaid spending will increase both nominally and in real terms.

Eligibility

Low-income families, qualified pregnant women and children, recipients of Supplemental Security Income (SSI), and individuals who experience certain permanent disabilities are examples of those eligible for Medicaid. Modified Adjusted Gross Income (MAGI, 42 CFR 435.603) is the basis for determining eligibility for most individuals. The federal Department of Health and Human Services (HHS) issues guidelines each year to establish the federal income eligibility levels (FPL) for its assistance programs, which for 2020 are as follows in Alaska:[1]

Household Members	MAGI	Household Members	MAGI
1	$15,950	5	$38,350
2	$21,550	6	$43,950
3	$27,150	7	$49,550
4	$32,750	8	$55,150

For households with more than 8 persons, add $5,600 for each additional person.

[1] The HHS issues separate FPLs for Alaska and Hawaii in recognition of higher costs of living. For example, the FPL for a four-person household in Alaska is $32,750 while in the 48 contiguous states it is $26,200.

Medicaid income eligibility is expressed as a percentage of FPL. To qualify in Alaska, income may not exceed FPL levels of:

- **203%** for children;
- **200%** for pregnant women;
- **132%** for certain parents / caretakers of an eligible child; or
- **133%** for the newly eligible Medicaid expansion population under the Affordable Care Act.

Expansion under the Affordable Care Act

The federal Patient Protection and Affordable Care Act (P.L. 111-148), or ACA, includes a requirement that states expand Medicaid programs to cover individuals with incomes of up to 138% of the federal poverty level. However, the June 2012 U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius* made Medicaid expansion under the ACA optional for the states. Nonetheless, according to the Kaiser Family Foundation (KFF), to date 39 states have expanded, or plan to expand, Medicaid programs under the provisions of the ACA. Alaska did so through an executive order issued in July 2015. Several other states continue to explore expansion through the legislative process, executive action, and/or ballot initiative.

Primary Funding Mechanisms

Medicaid funding is shared between states and the federal government and typically trails only education as the largest single component of each states' spending. A statutory formula annually establishes the Federal Medical Assistance Match Percentage (FMAP), which is designed to ensure that states with per capita incomes lower than the national average receive the highest proportional rate of federal contributions. For fiscal year 2021, those rates range from the minimum under law of 50%—received by Alaska and twelve other states—to 77.76% in Mississippi. For the "newly eligible" population of Medicaid enrollees under the ACA, the FMAP is 90% nationwide and will remain at that rate unless federal law is amended or repealed.[2]

Mandatory and Optional Benefits

Federal law requires states to cover certain *mandatory* benefits, but states may also offer *optional* benefits as prescribed by CMS.[3] Mandatory service categories include inpatient and outpatient hospital, nursing facility, physician, home health care, laboratory and x-ray, and transportation to medical care; as well as early and periodic screening, diagnostic, and treatment for individuals under age 21 (EPSDT). Optional benefits include, for example, prescription drugs, physical therapy, occupational therapy, dental services, prosthetics, eyeglasses, chiropractic care, hospice, mental health, and optometry services. Personal care and community-based services intended to keep individuals in their family homes, who would

[2] In addition, section 6008 of the Families First Coronavirus Response Act (P.L. 116.127) provides a temporary increase in the FMAP of 6.2 percent through March 31, 2021, unless extended.

[3] To be eligible for Medicaid, individuals must meet income and resource requirements and meet the requirements for eligible populations. The federal government sets minimum eligibility levels for coverage and states have the option to expand eligibility to higher incomes.

otherwise require more costly institutional care, are also considered optional services. However, because states are given latitude on methods of delivery, and due to the ways in which certain services overlap, the line between mandatory and optional benefits is not always clear.

It is worth noting that over time, the role of optional and mandatory services has changed (e.g., the increased reliance on prescription drugs—an optional service) and continues to evolve as states innovate to improve service and control costs. Further, some previously optional services, such as medication-assisted treatments, have become mandatory, and under the Affordable Care Act, certain "optional" services are mandatory for at least part of the adult population.

Generally, federal Medicaid law requires states to fund the same benefits statewide for all eligible individuals. Additionally, covered services must be comparable, regardless of an individual's diagnosis or condition. While states define the amount, duration, and scope of the Medicaid services they cover, federal law requires that coverage of each mandatory and optional service be "sufficient in amount, duration, and scope to reasonably achieve its purpose."

