MEDI-CAID DIREC-TIONS 4-09-01

TONY KNOWLES, GOVERNOR
State of Alaska

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

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EDUCAID

A Report of the Governor's Council on Disabilities and Special Education's Position Regarding the Use of Medicaid Funds to Reimburse School Districts for the Costs of Special Education and Related Services to Medicaid Eligible Students

Prepared for the Governor's Council on Disabilities and Special Education by The Research Group, Inc.

January, 1997

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Purpose

The purpose of this report is to summarize the position, concerns and recommendations of the Governor's Council on Disabilities and Special Education regarding the use of Medicaid funds to reimburse school districts for health-related costs of Special Education to Medicaid eligible students. While this practice is presently conducted in a number of states, it is not policy in Alaska.

The Council began its review of this approach in August of 1996. After initial discussions the Council contracted Sandra Peterson of Portland-based Healthcare Business Education to conduct a review of other state policies and experiences with using Medicaid funds to pay school districts and to make recommendations to the Council on how this approach might be implemented in Alaska. In particular Peterson notes in her report the quite different approach that this funding policy represents:

> As a background to understanding the task, one must recognize that the concept of Medicaid reimbursement for students with developmental disabilities is somewhat antithetical to traditional medical assistance programs. The most prevalent barrier is the lack of knowledge and understanding about what Medicaid can and cannot fund and about what schools, through special education, can and cannot do. The complexities of each area usually wear out even the most well-intentioned program planners when it comes to designing funding systems for children with special needs. (Peterson Report)

That report is submitted under separate cover.

Peterson's work was presented in draft form for initial comment to a five member work group of the Council, also attended by representatives from the Department of Education and the Division of Medical Assistance. On October 9, 1996, this work group reviewed 1) the background to the process; 2) other states' experiences with this funding approach; 3) anticipated barriers to enacting this policy; and 4) recommendations for implementation of the policy approach. Their information was forwarded to the Council along with a draft policy recommendation for review and action.

The Council's Position

The Council is guided by the primary goal of improve the level of services for of all Special Education students. If certain conditions were met, the Council believes that this method of Medicaid billing could help to meet this goal. If properly implemented, the benefits that could be gained are increased revenues, elimination of duplication in service delivery and student testing, and coordination of resources.

While improving these services, however, we cannot accept a loss of Medicaid funding for other programs.

It is the position of the Council, that current levels of state funding to schools for Special Education students **must not be reduced** as a result of using a Medicaid billing method. In addition, revenue produced by this new system **must be used by schools solely for the improvement of services to Special Education students.**

In at least 27 other states, school districts use this method of billing to fund services to Medicaid eligible students. However to avoid some of the barriers experienced by other states, the Council's recommendations must guide the implementation of Educaid in Alaska.

Although there are potential benefits for students in special education by creating a Medicaid billing program for health services, it will take a substantial effort to resolve the many and varied issues that such a program will generate.

It is the opinion of the Governor's Council on Disabilities and Special Education that the implementation of Educaid would supplement present levels of funding and provide needed improvement to services benefiting Special Education students.... revenue produced by this new system must be used by schools solely for the improvement of services to Special Education students.

Implementation Requirements

•To be consistent with the Council's goal of enhancing funds to Special Education students, federal supplanting issues must be evaluated.

There are regulations affecting how federal Medicaid funds may be displaced. If the program is adopted, it will be tempting to reduce state funding to districts.

Educaid should not be implemented if other Medicaid funds are lost as a result, or if state funds are reallocated away from Special Education students.

• A student's Individual Education Plan (IEP) should describe the basic health services that would be reimbursed through this program. These include, but are not limited to, physical, occupational and speech therapy, skills orientation and mobility for blind, deaf and developmentally delayed (excluding academically delayed), visual and audiological treatment, and mental health evaluation and treatment. Independent school-based, family-centered, care coordination must be developed along with these services, but could be included either as a school district administrative cost or a direct service consistent with present DMA practices.

The Council also believes that it will be necessary to require service coordination **through an independent school-based, family-centered care coordination plan for students.**

Other covered services and support activity directly related to the IEP could be reimbursed through this program such as costs for transportation and transportation aides, screenings and evaluations to determine eligibility, health care aides, nursing services and

delegated nursing tasks, and direct expenditures for outside medical evaluations.

• Medicaid funded services to individual students and other Medicaid recipients must be maintained.

It is understood that TEFRA (Tax Equity and Fiscal Reconciliation Act of 1982) recipients have a capped limit. In general, TEFRA payments have never exceeded the cap in a school-based Medicaid program. This, however, should be planned for and monitored. There should also be a full discussion of the potential impact of this funding approach on Medicaid funding for all eligible persons.

• Although exceptions should be made for those districts that demonstrate that it can't be implemented in a cost efficient manner, the program should be required for all dist.

The Council recognizes the unique concerns of both rural and urban districts. Consequently, we would recommend that a series of positive incentives be developed to ensure participation by as many districts as possible. It is estimated that three years would be required for full program implementation.

Maximum participation of individual students will increase funds to Special Education programs as a whole. The experience in Oregon and other states shows us that a **voluntary program suffers from higher costs, duplication and inefficien** when districts choose to join the program at different times. Alongside the implementation of this program, existing revenue streams to local districts must continue at current levels to create a net gain in services to Special Education students.

In order to streamline procedures and to eliminate errors in billing, the Division of Medical Assistance (DMA) should develop a **database of students who are Medicaid eligible.** The Council is concerned that some parents may have a culturally-based reluctance to identify

their children as Medicaid eligible in a school environment. This issue must be addressed before the system is put in place and information describing the program should be developed and made available to the public before the program starts.

• *The program should be administered by the Division of Medical Assistance (DMA), under the direction of a steering committee composed of members from the DMA, the Department of Education (DOE) and Regional School-Based Billing Centers (RSBBC). A project leader should provide organizational administrative support.*

The committee would oversee the project leader, be responsible for program evaluation, and collaborate among all agencies serving children with special needs. The project leader should be under the direction of the DMA but must possess a working knowledge of the Special Education environment.

• *Establish guidelines for the operation of Regional School-Based Billing Centers.*

The establishment of Regional School-Based Billing Centers, should take advantage of current regional service hubs to minimize costs. These centers would gather data directly and report to the Department of Education and the Division of Medical Assistance. These agencies would then collect, process and share reports with one another and the Governor's Council.

The Council has identified a number of ways to facilitate the gathering of accurate student data. In particular, the State should establish a unique confidential identification number for each student that would follow him or her, rather than remaining at the child's district. This would enable the regional centers to maintain up-to-date lists of Special Education students, and those students with screenings planned. The DMA could use these lists to determine student eligibility for Medicaid reimbursement.

• DMA, through the project leader, should be responsible for monitoring Medicaid activity and reporting levels through Medical Manag :ment Information System (MMIS) reports.

MMIS reports would be used to identify overlapping services and to assess comprehensive funding levels. This information would be provided to the Council for use in making recommendations for managing services more efficiently and effectively.

• An evaluation component should be included to assess the success of this approach.

Evaluation would be the responsibility of the committee and its staff or contracted agent. Peer review committees could be used to perform audits as present DMA and DOE staff and audit schedules are not sufficient to ensure regular review of participants. The DOE would continue to be responsible for school district compliance with Special Education law.

• Speech/language therapists should be certified to American Speech and Hearing Association (ASHA) standards.

While a number of Alaska school districts presently encourage ASHA certification for speech/language instructors, this requirement would have to be met by at least one person working with each school district. ASHA certification could be offered through the University of Alaska, but ongoing training for this professional certification must also be provided. Contracting agents such as the Southeast Regional Resource Center (SERRC), which provides speech/language services to smaller districts, would have to maintain these same training standards.

- *Support staff must have introductory and ongoing training in Medicaid reporting and documentation requirements.*

There are also a number of non-reimbursable costs associated with learning proper reporting procedures for school staff that will be involved in submitting claims. These non-reimbursable costs and training needs would be charged to the districts as staff development costs. These training needs would be ongoing.

- *Costs to provide education of staff and the processing of data from the service provider to the DMA should be shared by districts that benefit from Medicaid reimbursement.*

Even as districts share the costs it should be remembered that State funds to Special Education students must be enhanced by this new program and not reallocated to other areas.

- *Uniform software should be acquired that can import data bases and generate reports for school administrators.*

Efficient data management and analysis is impossible without this technology. Present DMA technology is not sufficient. There would also be minimal hardware requirements for regional billing centers.

- *The DMA should recognize a new class of providers that would meet the needs of this program such as school districts and regional billing centers.*

Without this provider designation, Medicaid payments to the districts would not be possible. Smaller districts contract for speech/language services rather than maintain a person on staff. To allow these districts to meet the minimum requirements of this program, independent contractors, such as SERRC, should be granted status as an Interagency Service Provider.

Potential Concerns

The Council has identified a number of barriers which must be overcome before Educaid is implemented. The concerns fall into two general categories: 1) funding of Educaid; and 2) barriers encountered by other states, which potentially exist in Alaska, as described in the Peterson report.

A list of these concerns follows. These barriers are also addressed within the discussion of the implementation recommendations.

- ***Ensuring that Medicaid funds do not displace public education foundation formula funds.***

It is the Council's position that Medicaid payments to school districts should not supplant existing funding to districts.

- ***Gaining legislative approval to authorize implementation costs and DMA activities (including new provider type).***

Legislative action will require a comprehensive assessment of cost of implementation and ongoing services and training. The need for school-based, family-centered care coordination must also be addressed.

- ***Establishing an economical and accountable system that coordinates the health care and educational agencies that assist the Special Education student.***

A new accounting system of students served through this program could bring together all the players, reduce duplication and even reduce the number of assessments for children. Authority for this program must also be established.

• *Gaining Health Care Financing Administration (HCFA) state plan approval.*

A comprehensive list of exceptions would need to be developed in conjunction with discussions with HCFA. These hurdles would be addressed as they came up.

• *Determining Medicaid eligibility in a manner which is efficient and relevant for school districts and other billing centers.*

This is addressed in the recommendations, and includes establishing a confidential student number, and acquiring new database software. Special attention should be paid to the cultural context of service delivery, and the feasibility of this method of Medicaid payment in smaller districts.

• *Gaining appropriate credentials for school district professional staff.*

This is addressed in the recommendations, which suggest certifying all speech/language therapists to ASHA standards. This could be achieved through the establishment of a program at the University of Alaska.

• *Changing the Division of Medical Assistance (DMA) claims processing system to include school districts and potentially a new provider type.*

Costs of changes to program language, manuals as well as costs to train parents, other agencies and DMA staff about billing requirements, are not reimbursable and must be determined. There may also be a need to change present legislative and regulatory authorization for provider types.

Summary

It is the position of the Governor's Council on Disabilities and Special Education that the primary goal of Educaid is to optimize services to all Special Education students.

The Council would only support using Medicaid funds to reimburse school districts for health-related costs of Special Education for Medicaid eligible students if the implementation requirements are met and the Council's potential concerns are addressed.

Educaid must not be undertaken if it results in a loss of health services or long term care that is now provided by Medicaid dollars to people with disabilities and other served populations.

Action should only be taken if revenues produced by this new billing system are all directed back into Special Education.

H ealthcare

B usiness

E ducation

December 15, 1996

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Sj: Revisions to Report of October 16, 1996 and Response to Dave Williams' letter of November 13, 1996

Dear David:

The following is a response to my review of the Council Meeting of October 30, a review of the DRAFT recommendations dated November 15 and Dave Williams' letter of November 13, 1996. I apologize that I was unable to review these materials and provide a response earlier. Since my contract deadline was October 16, I took another project that began the morning of November 4 and have been mostly out of the office since that time. We also had the traditional Alaskan experience of having our flight out of Anchorage cancelled due to ice and spent most of the night in the airport--not arriving in Salem until late Friday afternoon. This threw my report and recovery time into the following week.

In addition to the changes to the report, this memo, hopefully, addresses most of Dave Williams' concerns as well. I appreciate your sharing his memo. It was pretty apparent from the October 30 discussion that my desire to be objective was somehow not conveying the message that the council should be impressed by the many practicalities of implementing this program. In light of the revenue projections, the degree of effort on the part of the schools and the DMA was minimized. The meeting was extremely useful and the process gave me a greater understanding of your environment and decision-making process.

The revised calculations reflecting input provided by the Council show the cost projections will be somewhat higher--implementation costs are now estimated to run $471,750 and annual operating costs will run $867,600. These expensed amounts would result in $1.8 million net to the state the first year-- assuming the best-case scenario in overcoming barriers and gaining necessary approvals. The start-up costs could be recovered over the first three years. Many variables come into play, however, and it is impossible to know how delays in the implementation tasks identified in the report would affect the cost. Major changes to the report start on page 37 where I also reformatted the cost summary in order to more easily see the breakout. Other changes are spread throughout the document. I believe I addressed all the concerns of the Council, particularly the Council's reasons to pursue Medicaid funding as indicated on page 10.

The State of Alaska, no doubt, has the potential to realize and benefit from implementing a Medicaid billing program for school special education health services. This potential was

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not fully address the many and varied immeasurable issues that will surface and require substantial effort to work through to resolution--not all issues will be resolved to an acceptable end--and, considering the major tasks, I am doubtful that the potential can be realized.

An observation about the meeting:

Several in attendance stated they had scanned, but had not completely read, the report. As is somewhat typical, discussions focused primarily on revenue projections and costs of implementing the program. Full discussion of pros and cons was not possible because many at the table had not had the opportunity to read and reflect on the operating and administration issues. The only school administrator who would likely be directly involved in implementing the program at the school level was Dave Thomas who was essentially silent throughout the discussion.

Weighing the risk, district by district:

One reality that could not be reflected in the cost projections was and is the uncertainty that the level of effort will result in a proportional level of return by each district. Participating is a risk. Part of the reason is that the decision to participate must be based on limited information. The break-even point depends on a number of variables--which will not be known until a district actually is already committed to the task.

In order to systematically calculate rate projections, the numbers spreadsheet per district were prepared according to the estimates provided by the DMA and the information provided by Juneau School District. These did not include frequency actuals even within the Juneau School District. Since Juneau gathered its own information, one cannot be certain that the IEP's were written in a Medicaid-approved format that clearly identified the frequency of services. Nor were the numbers fixed or steady. And, the method of determining service levels within Juneau School District will differ somewhat from what can accurately be anticipated in other districts. The numbers were based on identified IEP services--more detailed criteria will result from the process of gaining HCFA approval. This means that in reality, a district may gear up for participation thinking they will be able to bill for 20-30 children when, in fact, only 6-7 are receiving services that qualify. On the other hand, the reverse could also result. The report attempts to identify the many variables and the policy approved by HCFA in other states in order to lay a foundation for what the potential is in the State of Alaska. The Council should be prepared to present districts with the risks and the unknowns as well as the benefits.

New information:

Another point that needs to be emphasized about relying on straight projections in a sea of variables is that serving Medicaid children implies that one knows which students are Medicaid eligible. We discussed this issue but there is new information. This fall Oregon undertook a study (unknown prior to the Alaska report) to verify eligibility based on the best efforts of both agencies. In 1993, the Medicaid program developed an "upload-download" system to provide schools the capability to upload their student data directly into Oregon Medicaid files to verify eligibility. The cost to Oregon Medicaid was approximately $5,000 in systems staff time; the equipment was already in place. The accuracy of this upload-download process had not been thoroughly tested between the two entities until now. This process replaced the need for districts to pay $100 each month to have a leased line with on-line access to Medicaid eligibility screens. However, when verified, Oregon learned that discrepancies in the information gathered by Medicaid and the information gathered by districts resulted in a 25% - 32% "false not-eligible" report. This means that

t resolved discrepancies between provider-payer in names, date of birth and Social Security numbers ran between 25%-32%. To research these numbers is extremely time consuming and often futile. Unless Social Security numbers are captured accurately and used to verify eligibility, school providers are not likely to be able to know all students who are eligible. And, unless names are exactly matched, eligibility verification is often a negative. Federal law requires verification to be matched on two out of three pieces of identification furnished by the provider, no less. The Alaska report assumed full identification of all Medicaid eligible children. The recent Oregon study indicates as much as 32% of the Medicaid population will not be learned and, therefore, reimbursement will not be possible.

Just because you can, doesn't mean you should.

The report to the Governor's Council included identification of issues and steps involved in evaluating the potential. Obstacles that arose in the development of the program in other states were identified. Resolutions were spelled out to demonstrate how issues that were challenging were overcome. This should not be interpreted by the Council that all resolutions were worth the effort or expense-only that problems were solved and how they were solved. No two states are alike. Alaska faces most of these same obstacles that will require effort to resolve. In addition, Alaska faces other obstacles which no other state has faced--such as that SERRC has no legitimate standing as an educational entity. This obstacle, if not satisfactorily resolved, affects the potential considerably.

An issue that was not part of the report or discussion but apparently was a factor for Council consideration:

A billing company reported that Alaska schools could retroactively bill Medicaid for two years prior to the start up of the program. The state which was allowed to back bill for two years was permitted to do so because HCFA made a technical error and delayed in responding to a request. Retroactive billing would only be possible if the districts had systematically documented services according to Medicaid requirements. States which allow back-billing would only legitimately do so because services had been provided and documented but, for technical reasons, billing had been delayed. Each state defines the period of timely claims submission--up to one year from the date of service--which is a federal Medicaid limitation.

Documentation and reporting service levels must occur at the time the service is delivered. To retroactively compile data to submit claims is like reconstructing "tax deductible record-keeping after you know you're going to be audited." It is bad practice and extremely risky. If states had been compiling data all along but withholding claims upon approval to submit, billing retroactively would be possible. However, to retroactively fabricate records in order to gain Medicaid reimbursement is highly inappropriate and not recommended. Because other states reportedly back-billed for a time period does not mean it is allowed or authorized. In fact, an audit is more likely today than five years ago when school billing was a new issue.

Some district staff believe services are clearly documented now and so would not require additional or different documentation. While documentation is not radically different from special education documentation, it is different. Medicaid documentation requires attention to times, dates and description of services, not lesson plans and attendance as is more common in the school setting. It is unlikely that a school administrator could confirm that their documentation procedures would meet Medicaid standards when those standards are not commonly known, nor, in most cases have they been discussed within the state. In

any case, Alaska state law only allows Medicaid providers to retroactively bill six months from the date of service. This requirement must be equally applied to all provider categories.

While the State of Alaska clearly has an opportunity to draw federal funds by developing a state Medicaid billing program for school providers, this opportunity must be carefully assessed not only on the financial potential, but also on the practicality of the issues, considering that only a certain right combination will make the opportunity worth the effort. Juneau, for example, with revenue projections of $163,000 per school year, has some of the greatest logistical advantage. Even so, implementation costs for Juneau will be nearly equal to the Anchorage district that has a far greater reimbursement potential--about $1 million each school year.

Other issues yet to be considered:

1. Costs related to the district undergoing a Medicaid audit are unknown and, cannot be projected since variables include the audit findings. Some audits end at the first review of the records; others end only after a lengthy due process that may result in findings considered fraudulent according to Medicaid regulations. This cannot be known.

2. Union issues regarding change in workload or job descriptions that surfaced in other states may become an issue and result in legal costs as well as administrator's and staff time and commitment. Since this is unknown and cannot be anticipated, it cannot be included in cost projections.

3. State matching funds are required to be paid by schools themselves. While the Council acknowledged this was necessary, <u>how</u> the fund transactions would occur was not addressed. In Oregon, for example, the dollars were originally matched from the "Handicapped Child Fund." After the first three years, that funding source dried up. The "state" then withheld funds from its allocation of school funding support based on accountings of payments made to districts by the Office of Medical Assistance Programs. Due to restructuring school funding, a Secretary of State audit found that practice no longer acceptable.

   Alaska also pays for most school service from its foundation dollars--state dollars. If the money cannot be withheld at that point, the DMA would have to generate a billing to each school, based on enrollment information against which claims are paid, each month or quarter, to reimburse the DMA for use of its state matching funds. This can become complex for DMA to track and bill because each district is likely to be enrolled under the regional billing center. Billing each district also requires districts to track and report federal funds separately. It may also be a contractual issue between the DMA and its intermediary, First Health.

4. The report did not directly deal with how the funds were to be used because this was the responsibility of the Governor's Council. It was clear that members of the Governor's Council and the school districts that generate the revenue wanted to assure that Medicaid dollars be used to provide services that otherwise would not be provided. From review of the draft of the Governor's Council recommendations, use of funds is not identified specifically. The concern is that if these dollars are not earmarked and trackable to specific services or a range of

services, they will be cyphoned off by others--even at the legislative level. This would leave the school districts with the burden of generating revenue that does not guarantee that those responsible for the work will reap the desired benefit. To allow the incentive to be lost through oversight or assumption would prescribe doom to the potential revenue.

Since the Governor's Council Draft Report indicates a strong value placed on family-centered care coordination, perhaps funds could be used for care coordination. To buy more of the same kinds of services as indicated in the Council's recommendations implies the services are not currently provided, which cannot generally be assumed. (Several districts in Oregon purchased laptop computers with their Medicaid funds--to provide more efficient documentation and reporting capabilities of staff.)

The unique circumstances under which Alaska must implement the proposed billing program mean the outcome will be different from any other state's program or experience. In some ways, the path will be smoother because of the pioneering efforts. In other ways, the path will be rougher because of the timing of Alaska's effort--HCFA has learned from other's efforts and addressed policy issues that will be more restrictive. In the future, as HCFA and State staff members turn over and as Medicaid budgets tighten, new regulations may be imposed. School providers are clearly at the mercy of another agency over which they have no control. In order to bill into the Medicaid program successfully, streamlined procedures and methods of verifying eligibility and the capacity to interact successfully with the state's claims processing contractor are necessities. Anything short of a full commitment from both agencies' leadership should signal decisionmakers that frequent confrontation and problem-solving will become necessary.

Culturally-based sensitivity discussion

Another concern expressed by the Governor's Council was the sensitivity to culturally-based reluctance to identify children as Medicaid-eligible. In the effort to learn which children are billable and which are not, even dedicated staff who are especially considerate and sensitive can inadvertently offend or call attention to the billing effort. This risk is real. While confidentiality is always a concern and to be respected, in the sometimes frantic effort of seeking reimbursement for services, the practicality of "needing to know" often means a lessening of sensitivity--much like the need for modesty that often gets pushed aside in the medical setting in an effort to provide needed medical treatment. The environment of serving children in general, and particularly, children with special needs at a time when resources are extremely limited increases the likelihood that Medicaid eligibility will become known--often against the wishes of those involved.

Comprehensive compliance auditing discussion

The last issue that was not included in the original report also surfaced at the Governor's Council. The orignal assumption was that the State Department of Education currently provides comprehensive special education compliance reviews every three years. From the discussion at the October 30, 1996 meeting, staff shortages mean that the frequency and depth of DOE compliance auditing may be unpredictable. Medicaid audits and special education audits review different regulatory issues and, so, cannot be provided by the same staff. But, the regulations are premised on "individual" needs and the Medicaid program relies on the special education process to define the steps and provide the documentation.

If there are compliance issues within special education, there will also likely be compliance issues within Medicaid. This is of great concern to the author of the report since the

recommendation assumed reliable compliance audits within the special education environment.

