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Affordable Care Act Medicaid changes and Hospital-based Medicaid Determinations (Presumptive Eligibility)

The Patient Protection and Affordable Care Act (ACA) brings an unprecedented change to the availability of health care coverage. It restructures the way people with lower income access health coverage by subsidizing care through the Medicaid system or private health insurance. This paper is an overview of some of the Medicaid eligibility system changes under ACA effective January 1, 2014 with a focus on how hospital-based Medicaid eligibility determinations, called "presumptive eligibility" could work for Alaska hospitals.

Background

Medicaid was created in 1965 by the federal government to provide low-income people with health care coverage. It has been expanded over the years to provide coverage to different groups at various income levels. One of the most significant expansions was the 1998 Children's Health Insurance Program (CHIP) which led to the creation of the Alaska's Denali KidCare.

The program is administered by the states which have broad authority to modify the rules to fit their needs, as long as they meet federal guidelines. Alaska Medicaid eligibility is administered by the Department of Health and Social Services, Division of Public Assistance (DPA). The federal and state governments contribute to finance services; the federal government pays 50% of Medicaid and 65% of Denali KidCare services. Services provided in tribal health facilities are 100% federally reimbursable.

The Affordable Care Act (ACA) is the most far-reaching piece of domestic health legislation since 1965 Medicaid enactment. The most significant changes to health care coverage are:

1. Allowing states to expand their Medicaid coverage to all adults under 65 who have income under 138% of the federal poverty limit (Alaska has not yet accepted this state option which would cover about 40,000 uninsured adult Alaskans according to the Urban Institute, *Medicaid in Alaska under the ACA*);
2. Changes to the way Medicaid income eligibility is determined and eliminates the asset limit for adults under 65 and 18 to 20 year olds; and
3. Establishment of a mandate for a marketplace insurance exchange (Exchange) to allow people not covered by employer-based insurance to "shop" for health coverage. People with income under 400% of the federal poverty limit (FPL) will receive a "sliding scale" subsidy through a tax credit to pay their premium ranging from 3% of their income at the low end to 9.5% at the 400% level.

Annual 2013 Alaska Federal Poverty Level (FPL), by Household Size

% of FPL	1-person	2-person	4-person	
100%	$ 14,350	$ 19,380	$ 29,410	
138%	$ 19,803	$ 26,744	$ 40,586	Expanded Medicaid
400%	$ 57,400	$ 77,520	$ 117,640	Subsidized Exchange

Source: http://aspe.hhs.gov/poverty/13poverty.cfm
Note: 138% of poverty = $9.52 an hour; 400% = $27.60 an hour.
At 138% a person pays $594 annually toward health insurance; at 400% the contribution is $5,453.

Gap in the Affordable Care Act: ACA was initially designed to provide coverage for all with the idea that people would shift between Medicaid and the Exchange as their income rose or fell. In 2012 the US Supreme Court ruled that states may choose whether or not offer Medicaid to all adults. Some have decided not to provide the coverage leaving a gap for adults with incomes under 100% of poverty. People with income of at least 100% of the FPL are eligible for the Exchange tax credit subsidy. However, if their income is under 100% of the FPL, they are not eligible for either the Exchange subsidy or Medicaid unless they fit into one of the current coverage categories (children or caretakers of dependent children).

Alaska Medicaid Eligibility Categories and Eligibility

Currently to be eligible for Medicaid in Alaska a US citizen or qualified legal immigrant must satisfy two tests:

1. Be in a "categorically" eligible group which are generally:
    a. Pregnant women and children through age 18 (Denali KidCare);
    b. Parents/legal caretakers of children under 18 and 19-20 year olds (Family Medicaid); or
    c. Blind, disabled and/or elderly (linked to Alaska Adult Public Assistance (APA) and/or need for nursing home or institutional care); and
2. Meet the monthly income and asset limits set by the state that vary according to the group a person falls into as shown on chart below.

Medicaid Eligibility Category	Monthly Income Limits				Asset Limit
	% of FPL	1 person	2 person	4 person	
Denali KidCare Pregnant Women and Children Under 18	175%	$ 2,093	$ 2,872	$ 3,680	None
Family Medicaid Parents/caretakers of Dependent Children	70-84%*	$ 857	$ 1,369	$ 1,713	$ 1,000
Blind, disabled, 65+ (APA related)	110-120%	$ 1,319	$ 1,954		$ 2,000
Disabled/elderly Institutional Care	178%*	$ 2,130			$ 2,000

Sources: http://dhss.alaska.gov/dpa/Documents/POLICY/PDF/2013%20Med_standards.pdf and http://dhss.alaska.gov/dpa/Documents/POLICY/PDF/2013%20APA%20Standards.pdf

*Standards for these groups are not based on the FPL so the percentages vary by household size.