Benefit Restrictions and Cost Containment

Because Medicaid represents a large portion of states' budgets, policymakers are keen to identify efficiencies and create savings through program eligibility, administration, provider reimbursement practices/rates, and reduction or elimination of optional benefits. A review of each of these approaches is beyond the scope of this paper; however, the National Conference of State Legislatures provides a "toolkit" for state legislators that reviews both common and innovative approaches to Medicaid policy.

Our review of state experiences with reducing or eliminating benefits suggests that such policies be approached in a methodical and holistic manner. Many states have cut optional benefits—the most common being dental services—and have found that reductions in funding for such benefits shifts rather than eliminates costs. For example, if a Medicaid recipient suffers from an illness but elects not to seek medical intervention because it is not covered by her plan, the result may be more costly treatment at a later date, such as an emergency room visit or hospitalization, which can be orders of magnitude more expensive than those provided in a typical primary care setting. Since an emergency room cannot turn someone away for lack of sufficient coverage or ability to pay, higher costs are incurred by a clinic or hospital. In turn, those providers charge Medicaid for the more costly emergency services. If bills go unpaid for lack of insurance or other resources, "uncompensated costs" are either absorbed as "charity care" and/or passed on to private payers—primarily private insurance companies—through higher fees for services to compensate for the losses experienced by providers. Ultimately, individual consumers end up paying through higher healthcare premiums or direct billing costs.

Eliminating optional benefits for certain categories of recipients is, however, among the *cost containment measures* permitted under AS 47.07.036 should the Alaska Department of Health and Social Services determine that Medicaid costs will exceed appropriations made by the Legislature in a given fiscal year. That section directs the department to "take all reasonable steps to implement cost containment measures that do not eliminate program eligibility or the

scope of services." Those specific steps include implementing new utilization review procedures, changing provider payment rates, requiring precertification for coverage of services, and making agreements with the federal government to assume responsibility for coverage of some individuals through other programs such as the Indian Health Service or Medicare.

Even with the cost containment measures described above, legislators are sometimes tempted in difficult budget circumstances to simply provide a lower amount of funding than is requested by the DHSS. In Alaska and elsewhere, this approach has largely proved ineffective or counterproductive. For example, in FY18 Medicaid appropriations were $38 million short of the general fund amount required to fully pay providers ($20.0 million in a legislative reduction; $15 million associated with a delayed Medicaid Management Information System certification adjustment; and $2.8 million due to other factors). This short funding resulted in payment delays to some large service providers beginning in early June 2018. Smaller providers continued to be paid and a few others that contacted the department with cash-flow concerns were promptly issued payments. On the first day that FY19 money was available, all successfully adjudicated claims (that is, claims requiring no additional review or correction) that had been filed in FY18 were paid. Short funding the program did not reduce costs. Instead, unpaid FY18 claims were simply rolled forward into FY19. This put FY19 in a short-funded position, ultimately resulting in a $15 million supplemental appropriation.

Waivers

Although federal law sets Medicaid minimum standards related to eligible groups and required benefits, it offers latitude for states to make decisions about program eligibility, optional benefits, premiums and cost sharing, delivery system and provider payments. States may apply to CMS for formal "waivers" from standard requirements that provide additional flexibility to design and improve their programs or allow for the exploration of innovative solutions and cost savings measures. More information on waivers is provided by the National Conference of State Legislatures.

Alaska currently has five Medicaid waiver programs in place that deliver home and community-based services to a range of recipient groups.

Public Assistance Hold Harmless Program

In 1982, Alaska lawmakers recognized that the Permanent Fund Dividend (PFD) creates an unintended consequence of temporarily pushing the incomes of many recipients of state public assistance benefits above maximum eligibility limits. Loss of benefits creates hardships for recipients and logistical challenges for agencies that administer benefit programs. The PFD could cause administrators to annually disenroll large numbers of program participants *en masse* only to be forced to reenroll the same people weeks later when income and assets again fall to eligible levels.

To solve these problems, the legislature enacted AS 43.23.075, which prohibits the Alaska Department of Health and Social Services from considering the PFD when determining eligibility for public assistance programs. At the same time, lawmakers established the PFD Hold Harmless

program, which allows the DHSS through joint agreement with the federal government to cover benefits for persons denied medical assistance due to PFD income (Ch 102 SLA 1982) for the period when they would otherwise be income-ineligible. This is paid out of the amount appropriated for the PFD each year.