As one involved in the daily operations of a Medicaid billing program that supports services to children with special needs, I am aware, more than most, of the effort and expertise needed to keep this kind of program on a positive track. Over the past six months I have been observing Alaska's potential in its own environment. I see a desire to move forward with this effort but the necessary expertise does not seem to be available. As indicated in the report: Alaska needs to develop its own expertise. Those who are capable must have strong Medicaid and Special Ed background in order to develop a viable school billing program. No available leadership has surfaced. Capable, yes; available, no. This effort is major and responsibilities to get the program up and running cannot be included with other responsibilities--at least at the start-up. It will require a single-focused effort by highly organized and skilled persons. Considering that during the process of researching the potential and the follow-up to the council meeting, literally everyone contacted within DOE, DMA and the schools seemed overwhelmed with current responsibilities. For example, three phone calls to one key administrator for information were not returned. This environment will make it impossible for anyone to be successful.

If you have any questions or comments, please call me to discuss it. Thank you for your support and the opportunity to assist the State of Alaska with the research and process of Medicaid billing. I hope things are going well for you and the Council and that you will be able to complete your recommendation process soon. I wish you and your capable staff a wonderful holiday season!

Sincerely,

Sandra Peterson

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cc: Dave Williams, DMA

REPORT FOR:

The GOVERNOR'S COUNCIL ON DISABILITIES
AND SPECIAL EDUCATION

REVIEW AND ANALYSIS:

EVALUATING THE POTENTIAL FOR THE STATE OF ALASKA TO PURSUE MEDICAID FUNDING FOR HEALTH-RELATED SPECIAL EDUCATION SERVICES

October 16, 1996

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I. ACKNOWLEDGEMENTS

Thank you to the individuals and agencies who generously contributed their time, effort and resources to gather information and data which helped in developing the recommendations and evaluating the potential for the State of Alaska.

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Millie Ryan	Governor's Council on Disabilities and Special Education
Bob Tanna	HCFA, Regional X, Medicaid Provider Requirements, Seattle, Washington
John Hart	University of Alaska, Continuing Education
Brian Saylor	University of Alaska Anchorage

II. INTRODUCTION: HOW THIS REPORT IS ORGANIZED

This report includes several separate sections which are intended to provide background and information critical to understanding the issues around the potential to pursue Medicaid funding to reimburse school districts for health-related special education services. It is intended to be a basis on which the Governor's Council on Disabilities and Special Education can make a decision.

EXECUTIVE SUMMARY

This section provides a brief summary of the issues to be addressed around implementing an efficient Medicaid School-Based Health Services Program in the state of Alaska, the rationale for the recommended approach and the barriers to be overcome as well as a brief description of the economic and fiscal impacts.

PROCESS FOR DEVELOPMENT OF RECOMMENDATIONS

This section describes the process which was used to develop the report. This includes the various information sources both in the state as well as outside the state that were instrumental in gathering input for this report. This also includes a section about the contractor's background and experience in the subject areas.

SUMMARY OF RECOMMENDATIONS AND BARRIERS

This section lists each of the key issues and the barriers that had to be considered in the development of the report and the recommendation associated with each of these issues. More detailed discussions of the issues and recommendations are provided later in this report.

BACKGROUND AND ENVIRONMENT

This section provides general information on the current state and federal laws relating to Medicaid funding for health-related Special Education services. The basic rationale for pursuing this funding source and the experience of other states are also discussed.

REVIEW OF MEDICAID REIMBURSEMENT REQUIREMENTS

This section builds on information provided in a publication entitled, "EPSDT School-Based Children's Medical Services Program" produced in June 1993 by the State of Alaska, Department of Health and Social Services, Division of Medical Assistance and a Proposal entitled "Medicaid School-Based Health Services" by the State of Alaska, Department of Health and

Human Services, Division of Medical Assistance dated September 21, 1993. This background of Medicaid and Special Education requirements is intended to provide the Characteristics of an efficient program that meet Medicaid and Special Education criteria.

IMPLEMENTATION ACTIVITIES

This section includes implementation activities of enrolling school districts as Medicaid providers using information provided by the Division of Medical Assistance and two sample school districts. It also includes the implementation activities of the Department of Education and the Division of Medical Assistance as well as describes other implementation activities of the Alaska State Legislature and DMA State Plan Amendments and Federal Waiver requests that may become necessary if the program is implemented.

THE KNOWLEDGE BASE: ANALYSIS

This section includes a summary of key data which has been gathered by the contractor regarding numbers of children who are receiving services in the school environment under special education . This summary includes an analysis of the scope, frequency and level of services which may result in reimbursement for the school districts. It includes data from the Alaska census and the Alaska DOE special education census reports required by federal law. It also includes MMIS reports from the Alaska Division of Medical Assistance as well as selected school district statistics.

ISSUE DISCUSSIONS: EVALUATING THE POTENTIAL

This section presents a series of issue discussions regarding the key questions that must be addressed before the Governor's Council on Disabilities and Special Education can make a decision. This basic format includes discussion issues which surfaced in other states during the development of their School-Based Health Services program. It also includes discussion of unique issues which surfaced as a result of research and analysis while developing this report. It also includes principles and criteria for an evaluation plan.

FISCAL IMPACT SUMMARY

This section includes a brief summary of the fiscal impact on the State of Alaska if a Medicaid-funded School-Based Health Services program were implemented. This summary was prepared by an independent consulting firm.

III. EXECUTIVE SUMMARY

This section provides a brief summary of the issues to be addressed around implementing an efficient Medicaid School-Based Health Services Program in the state of Alaska, the rationale for the recommended approach and the barriers to be overcome as well as a brief description of the economic and fiscal impacts.

The report reviews and analyzes the costs and benefits of enrolling school districts to bill Medicaid for special education health-related services. The report is intended to assist the Governor's Council on Disabilities and Special Education in its decision to pursue Medicaid reimbursement to provide more services to children with special needs. Cost projections are conservative so as not to overstate the potential revenue and expenses of implementation and operation that offset revenue are also provided.

The several barriers the State would have to overcome include political barriers at the state level--barriers which would allow districts to keep the funds they generate--as well as Medicaid regulations that will require waivers in order for an efficient system to be implemented. Several technological barriers also exist: (1) development of a Medicaid eligibility verification system that is efficient for school districts and (2) revision of the Division of Medical Assistance Medical Management Information System. Any one of the identified barriers that cannot be overcome could result in the project's failure.

The recommendations, if implemented, will result in a cost-effective system that allows districts to benefit from billing Medicaid. Without careful system design, full participation by districts, legislative support, recommended waivers approval and without utilizing the rehabilitation model instead of the traditional medical model, however, the resulting reimbursement system could create a cumbersome mechanism with limited benefits and little return for the level of effort required. The potential for new revenue cannot be realized without full effort and support from the state's leadership.

The basic strategy in developing an efficient and effective system was to build the program around the federal special education legal requirements that districts must follow. This strategy reduced the cumbersome processes which control service levels for traditional Medicaid programs and built upon existing federal laws, service delivery within the special education environment and fine-tuned the existing Medicaid reimbursement system.

The design included mandating full participation for all districts for which it is reasonable. The design of the mandate included incentives which assured districts keep the funds they generate and can determine use of funds in a fair and appropriate manner. The program implementation included a

start date of Fall of 1997 and a three-year time frame to allow for development of staff, policy and procedures and necessary legislative and federal approval.

Process for Development of Recommendations

The process for developing the recommendations began with gathering and reviewing information about Alaska's Medicaid programs. Medicaid programs background information was provided by the Department of Health and Social Services, Division of Medical Assistance who also provided information about the proposed school-based health program and the current time study program funded by Medicaid. Background information was reviewed and discussed with DMA staff.

Information was also gathered from 27 other state school-based Medicaid program managers to determine what their issues and experience in billing Medicaid have been.

The contractor drew on extensive experience with the School-Based Health Services Billing Program in the state of Oregon where over $10 million in Medicaid funds have been generated in 1996 for school districts through this program. Using this program format as a model for the potential, the contractor began to identify the essential requirements necessary for a viable Medicaid program in the special education setting in the state of Alaska.

In developing program parameters, recommendations were limited to Medicaid reimbursement for health-related services to student's with IEPs and to those services delivered by appropriately credentialed school staff. As each Medicaid requirement was identified, research was conducted which provided information about the ability of the school districts in Alaska to meet the Medicaid requirements. Options and variables were considered. Some alternatives were discusssed with federal Medicaid regulators in Region X of the Health Care Financing Administration. And, the Code of Federal Regulations provided guidelines to options when other specitic requirements were found to be unmet.

When findings indicated no alternatives were available, for example, when it was clear that some school providers were not appropriately credentialled to be reimbursed by Medicaid, options were explored for these providers to gain the appropriate credential.

Data provided by the Division of Medical Assistance which calculated Medicaid-eligible populations by school district was used to identify statewide potential. DMA data was used to match even more specific data provided by the Juneau School District. This data represented actual numbers of children served in each category as well as the actual numbers of children receiving billable services. This information, combined with other information from the Oregon model, provided the basis for the statistical calculations.

The potential revenue calculated was a conservative reimbursement amount based on the cost to deliver the service. The next step was to adjust revenue projections to reflect the way services are provided in various locations within the state. This net revenue was then projected over a three-year period which provided a basis for certain other recommendations.

ABOUT THE CONTRACTOR...

As an employee of the Oregon Office of Medical Assistance Programs from 1981 through September, 1995, Sandra Peterson was project coordinator for the Oregon School-Based Billing Program which was developed soon after federal legislation permitted states to pursue Medicaid funding for health-related special education services. Sandra spent two years at the Oregon Department of Education developing guidelines , evaluating service activity and training and presenting program details to professional, administrative and clerical staff.

After implementation of this new Medicaid program, Sandra returned to OMAP to develop and implement a new Automated Information System, coordinate provider information and manage provider services staff prior to and during implementation of Phase I and II of the Oregon Health Plan. She left the State of Oregon in September of 1995 and currently contracts with health-care provider organizations who primarily serve the various Medicaid populations--mental health, Indian health, public health departments and school districts--to advise on Medicaid policy, technical issues, (electronic telecommunications for claim and eligibility verification) and provide organizational leadership.

In October 1995 she became the Executive Director of the Education-Based Medicaid Corporation, a non-profit corporation of school districts for whom she provides organization leadership, technical assistance and consultation on matters of billing Medicaid.

Summary of Recommendations for Implementing an Alaska Special Education/Medicaid Billing Program

ISSUE	RECOMMENDATION
Administration Where should responsibility for administration of the program be placed?	The Division of Medical Assistance and an interagency advisory group composed of members from DMA, the Department of Education (DOE) and Regional School-Based Billing Centers should administer the program. This group should enlist the services of a project leader who provides organizational administrative support. Besides providing project leadership for school districts that bill for Medicaid reimbursement, the primary objectives of this advisory group should be to promote effective collaboration among all agencies serving children with special needs.
Infrastructure What is the most efficient and least costly infrastructure needed to administer the billing program?	The Division of Medical Assistance should contract directly with Regional School-Based Billing Service Centers. These Centers would gather service data from districts and report data to DOE and DMA (MMIS) who would then collect, process and share reports with one another and the Governor's Council.
Coordination How would implementation activities be coordinated?	The interagency advisory group should determine activities of the project director who would lead districts through the process according to a workplan. Three years would be required for full program implementation.

Covered Services

What services should be included in the billing program?

Basic Health Services should include physical, occupational and speech therapy, skills orientation for blind, deaf and developmentally delayed (except academic) visual and audiological treatment, certain mental health treatments.

Screenings and evaluations to determine eligibility for special education and health care aides, nursing services and delegated nursing tasks, and direct expenditures for outside medical evaluations should also be included.

Transportation costs to the covered services and support activity directly related to those services identified on a student's Individual Education Plan which have been determined according to federal rules and regulations should be covered as reimbursable.

Training

What training would be required for districts?

Requirements to meet Medicaid standards include learning how to report and document information. Support staff must also learn technical billing procedures. These procedures are all new to the school districts. Inservice workshops for orientation as well as ongoing training would be required.

Continuing education for service providers who need to meet Medicaid provider standards in order to bill for services would also need to be made available.

School District Participation

Should a school-based Medicaid billing program be mandated or optional for districts?

Based on qualifying criteria, school districts should be required to participate in Medicaid reimbursement so consistent and reliable procedures can be developed. Without full participation, resources cannot be adequately managed.

Verifying Medicaid Eligibility

How would school districts verify which students were Medicaid eligible?

DMA would have to develop a way to provide a database match of students who are Medicaid eligible. Monthly verification by name, date of birth (DOB) or Social Security Number (SSN) is necessary to identify on which children to submit a claim.

Monitoring

Who would monitor the overall services to Medicaid children?

DMA, through Billing Center/District Peer Review Committees, should be responsible for monitoring Medicaid billing activities and reporting service levels. MMIS reports can provide a basis for analysis. Peer review Committees could utilize MMIS reports and make policy recommendations as well as provide educational audits to districts. Analysis could also identify overlapping service areas. The Governor's Council on Disabilities and Special Education should then be able to make recommendations to the Governor for managing services more efficiently or effectively.

Duplicate services

Can duplicate services be measured?

One way to gather data (which the state currently does not have) is to bill school health-related services through DMA's Medical Management Information System.

Collecting data from several agencies through the same system would allow management reports to display data that can be analyzed for duplication of services.

Primary Reason to Bill Medicaid

What is the primary reason to pursue Medicaid funding?

The overriding reason to pursue Medicaid funding would be to improve programs and services provided to special needs children served by the several agencies and funding sources. Services may be expanded to children who need treatment but may not qualify under the current criteria. Care coordination services not currently provided to families may also be provided by districts with Medicaid revenue.

MMIS can also provide detailed service information critical to efficiently and effectively manage services to children with special needs throughout the state of Alaska.

Revenue

What "costs" could be shared or what revenue could be anticipated from federal Medicaid matching funds?

Costs to provide education of staff and the cost of processing the data from the service provider to DMA should be shared by districts that benefit from Medicaid reimbursement.

Revenue based on costs of providing services would grow as more districts became organized to gather information and as more speech teachers became ASHA certified. Projected annual revenue is provided in the body of the report.

New dollars into the state

What amount of revenue can be expected to be generated from the federal matching funds by billing Medicaid for health-related services provided in the school setting?

For each Medicaid dollar generated, 50% is from federal taxes. Theoretically, because reimbursement levels are based on the cost to deliver the service, no "profit" or excess is built in. Reducing funding at any level based on Medicaid reimbursement would result in decreased dollars for district to provide services and programs.

Before state decisionmakers consider reducing legislative funding appropriations

	due to Medicaid billing, compliance with federal supplanting issues neet to be fully evaluated. Another consideration: One district may be able to recover Medicaid dollars because they have a high percentage of students who are Medicaid eligible. Other districts may have none. To reduce funding across the board could unfairly penalize districts who have no Medicaid reimbursement potential.
Stability of Medicaid Eligibility How stable is the Medicaid population who may also be receiving reimbursable health-related services?	Many variables control who is Medicaid eligible. On any given month, one third of the Medicaid population or information may change: eligibility status, name or address etc. Other variables contributing to reimbursement instability include unpredictable rates of reimbursement, federal cooperation, covered conditions, services and service levels. Special eduation criteria can also experience changes, such as expansion of needed services or reduced identification of students. Alaska is currently at an above-average level of special education identification at 13% statewide. This percentage is more likely to move downward toward the national average of 11% of the state student population base. (Reported by Average Daily Membership-ADM)
Timing When could the state realistically expect to begin operating a Medicaid billing program in schools?	School year 1997-98 is the earliest a program could begin. Implementation activities will take a year--assuming major barriers are overcome.

Because Medicaid funding criteria and levels are likely to change at the federal level, the "window of opportunity" for the state of Alaska to develop this kind of program will not likely extend past 1997.

Technology

What technology is needed to communicate and manage data efficiently?

The DMA has free software that electronically communicates claims data from providers to DMA. While this would be adequate for submitting claims data in order for MMIS to make a payment decision, it would be necessary to develop software that can import data bases and generate reports to school administrators.

Efficient data management and analysis is impossible without this technology.

Hardware requirements would be minimal and necessary only for the billing centers.

Summary of Barriers to Implementing a Medicaid Billing System to Gain Reimbursement for Special Education Health-Related Services

What are the barriers in implementing a Medicaid School-Based Health Services Program?

Certain barriers which must be overcome are significant, but not insurmountable. As a background to understanding the task, one must recognize that the concept of Medicaid reimbursement for students with developmental disabilities is somewhat antithetical to traditional medical assistance programs. The most prevalent barrier is the lack of knowledge and understanding about what Medicaid can and cannot fund and about what schools, through special education, can and cannot do. The complexities of each area usually wear out even the most well-intentioned program planners when it comes to designing funding systems for children with special needs. The following explanation attempts to provide some perspective:

Historically, federal and state Medicaid policies and procedures have been designed to fund only the levels of service that are medically necessary--services which have traditionally restored a patient to an acceptable level of "health." This means the general policies, the claims processing systems and the control procedures are designed to prevent funding for all but the minimal level of "necessary services."

Medicaid programs do not, generally, develop policy to provide services aimed at achieving age-appropriate function for children. A school reimbursement program which funds services for children with developmental disabilities (and whose treatment may be seen as experimental in the traditional sense) is, therefore, contrary to the basic design of most medical assistance programs nationwide. These same programs also assume that services will be delivered in a traditional medical setting such as a hospital or a clinic. School buildings, as a medical setting, is not on the list of acceptable medical settings in federal Medicaid regulations. Nor do regulations recognize the need to deliver health services to a child who might be traveling on a bus from home to school. The comparable medical setting, of course, is an ambulance. These new settings for service delivery don't fit conveniently in either the Medicaid tradition or in the education tradition. Nor do regulations recognize the need to deliver service "in the least restrictive environment" which is a federal mandate in the educational setting.

There is also ongoing debate about what the individual needs of the child with disabilities are. Medicaid policy may take one stance; special education, another: For example, consider the ventilator-dependendent child who requests Medicaid funding for a portable ventilator: in some states, Medicaid policy covers a stationery ventilator, but considers a portable ventilator "not medically necessary"--or "for convenience only and frivolous"--even if it is less costly. This lack of recognizing that, today, children with disabilities go to school and they need portable equipment is another barrier.

Inflexible policies are slow to change because the historical standard is based on a traditional medical setting where the patient is transported to the service. That same concept, however, is also why Medicaid reimburses for transportation of a student to a covered Medicaid service. In the school setting, that means if the IEP requires transportation (school bus) in order for the child to get the occupational therapy provided by the District OT, then mileage could be reimbursed by Medicaid.

Another Medicaid policy resulting from the traditional medical setting is the barrier which describes what the relationship must be between the provider agency (the school district) and the health-caregiver. According to Medicaid, the relationship between a provider agency and the caregivers must primarily be employer-employee and not contractual. This regulation makes it difficult for a small district to be recognized by Medicaid as a provider agency because small districts often contract for their health-related services. These few examples are reasons why it is difficult to fund services in the school setting with Medicaid.

On the special education policy level, specific health-related services are mandated by federal legislation. Procedures are strictly defined, including set timelines for referrals, evaluations, decision-making teams to determine special education eligibility, decision-making teams to determine services to be delivered etc. State Departments of Education monitor school districts for compliance with these federal policies and procedures. When the process has been followed but services cannot be agreed upon, the grievance process or court system may decide which services a school will provide. While many services are provided under the special education mandate, many other services are limited by the same mandate. The limits are not understood by many decisionmakers. To quote from a March 1996 study on "IMPACTS OF STATE MEDICAID DEMONSTRATION WAIVER PROGRAMS ON CHILDREN" by Harriette B. Fox and Margaret A. McManus:

> ". . .benefits are limited for developmental or habilitative services, most importantly ancillary therapies, although these services may be covered by the OHP (Oregon Health Plan) when furnished through the schools."

While this statement may be explained as a poor choice of words, it is a common assumption, both within and outside the medical community, that when benefits are limited for developmental or habilitative services by lack of health-care funding, referring a child with disabilities to the local public school system will result in the necessary therapy for that child's condition at no cost and regardless of the child's needs.

The reality is that schools are mandated, under special education regulations, to provide health-related services, including therapies, <u>for those students who qualify through special education in order for that student to benefit from his education.</u> And, no

more. Some children need more therapy services than those mandated under special education legislation.

With the above background which discusses a knowledge barrier that extends beyond the state of Alaska, the following outlines the specific barriers the state of Alaska would need to overcome to implement a successful Medicaid funding program within the school district setting:

1. Determining Medicaid eligibility in a manner which is efficient for school districts. There are nearly 125,000 children in the Alaska Public School System; schools need to know which students are Medicaid eligible at the time of service.

2. Gaining ASHA certification for district speech/language teachers. Teachers may have a masters level speech/language degree, but not ASHA certification--a Medicaid requirement. Other "medical" credentialing requirements may also apply.

3. Gaining HCFA state plan approval for issues that appear to violate HCFA requirements. Examples: allowing SERRC to become enrolled as a school provider when SERRC is not recognized by the state DOE as a school entity; approval of a TPL waiver (third party liability requirement)

4. Changing the DMA claims processing system to include a new provider type: school districts.

5. Gaining legislative approval to authorize implementation costs and DMA activities to include permitting a new provider type.

6. Risking loss of other Medicaid funded services. Ongoing monitoring would be required to assure there is no unintended negative impact on programs or on children with special needs. Examples: the TEFRA option and the Medicaid-funded time study for administrative services.

7. Establishing an efficient, economical and accountable system for two program areas--education and health care--that already have strict federal mandates but have little control over the needs of the population served.

IV. BACKGROUND AND ENVIRONMENT

This section provides general information on the current state and federal laws relating to Medicaid funding for health-related Special Education services. The basic rationale for pursuing this funding source and the experience of other states are also discussed.

Discussion of Federally Authorized Programs for Children with Disabilities

To understand both the Medicaid and the Special Education environment, it is necessary to describe the several federally authorized programs which apply to this examination of funding services to children with disabilities. When programs are optional for states, this examination will indicate state options by underscoring the text. Otherwise, the assumption should be that the programs are federally mandated. Alaskan agencies responsible for administering federal programs are indicated.

The following discussion of federal programs is necessary to fully examine the question and to lay the foundation for the Council in its decision-making process.

A.1. Medicaid

Medicaid, a federal/state funding mechanism, was established in 1965 by Title XIX of the Social Security Act to provide medical assistance for selected groups of low-income individuals and families. The states have considerable flexibility in structuring their Medicaid programs.

Within broad federal guidelines, each state Medicaid agency determine:

- who is eligible
- types, amounts and duration of the services covered
- sets the rates of reimbursement for services.

As a result, Medicaid varies considerably from state to state.

Responsible Agency: In the state of Alaska, the single state Medicaid agency is the Department of Health and Social Services, Division of Medical Assistance.

According to the Annual Report FY95 of the Division of Medical Assistance, 55,202 children from birth through 20 years of age were Medicaid eligible and enrolled for the Healthy Kids Program which is the name of Alaska's EPSDT Program.

A.1. a. EPSDT Program

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is the child-specific federally required component of the Medicaid program. All Medicaid-eligible children are entitled to services under EPSDT.

The EPSDT program covers

- periodic screening to detect physical, mental, vision, hearing and dental problems.
- treatment (including hearing aids and eyeglasses) and dental care (including preventive, restorative and emergency care, and, when necessary to correct a disabling condition, orthodontics.)

States must pay for partial or full health assessments between regularly scheduled screens if a child is suspected by anyone (parent, educator, developmental or health professional) of having developed any type of problem, whether new or whether a pre-existing condition that has worsened.

A.1.b. Capturing EPSDT data in Alaska

Processing claims through the DMA's Medical Management Information System (MMIS) allows the state to report the screenings, evaluations and treatment for children served through Medicaid funding. DMA reports that certain EPSDT information is missing due to the encounter reporting methods of the Indian Health Service (IHS) facilities. DMA reports cannot differentiate among the various services provided from IHS facilities.