Length of Eligibility

- Denali KidCare eligibility continues for 12 months once authorized, regardless of changes in the family's circumstances for children and through a 3-month postpartum period for pregnant women. When those periods of eligibility are over, they are reassessed to see if they are eligible again.
- All other categories have month-by-month eligibility. People report changes in their financial status and eligibility is determined using that information. This can result in loss of eligibility, usually at the end of the month following the change.

Retroactive Medicaid Eligibility

Medicaid may be available to a person who did not apply for assistance until after they received care, either because they were unaware of Medicaid or because the nature of their illness prevented the filing of an application. "Retroactive Medicaid" allows eligibility to be determined for each of the three months prior to the month of their initial application. It is available when:

- There is an unpaid medical bill for a service provided in the month;
- The individual falls into one of the Medicaid eligibility categories; and
- They meet the financial tests for the coverage.

Application for retroactive Medicaid coverage may also be made on behalf of a deceased person. Payment will be made for covered medical services provided to the deceased person during each month the person was eligible for Medicaid during the three month period.

The Affordable Care Act Insurance Affordability Programs

The ACA brings a new way of thinking about Medicaid so that it becomes a piece of an overall system of coverage. The ACA system of coverage was designed so that people could move seamlessly between Medicaid and subsidized purchase of private coverage though tax credits of insurance on the Exchange. Together, these are referred to as "Insurance Affordability Programs." It is expected that people will shift between the two types of programs as their income rises and falls so the way household composition and income are being considered were aligned based on how the IRS considers household and income for tax purposes. This, along with new mandates requiring simplification and streamlining, brings a significant shift to the Medicaid program.

This chart provides an overview of some of the many upcoming changes to Medicaid eligibility determinations. More detail on two of the changes, income determinations and presumptive eligibility, follow.

Application Process		
Current	**New Mandatory Requirement**	**State Option**
Medicaid application is same as for Food Stamps (SNAP) and other assistance programs. Denali Kid Care is a separate streamlined application.	Single application for Medicaid, Denali KidCare and Exchange subsidy programs.	Offer a multi-benefit application in addition to the new application for insurance affordability programs that can be used for all assistance programs.
Medicaid requires in-person interview. Denali KidCare – no interview.	No interview.	
Applications may be downloaded, completed and mailed to DPA for Denali KidCare. Medicaid application may be downloaded for completion before going to the interview.	Application available by phone, mail, in person, and online.	
State website explains various programs, provides downloadable applications.	State must provide a website linked to the Exchange that allows comparisons of coverage options and the opportunity to apply, enroll, and renew online.	

Eligibility Determination		
Current	**New Mandatory Requirement**	**State Option**
Asset test for Medicaid, not Denali KidCare.	No asset test.	
Rules on what income counts are based on the old welfare (Aid to Children with Dependent Children) rules.	Use the new Modified Adjusted Gross Income (MAGI) standards to determine eligibility. These are, for the most part, aligned with how the IRS considers income.	
	Use new rules to determine household composition also based on IRS tax rules.	
Paper documentation required to verify ID, citizenship, household, income, etc.	Use electronic data sources to verify; only require when self-attested and electronic data are not reasonably compatible.	Accept applicant statements, without requiring data verification, for all criteria except citizenship and immigration status.
DPA makes all eligibility determinations.	Hospitals that participate in Medicaid may make presumptive eligibility determinations if they choose to do so. *(More detail on this is provided in Presumptive Eligibility section.)*	Presumptive eligibility for children, pregnant women, caretaker relatives and the new adult only group (if state chooses to provide) may be determined by other qualified entities (schools, clinics, community groups, etc.)
Medicaid Coordination with the Exchange		
Current	**New Mandatory Requirement**	**State Option**
	When someone is found ineligible for Medicaid, their electronic account is transferred to the exchange to be screened for tax credit subsidy.	
	Develop a secure electronic interface for data matching and eligibility determination.	
	Allow the Exchange to make either an assessment for final determination of MAGI-based Medicaid eligibility.	

Source: Adapted from FamiliesUSA, http://familiesusa2.org/assets/pdfs/medicaid/Eligibility-Changes.pdf

Income Determinations

Eligibility determinations will use a methodology called MAGI, acronym for Modified Adjusted Gross Income. MAGI uses annualized income from the individual or family's IRS tax returns as a basis for

income eligibility determination, then expected changes are considered in order to make a final determination.