A.1.c. Children with Complex Medical Conditions in Alaska

Statistics from the Division of Medical Assistance Annual Report FY95 show that there were 35 Children with Complex Medical Conditions under their Medicaid Home and Community-Based Care Program. Medicaid-covered services received by these children totaled $1,333,942 in expenditures for FY 95.

In addition, the state of Alaska participates in an optional federal Medicaid eligibility program known as the TEFRA Option (from the Tax Equity and Fiscal Reconciliation Act of 1982) or also known as the "Katie Beckett" provision. Under this provision, states can extend Medicaid to certain children with disabilities who live at home. The term "Katie Beckett provision" derives from the case of a ventilator-dependent child who could have been cared for at home but remained institutionalized only because the income and resource rules made her ineligible for SSI and therefore ineligible

for Medicaid. Children must meet the SSI definition of disability and must require the level of care that is available in a hospital or a nursing home but which can also be appropriately provided outside the facility.

To qualify for the TEFRA option under Medicaid, a child must meet all the following criteria:

- be 18 years of age or younger
- have a qualifying disability as defined under federal law
- meet the institutional level of care requirement
- have a plan of care with cost equal to or less than that which would be required to maintain the child in an institution.
- child must live in her natural home

The Division of Medical Assistance funded services to 172 children under the TEFRA option during FY 95. Total TEFRA Medicaid expenditures for FY 95 were $1,238,552.

A.2. The SSI Program (for children with disabilities)

The Supplemental Security Income (SSI) prgram for children is a federal benefit program for children with chronic illness (of significant health impairment) and disability. SSI is a federal cash-assistance program funded and administered by the federal government through the Social Security Administration (SSA). Its purpose is to guarantee a minimum level of income to children who are blind or disabled. Children who receive SSI benefits have severe chronic health problems which last 12 continuous months or are expected to result in death, are disabled or blind and have limited income and assets. These benefits are important to families whose children have diverse, extraordinary needs. In addition, SSI eligibility can provide an avenue to health-care insurance through Medicaid.

Medicaid covers many of the health-care expenses that mount up quickly for children with chronic illness or disabilities. In 31 states children eligible for SSI are automatically enrolled in Medicaid. In another seven states, including Alaska, children who are eligible for SSI are eligible for Medicaid, but are required to apply for Medicaid and SSI benefits separately.

Responsible agency: In the state of Alaska, eligibility determination for children with disabilities is the Division of Vocational Rehabilitation Disability Determination Unit.

A.2.a. Eligibility Criteria Changes Affecting Children receiving SSI

A provision of the July 17, 1996 Welfare Reform Legislation eliminated the Individual Functional Assessment (IFA) tool as a basis to determine eligibility. Many children with disabilities were determined eligible for SSI

using this assessment tool. New criteria is now being developed to reevaluate those children. It is unknown how many children in Alaska will be affected by this change in federal legislation. Early projections, nationally, however, indicate the overall drop in eligibility to be small--at the 5% or less level.

A.3. Special Education

Special education and related services are designed to meet the unique needs of a child with a disability, in conformance with each child's individual education plan. Such services include, but are not limited to , specially designed instruction, transportation and such developmental, corrective and other supportive services as required to assist a disabled child to benefit from special education, including speech pathology and audiology, psychological services, physical and occupational therapy, recreation and medical and counseling services. Medical services are for diagnostic and evaluation purposes only.

Responsible agency: Special Education in Alaska is administered by the Alaska Department of Education.

A.4. Early Intervention

Part H of the Individuals with Disabilities Education Act provides assistance to states to develop and implement statewide, comprehensive, coordinated, multidisciplinary, interagency programs of early intervention services for infants and toddlers with developmental delays and their families.

Children from birth through 2 who are experiencing developmental delays in cognitive development, physical development, language and speech development, psychosocial development and/or self-help skills, or those who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay are eligible. At state discretion, eligible children may also include those from birth through 2 who are at risk of having substantial developmental delays if early intervention services are not provided. Families of eligible children are also eligible for services.

Covered services include those designed to meet the developmental needs of infants or toddlers with disabling conditions in conformity with an individualized family service plan (IFSP).

Such services include those provided by qualified speech and language pathologists and audiologists, occupational therapists, physical therapists, psychologists, social workers, nurses and physicians in conformity with an individualized family service plan.

Responsible agency: In Alaska, the Department of Health and Social Services, Maternal Child Health (MCH) is responsible for the Infant Learning Program and is the lead agency for the Early Intervention Program.

INTRODUCTION:

While thirty-eight states report they have a Medicaid program to reimburse school districts for health-related services prescribed on the Individual Education Plan for each Medicaid-eligible child, the programs vary widely and participation and success are mixed. Some Medicaid programs require (1) each employee (who is medically credentialled) to enroll as a Medicaid provider, (2) a physician referral for each service and (3) require school districts to bill all private health insurance before pursuing Medicaid as a funding resource. Each of these requirements precludes school districts from successfully participating in a billing program since these requirements run counter to the operations of an education program. In some cases, there is a direct violation of ethics: for example, a public school system must provide a "free and appropriate public education" and can be legally at risk if they use a child's private health insurance.

Since the contractor's experience was primarily in Oregon where great care was taken to utilize the strengths of the Medicaid requirements through the EPSDT program and to develop a program that respects the federal-defined special education process, twenty-seven other states were contacted to capture and highlight what was working and what was not working throughout the nation.

A summary of the responses from other states follows:

<u>What are the primary reasons school districts do not bill for school-based services through the School Reimbursement Medicaid Program:</u>

Sixteen out of 27 states reporting identified paperwork as primary reason school districts have not wanted to participate in the Medicaid billing program.

Nine out of 27 states reporting identified concerns about Medicaid funding as reasons school districts have not wanted to bill Medicaid.

•Florida reports that 1) school districts are not participating because it is not profitable, 2) districts must bill only direct costs so the incentive to participate is low, 3) speech therapists do not meet federal provider requirements and 4) most services are considered educational and are not Medicaid reimbursable.

•Nevada schools don't pursue Medicaid funding because only the large districts can benefit and they believe it is too difficult for small districts to pursue reimbursement.

•Illinois schools have aggressively tried to build a Medicaid reimbursement program for several years, however, they report that many districts do not participate because Medicaid regulations make it difficult for them to enroll as providers.

•New Mexico schools are not only concerned about the impact of additional federal requirements they are subjected to by billing Medicaid but they are also concerned about the perceived complexity of the billing process.

Not all states have the same concerns:
•For example, the state of Nebraska requires participation by public schools if they provide therapy to any Special Education students. The Nebraska Governor has contracted with a billing service that promotes districts to bill for all services in order to maximize the federal draw. Nebraska learned, however, that many of the school districts have no special education students who receive occupational therapy, physical therapy or speech therapy; some speech therapists are not qualifiable by Medicaid, and some schools have no Medicaid-eligible students that do not have other insurance. This means the district must pursue the private insurance first before billing Medicaid. If they do not pursue all other resources, then they cannot bill Medicaid for the services.

What services do most states include in their Medicaid School-Based Programs?

•Twenty-two out of 27 states can bill for therapy services; 11 out of 27 can bill for EPSDT screenings and subsequent evaluations. Other services, like nursing varies from state to state.

Do any states allow school districts to bill for nursing services?

•Direct nursing services can be billed in14 out of 27 states with the state of Missouri only allowing services provided by a nurse practitioner to be billed. This is because in Missouri, RNs and LPNs do not have provider standing with Medicaid. As in most Medicaid programs, RNs and LPNs can bill only for private duty nursing.

Do any states mandate that schools bill Medicaid for IEP services?

•Idaho and Utah mandate schools bill Medicaid for IEP services. They have also mandated that all of the revenue goes to the state budget. Incentives to participate are low and Idaho Medicaid is considering changing the current

distribution of Medicaid reimbursement for IEP serves to allow schools to retain more of the funds.

Consultation with Oregon School Providers

•An informal telephone poll of Oregon school districts asked service providers if they had a choice to bill or not to bill Medicaid. Districts were also asked what their biggest initial hurdle was. Results follow:

Eighteen out of 20 said they would chose to bill Medicaid because the revenue was seen as beneficial to the district and the students served. The biggest hurdle was licensing or obtaining ASHA certification for speech therapists who were not properly credentialled for Medicaid reimbursement.

Comments: Documentation practices required by Medicaid have raised the standards of special education reporting. These increased standards have been beneficial to the district, to communication between service provider and has improved recordkeeping practices of student health-care special education records.

Improvements in documentation practices have led to better continuity of care when students move out of the district or are required to be treated by another service provider.

Speech pathologists who had to return to class to continue their education in order to become qualified to bill Medicaid report that their level of professionalism has improved significantly. They report they are more marketable for employment in another setting such as a hospital, rehabilitation center or nursing home and they take pride in their elevated standing among other special education professionals.

Overall, there were 397 speech therapists in Oregon schools in 1991; approximately 60% had to upgrade their Teacher's Standards and Practice Commission credentials to either American Speech and Hearing Association (ASHA*) certification or Oregon State Licensure. To date approximately all but 15% have accomplished this standard over the past five years.

Nearly all districts report they have rewritten job requirements for speech pathologists to include state licensure, Clinical Fellowship Year (CFY), or ASHA CCC as a condition of employment. Not all districts, however, require ASHA certification.

Most districts initially paid for the licensure process and the annual license fee for the first five years. The cost to districts to educate and certify their speech pathologists averaged $4,000 in one Education Service District. Costs have varied from district to district because some service providers needed

more additional education than others. Now, most all districts require employees to pay for professional licenses. Continuing education, however, is generally an employee benefit within the educational community.

ASHA Certificate of Clinical Competence

The American Speech and Hearing Association (ASHA) is considered by most speech pathologists to be a highly influential professional organization. The author participated in a national ASHA conference in Baltimore, Maryland in May of 1991 when the mood of the organization was extremely hostile to the concept of school districts billing Medicaid for services provided through special education programs. They feared the dollars taken by schools would diminish the pool of dollars going to private providers.

Today, the American Speech and Hearing Association embraces this school billing effort in part because school provider membership has brought increased financial and political support to the organization and has raised the awareness of public educators of the importance of professional medical credentialling.

ASHA has revised its standards and methods of obtaining certification to meet the need of speech pathologists who had to be able to maintain employment while obtaining ASHA certification. It is now possible to obtain ASHA certification without taking a leave of absence to return to school. Many universities have developed programs for speech pathologists who desire to obtain ASHA certification. There are three university programs in Oregon, and several in other Northwest states; however, there are currently none in the state of Alaska.

Those districts in Oregon that required speech pathologists to obtain certification felt the greatest benefit has been to the infants, children and youth who have a superior quality of therapy with the higher standards.

The Union ESD Special Education Director, when asked if he would force his speech staff to upgrade to ASHA standards, said, "absolutely. It was one of the best things I ever did for kids." Even though the ESD's outlay for the 20 speech pathologists employed by the ESD was $80,000, the Director said it was a wise staff development investment. The new standard impacted speech pathologists statewide. The author spoke with no one who said they wouldn't upgrade their speech staff standards. All interviewed said the result has been positive in every way--although the process was sometimes painful.

V. REVIEW OF MEDICAID REIMBURSEMENT REQUIREMENTS

This section builds upon information which was provided in a publication entitled, "EPSDT School-Based Children's Medical Services Program" produced in June 1993 by the State of Alaska, Department of Health and Social Services, Division of Medical Assistance and a Proposal entitled "Medicaid School-Based Health Services" by the State of Alaska, Department of Health and Human Services, Division of Medical Assistance dated September 21, 1993. This update is intended to provide the Characteristics of an efficient program that meet Medicaid and Special Education criteria.

MEDICAID REIMBURSEMENT REQUIREMENTS

A fundamental Medicaid requirement is that the provider of services must verify eligibility prior to delivering a service.

However, the current method of phone verification would not work efficiently for either the Division of Medical Assistance or for school districts. To request phone verification monthly on over 15,000 children would be highly impractical and costly.

The school setting is unlike other health-care provider settings in that the physician or hospital provider usually has benefit of the patient providing the Medicaid-coverage ID card. In the school setting, it is impractical and discriminatory to ask a child to produce proof of Medicaid-eligibility.

A school district may know how many students are Medicaid eligible, but they don't know which students are Medicaid eligible.

Which service activity can be reported for Medicaid reimbursement?

Education-based reimbursement for special education health (medical) services is still a new concept nationwide. It requires a careful examination of what service activity can be reported to qualify for Medicaid reimbursement. No two states have approached the issue the same and no two states have the same program or procedures.

The success rate of education-based health-related service coverage varies widely state by state. In some states the Medicaid agencies have maintained a traditional-medical setting approach and have required schools to become Medicare-institutional certified following hospital criteria. Other state Medicaid agencies have attempted to consider the educational setting and the federal requirements of both the education setting and the medical setting. The federal regulations coming from the Office of Special Education and the Health Care Financing Administration are the source documents for fully exploring the marriage of these health care delivery settings.

In Alaska, the Division of Medical Assistance would need to fully understand how the services are delivered in the special education setting in order to write policy that makes sense to health-care providers who will report and document services provided. Which activites and what activity level should be reported for Medicaid reimbursement must be fully explained to the school providers whose instructions and objectives to date have been to help the students benefit from their education--not to meet medical objectives. Some service activity is obviously medical; other service activity is obviously educational; other service activity needs to be examined by both educators and DMA to explore the potential. This is a new setting for health-care delivery. There is little precedence. Knowledgeable persons who take time to observe, learn and apply basic Medicaid regulations can define a program to meet the needs of the service providers in the eduational setting. It is no small task, however. It will take several years to fully develop policy.

Two examples: (1) Traumatic Brain Injury (TBI) was not considered a special education classification a few years ago. (2) Children diagnosed as Autistic is also included special education eligibility classification. Both categories of children require extensive medical intervention. The TBI child has more clearly defined medical needs than the child who has been diagnosed as autistic. Autism, however, is a medical diagnosis. Some medical treatment programs are covered by Medicaid under a more-traditional mental health rehabilitation category.

For the autistic child, the debate about what treatment is educational and what treatment is medical is a national debate. Nationally, there is also little agreemen' about what is or what is not effective treatment for children diagnosed as autistic. And, many decisions about what treatment is necessary is being decided in the court system--not by educators or by the medical community. Whatever policy is developed about services delivered to these populations today will undoubtedly change as more knowledge about effective treatment for these children is gained.

Technology forces Medicaid reimbursement in other-than-medical settings.

As in the past, medical technology advancements permit more children to live in the home and community setting where services must be delivered. Precisely which services will be billable to Medicaid and which will not be billable cannot be determined by a general policy. Observation and analysis by a knowledgeable Medicaid policy person will be required in order to develop specific guidelines to education-based service providers that can withstand a Medicaid audit.

New policy and providers prompts ongoing Medicaid analysis.

The providers of services cannot unilaterally determine which of the services services they provide are billable. Likewise, a Medicaid policy person cannot write policy that is so vague as to mislead providers to report any service activity for Medicaid reimbursement. This approach to opening Medicaid funding is irresponsible. One cannot expect a claims payment system to deny claims for inappropriate services when the service categories are broadly defined. On the other hand, the claims payment system (called the Medical Management Information System--MMIS) that actually pays the claim is set to pay according to editing criteria. It would be just as irresponsible to define each procedure so specifically that the procedures must be coded to the degree of the medical community. These universally-adopted procedures have taken decades to define in the physician and hospital settings.

"Who" delivers the service is critical to Medicaid reimbursement.

To further complicate the "what's covered and what's not" issue, services are not delivered the same throughout the state. Urban areas have more access to medically-qualified staff who give more direct service; rural areas are often remote from the medically-qualified staff who may only deliver direct services to students once a month or even more sporadically. The problem of having access to medical providers in rural settings is universal throughout the United States, not just in Alaska. However, it is of greater significance to Alaska because of the remoteness and size and the lack of transportation infrastructure that makes these rural communities dependent on others to provide services.

Urban areas usually employ more direct service providers; rural areas and villages usually contract for service providers who are paid daily to evaluate, treat the student and monitor services delivered by para-professionals who do not qualify as medical providers under Medicaid standards. Services delivered by para-professionals in educational settings are generally not reimbursable by Medicaid.

Basic Medicaid rule: Medicaid reimburses only the provider of services.

In exploring which school districts provide their own special education health-related services and which contract with others outside their district, it became known that 35 of 54 school districts contract with South East Regional Resource Center (SERRC). SERRC is a non-profit service organization which employs medically-credentialled staff who provide evaluations and treatment

of referred children, and who provide education and monitoring of paraprofessionals who actually deliver most of the health-related services.

SERRC is the provider but SERRC is not a school district. Therefore, for Alaska DMA to define the school district as the provider of services would eliminate the services provided by SERRC. While other states have defined school districts as the provider of services, it may be possible to otherwise define the education-based health-related provider to include SERRC, but this situation would depend heavily on HCFA approval. Without including this health-care provider, the majority of these small districts would be ineligible to receive Medicaid reimbursement on any level.

Medicaid task: Sorting out which service activity is "medical" in nature and which service activity is "educational" in nature.

HCFA's explanation was that the intent of the amendment under section 411 (k) (13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) was "to ensure that services that would ordinarily be provided or paid for by other agencies for handicapped children would be continued." Covered services would include those, "that are medical or remedial in nature."

HCFA specified that formal educational services were those relating to training in traditional aacademic subjects. Subject matter rather than setting, time of day or class size determined whether or not a service was education. Within this context, there are overlapping objectives of services delivered in the educational setting which must be clearly identified so the school service providers understand what is educational and what is medical. Even though the service provider is medically credentialled to perform the task, this identification process is no simple task. Every state must undertake the identification of services task--recognizing the historical nature of each unique environment--the one for educational purposes and the other for medical purposes.

Why Medicaid reimbursement is a funding source: The changing nature of services delivered in the educational setting.

The full impact of IDEA had not begun to be felt until recent years. All children, regardless of their disability, have had a right to a free and appropriate public education since the inception of Public Law 94-142 in 1975. This federal requirement opened the door, in some cases, for the public schools to provide extensive evaluation and treatment services that could only legally and ethically be provided by medically-qualified staff. It was for this reason that the need to explore and support health-related services in the educational setting has become a necessity.

The impact of IDEA will continue to expand and will need to be re-evaluated as the nature of the services delivered in the educational setting continues to cross into the medical environment. Attempts to change the IDEA process through federal reauthorization of the Act have been unsuccessful.

States which attempt to control budgets find themselves in competitive environments where one state agency cost shifts to another to rid themselves of costly programs. When the federal government mandates responsibility to one area, in this case to Education, that agency is left somewhat defenseless and often underfunded. The federal government promised to fund health-related services by up to 40%. To date, federal funding has not exceeded 12%. Other states' experience shows that those states which have not mandated collaboration nor participation among all responsible agencies have been left with little or no support for the task of funding medical services delivered in the educational setting, particularly through special education.

As resources become even tighter, educational agencies will experience attempts by other agencies to shift more and more costs by referring to school districts in order to deliver services to children in the educational setting. In some states where Medicaid managed care has become commonplace, the services ordinarily provided in a fee-for-service environment have been delayed or not provided at all through the managed care providers. The result: children with developmental disabilities have been referred to the education system for evaluation and treatment--the assumption being that the service is a "free" service to all children through Special Education--an assumption which may or may not be based on reality.

Considering the many changes occuring all at once in the health-care community and the lack of understanding of how services are provided in the education community, some communication errors are unavoidable. States that strategically plan for such changes by including all agencies who serve children, however, can avoid most of these unintended results.

An Example of Unintended Results that may Result from Schools Billing:

Alaska's Department of Health and Social Services, Division of Medical Assistance 1995 Annual Report shows there were 35 children with complex medical conditions who received services under the Medicaid Home and Community-Based Care Program and 172 children who received Medicaid through the TEFRA (Tax Equity and Fiscal Reconciliation Act of 1982) Option. One of the primary considerations under these Medicaid-covered reimbursement options is that the cost to provide services outside the institutional setting would be equal or less than that which would be required to maintain the child in an institution.

Since the costs to provide health-related services in the education system has not previously been measurable through the MMIS claims processing system, it is conceivable that this additional cost would cause some children's expenses to increase to the point that they no longer qualified to receive Medicaid coverage through these programs and options.

Case in point: Some of these children would be receiving the following services in the school-setting that would be reimbursable under a School-Based Program:

Occupational Therapy	Speech Therapy
Physical Therapy	Daily Skills Training
Personal Care Attendant	Hearing and Audiologal Services
Low Vision Services	Orientation and Mobility Services
Nursing Services	Delegated Nursing Services
Evaluation services in all categories above	Transportation to and from school-based providers of these services

Depending on the level of services and reimbursement costs, this "package" of services based on individual need could add up to several thousand dollars in monthly reimbursement to school-based providers.

DMA is responsible for fiscal oversight and monitoring of program costs and would be required to add the costs of delivering services in the school setting to the overall costs of Medicaid expenditures. This unintended outcome impacting one or more children currently receiving Medicaid through these programs/options would clearly be counter-productive. An initial comparison between those children receiving services at school and those children in the TEFRA Option program shows little risk that these children would exceed their allowed threshhold amounts. Expenditures should be tracked closely, however, if a school billing program were implemented.

Note: Other states may not have encountered this because they do not participate in the TEFRA Option or they have minimal school reimbursement programs.

SPECIAL EDUCATION: UNDERSTANDING THE AUTHORIZATION FOR MEDICAID REIMBURSEMENT

The first consideration for the Council is to understand the limit of the school district population under consideration. Only students receiving a health-related evaluation or treatment under the "IDEA" legislation qualify for Medicaid reimbursement under the P. L. 94-142 and Title 4, Chapter 52 Alaska Administrative Code.

School districts must have a process in place to take referrals of educators, parents, the medical community, specialists, the courts, to adequately assess a referred child's condition to determine whether or not either special instruction or treatment is necessary for a child/student to benefit from his education. Special Education law covers children from school age (6) through their 21st birthday.

This "process" is defined by federal law complete with timelines which are a critical part of the process. School districts risk financial penalties if they are found to be in violation of the special education requirements. The categories of disabling conditions defined by federal law and are explicitly defined and described in the Alaska Administrative Code: Title 4, Chapter 52 Special Education Regulations (January 1995) produced by the Alaska Department of Education. Categories qualifying for special education are these:

Mental Retardation
Hearing Impairments
Speech or Language Impairments
Visual Impairments
Serious Emotional Disturbance
Orthopedic Impairments
Other Health Impairments
Specific Learning Disabilities
Deaf-Blindness
Multiple Disabilities
Autism
Traumatic Brain Injury

It is imperative to acknowledge that the only services qualifying for Medicaid reimbursement are those evaluation, treatment or related services provided through the above categories. As identified above, these categories are specifically defined in federal legislation. The scope of any proposed Medicaid reimbursement is not intended to cover any evaluation, treatment or related services outside those categories as there is no authorization to do so.

For example, a child may have been injured in a car accident which significantly impairs this student to participate in his educational program. While the school district may accommodate that student under separate federal legislation so he can continue his educational program on schedule, this "injurious condition" would not likely qualify for "special education." One reason is that the federal definition requiries that the disabling condition be a disability of nine months or longer in duration. In other words, the criteria for special education qualification is specific and unless the process is

followed according to the federal law, one could not and should not assume that a child qualifies.

Reimbursement for Health-Related Service Delivery in the Alaska Educational System: One Way it Could Work

One way to reimburse for health-related special education services in order to meet federal requirements to make payment to the provider of services is to develop and to then contract with regional educational entities. There may currently be regional organizations which could assume the role and responsibility of a "billing center." An example could be

1. The "Southeast Regional School-Based Provider System of Juneau,"
2. The "Southwest Regional School-Based Service Center"or
3. The "South Central Regional School-Based Provider System of Anchorage" etc.
4. The "North Central Regional School-Based Provider System of Fairbanks"

These "four" designated School-Based Provider Systems would function as the "billing provider (in MMIS terminology) or billing center or health-services administrator" and could be a consortium of local education agencies (school districts) responsible for health-related services under special education law. Conceptually, these organizations could also serve as Intermediate Service Agencies with multiple functions.

These Provider Systems could receive payment based on electronic reporting on claim format to the Division of Medical Assistance with the following information:

•Name, and Medicaid number of the child.

•Condition of the child reported according to the ICD-9 diagnosis coding system. (Cross-coding of child's primary disabling condition according to special education category would allow sophisticated analysis for tracking services.)

•Description of services delivered reported according to procedure codes developed specifically for this purpose. This information would include date of service, units of service, place of service and amounts charged. Amounts charged would be based on the cost of delivering and supporting the service.

•Provider identification number: Juneau School District, Fairbanks School District etc. would be considered the provider of services.

These "providers" would be responsible for assuring that the service was delivered by an appropriately credentialled service provider.

When a service could not be delivered directly by a school provider, the S-BP System could "contract" for services to be delivered by other community providers such as Southeast Regional Resource Center or the local mental health contracted provider. These services could also be billed through a School-Based Provider Billing Program. This "contract" billing would not necessarily add new services, but could provide revenue for more adequate service levels that should be given, but cannot be provided due to limited funding. "Contract" billing would also allow existing relationships which are currently providing efficient health service delivery to continue. Contract services could be billed at the same or different rates under a separate procedure code from those services provided by staff.

This billing center would keep service records identifying the plan of treatment (the Individual Education Plan which identifies all health-related services to be delivered) as well as all service logs which furnish the documentation of service delivery.

One of the primary functions of this "administrator" would be to identify students who are Medicaid eligible and forward pre-headed service logs to the treatment provider on a routine basis ie. monthly.

Services could be expanded beyond special education in the future as DMA determined other services that could be reimbursed through these Provider Systems i.e. EPSDT screenings or mental health.

This service delivery model focuses on the school setting as a natural and efficient way to deliver services to children, including children with special needs. The alternative model focuses on the medical setting as the primary method of delivering services. The medical setting is the method of choice for those states where managed health care plans are the primary delivery methods for the Medicaid population.

As all states, the Alaska Division of Medical Assistance has been investigating ways to control costs while assuring quality care. One option could be managed care. This consideration may be a factor in the direction the state chooses: coordination through the educational setting or the medical setting.

It is recommended that any exploration of an integrated service delivery model include the process of identification and service delivery through federal and state special education and early childhood special education and be expanded to include early intervention (Infant Learning Program) in the future.

Several other states, including Oregon, have designated the Department of Education as the lead agency for the Early Intervention program. This increases the federal participation to the School-Based School Billing to include the birth-3 age range. The percent of infants in the Early Intervention program is much higher than pre-school and school-age only. Alaska would not have benefit of receiving reimbursement through a school-based billing program for like services provided to the Early Intervention infants who qualify for Medicaid unless and until this population was included.

Many health-care services are delivered in the school-setting outside of special education, including routine public health services (communicable disease control, head lice etc.) and alcohol, drug and tobacco, teen pregnancy, as well as other health impairments (allergies, medication administration and monitoring).

Efficient and effective health-care service delivery integration to children doesn't happen easily for two reasons:

1. As one perceptive speaker succinctly described the problem: Within both the education and medical environments there is a pervasive and traditional disease known as "TURF-DUMB."

2. Even when this "disease" is in check and the motivation "to do the right thing at the right time" is great, the health-care needs, delivery and funding of services to children with disabilities is incredibly complex.

With this basis, the following characteristics of an efficient program that meet Medicaid and Special Education criteria are identified:

Characteristics of an efficient program that meet Medicaid and Special Education Criteria.

1. DMA will establish billing relationships with a few billing centers such as "four" rather than each school district. This will:

a. Provide an efficient and simplified structure since DMA would be communicating with four entities instead of 55.

b. Allow a train-the-trainer structure for ongoing communication, education and information-sharing. The "four" entities could develop site coordinators at each reporting district and provide the staff training, monitor the billing activity and documentation. Staff turnover could best be handled

by cultivating resources who know both Medicaid requirements and special education requirements.

c. Keep costs low for hardware, software and eligibility verification. DMA would only need to establish electronic connections with these four entities. Interaction with DMA staff would be more manageable with four points of contact than with 55.

d. Provide flexibility in district needs vs. state needs. Reporting could be uniform to the state yet be flexible enough to meet local district needs and differences. Billing centers would be responsible for all reports to DOE and DMA.

2. The school billing program will include all services that can be covered under a Medicaid rehabilitation program that are also required through health-related special-education and prescribed in the plan of treatment known as the Individual Education Plan, such as:

Occupational Therapy	Speech Therapy
Physical Therapy	Daily Skills Training
Personal Care Attendant	Hearing and Audiological Services
Low Vision Services	Orientation and Mobility Services
Nursing	Delegated Nursing Tasks
Evaluation services in all the above categories	Transportation to and from school-based providers of these services
Counseling and mental health	

3. Health-care providers who are qualified to deliver services under the rehabilitation model but who may not be reimburseable under a medical model will qualify based upon careful examination of medical credentials or academic standards recognized within the state of Alaska. Providers of services for which there is no medical standard may qualify through other examination standards.

4. The federally-defined process of identification and eligibility for special education services would be the reimbursement model on which to base program coverage decisions and policy. Through the Medicaid EPSDT program, identification, screening, evaluational, referral and treatment through the IEP process can all be reported under EPSDT services so DMA can continue to meet its federal standards.

By designing the Medicaid program around the IEP program there will be the least disruption (1) to the child who has been referred and identified as needing a related-health service under federal special education rules and regulations and (2) to the service provider who is legally required to follow the IEP process. School districts with the responsibility to follow special

education law will continue to identify, refer and evaluate Medicaid-eligible children as with all children and to begin treatment according to the specific timelines required by law--without delay caused by physician referral, DMA authorization or managed care plan referral or authorization requirements. Such delays cannot be tolerated for children with developmental disabilities.

To design a program to meet the traditional Medicaid model would unnecessarily delay or withhold services to children with developmental disabilities and could also create a system which provides negative incentives for schools to postpone or withhold services pending Medicaid authorization procedures. This program design would defeat the purpose for which the special education process was developed.

5. Reimbursement rates to school districts would be based on the cost of delivering the service in the school setting and not according to private provider reimbursement which may include profit. Each district may report a separate fee schedule for the services provided, however, DMA may reimburse at one or more levels. Costs and reimbursement rates should be revised annually.

6. Out-of-pocket medical services should be reimbursable to districts for medical evaluations provided for a specific child when those services cannot be obtained by a district provider.

7. Services which are contracted by districts because it is the most efficient way to obtain needed qualify services should be reimbursable to districts, based on cost to purchase the service and for which the provider qualifies under federal Medicaid enrollment requirements. Until and unless federal laws are changed, some small districts may not qualify to be an enrolled Medicaid provider because they do not "employ" any staff person for whom services may be billable.

8. School districts should provide their own state matching funds for special education so that the Medicaid program budget remains neutral. Medicaid or other state funds would be used for non-special education services. The differences could be tracked precisely based on procedure codes billed.

9. While the Division of Medical Assistance has the legal obligation, the leadership would be shared with the Education providers through the four billing centers. These responsibilities would include reporting expenditures to districts and provide oversite activities to monitor service levels and provide ongoing technical support and training to district staff. Requesting federal waivers and state plan amendments, developing program policies and establishing eligibility verification methods, producing provider manuals, revising the MMIS system to recognize school districts as providers,

calculating reimbursement rates, developing procedures and paying claims, however, would be the ongoing responsibility of DMA. Program maintenance and liaison between DMA and the billing centers would also be required.

VI. IMPLEMENTATION ACTIVITIES

This section includes implementation activities of enrolling school districts as Medicaid providers using information provided by the Division of Medical Assistance and two sample school districts. It also includes the implementation activities of the Department of Education and the Division of Medical Assistance as well as describes other implementation activities of the Alaska State Legislature and DMA State Plan Amendments and Federal Waiver requests that may become necessary if the program is implemented.

A. COSTS AND BENEFITS OF ENROLLING SCHOOL DISTRICTS AS MEDICAID PROVIDERS

SUMMARY of COST PROJECTIONS

	Implementation	Ongoing
DMA costs		
Capital	$35,000	
Training (guide)	$10,000	
Operations	000	
Staff	$68,400	$98,800
Travel		$15,000
SubTotal	$113,400	$113,800
Billing Centers		
Capital	$16,000	
Training	000	
Operations		$72,000
Staff		$316,800
Travel		$60,000
SubTotal	$16,000	$448,800
Districts		
Capital	000	
Training	$276,500	
Credentialing	$ 80,250	
Operations		
Staff (Not out of pocket)		$300,000
Travel		
SubTotal	$356,750	$300,000
TOTALS	$471,750	$862,600

($300,000 of this is not out of pocket)

SUMMARY OF REVENUE PROJECTIONS

YEAR 1:	$5,300,000	or	50% = $2,650,000 (new) federal revenue
YEAR 2:	$5,500,000	or	50% = $2,750,000
YEAR 3:	$5,600,000	or	50% = $2,800,000

When the costs are subtracted from the net revenue, Alaska will benefit by approximately $1.8 million the first year--most likely increasing the benefit as the program matures.

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Billing Center Costs (Proposed 4 sites)

The following expenses would likely be borne by the aggregate school districts. Figures are rounded for ease of comparison. Costs and expenses are used interchangeably.

Expense:	Rate/cost	Duration
Staff costs		Implementation/ongoing

The following staff will be employees and subject to 50% admin overhead added to salaries (admin included):

Coordinator (Supv) (.75 FTE)	$45,000	Each year; ongoing
Clerical Expenses (.75 FTE)	$27,000	Each year; ongoing

Three sites will cost out at the above rates; one remote site costs out at 40% differential. Calculations include four sites with one reflecting the differential.

TOTAL Estimated Staff costs (Including one site at 40% differential)	$316,800	all sites
Operating Expenses Office supplies and forms	$1,500/mo	Each year; ongoing
TOTAL Estimated operating expenses	$72,000	all sites
Equipment costs		
486 computer, printer, terminal, modem, etc.		$2,000 hardware
Communications software and tracking		$2,000 software
TOTAL Estimated equipment costs	$16,000	all sites
Travel expenses For training, meetings and oversite activities.		
TOTAL Estimated travel expenses	$60,000	all sites

DISCUSSION OF DISTRICT IMPLEMENTATION costs (55 districts):

1. Training costs: There are approximately 428 professional staff and 55 clerical staff statewide who would need training to participate in the billing program. Due to the few hours of time, the costs for this would most likely not be actual dollars expended. In keeping with the conservative approach to this project, however, these costs are treated as actual dollars.

Professional Staff Training Costs: For cost projections, contractor assumed average staff salaries of $70,000 (FTE) plus 50% admin overhead. Training time assumed to be 8 hours/school year for each professional staff person (includes meeting time to discuss Medicaid billing) X 428 staff. ($617 each professional)

SUBTOTAL estimated professional training time costs: $264,000

Clerical Training Costs For cost projections, contractor assumed average clerical (Billing) staff salaries of $30,000 plus 50% admin overhead. Training time assumed to be 16 hours for each district coordinator --$226 x 55 (includes meeting time to discuss Medicaid billing) staff statewide.

SUBTOTAL Estimated clerical training cost $ 12,500

TOTAL Estimated (Indirect) Training Costs $276,500 Implementation

2. Indirect Staffing costs Each of the 55 district would need to designate a facilitator and administrator to be responsible for reporting and administrative oversite. Variables: Not all districts will participate; however, the assumption for estimates include participation at 100%.

Position and estimated % FTE		Cost	Duration
District Billing Facilitator	.10 FTE	$1,500	Annual
Administrative (supv)	.05 FTE	$4,000	Annual

TOTAL Estimated Indirect staffing costs for district coordination = $300,000

TOTALS (1) and (2) = $558,000 Estimated Statewide Cost to Districts

3. Credentialing costs At start up, $750 continuing education for each uncredentialed staff person may be needed; all other educational costs would be borne by individual staff as in the past.

From data supplied by Anchorage, Juneau and SERRC, 75% of all service providers (including speech) are currently professionally licensed or would be reimbursable under a rehabilitation model. An actual comparison of staff credentials would take approximately three months to assess.

TOTAL Estimated Statewide Direct cost for credentialing $80,250 statewide

TOTAL PROJECTED ANNUAL REVENUES	$5,300,000 (Rounding up)
TOTAL PROJECT IMPLEMENTATION COSTS	$ 471,750
TOTAL PROJECTED ANNUAL EXPENSES TO COLLECT REVENUE	$ 862,600

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DISCUSSION OF REVENUE PROJECTIONS The estimated revenues are conservative and the variables include:

1. Age range covered. The estimates include only those students receiving services under special education. If the Early Childhood population (3 - 5 year olds) were included, this would expand the reimbursement base. Likewise, if the Infant Learning Program (Birth - 3 year olds) were included, this would also expand the reimbursement base.

2. The availability of qualified staff. Estimates include assumptions on a somewhat equal basis statewide. This is particularly variable in the state of Alaska. Some districts would be unable to receive any reimbursement due to lack of service providers.

3. Number of Medicaid-eligible children receiving billable services by qualified providers on any given date. Estimates will vary district by district and from month to month and year to year in response to the varying economic conditions in Alaska. Based on the Division of Medical Assistance estimates of eligible children in each school district, the percent of children who are Medicaid eligible varies from 1% in Chugach to 71% in Kashunamiut with the average being 24%.

4. Frequency of service by qualified providers. Some larger districts such as Anchorage, Juneau, Kenai have on-staff professional service providers directly delivering the service. Other districts depend on contract service providers who may only deliver a direct service once a month. This unpredictable frequency of billable services will also cause fluctuations in revenue.

5. IEP services identified and appropriately indicated. District practices also vary in identifying and detailing the IEP plan of treatment. This

variable will also result in unpredictable revenue projections from district to district.

6. Efficient communication systems/coordinating technologies. Unless a statewide communication system can be implemented with efficiency, eligibility verification and reporting of services for billing to DMA will result in inconsistent and unpredictable revenues.

7. Transportation services that may be billable. There is currently no way to assess the potential revenue from transporting the child to a Medicaid-billable service. The variety of conditions by which districts identify transportation on a child's IEP and the actual provision of services cannot be calculated with any predictability. Therefore, these costs are not included in the revenue projections except for the Juneau School District. Potentially, small districts could benefit the most from transportation reimbursement; however, they are also least likely to have standing as a Medicaid provider due to federal requirements that they "employ" their staff.

BENEFITS TO CHILDREN AND FAMILIES, SCHOOL DISTRICTS AND THE STATE OF ALASKA:

1. Improved quality of service to children by promoting higher standards of therapy staff. Focus on professional medical licensure reinforces current direction of education to have the highest professional standards wherever possible.

2. Increased revenue to districts to fund improved overall services to all children, particularly children with special needs.

3. Increased internal and external awareness of special education process, including timelines and legal requirements.

4. Increased cooperative agreements between medical community, managed care organizations that surface, and school medical providers.

5. Provides opportunity for professional growth and awareness of medical model blending with educational model of delivering services. Many education therapy staff have not worked outside the school setting.

6. Improved special education recordkeeping and staff communication which should result in better coordination of services to children with disabilities.

7. More frequent inclusion of nursing staff in MDT and IEP meetings. Increased awareness that nursing assessments can prevent unnecessary therapy because student had medical condition undetectable by therapy staff.

8. Reduces potential for duplicate evaluations thereby reducing unnecessary stress on children and unnecessary time and effort of families with children with disabilities.

Intangible Costs that may become Management Issues:

1. Resistance of staff to the review of job and treatment activities.

2. Resistance of staff to improve service delivery documentation. Some districts currently require no progress reporting other than that which is officially required on the IEP and re-evaluation schedule.

3. Revision of job descriptions to include Medicaid reporting, tracking and documentation activities.

4. Perception that districts will change IEP procedures or policy to "chase" Medicaid dollars.

5. Perception that districts will be induced to divert qualified staff to Medicaid-eligible children while non-Medicaid-qualified staff will be assigned to other students. May result in parent complaints or ethical issues within some districts.

6. Belief that increased workload for reporting, tracking and documenting services for Medicaid-eligible children is unreasonable and unnecessary. May result in union issues in some districts.

B. IMPLEMENTATION ACTIVITIES AND PROGRAM COSTS NECESSARY FOR STATE AGENCIES:

COST TO DEPARTMENT OF EDUCATION

Other than participating in planning meetings of key DOE staff, there should be few costs to the Alaska Department of Education. Support would be policy analysis and program development versus technical, administrative or oversite. DOE should assure that special education procedures are understood and followed during development of a Medicaid reimbursement program. This report assumes Special Education monitoring occurs statewide on a required three-year cycle.

COST TO DIVISION OF MEDICAL ASSISTANCE (DMA)

Costs to DMA could be substantial since it requires developing a new provider type, system changes and federal waiver and state plan amendment approval. The major tasks necessary for program implementation are outlined with estimates of staff cost required to complete the tasks follow:

1. Establish new provider type for schools billing Medicaid for Special Educationclaims processing modification. This requires legislative authority as well as significant system modification.

2. Provide streamlined eligibility verification method

3. Request Third Party Waiver and State Plan Amendment from HCFA The waiver process and SOA could include travel to HCFA Region X in Seattle and the process can be labor intensive due to a written response process to explain program to approving authority.

4. Gain State Legislative Approval for School-based Reimbursement Program. This process could be procedurally cumbersome but may not be politically difficult if the legislature acknowledges revenue benefits the state would receive.

5. Develop policy and provider manual including forms and process This task can be tedious and timecomsuming and will likely include annual revisions. Contractors can assist with the task.

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Project Leadership costs may be borne by districts but included in DMA costs. Funds for this leadership would likely need to be forward funded as DMA would not have this in their budget.

Implementation Project leader(.50 FTE)		
Contract Costs	$46,000	Each year; first three years
Travel Expenses	$15,000	Each year; first three years
SUBTOTAL Project Leadership:	$61,000	Annual for three years

DMA staff time equal to the following FTE to complete implemention and administrative tasks by current staff. Salaries used were provided by State Personnel salary levels. Implementation period is considered to be the first 6 months prior to program: Fall 1997.

Position	Ongoing	Implement
$46,000 for Policy Analyst	.20 FTE	.50 FTE Imp
$24,000 Clerical	.10 FTE	.25 FTE Imp
$40,000 Systems Analyst	.05 FTE	.50 FTE Imp

Assume addition to salary of 50% of salary for benefits, supervision and office set-up (Admin overhead)

SUBTOTAL Estimated Current Staff Costs to implement program:
$68,400 First six months

SUBTOTAL Estimated Current Staff Costs for ongoing program:
$37,800 Each Year; ongoing

Can be agency or contract staff. HCFA will match 50% for development and operations coverage. This match rate will not be included in cost projections.

DMA system changes	$30,000
Eligibility verification system	$ 5,000
Production of Provider Guide	$ 10,000
Staff travel expenses:	$ 15,000

TOTAL Estimated Implementation Costs	$ 113,400	Six months Prior
TOTAL Estimated Ongoing Costs	$ 98,800	Annual (3 Years)

VII. THE KNOWLEDGE BASE: ANALYSIS

This section includes a summary of key data which has been gathered by the contractor regarding numbers of children who are receiving services in the school environment under special education. This summary includes an analysis of the scope, frequency and level of services which may result in reimbursement for the school districts. It includes data from other states' experience as well as from the Alaska DOE special education census reports required by federal law. It also includes MMIS reports from the Alaska Division of Medical Assistance as well as selected school district statistics.

Estimating the potential for reimbursement through a School-Based Billing Program for health-related services was based on data provided by the following agencies:

- The Division of Medical Assistance who generated a report identifying the number of Medicaid eligible children in each of Alaska's 55 school districts.

  This report for Fiscal Year 1995-96 school revealed the total Medicaid-eligible student population to be 27,275 out of District Attendance figures of 122,770 or 22.2% of the population. For purposes of estimating numbers being served through special education, a conservative estimate based on actual figures in Oregon, is that 24% of the special education population receiving billable services are also Medicaid eligible.

- Juneau School District provided actual counts of providers according to a table of billable service providers used in Oregon. The district also provided a count of students receiving services that qualify for reimbursement under the rehabilitation service delivery model. These numbers were used to calculate potential revenue for that district as well as provide the basis for projecting numbers for other districts and the state.

- The Alaska Department of Education provided the Federal Report of Children and Youth with Disabilities receiving Special Education under Part B of the Individuals with Disabilities Education Act for December 1995. This report identifies number of service providers, by category, as well as number of children identified, by category, to qualify for special education. For purposes of calculating potential revenue and based on experience in the State of Oregon, children within the Learning Disabilities category receive few, if any, reimburseable services so that category was excluded in revenue projections.
  This report identifies 15,600 children (rounding) receiving

special education services and 428 professional staff statewide who deliver services. Neither figure represents actual numbers for purposes of calculating revenue.

Each year, the Alaska Department of Education must systematically collect statistics from all school districts for the current school year in compliance with federal law. This requires reporting the number of students qualifying under the above primary disabling condition categories: the "December 1 child count" for school year 1995 (96) for students aged 6 - 21 was 15,598. (This total includes optional reporting categories that may affect those who qualify by some 640 students.)

For purposes of this report, there were 15,600 students who were identified for special eduation in Alaska. The total school population for the same school year was 122,770. This reflects approximately 13% of the total student population identified for special education which is slightly higher than the national average: 11%. For a more comprehensive analysis of the collection and reporting, interested persons should contact the Alaska Department of Education.

- Southeast Regional Resource Center also provided data for districts they serve and for which service categories they provide and estimated the approximate frequency of direct services. SERRC serves 34 of the 55 districts, but provide billable services to only 29 districts.

The most reliable data available was that provided by Juneau School District who also provided names and date of birth to DMA for a future match against Medicaid eligibility files for more accurate numbers of Medicaid-eligibile children in that district. The data provided by Juneau School District was, therefore, used as a basis for revenue projections, as reflected in the tables provided by Health Outcomes Plus.

One notable variable is the service level of speech services at 23% of the total number of billable services provided. In Oregon, actual frequency and services provided equal 68% of the total revenues received. Due to the frequency and numbers of children who actually receive speech therapy across several disability categories, the 23% figure may be very low.

Due to the high cost of implementing a school-based billing program and the considerable level of effort, revenue projections are conservative and, lacking actual data, a consistent methodology was used and errs on the conservative side. The revenue projections follow.

VII. ISSUE DISCUSSIONS: EVALUATING THE POTENTIAL

This section presents a series of issue discussions regarding the key questions that must be addressed before the Governor's Council on Disabilities and Special Education can make a decision. This basic format includes discussion issues which surfaced in other states during the development of their School-Based Health Services program. It also includes discussion of unique issues which surfaced as a result of research and analysis while developing this report. It also includes principles and criteria for an evaluation plan

Principles and Criteria
For evaluating
The administration and infrastructure
of an Alaska Medicaid/Special Education Billing Program

The administration and infrastructure of the system would be:

EFFICIENT, ECONOMICAL AND ACCOUNTABLE TO taxpayers, providers, state agencies, local districts and , most importantly, to the children (students) served.