Although the conversion to MAGI was designed to work with a minimal effect on current Medicaid eligibility, there will be some changes as adjustments are made to align with the IRS methodology on income and household composition. This will result in some people gaining Medicaid eligibility while and others will lose it. Some examples of the different ways income is considered pre and post-ACA are:

Countable to Not Countable:	Not Countable to Countable
• Social Security Disability • Child Support • Veteran's Benefits • Workman's Compensation	• Stepparent Income • Income of working siblings (in the household • Possibly Permanent Fund Dividend (see below)

Native Corporation payments and dividends will continue to be excluded.

The Permanent Dividend Program (PFD) payments are currently not countable for Medicaid, but with the change from monthly to annualized income determinations, it is possible they could be considered as countable. The determination is pending at the federal/state levels. If PFD payments are required to be annualized and counted, it could cause some people could be "over income" which would, by state law, put them into the "Permanent Fund Hold Harmless" program. This program uses PFD funds to pay for the benefits a person would be eligible for if they did not receive a PFD payment. Since the PFD is not currently counted, this would be a new expense to the PFD Hold Harmless program and could be significant, depending on the number of people and the medical services they need.

Hospital-based Medicaid Determinations or "Presumptive Eligibility (PE)

Current Medicaid rules allow states the option of approving a hospital, clinic and or other entities to make a "presumptive" Medicaid eligibility determination at the time services are provided. This is done by staff asking questions to determine probable eligibility which could open the door to a temporary eligibility period for Medicaid. The recipient must then pursue an application through the state to continue eligibility

About 32 states currently have presumptive eligibility, mostly focused on children and pregnant women. Alaska did not implement the option, but DPA has "outstationed" a state eligibility worker to accept applications and make determination at Providence Hospital.

The ACA significantly expands presumptive eligibility by allowing hospitals that participate in Medicaid to conduce presumptive eligibility for Medicaid-eligible populations regardless, whether or not the state has taken the option. It is the hospital's decision to participate in the program if they wish to do so provided they:

1. Are a Medicaid provider;
2. Notify the state Medicaid agency of their intent to make presumptive eligibility determinations;
3. Agree to make determinations consistent with state policies and procedures; and
4. Have not been disqualified by the agency.

The ACA allows inclusion of the adult expansion group in presumptive eligibility determinations. However, states are allowed the option of limiting hospital-based presumptive eligibility to pregnant

women, children, parents/caretaker relatives, or disabled adults. Thus, state that choose to cover the adult expansion group will be allowed to exclude the group from being determined presumptively eligible by hospitals. Services received under the presumptive determination are paid for by Medicaid, even if the state determines that the person was not eligible.

Conceptually, presumptive eligibility by a hospital would work like this:

- Person fills out application at the hospital on line or by completing a paper application which would be the same, simplified application that the State and Exchange uses.
- Using state standards, the hospital worker enters information into a computer system that determines If person:
  - meets citizenship/legal immigrant criteria;
  - fits into allowable Medicaid category; and
  - if their income is under the limit for that category.
- If determined eligible for Medicaid, the determination and application would be forwarded to DPA for benefit issuance and review.
- If determined ineligible for Medicaid, the information, application would be forwarded on for Exchange eligibility. Medicaid provides coverage for the presumptive eligibility period with no repercussions to the provider (hospital).

When ACA is fully implemented as envisioned, presumptive eligibility may not be necessary as the on-line, electronic based system will be simple, seamless and quick, so there may not be a need to create a temporary eligibility period. However, until that time, presumptive eligibility determinations in hospitals could be beneficial in providing coverage, not only for those determined potentially Medicaid eligible, but as a potential portal or referral to coverage through the Exchange. It could also help fill the gap during the 2014 start-up of the new coverage system. As with any large scale change, access to the affordability program systems may be slow during implementation.

It is unknown how many people presenting at hospitals for services may be eligible to access Medicaid through a presumptive determination, especially since Alaska is not accepting the Medicaid expansion to cover all adults, or the "expansion group" at this time and if they did, they could exclude the group from hospital-based presumptive eligibility. The determinations will be limited to the existing eligibility groups, although it would be for all groups, including elderly, blind and disabled (presumably who receive Social Security disability).

More to Come

This paper is intended to be an overview of the major changes affecting Medicaid and low income people under the Affordable Care Act. Many details remain to be worked out at the state level for the Medicaid piece and the federal level as they establish the Exchange that will be available to Alaskans. Outreach and information from the federal side is expected to start later this summer prior to the roll out of the Exchange in October. The state Department of Health and Social Services is working on the changes but has not announced an education/outreach strategy as of the date this paper was written.