Providing funding without reporting requirements that allow responsible management of funds cannot be considered by state administrators. Reporting scope, frequency and level of services provided is critical to future allocation of resources.

Utilizing current methods of reporting is an efficient use of the infrastracture in place in the State of Alaska. Modification of existing systems would assure an efficient, economical way to manage taxpayer dollars while capturing important data about services delivered.

Aggressive reporting requirements serves two important purposes:

1. Provides maximum federal participation as well as allows administrators the benefit of making informed decisions about health-related needs, better interagency coordination and delivery of services to children with disabilities.
2. Provides a reliable system that identifies duplication of services, disparities in services provided throughout the state and deficiencies in program policies. Clearly defined reporting requirements are easier for regulatory agencies to monitor.

SEAMLESS IN TRANSITION students should be able to continue to receive special education related services without experiencing delay or disruption in delivery of needed services.

A transition plan should be developed if the Council decides to implement a Medicaid-funded School-Based Health Services Program.

Providers of service should receive adequate training to be certain they understand service delivery, reporting and documentation requirements.

COST EFFECTIVE AND LEAST DISRUPTIVE (in the long run) to providers of therapy services for districts, to district administrative staff and to state agencies.

The program established to reimburse educational-based health-related programs should be designed specifically to accommodate the service delivery setting required by the federal special education legislation.

New federal funding should be measurable and earmarked to meet health-related needs of student that the state could not otherwise afford. Legislature as well as all involved agencies should agree to how any new federal funds would be used.

Districts should be reimbursed directly for all costs related to generating federal funding and receive benefit for health-related services to students.

Based on qualifying criteria and standards, school districts should be required to participate in the Medicaid reimbursement program so consistent and reliable procedures can be developed and maximum reimbursement potential can be realized. Without full participation, resources cannot be adequately managed.

AS SIMPLE AS POSSIBLE: the administrative structure should be as simple as possible to keep costs down, and be built to achieve the intent of federal rules and regulations while recognizing the limitations inherent in funding services where the need is always greater than the resources.

Neither the state Medicaid agency, the Division of Medical Assistance, nor the state Department of Education currently has the capacity to administer the program within their existing systems. Only by developing an interim structure could these agencies efficiently operate and administer a School-Based Health-Related Reimbursement program.

Several tasks, such as verifying which special education students are Medicaid eligible, would need to be systematized in order for school districts

to learn on which students to submit claims. The only mechanism now available to learn which students are Medicaid eligible is an automated phone verification system for providers who may inquire about a patient/student's Alaska Medicaid eligibility on a one-at-a-time basis.

RESPECTFUL OF FEDERAL SPECIAL EDUCATION RULES AND REGULATIONS AND FEDERAL MEDICAID RULES AND REGULATIONS AND LIMITS OF LOCAL SERVICE DELIVERY IN THE EDUCATIONAL SETTING:

Both federal programs, Special Education and Medicaid, are based on individual needs. Both federal programs are based on access to service issues.

The system should respect both the Medicaid purpose which is to provide access to needed medical services and the Special Education purpose which is to provide access to needed educational services. Both serve health-related needs of children as defined in federal laws and both are limited by program requirements and by the availability of health care providers who can meet those needs.

Full evaluation of special education requirements and Medicaid requirements should be performed before a Medicaid program is developed. This report is intended to provide information about most of the key requirements that need to be addressed. Many detailed and specific program requirements play a role in the ultimate success or failure of a Medicaid reimbursement program.

For example, a Medicaid reimbursement program should not be considered that encourages violation of the intent of health-related services provided in a special education setting.

Physical and occupational therapy services provided through the educational system are restricted in scope by the requirement that the goals be relevant to educational access. Some children with special health needs (e.g., those with mild physical disabilities) may not be eligible for services in the educational setting. This means that specific diagnosis may not be funded under either the federally mandated special education program or the state's Medicaid program.

Educationally based therapy programs usually do not have the capacity to address medically necessary therapy needs. The capacity and flexibility of service delivery through the educational system also varies greatly from location to location depending on the availability of service providers.

Services delivered through the educational system for children with special health needs are pertinent and beneficial. However, educationally based services may not be adequate in scope, frequency or format to provide the appropriate range of medically necessary therapy services for children with special health needs.

A thorough program evaluation of which services can be provided in the educational setting is possible when the program is underway--if there is a willingness by both parties to do so. What often happened in other states: there was no ongoing evaluation of service delivery. Medicaid program and policy staff are either unaware of service delivery gaps or assume no responsibility to plug the gaps. It would be impractical to be able to identify all the gaps before a program was implemented.

These gaps, once identified, could be met through the EPSDT process. This would : 1) allow the need to surface, 2) allow the diagnosis code (which identifies the condition that is not being treated) to be added to the "covered" benefits for children and 3) allow payment for these services to be authorized according to Medicaid criteria and be paid by the MMIS claims processing system.

Conversely, when a duplication of services is identified through evaluation and analysis of MMIS reports, ongoing program evaluation would surface this redundancy of services. The Medicaid program and policy administrator could then take appropriate action to prevent further duplication of services.

When an MMIS system is used effectively, it provides invaluable management information which controls costs for the entire state, not just the Medicaid agency. First, the information must be provided to that MMIS system. One way to gain control of the information is to report all health-related services paid through Medicaid through that system. This is not always popular or practical or appropriate.

When comprehensive service delivery to children with disabilities is uncoordinated with few measurable tools in place, gaps in needed services continue without systematic ways to remedy the need and duplication of services are allowed to continue. This may not be a problem in the State of Alaska: administrators have other indicators which give information about gaps in coverage or duplication of services. However, an MMIS system that captures precise data is one of the most efficient and effective ways to gather this information. Projections about service needs outside the Medicaid population can be made based on this information as well.

For this reason, if for no other, the Council should seriously consider implementing a Medicaid reimbursement program for School-Based Health Services Program.

Medicaid reimbursement programs cannot simply say to the educational provider "Go ahead and meet those needs and we'll pay for it."

The Medicaid program should be designed around the special education setting to the extent possible to maximize the revenue potential and minimize the program impact.

Each program area--special education and Medicaid--needs to evaluate the reimbursement program potential based on federal regulations which cannot be changed versus state program regulations or system requirements which may be inconvenient, but possible, to change.

In other words, a Medicaid reimbursement program focus should first be developed on what can be accomplished under the above criteria instead of what cannot be accomplished. Secondarily, the program focus should be on the cost to implement these changes--which may override what can be accomplished.

A PARTNERSHIP: an efficient program that meets both Medicaid and Special Education criteria will be a system that involves all agencies to the best advantage in meeting the special health-care needs of the children living in each Alaskan community.

IX. FISCAL IMPACT SUMMARY

This section includes a brief summary of the fiscal impact on the State of Alaska if a Medicaid-funded School-Based Health Services program were implemented. This summary was prepared by an independent consulting firm, Outcomes Plus. Calculations were made by Joseph Madden.

BUDGET METHODOLOGY

INTRODUCTION

The budgetary assumptions were based on data provided by different factions from the state of Alaska. This section will describe the process of how the provided data was implemented in the calculations of the budget.

The goal of this analysis was to assimilate a budget that was consistent throughout each step.

The Juneau School District supplied us with the most comprehensive data. We determined to predict their annual expenses (costs, and, therefore, the basis for reimbursement) for predicting the other school district's expenses.

There are significant differences between the Juneau district and some of the other districts, those differences will be addressed.

JUNEAU SCHOOL DISTRICT

The type of services and the number of students receiving billable services was found on form A1. Occupational therapy, speech therapy, physical therapy, vision services, psychological evaluations, basic mental health, counseling and access mental health were the services evaluated. Additional, nursing and health services were included as expenses.

The next step in the process was to determine the level of service delivered. Hours per month and number of interactions per year were based on assumed direct service levels of twice weekly at 20 minutes each plus indirect service of 20 minutes/week. The number of students engaging nursing services was based on the average assessment and plan coordination of one hour/month per student identified needing nursing services on their IEP. The level of health aide services was based on Juneau District's estimate of ten Medicaid-eligible students who required health care aids an average of four hours/month. Without thorough evaluation of how services are delivered, this estimate is also very conservative in frequency.

The hourly rate ($70/hr, $35/hr) was based on the contractor's experience with fees paid for these services in the State of Oregon and compared with salary schedules provided by Juneau School District. It was determined through the federal government pay differential for federal employees serving in Alaska that the differential between Oregon and Alaska rates were 25%, hence the additional expense. Psychological evaluation service costs were based on an assumed evaluation time of 8 hours per school year.

The costs were determined by multiplying # Students, Hrs/mos, Times/yr, AK 25% differential and that result is posted in the cost column. Health services expenses (3.5%) were determined from the actual medical evaluation expenditures of the Juneau School District.

Transportation expense was based on assumptions provided by average daily transports of six-miles one way twice weekly for the school year or 96/mi/mo. The costs were determined by multiplying # Students/Miles/mos, Times/yr, AK 25% differential and that result is posted in the cost column.

The total is $1,357,872. The ratio of 24% billable was defined by assuming the actual percent of Medicaid-eligible children receiving a special education service through Oregon's billing program, resulting in a Medicaid eligible amount of $352,889. The State of Alaska's reimbursement rate is 50%, therefore, Alaska's share of the cost is $162,945.

SERRC SCHOOL DISTRICTS

SERRC is a provider that many of the school districts employ to deliver services to their students. Their level of service is significantly different than the Juneau School District. Therefore, it was necessary to group these districts together and compute the aggregate expenses. The districts included in this group are listed in Table 3, "SERRC School Districts."

There are two major assumptions with this group of districts:

1. The expense and hours per students were the same within all the school districts in this group.

2. The percentages of students receiving specific services are equal to the percentages that the Juneau students are receiving.

The hour per month figures were provided by SERRC information which assumes only one hour/month for each direct service provided by a billable service provider.

The next step was to determine the number of students receiving specific services within this group. The first step was to determine the percentage of Juneau students receiving specific services.

The total number of students in Juneau for fiscal year 1996 was 5,515. This figure was derived from the table of "Medicaid Eligible Students by School District, Age 5-20". It was determined by the Alaska Department of Education federal report that 13% of total students are special education students.

We know the number of Juneau students that received specific services from table A1. Therefore, we determined the ration of specific services by taking the actual count of students divided by the total number of special education students. Please refer to Table 2, "Service Coefficients".

The next step was to aggregate the total number of students in SERRC school district, 15,692 students. Then 13% of them, 2,040 students, are determined to be special education students. We took the ratio (e.g. 5% received OT) calculated in Table 2, and multiplied them by the 2,040 special education students to determine the number of students within the SERRC coverage that received the specific services.

With the assumed number of students receiving specific services, we then applied the same formula of multiplying #Students, Hrs/mo, Times/yr, AK 25% diff and that result is posted in the cost column. Please refer to "Table 4, SERRC School Districts."

In this example, transportation expense is left out. There was not enough definitive information to generate a reasonable prediction. This is primarily due to Alaska's demographic and geographic structure. We believe that transportation expense is a significant factor.

Given the calculations and assumption, the total for the SERRC schools is $1,433,245 with $343,979 being Medicaid eligible. Alaska's share of the expense would be $171,989.

AGGREGATE ALASKA SCHOOL DISTRICTS

The last group were the school districts remaining after the consideration of the SERRC schools and Juneau. This group represents nearly 83% of the students. The methodology implemented was the same as used in the SERRC calculations, with the exception that the amount of service, hours/month, was calculated at the Juneau rates. This is a significant assumption given the wide variation in district demographic and geographic characteristics.

We implemented the same percentage of specific services (e.g. 5% for OT). There are a total of 101,453 students in this group, with 13,189 students receiving special education, refer to Table 5, "Aggregate AK School Districts".

As with the SERRC group, transportation expenses were not included due to a lack of clearly defined parameters.

The total expense for this group was $21,842,685, with $5,242,244 Medicaid eligible. This left Alaska's share of this expense at $2,621,122.

Implementation costs equal	$471,750	All activities
Annual Operating expenses equal	$862,600	Statewide

At full implementation:

Revenue Projections	$2,621,122	
Less Operating Costs -	862,600	
PROJECTED ANNUAL TOTAL impact:	$1,758,522	Anticipated federal revenue to the State of Alaska minus operating costs to generate the revenue

gible for Medicaid. The Task Force acknowledges the value of home and community-based long-term care services and recommends this legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail.) ❖

MEDICAID COVERAGE FOR ALZHEIMER'S PATIENTS

The Task Force requests the Departments of Administration and Health and Social Services review all options available to the state, including Medicaid, to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and Related Disorders.

Alzheimer's Disease and Related Disorders (ADRD) refers to cognitive impairments that are progressive and degenerative in nature. As a result of these impairments, effected adults require supervision and cueing from other individuals in order to adequately and routinely perform activities of daily living and instrumental activities of daily living.[30] People whose sole diagnosis is Alzheimer's Disease and Related Disorders do not typically require daily supervision by medical professionals.

"To be eligible for Alaska's Medicaid long-term care waiver programs, applicants must require skilled nursing services."

To be eligible for nursing home care and home and community-based services from Alaska's Medicaid program, applicants must be low-income and require skilled nursing or intermediate care. Persons whose sole diagnosis is ADRD typically do not meet the criteria for skilled nursing or intermediate care and consequently, the Alaska Medicaid program will not pay for nursing home placement or home and community-based services.

Alaska is only one of two states whose Medicaid eligibility standards for nursing home and home and community-based services require that the patient needs "professional-level medical supervision."[31] This requirement, as determined by the Department of Health and Social Services, effectively eliminates eligible Medicaid ADRD-only patients from the state's major long-term care services.

Persons with ADRD may have great difficulty living without assistance.[32] Currently for many people who suffer from ADRD, respite service for their families is the only long-term care service available.[33] The Task Force recognizes the desire for additional assistance for this particular group of Alaskans and understands that

the temporary relief provided to the family caregivers is not enough to adequately address the pressing long-term care needs of an ADRD individual.

However, modifying the Medicaid eligibility requirement for ADRD-only patients may have budget implications for the state.[34] Approximately 40 percent of the cost for qualified Medicaid patients is paid from the state's General Fund. Some states have reduced the budget impacts by requiring that all long-term care patients receive universal care plan counseling. (Please see recommendation 20) The effect of this requirement has been to place residents in the least restrictive long-term care setting, which often is also the lowest-cost setting. The effect has been to prolong the time that residents can pay for their own care, and therefore, reduce the potential cost to the Medicaid program.[35]

"Persons with ADRD may have great difficulty living without assistance."

In addition to the budget concerns, the Division of Senior Services may not have the capacity to serve the additional clientele who may apply for home and community-based waiver services if ADRD is included as an eligible diagnosis.

Even though changing the Medicaid eligibility requirement to include ADRD-only patients raises serious concerns, 48 other states offer Medicaid programs to patients suffering from only Alzheimer's Disease. Alaska should too.

The Task Force requests the Department of Administration and the Department of Health and Social Services review all options available to the state, including Medicaid, to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and Related Disorders. Also, the Task Force requests that a preliminary report outlining the departments' findings be submitted to the President of the Senate and Speaker of the House by April 30, 1999. ❖

INCREASE MEDICARE ACCESS

RECOMMENDATION 15

The Task Force requests the Department of Health and Social Services conduct a review of Medicare patients' access to medical services within the state and, if warranted, explore options to increase their access to health care.

The Task Force heard testimony regarding individuals covered by Medicare who were having difficulty accessing health care services. General concerns were ex-

OPTIONS FOR REACHING PEOPLE WITH DEMENTIA AND OTHER COGNITIVE IMPAIRMENTS

Option 1. Change nursing facility level of care regulations to include people with serious cognitive impairments. Because it uses the nursing facility level of care as an eligibility criterion, this allows the Medicaid Home and Community-Based Services waiver to serve people with dementia and other cognitive impairments.

Option 2. Add Medicaid Home and Community Care for Functionally Disabled Elderly Option – this option allows state to provide services to people age 65 and older who do not meet nursing home level of care, but do meet separate functional impairment criteria, as defined in federal law. It includes people with cognitive impairments such as dementia. It does not cover people who would only qualify for Medicaid using the more generous financial eligibility requirements for people who meet nursing home level of care.

	1. Expand Waiver	2. Add Option
Who is categorically eligible?	Any person who is disabled or age 65+ who meets NF level of care.	Individuals who are age 65+ who meet separate criteria for functional impairment.
Implementation	Requires regulation change, training of NF and HBC provider staff.	Requires statute change, implementing regulations, EIS and MMIS computer system changes, and training of HCB staff.
Financial Eligibility	$1,536/month for an individual. Spouse's income not counted. $2,000 countable resource limit. Spouse may retain up to $84,120 in countable resources.	$951/month for individual, $1410/month for couples. $2,000 countable resource limit. No spousal resource provision.
Service Package	All regular Medicaid services plus special HCB waiver services defined by state.	All regular Medicaid services plus special services defined by state (can be different from waiver).
Spending Restrictions	Average cost of people on waiver cannot exceed the average cost of serving people in institutions.	Average cost of people in option cannot exceed 50 percent of average cost of Medicare NF services.
Care Coordination	Assessment can be performed by private care coordinator who may be affiliated with a nursing home or HCB provider (except assisted living provider if client is in assisted living).	Assessment must be performed by public or nonprofit entity that is not affiliated with a nursing home or HCB provider.
Impact on Nursing Homes	People who meet expanded criteria are eligible for Medicaid coverage of nursing home.	No expansion of Medicaid nursing home coverage.

Prepared by Division of Medical Assistance, 4/01

Option 1

Expanding Nursing Facility Level of Care Criteria

Percent Served on Waivers	66%
Percent Served in Nursing Homes	34%
Percent Already on Medicaid	68%

Per Person Costs:

Waivers	
FY 02 Waiver Services	$ 14,616
FY 02 Other Services	$ 8,512
Nursing Facility	
FY 02 Nursing Facility	$ 81,528
FY 02 Other Services	$ 2,936

Total Costs:

	FY 02	FY 03	FY 04	FY 05	FY 06
Total Number of Recipients	75	150	200	250	300
Waiver Recipient Costs	$ 429,159	$ 1,716,634	$ 2,288,846	$ 2,861,057	$ 3,433,268
Nursing Recipient Costs	$ 1,051,463	$ 4,205,853	$ 5,607,803	$ 7,009,754	$ 8,411,705
Total	$ 1,480,622	$ 5,922,487	$ 7,896,649	$ 9,870,811	$ 11,844,973
General Fund	$ 631,041	$ 2,524,164	$ 3,365,552	$ 4,206,940	$ 5,048,328

Assumptions:
Approximately 100 people currently qualify for service, 50 people would be added each year.
In the first year, 75 people would enter service for 1/2 year. The remaining 25 people would be added in the second year, along with the 50 additional people.

Option 2

Add Medicaid Home and Community Care for Functionally Disabled Elderly Option

Percent of Target Population Served 68%

Per Person Costs:

FY 02 Service Cost $ 14,616

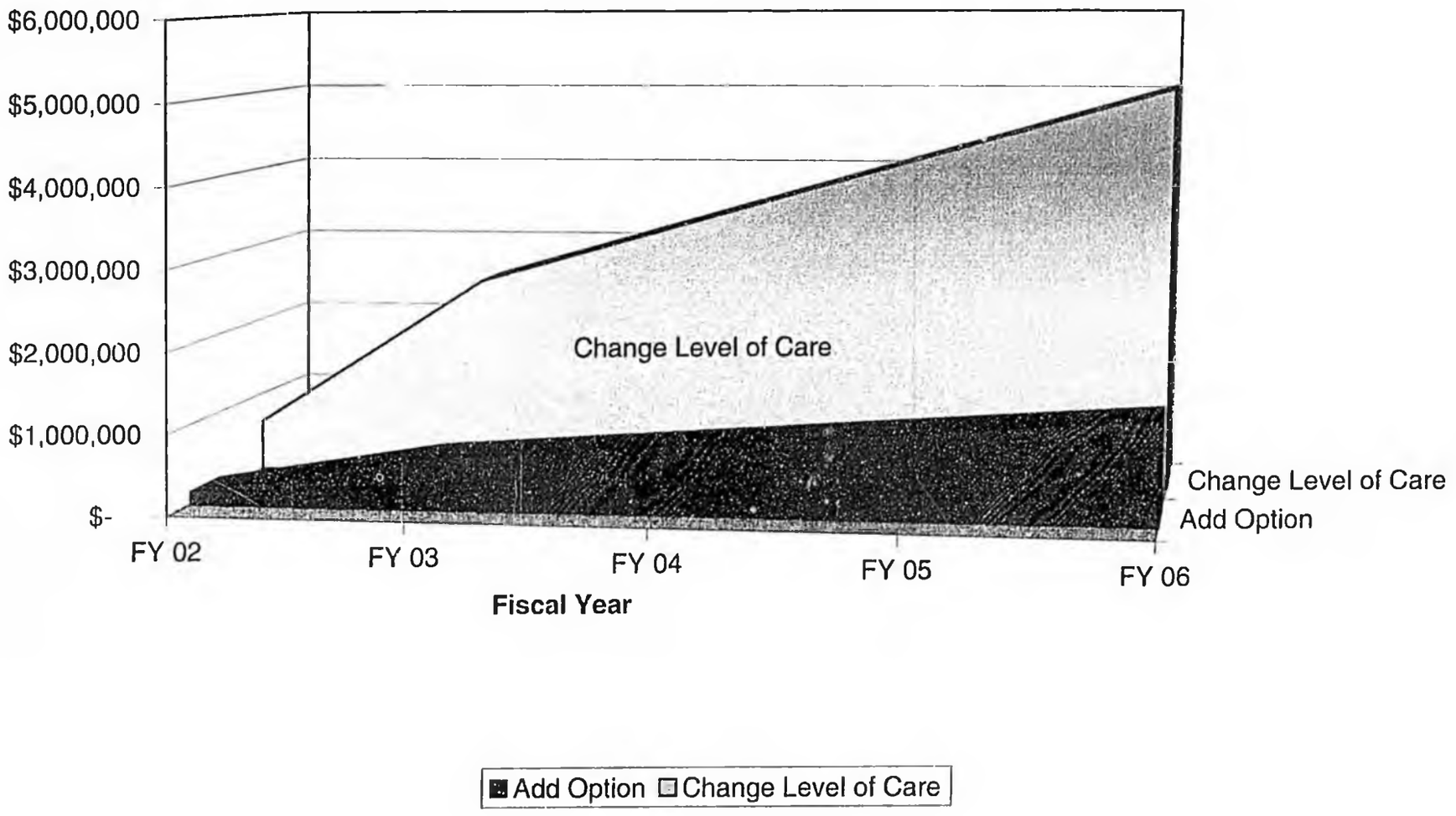
Total Costs:

	FY 02	FY 03	FY 04	FY 05	FY 06
Total Number of Recipients	51	102	136	170	204
Option Service Costs	$ 372,703	$ 1,490,811	$ 1,987,748	$ 2,484,685	$ 2,981,622
General Fund	$ 158,846	$ 635,384	$ 847,178	$ 1,058,973	$ 1,270,767

Assumptions:
Approximately 68 people currently qualify for service, 34 people would be added each year.
In the first year, 51 people would enter service for 1/2 year. The remaining 17 people would be added in the second year, along with the 34 additional people.

32 percent of the target population would not be served by the option because they failed to meet Medicaid financial eligibility criteria for people who do not meet institutional level of care.

General Fund Costs of Options



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"To be eligible for Alaska's Medicaid long-term care waiver programs, applicants must require skilled nursing services."

To be eligible for nursing home care and home and community-based services from Alaska's Medicaid program, applicants must be low-income and require skilled nursing or intermediate care. Persons whose sole diagnosis is ADRD typically do not meet the criteria for skilled nursing or intermediate care and consequently, the Alaska Medicaid program will not pay for nursing home placement or home and community-based services.

Alaska is only one of two states whose Medicaid eligibility standards for nursing home and home and community-based services require that the patient needs "professional-level medical supervision."[31] This requirement, as determined by the Department of Health and Social Services, effectively eliminates eligible Medicaid ADRD-only patients from the state's major long-term care services.

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the temporary relief provided to the family caregivers is not enough to adequately address the pressing long-term care needs of an ADRD individual.

However, modifying the Medicaid eligibility requirement for ADRD-only patients may have budget implications for the state.[34] Approximately 40 percent of the cost for qualified Medicaid patients is paid from the state's General Fund. Some states have reduced the budget impacts by requiring that all long-term care patients receive universal care plan counseling. (Please see recommendation 20) The effect of this requirement has been to place residents in the least restrictive long-term care setting, which often is also the lowest-cost setting. The effect has been to prolong the time that residents can pay for their own care, and therefore, reduce the potential cost to the Medicaid program.[35]

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Implementation	Requires regulation change, training of NF and HBC provider staff.	Requires statute change, implementing regulations, EIS and MMIS computer system changes, and training of HCB staff.
Financial Eligibility	$1,536/month for an individual. Spouse's income not counted. $2,000 countable resource limit. Spouse may retain up to $84,120 in countable resources.	$951/month for individual, $1410/month for couples. $2,000 countable resource limit. No spousal resource provision.
Service Package	All regular Medicaid services plus special HCB waiver services defined by state.	All regular Medicaid services plus special services defined by state (can be different from waiver).
Spending Restrictions	Average cost of people on waiver cannot exceed the average cost of serving people in institutions.	Average cost of people in option cannot exceed 50 percent of average cost of Medicare NF services.
Care Coordination	Assessment can be performed by private care coordinator who may be affiliated with a nursing home or HCB provider (except assisted living provider if client is in assisted living).	Assessment must be performed by public or nonprofit entity that is not affiliated with a nursing home or HCB provider.
Impact on Nursing Homes	People who meet expanded criteria are eligible for Medicaid coverage of nursing home.	No expansion of Medicaid nursing home coverage.

Option 1

Expanding Nursing Facility Level of Care Criteria

Percent Served on Waivers	66%
Percent Served in Nursing Homes	34%
Percent Already on Medicaid	68%

Per Person Costs:

Waivers	
FY 02 Waiver Services	$ 14,616
FY 02 Other Services	$ 8,512
Nursing Facility	
FY 02 Nursing Facility	$ 81,528
FY 02 Other Services	$ 2,936

Total Costs:

	FY 02	FY 03	FY 04	FY 05	FY 06
Total Number of Recipients	75	150	200	250	300
Waiver Recipient Costs	$ 429,159	$ 1,716,634	$ 2,288,846	$ 2,861,057	$ 3,433,268
Nursing Recipient Costs	$ 1,051,463	$ 4,205,853	$ 5,607,803	$ 7,009,754	$ 8,411,705
Total	$ 1,480,622	$ 5,922,487	$ 7,896,649	$ 9,870,811	$ 11,844,973
General Fund	$ 631,041	$ 2,524,164	$ 3,365,552	$ 4,206,940	$ 5,048,328

Assumptions:
Approximately 100 people currently qualify for service, 50 people would be added each year.
In the first year, 75 people would enter service for 1/2 year. The remaining 25 people would be added in the second year, along with the 50 additional people.

Option 2

Add Medicaid Home and Community Care for Functionally Disabled Elderly Option

Percent of Target Population Served 68%

Per Person Costs:

FY 02 Service Cost $ 14,616

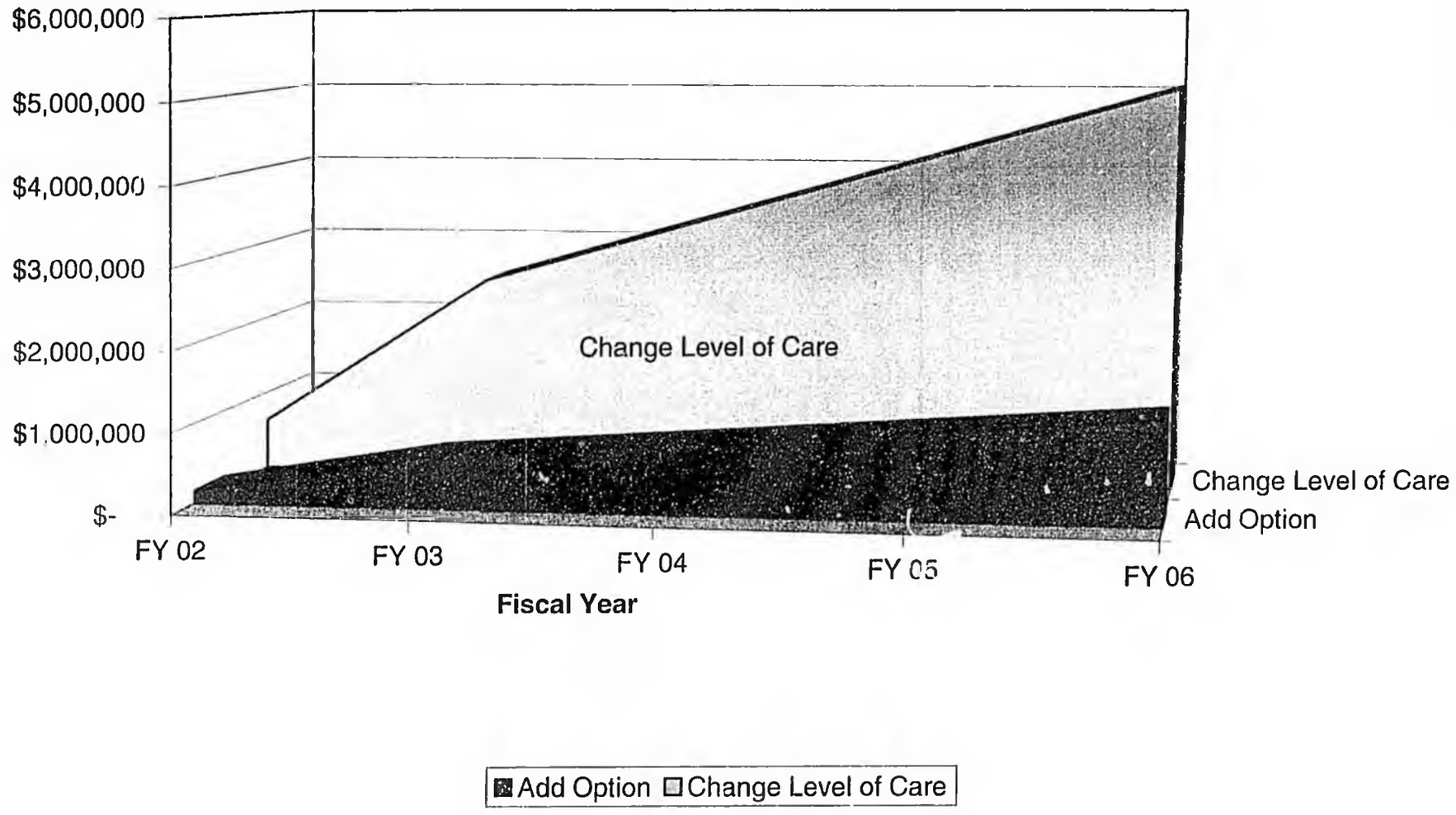
Total Costs:

	FY 02	FY 03	FY 04	FY 05	FY 06
Total Number of Recipients	51	102	136	170	204
Option Service Costs	$ 372,703	$ 1,490,811	$ 1,987,748	$ 2,484,685	$ 2,981,622
General Fund	$ 158,846	$ 635,384	$ 847,178	$ 1,058,973	$ 1,270,767

Assumptions:
Approximately 68 people currently qualify for service, 34 people would be added each year.
In the first year, 51 people would enter service for 1/2 year. The remaining 17 people would be added in the second year, along with the 34 additional people.

32 percent of the target population would not be served by the option because they failed to meet Medicaid financial eligibility criteria for people who do not meet institutional level of care.

General Fund Costs of Options



MEDICAID SERVICES AND GROUPS NOT IN CURRENT STATE LAW

OPTIONAL SERVICES
Chiropractic
Case Management (for additional populations)
Christian Science Nurses
Christian Science Sanatorium
Clinic services
Community Supported living arrangements
Adult dental services (preventive and restorative)
Dentures
Diagnostic services
Emergency Hospital services (for hospitals not enrolled)
Podiatry
Preventive Services
Private Duty Nursing
Respiratory Therapy
Screening services
Home and community care for functionally disabled elderly
Services of any type of practitioner licensed under state law

- Psychologists and Psychological Associates
- Licensed Clinical Social Workers
- Marital and Family Therapists
- Acupuncturists
- Licensed Professional Counselors
- Naturopaths

OPTIONAL GROUPS
TB infected individuals
Women diagnosed with breast or cervical cancer under the CDC Program
Aged and disabled with incomes to 100% of the Federal Poverty level
Expanded Working Disabled Option
Medically Needy families and children
Medically Needy Aged and Disabled
Independent Foster Care Adolescents
Presumptive eligibility for pregnant women
Presumptive eligibility for children
Other groups of low income people under a Demonstration Waiver
Family Planning Waiver

OTHER SERVICES OR GROUPS THAT HAVE BUDGETARY IMPLICATIONS BUT MAY NOT REQUIRE LEGISLATION
Alzheimer's and other conditions for nursing facility /waiver admission
12 month continuos eligibility for children
Non emergent transportation within communities of residence
School based services
Tobacco cessation services
More liberal financial eligibility and coverage policies

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

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

April 25, 2001

The Honorable Dave Donley, Co-Chair
The Honorable Pete Kelly, Co-Chair
The Honorable Jerry Ward, Vice-Chair
Senate Finance Committee
State Capitol, Room 508, 518 and 423
Juneau, AK 99801-1182

Re: Status of FY2001 Medicaid Expenditures

Dear Senators Donley, Kelly and Ward:

For your information we are providing you with an update on FY2001 Medicaid expenditures. We know you are currently working on the FY2001 supplemental and this should be useful to you.

Current FY2001 Status

As of today, April 25, Medicaid expenditures have exceeded $486,316.6 with a remaining balance available to pay claims of $11,053.1.[1]

It is important for you to note the following:

- Medicaid program pays claims very Tuesday.
- Medicaid program was able to pay all claims for April 23rd checkwrite.
- The remaining balance may not be sufficient to pay all claims for the May 1st checkwrite.
- It is imperative that action is taken on the supplemental appropriation bill prior to May 7th (Monday) so that funds are available for the May 8th checkwrite.
- Any interruption in Medicaid payments could have devastating effect on providers.
- Last year when Medicaid claims were pended (for lack of funds) several non-profit entities suffered cash flow problems.

The Department has a supplemental request pending legislative action that is needed to pay claims through the end of this fiscal year. This supplemental request includes authority to maximize the Division's ability to participate in Proshare. The additional Proshare payments were distributed to hospitals in March and all receipts from hospitals have been received. Of the $77.6 million supplemental request, $11.4 million is from statutory designated program receipts

[1] 4/24 checkwrite interface to AKSAS will run 4/25.

that have already been received but cannot be used without legislative action on the supplemental bill. Additionally, the Department has forwarded to OMB, a request for an additional $2,997.1 in federal funds due to an unanticipated increase in IHS Outpatient Hospital payments.

The department is reviewing all temporary measures available internally to make additional funds available for continued check-writes. For example, where feasible we have temporarily released encumbrances of approximately $4 million so that the Medicaid Services appropriation has additional funds to continue payments for the first week in May. However these are temporary measures only as they are valid obligations and will still need to be paid once the supplemental authority is approved.

Increased Medical Expenditures

In the past nine months, Alaska has experienced substantial increases in Medicaid payments for prescription drugs and waivers.

Prescription Drugs

Prescription drug cost increases have been on the rise for several years as shown below. From FY1999 to FY2000, costs have increased 24 percent. The Division projects an additional 21 percent increase by fiscal year end.

Fiscal Year	Pharmacy Costs
FY 1999	$37,288.2
FY 2000	$46,312.2
FY 2001 Projected	$55,900.0

In the first six months of FY2001, there has been a 19 percent increase in dollars spent and a 21 percent increase in claims made within the top ten therapeutic classes for pharmacy. Over 40 percent of these increases can be attributed to two drug classes: anti-arthritic drugs and anti-epileptic drugs. This is because new anti-arthritic drugs that lesson the chance of gastrointestinal distress have replaced older drugs that do not have the same benefit, and the new anti-epileptic drug, Gabapentin, is being prescribed as a replacement for several older drugs.

Home and Community Based Services: Waivers

Waivers provide services for adults with physical disabilities (APD Waiver), children with complex medical conditions (CCMC Waiver), persons with chronic disabilities caused by mental retardation and/or developmental disabilities (MRDD), and the elderly (OA Waivers) in a home environment. Persons on waivers must meet specific criteria as well as general eligibility criteria for Medicaid that would apply to the equivalent institutional population. Alaska's capacity for institutional care is minimal. Without waivers, approximately 1,500 Medicaid clients would need alternative placement; many of these Alaskans would be forced to leave the State.

The Division projects waiver costs will reach $68,700.0 by the end of FY2001. It is estimated that without waivers, institutional care could cost the State three times that amount.

Increased IHS Hospital Claiming Activity

IHS cost shifting is a procedure by which Division of Medical Assistance staff manually review claims paid to locate those that should be IHS claims at 100 percent federal funds. In doing so, increased federal funds are utilized while general funds become available for other incurred Medicaid claims. To accomplish this task, the Division has requested additional federal authority of $2,997.1. This additional authority will help Medicaid capitalize on available general funds to meet anticipated costs in the current year.

Current projections based on average weekly check-write data indicate Medicaid Services will be less than one full week short of funding if all supplemental requests are authorized. This amount will change weekly, as expenditures vary.

FY2002 Status

The Department's FY2002 budget request of $548.273.2 for Medicaid was based on a low-case scenario and included incremental changes from FY2001 of $12.8 million in general funds and $50.5 million in federal receipts. At the request of OMB the department has recently completed a mid-case scenario projection. This updated projection shows an increase from the Governor's FY2002 Request of $8.1 million in general funds.

		Federal	GF	Other	Total
Original Increment Request		**50,450.9**	**12,807.5**		**63,258.4**
Mid-Case Update					
	Children	(320.5)	(163.3)		(483.8)
	Adults	(795.9)	(405.5)		(1,201.4)
	Elderly	46.7	23.8		70.5
	Disabled	13,165.3	6,706.8		19,872.1
	Pro-Share	(2,281.5)	1,900.0	(3,433.7)	(3,815.2)
	Subtotal	**9,814.1**	**8,061.8**	**(3,433.7)**	**14,442.2**
Mid-Case Projected Increment		**60,265.0**	**20,869.3**	**(3,433.7)**	**77,700.6** *

As the chart above shows, there have been significant changes between the original low- case scenario and the recent mid-case update. For instance, we project disabled eligibles will increase by 2.7% with costs projected to increase by 8.3% from the low-case projection.

The mid-case scenario update also adjusts for the loss of the Department's ability to use Proshare as a means to leverage more match money since the federal government has recently scaled back this program.

Federal funding changes are still an unknown.* In addition to any reduction to the FMAP, the mid-case scenario information above does not include any adjustments between federal and general funds that may be necessary due to varying unknown federal factors. On one hand we could receive more federal dollars for increased IHS claims or reallocation for Children's Health

Insurance Program (CHIP). However, decreases in federal dollars could result federal program changes, etc. This could mean that more state dollars are needed to pay entitlement services.

Alaska is not alone in dealing with increases in Medicaid service costs. Rising medical care costs is a nationwide trend. The United States Department of Labor, Bureau of Labor Statistics' "Consumer Price Index: March 2001" reports "[m]edical care costs rose 0.4 percent in March to a level of 4.6 percent higher than a year ago ... hospital and related services advanced at 7.6 percent annual rate in the first three months of 2001 and increased 6.8 percent in the 12 months ended in March."

FMAP Update

The Department has prepared and distributed to interested parties a document titled "Unintended Consequences". This document can also be downloaded from the Division of Medical Assistance web sight at www.hss.state.ak.us/dma/. The document describes the problems and impacts on many states created by recent statistical methodology changes by the federal Bureau of Economic Analysis. This material has been distributed to the Commissioner's Office, Governor's Offices in Juneau and Washington DC, Alaska's Congressional delegation, the co-chairs of the House and Senate Finance Committees, and HCFA Region X. The Medical Care Advisory Committee and the Medicaid Rate Advisory Commission also received copies. The Congressional Senate Finance Committee co-chair has expressed some interest in addressing this problem during the budget process this summer.

The Division of Medical Assistance will continue to monitor current spending on a weekly basis to anticipate year-end expenditure levels and future program needs. Please do not hesitate to contact me with any questions or concerns regarding these issues.

Sincerely,

Karen Perdue
Commissioner

cc: Senator Alan Austerman, Capitol Building, Room 417
Senator Lyda Green, Capitol Building, Room 125
Senator Lyman Hoffman, Capitol Building, Room 7
Senator Loren Leman, Capitol Building, Room 516
Senator Donald Olson, Capitol Building, Room 510
Senator Gary Wilken, Capitol Building, Room 514
Annalee McConnell, Director, OMB
Jay Livey, Deputy Commissioner
Elmer Lindstrom, Special Assistant
Janet Clarke, Director, DAS
Bob Labbe, Director, DMA
Laura Baker, Chief Budget Analyst, DAS
Nancy Burns, Admin. Manager, DMA

MEMORANDUM

STATE OF ALASKA
Department of Education & Early Development
Division of Teaching and Learning Support

TO: Office of Senator Green

FROM: Greg Maloney

RE: Medicaid Funding for Education

DATE: April 17, 2001

Senator Green and Aurora:

Thank you very much for your time yesterday. The issue of Medicaid funding for special education and related services is a very complex issue for which we would like more time to work with appropriate agencies and individuals to develop policy suggestions. Specific issues that need to be addressed include

- sources for matching funds;
- mechanism for billing Medicaid for district expenses;
- Medicaid policy regarding out-of-state placement costs;
- federal and state limitations regarding allowable Medicaid costs;
- defining specifications for how Medicaid funds may be used;
- determining potential consequences of changing current Medicaid policy; and,
- obtaining technical assistance from federal sources and other states regarding effective Medicaid practices

Our goal is to work closely with stakeholders such as school districts, the Governor's Council on Disabilities and Special Education, the Department of Health and Social Services, and technical assistance providers to devise a workable plan to be presented during the next session.

Thank you.

FAX TRANSMITTAL INFORMATION SHEET

ALASKA DEPARTMENT OF
EDUCATION & EARLY DEVELOPMENT
Division of Teaching and Learning Support
801 West 10th Street, Suite 200
Juneau, AK 99801-1894

DATE: April 18, 2001

TO	
Name:	Aurora Hawke
Agency/Office:	Office of Senator Green
FAX #:	465-3805
Phone #:	

FROM	
Name:	David Sampson
Division/Office:	Special Education
FAX #:	465-2806
Phone #:	465-8693
Email:	David_Sampson@eed.state.ak.us

REFERENCING: Medicaid Funding for Education

COMMENTS:

This transmittal contains _2_ page(s) including the cover page. If you do not receive the total number of pages, please contact the sender.

Medicaid Directions

Presented to the Senate HESS Committee

April 2001

History of Medicaid

Basic Federal Framework

- **Title XIX of Social Security Act**
  - Created by Congress in 1965 (in the same bill which created Medicare) to pay for medical assistance for certain individuals and families with low incomes and resources.
  - Administered by each State, under a host of Federal rules.
  - Federal government and State share in cost of the program.
- **Regulations found in 42 CFR**
  - Sets forth broad guidelines for States to follow.
- **State Plan**
  - Contract with Federal government setting out what States are required to do and the States' choices of payment, coverage and administrative processes.

Basic Framework *continued*

- **Each State is required to designate a Single State Agency**
  - Department of Health and Social Services.
  - Administers State Plan.
  - Alaska joined the Medicaid Program in 1972.
  - New services and eligible groups have been added by the Alaska Legislature.
- **Each single State agency must designate a Medical Assistance Unit**
  - Division of Medical Assistance.
  - Develop, analyze, coordinate and evaluate the Medicaid program.
- **Eligibility for Medicaid**
  - Determined by Division of Public Assistance.
  - Historically tied to federally assisted or administered cash assistance programs.

Medical Care Advisory Committee

- Federal law requires each State to have a committee to advise the Medicaid agency in order to obtain Federal matching funds.
- Committee meets quarterly.
- Members appointed by Commissioner of Health and Social Services.
- Composition of current committee includes:
  - a pharmacist from Anchorage
  - a pediatric dentist from Fairbanks
  - a mental health provider from Juneau
  - a parent consumer from Anchorage
  - a parent consumer from Palmer
  - a physician from Anchorage
  - a senior citizen from Juneau
  - an advocate for the disabled from Kodiak
  - a hospital administrator from Valdez
  - a disability advocate from Fairbanks
- Patty Hong, a nurse at the University of Alaska Anchorage, is the current chair.

Federal Requirements for Program Administration

- The program must operate statewide.
- States must cover certain mandatory groups of people and certain mandatory services.
- Services must be comparable for all persons.
- Services must be provided in adequate amount, duration and scope.
- A recipient must have freedom of choice of providers.
- Medicaid is the payer of last resort.
- An applicant or recipient must receive notice of any adverse action and be granted an opportunity for a fair hearing.
- States may request "waivers."

Alaska Medicaid Program

A Brief History Timeline for Services and Eligibility

- July 6, 1972 — Alaska Medicaid program enacted.
- 1976 — Eye glasses, optometrist services, nursing home group eligibles, clinic services option (primarily community mental health centers), speech, hearing and language disorders option in effect.
- 1983 — Medicaid Rate Advisory Commission (MRAC) established in statute; first facility payment rates established under new law July 1.
- 1988 — Pregnant women, and children five years or younger with household income not exceeding 100 percent of Federal Poverty Level; case management and nutrition services for pregnant women; prescribed drugs.
- May 4, 1990 — Home and community based waiver services established.
- Dec. 31, 1992 — Effective date of HB 545, adds rehabilitation services for mental illness, alcoholism, and drug abuse to Medicaid.
- July 1, 1993 — HB 173 becomes effective: adds children in subsidized adoptions and the TEFRA option to the Medicaid program (TEFRA option grants eligibility to disabled children age 18 and younger who need an institutional level of care, and would be Medicaid eligible in an institution, to attain Medicaid eligibility living in the community).
- July 1, 1998 — HB 369 becomes effective: expanding Medicaid coverage for children and pregnant women with incomes up to 200% of the federal poverty level, and establishing continuous eligibility for children.

Eligibility for Medicaid

Medicaid Costs =

eligibles x services x reimbursement

Of the more than 50 Federal eligibility categories, Alaska covers 32.

Eligible Persons

- **Federally mandated groups – families and children**
  - Families meeting the old Aid to Family with Dependent Children (AFDC) financial criteria
    - Families who become ineligible for Family Medicaid due to increased earnings may receive up to 12 months extended Medicaid coverage.
    - Post-Medicaid coverage is required for four months for families losing eligibility due to increased child support collections.
    - Children receiving Title IV-E foster care or adoption assistance.
  - Children up to age 6 and pregnant women with family incomes up to 133% Federal Poverty Level (FPL).
  - Infants born to women on Medicaid are automatically eligible for one year.
  - Children up to age 18 with family incomes up to 100% FPL born after 9/30/83.
  - Certain aliens may receive coverage for emergency services only.

Federal Poverty Level (FPL) for family of three in Alaska: $1,475 monthly

Eligible Persons *continued*

- **Federally mandated groups – aged and disabled**
  - **A person qualifying for a Supplemental Security Income (SSI) payment.**
    - Certain groups who have lost SSI eligibility due to work related income.
    - Certain groups of people who lost eligibility due to Cost of Living Adjustment (COLA) increases in Social Security benefits
    - Disabled Adult Children are eligible for Medicaid. They are individuals who lost SSI because they started receiving social security payments when they turned 18.
    - Disabled Widows between the ages of 60 and 64 who lose SSI due to receipt of social security benefits.
  - **Qualified Medicare Beneficiaries (QMB)**
    - must have Medicare premiums and cost sharing covered by Medicaid. Income up to 100% FPL and twice the SSI resource standard.
    - Qualified Disabled and Working Individuals (QDWI) must have Part A Medicare premium paid for by Medicaid. Individuals who lost disability status because they returned to work. Incomes below 200% FPL and resources twice the SSI standard.
    - Special Low Income Medicare Beneficiary (SLMB) must have Medicare Part B premiums paid by Medicaid. There are three categories of income: 120% FPL, 135% FPL (an annual capped amount for each State) and 175% (who qualify only for partial payment of the Part B premium)

Eligible Persons *continued*

- **Optional groups: families and children**
  - ✓ Pregnant women and children with family incomes up to 185% FPL
  - ✓ Children in State custody or under State-only adoption assistance agreements
  - ✓ Children up to age 21 who meet the old AFDC financial standards
  - ✓ Persons under 21 receiving treatment in an inpatient psychiatric facility who meet the old AFDC standards
  - ✓ Optional targeted low-income children (State Child Health Insurance Program, or SCHIP), included in Denali KidCare
  - Medically needy – these are categories of women and children with higher incomes who can "spend down" their income and resources on health care in order to become Medicaid eligible

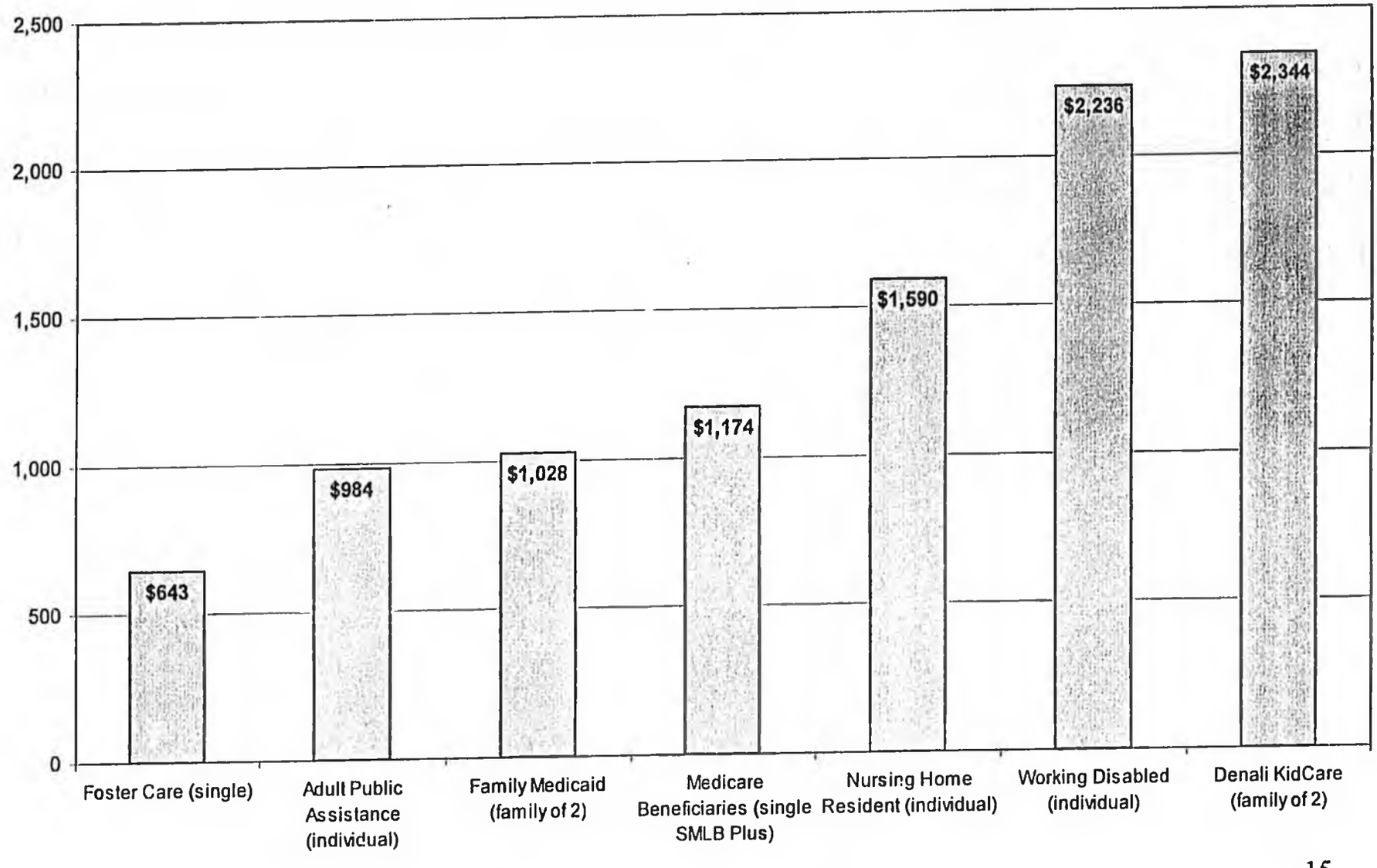
✓ ***Option selected by Alaska Legislature.***

Eligible Persons *continued*

- **Optional groups: aged and disabled**
  - ✓ Individuals receiving only a State supplemental payment (Adult Public Assistance) but *NOT* Supplemental Security Income (SSI).
  - ✓ Disabled children age 18 or younger who would be eligible if they were in a medical institution (TEFRA kids).
  - ✓ Individuals in need of an institutional level of care (300% of the SSI standard)
  - ✓ Persons in a facility who would be eligible for assistance if they left the facility
  - ✓ The "working disabled" with income up to 250% FPL
  - Medically needy – these are categories of aged and disabled with higher income who can "spend down" their income on health care in order to become Medicaid eligible.

✓ ***Option selected by Alaska Legislature.***

Monthly Income Standards Compared



Who will not qualify?

Adults* (ages 21-64) with no children -- regardless of their medical need or lack of financial resources.

**Unless the adult meets disability requirements.*

Services Covered

Federally Mandated Services

Children's Services

- All medically necessary health care services must be covered for eligible children.
  - ***Within the scope of mandatory or optional services under Federal law.***
  - ***Even if those services are not included as part of the covered services in that State's plan.***

Inpatient hospital services

Outpatient hospital services

Prenatal care

Vaccines for children

Physician services

Nursing facility services

Family planning services and supplies

Rural health clinic services

Home health care for persons eligible for skilled-nursing services

Laboratory and x-ray services

Pediatric and family nurse practitioner services

Nurse-midwife services

Federally qualified health-center (FQHC) services

Early and periodic screening, diagnostic, and treatment (EPSDT)

Optional Services

(✓ Selected by the Alaska Legislature for coverage)

✓ Ambulatory surgery center services
✓ Case management services
Chiropractic
Christian Science sanatorium
Clinic services
Community supported living arrangements
✓ Dental *(adults limited to emergency treatment for pain and infection)*
Dentures
Diagnostic services
✓ Durable medical equipment
Emergency hospital services (for hospitals not enrolled)
✓ Home and community care
✓ Home health
✓ Hospice services
✓ Intermediate Care Facility for the Mentally Retarded (ICF/MR)
✓ Services in an inpatient psychiatric facility for age 65 and older

Optional Services *continued*

(✓ Selected by the Alaska Legislature for coverage)

✓ Medical supplies
✓ Occupational therapy
Optometrist services
✓ Personal care services
✓ Physical therapy
Podiatry
✓ Prescription drugs
Preventive services
Private duty nursing
✓ Prosthetics and orthotics
✓ Rehabilitation services *(mental health and substance abuse)*
Respiratory therapy
Screening services
✓ Speech, language and hearing services
✓ Vision services

Plus: ✓ Any service as recognized under State law

Paying Providers

Facility Reimbursement

- Alaska law provides for a Medicaid Rate Advisory Commission (MRAC) to advise the department on rate setting for **facilities.**

- Alaska law requires that facility rates be set prospectively based on a fair rate for reasonable costs incurred by a facility.

- Hospitals – daily per diem rates are set for each facility based on their Medicare cost report. Outpatient services are reimbursed at a percent of charges.

- Nursing Facilities – daily rates are determined from the facility's Medicare cost report.

- Alaska has employed its Federal Disproportionate Share Hospital (DSH) allotment to support the State operated psychiatric hospital, Alaska Psychiatric Institute (API), for a number of years matching State general fund appropriations to API with allotment funds.

Provider Reimbursement Rates

Physician and others who bill physician codes

- use the Resource Based Relative Value Scale (RBRVS) which

  – compares the complexity of work (w), the practice expense (p), and the malpractice insurance cost (m) for each medical procedure, multiplied by a cost factor for Alaska (the Geographic Practice Cost Index or GPCI).

  – each procedure is assigned a Relative Value Unit (RVU) for each factor.

  – mathematical formula multiplies the RVU for each procedure by a State-adopted conversion factor of $49.90:

  [(RVUw X GPCIw) + (RVUp X GPCIp) + (RVUm + GPCIm)] X the conversion factor

Provider Reimbursement Rates

- Prescription drugs – reimbursement is made at 95% of the Average Wholesale Price of the drug plus a dispensing fee. Only those drugs for which the manufacturers have entered into a rebate agreement with the Federal government may be purchased.

- Laboratory services, Ambulatory Surgery, Rural Health Clinics are paid based on the Medicare rates.

- Other services – rates and fees for other services are developed in State regulation.

Program Accountability

- **Surveillance and Utilization Review (SURS)**
  - In order to determine that Medicaid funds are spent appropriately, the Surveillance and Utilization Review (SURS) function reviews service utilization of recipients and claims patterns of providers. Patterns of over utilization or aberrant billing are investigated and actions are taken to end the behavior.
  - SURS staff also send random letters to recipients to determine if services billed to the division were actually received.

- **Claim Check**
  - Claims auditing software package
  - Evaluates billing information and coding accuracy
  - Follows health care industry standards

- **Audits and On-Site Reviews**
  - Program staff and auditors on contract with the division may perform reviews of provider records to determine that services were provided according to program requirements and that records adequately document the level of services billed.
  - The division recovers funds from providers determined to have been erroneously paid through SURS functions, audits, and on-site reviews.

Program Accountability *continued*

- **"Primary Care Program"**
  - health care services are managed by a designated provider for recipients who over-utilize services or prescription drugs

- **Third Party Liability (TPL)**
  - The TPL function assures that other parties liable for payment for services received by Medicaid recipients are billed and funds collected.
  - TPL also operates the Buy-In program, in which Medicaid pays Part A and Part B Medicare premiums on behalf of dual beneficiaries so that Medicare pays their share of the costs of services.
  - The TPL unit administers contracts to search for liable parties including accidental injuries and insurance that may be available for collection and recovery of funds due Medicaid.
  - TPL also completes "Pay and Chase Waivers" that allows the State to recover from other insurance instead of requiring the provider to bill for those services before they bill Medicaid. These waivers are requested for services that are rarely covered by other payers, relieving providers from getting denials of claims in order to bill Medicaid.

Program Accountability *continued*

- **Prior Authorization**
  - approval is required before some services will be reimbursed
    - certain inpatient admissions
    - mental health rehabilitation
    - high cost medical equipment and procedures
    - transportation

- **Medicaid Provider Fraud Unit**
  - As required under Federal law, the Department of Law houses the Medicaid Provider Fraud Unit (MPFU). The division forwards any suspected fraud cases detected through SURS, audits, or tips from the public to the MPFU for investigation and possible prosecution.
  - The MPFU is an independent unit from the Department that works in cooperation with the US Department of Justice, the Office of the Inspector General and other Federal agencies.
  - Any provider convicted of fraudulent activity related to Medicaid or Medicare are banned from participation with any federally funded program.

Program Accountability *continued*

- **Care Coordination**
  - voluntary management of seriously ill, medically complex persons in Anchorage
  - services provided by nurses under state contract with PRO-West

Medicaid Financing

Federal Matching Rates For Services

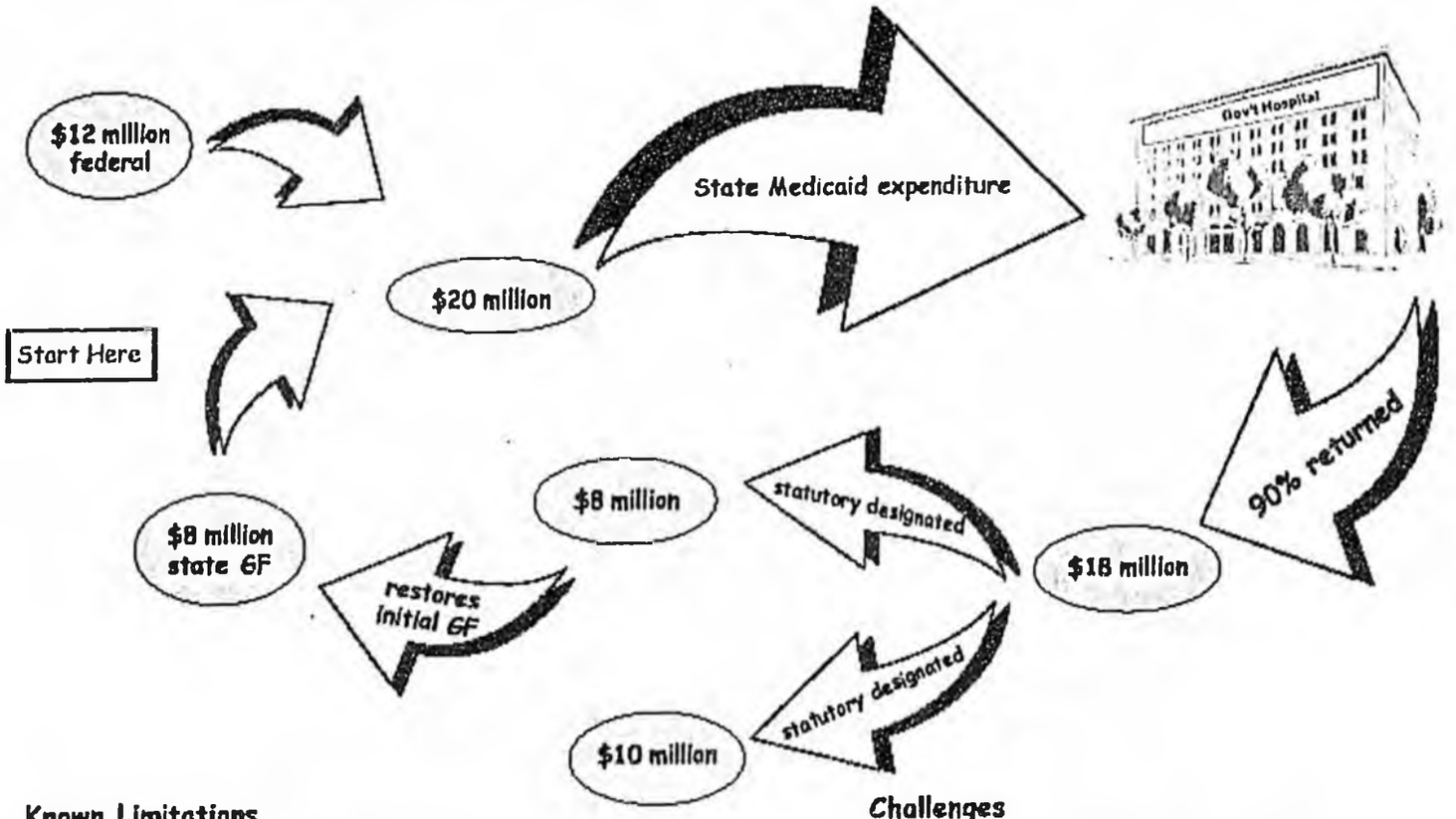
- Federal medical assistance rate (FMAP): 50% or more
  - FY01 for Alaska: 60.13%
  - 90% for family planning services
  - 100% for services provided to Alaska Natives by Tribal health care providers contracting for the provision of services formerly provided by the HIS

- Child Health Insurance match rate enhanced rate from FMAP
  - FY01 for Alaska: 72.09%

FMAP – Federal Medical Assistance Percentage

- Determined based on a statutory formula that compares the State per capita income to the national per capita income
- Minimum is 50%; Alaska received the minimum until FFY 98 when Congressional action increased the FMAP to 59.8% for three years
- Bureau of Economic Analysis (BEA) adopted a new methodology for income calculation, which radically affected Alaska, as the BEA began counting government contributions to retirement as income
- BEA change will result in a reduction of the Alaska FMAP to 57.38% in FFY 02 unless the Congressional delegation can achieve an additional change to the formula

Maximizing Federal Funds Through Inter-Governmental Transfers



Known Limitations

Must be within Alaska's Medicare upper limit
Expenditures must serve a new Medicaid purpose
Participating facilities must be:

- A hospital
- Government operated
- Enrolled in Medicaid

Challenges

Sufficiency of statutory or regulatory authority
Moving while the opportunity remains open
Assuring a reliable Medicare upper limit calculation
Identification of governmental policy issues:

- Notification or involvement of the Legislature
- Identifying the Medicaid purpose of the expenditure
- Determining which facilities participate
- How much of the expenditure to leave with the facilities

Hospital Pro-Share

- A means for making additional payments to qualified public hospitals that experience low occupancy, thus often low revenues
- Accomplished in cooperation with the Federal Health Care Financing Administration (HCFA) and the Alaska State Hospital and Nursing Home Association (ASHNHA)
- Hospital returns 90 percent of the payment made to the State, while retaining 10 percent to address any local needs in hospital services
- Funds retained for local purposes have provided means for replacement of outdated hospital equipment, payment of hospital debts, funding payroll, and paying other costs of hospital physical plant and operating costs
- Eleven public hospitals have benefited from Hospital Pro-Share payments

Hospital Pro-Share *continued*

- HCFA has taken a hard line on continuation of State plans which involve recycling Medicaid payments to reduce State share and increase Federal share
- Congress required HCFA to issue new rules by December 31, 2000 that limit further use of a pro-share approach
- Final regulations published January 12, 2001 and effective 60 days later will severely restrict Pro-Share payments within the next two years.

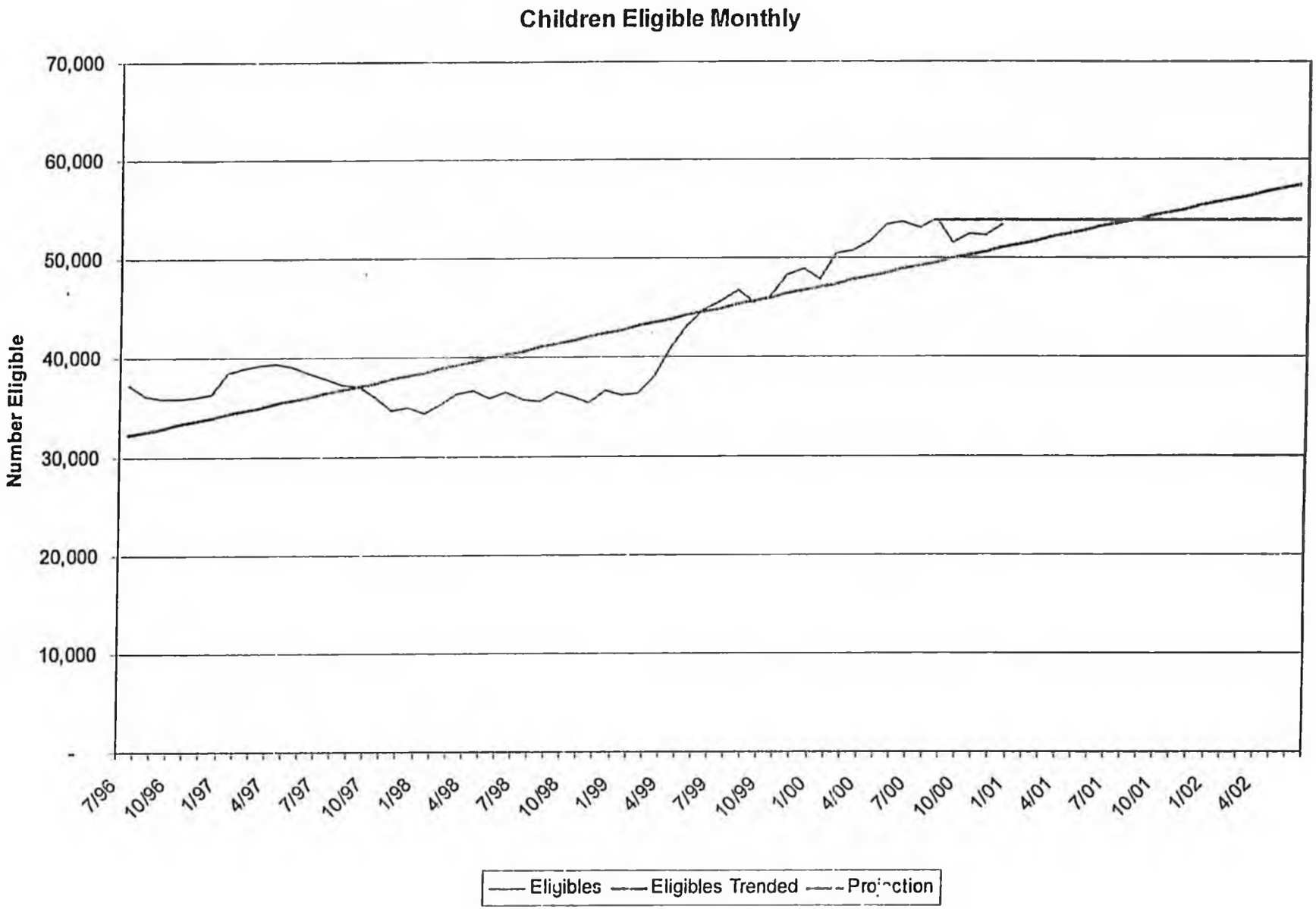
Alaska Medicaid Eligibles and Expenditures

Budget Projection Methodology

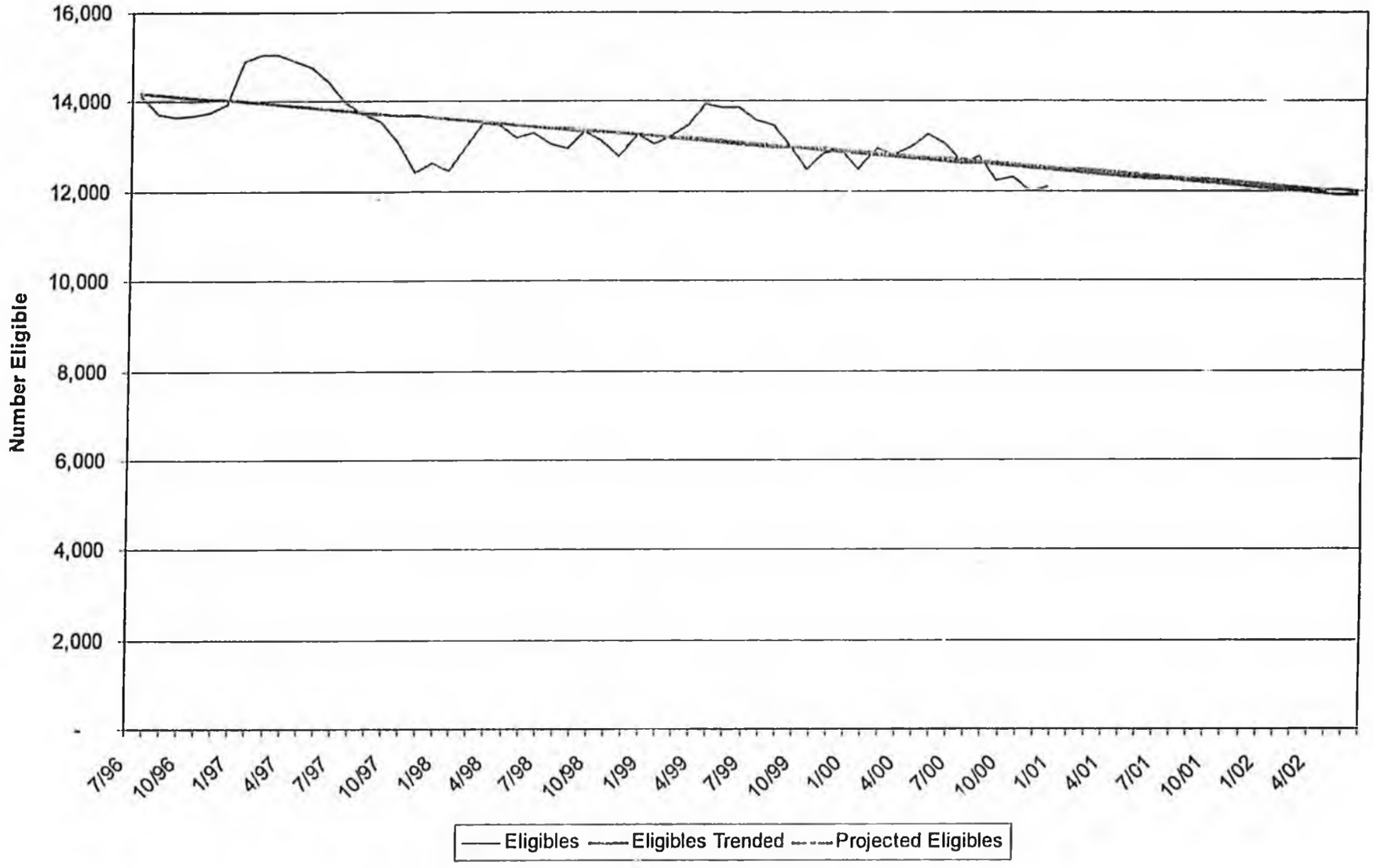
- Basic Formula: Total Cost for Services Per Month / Total Number of Members Enrolled Per Month = Total Cost Per Member Per Month.
- Formula is applied individually to each beneficiary group: Children, Adults, the Elderly, and the Disabled.
- Historical data post 5 years – monthly averages are determined.
- Computation of trend expressed in the form of a mathematical formula
  - results are definite and independent of any subjective estimate by the division
- Projections further developed by separate analysis of varying factors that affect Medicaid
  - anticipated changes in state and federal policy
  - related environment that will likely influence number of members and cost per member

Fiscal Year Analysis

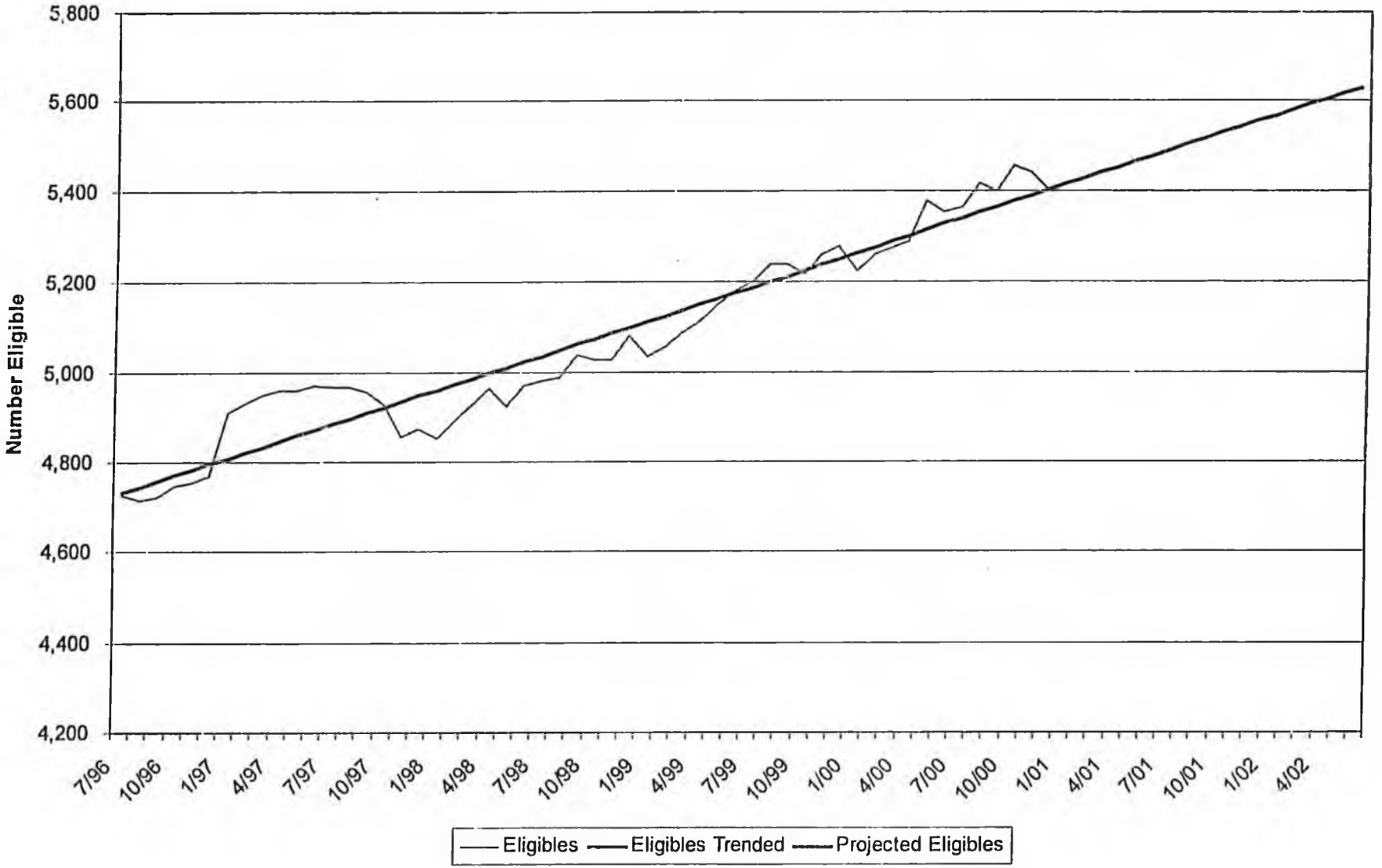
- On average, 76,664 Alaskans received Medicaid services each month during FY00.
- In FY01, an average of 81,178 Alaskans are receiving Medicaid services each month.
- Medicaid eligible members per month grew by 18 percent in FY00 from FY99. Children enrolled in Title XIX and Title XXI accounted for 97 percent of the 18 percent increase in total Medicaid eligible members from FY99 to FY00. The enrollment of eligible children is expected to level out during the last of FY01 through FY02.
- The average number of adults receiving Medicaid assistance each month decreased by 3 percent in FY00 from FY99. This is consistent with the trend of very slight decreases in the number of eligible adults each year since FY96.
- The average number of elderly Medicaid members per month has grown by 4 percent from FY99 to FY00. This is consistent with previous years and is expected to remain close to the same in FY02.
- The number of Alaska's Medicaid members in the Disabled category increased by 6 percent in FY00 over FY99. The Department expects the number of disabled members to continue to grow at approximately that same rate.


Children Eligible Monthly
Number Eligible
70,000
60,000
50,000
40,000
30,000
20,000
10,000
-
7/96
10/96
1/97
4/97
7/97
10/97
1/98
4/98
7/98
10/98
1/99
4/99
7/99
10/99
1/00
4/00
7/00
10/00
1/01
4/01
7/01
10/01
1/02
4/02
Eligibles
Eligibles Trended
Projection

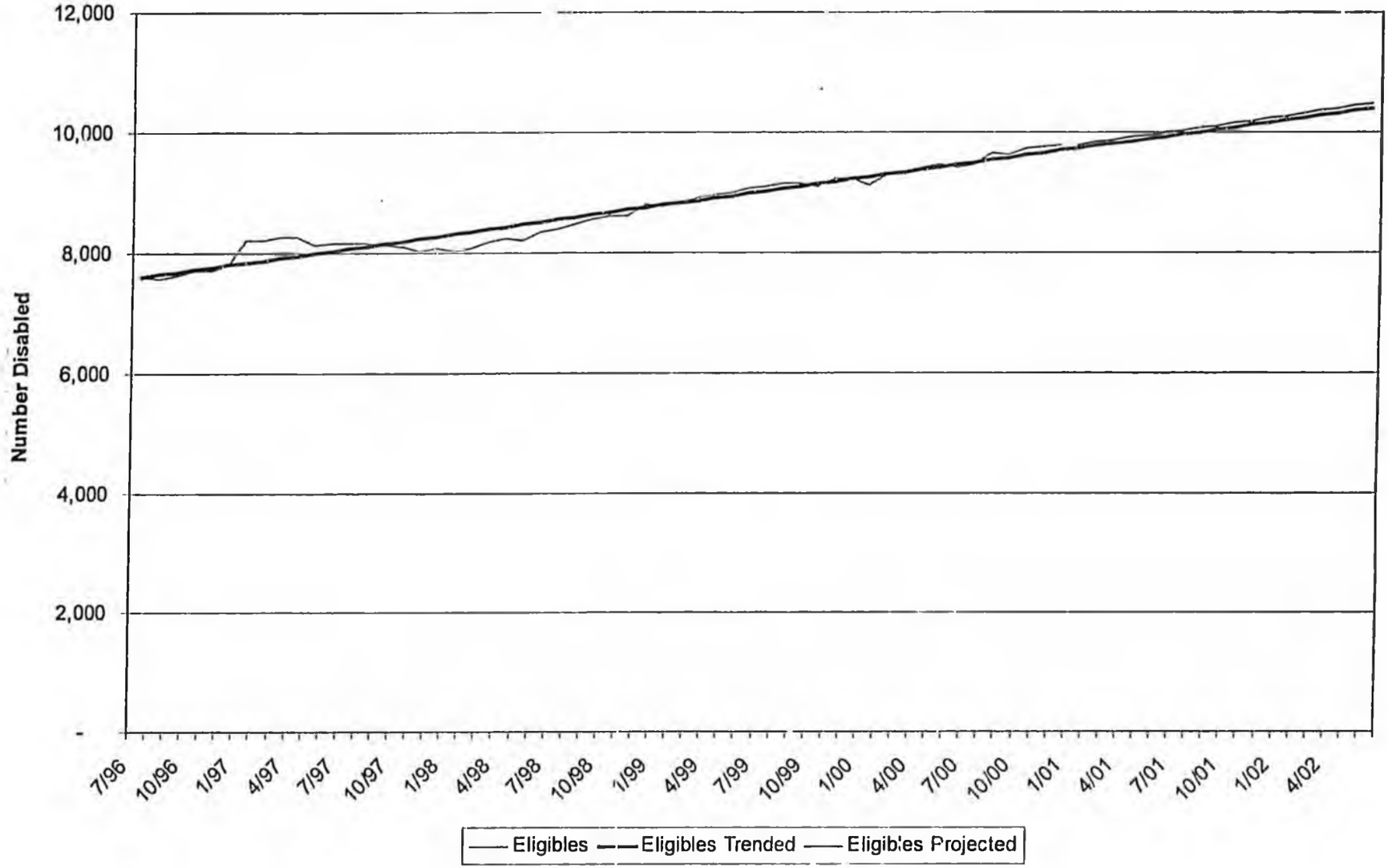
Adults Eligible Monthly



Elderly Eligible Monthly



Disabled Eligible Monthly

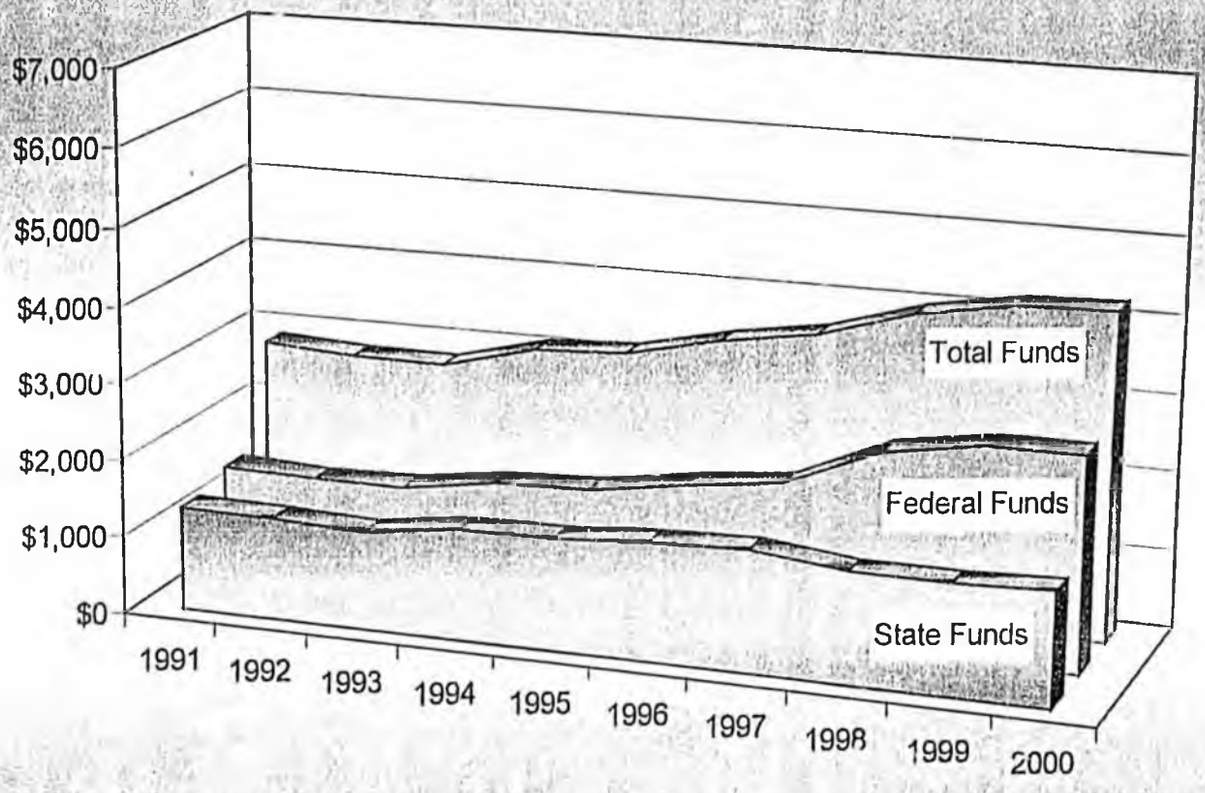


Medicaid Eligibles Per Month/Payments Per Month Comparison
Actual Year-to-Date Eligibles Members and Monthly Payments

		Eligibles	Payments
Jul-98	FY99	67,751	$30,566,969
Aug-98		68,127	$30,933,138
Sep-98		68,503	$31,299,307
Oct-98		68,879	$31,665,476
Nov-98		69,255	$32,031,645
Dec-98		69,631	$32,397,814
	Average	**68,691**	**$31,482,392**
		Eligibles	**Payments**
Jul-99	FY00	73,583	$41,640,431
Aug-99		74,721	$41,853,061
Sep-99		72,931	$32,488,834
Oct-99		72,961	$34,791,711
Nov-99		75,676	$39,239,654
Dec-99		76,415	$31,567,475
	Average	**74,381**	**$36,930,194**
		Eligibles	**Payments**
Jul-00	FY01	80,517	$48,657,787
Aug-00		81,840	$35,185,242
Sep-00		78,795	$39,833,712
Oct-00		80,049	$47,936,360
Nov-00		79,504	$38,451,446
Dec-00		80,684	$38,127,910
	Average	**80,232**	**$41,365,409**
		Eligibles	**Payments**
Change from FY99 to FY00		**5,690**	**$5,447,803**
Change from FY 00 to FY01		**5,850**	**$4,435,215**

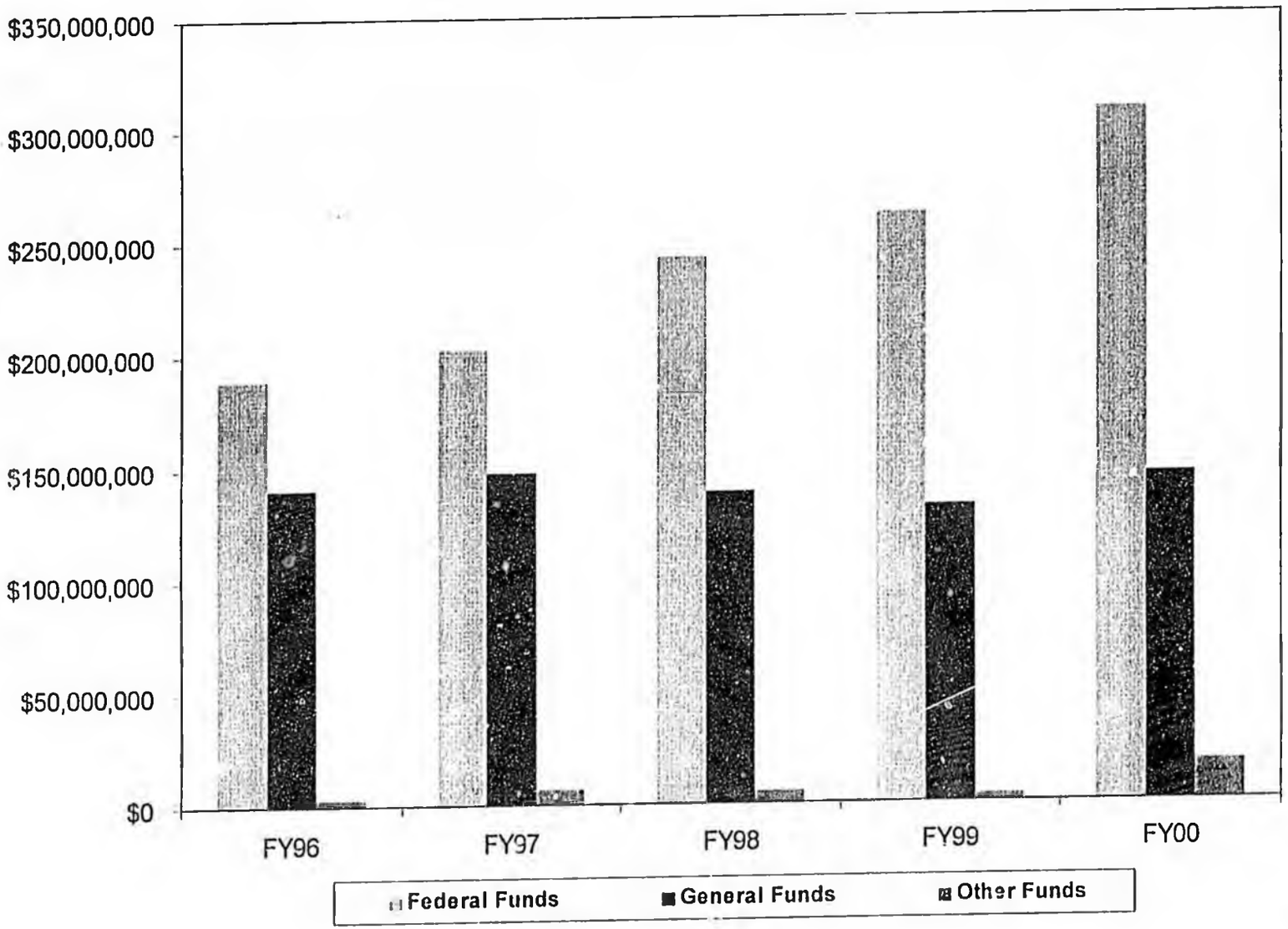
Data Source: Medicaid Management Information System (MMIS) via Juneau Claims & Eligibility Data Base (JUCE)

Average Annual Cost per Eligible Medicaid Beneficiary - Federal and State Shares (FY91 through FY 00 Actuals)



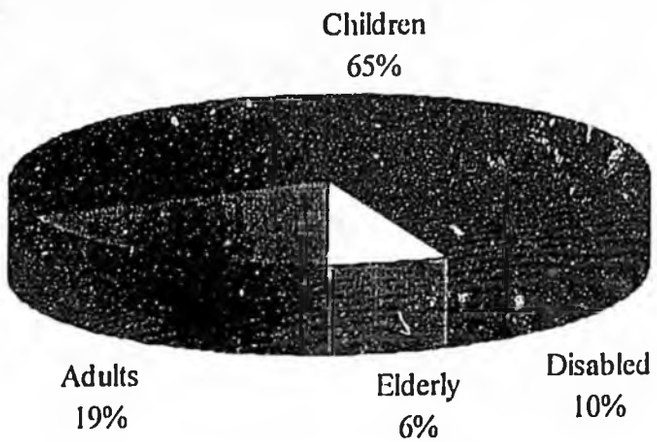
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
State Funds	$1,341	$1,308	$1,279	$1,427	$1,443	$1,531	$1,574	$1,422	$1,422	$1,469
Federal Funds	$1,508	$1,471	$1,481	$1,647	$1,690	$1,873	$2,029	$2,560	$2,765	$2,768
Total Funds	$2,849	$2,779	$2,760	$3,074	$3,133	$3,403	$3,603	$3,982	$4,187	$4,237

Medicaid Expenditures by Fund Source

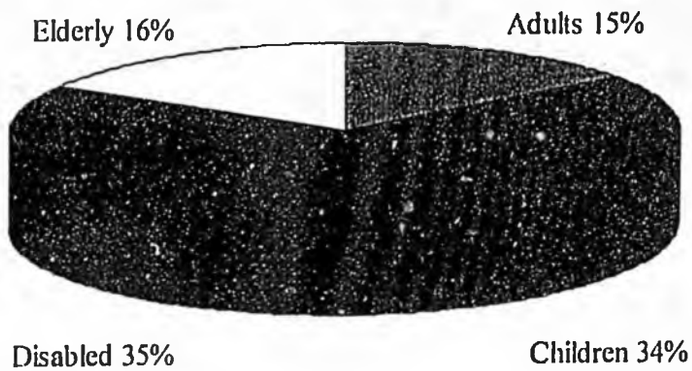


The Medicaid Population in Alaska

FY 2000 Eligibles by Beneficiary Group



FY 2000 Expenditures by Beneficiary Group

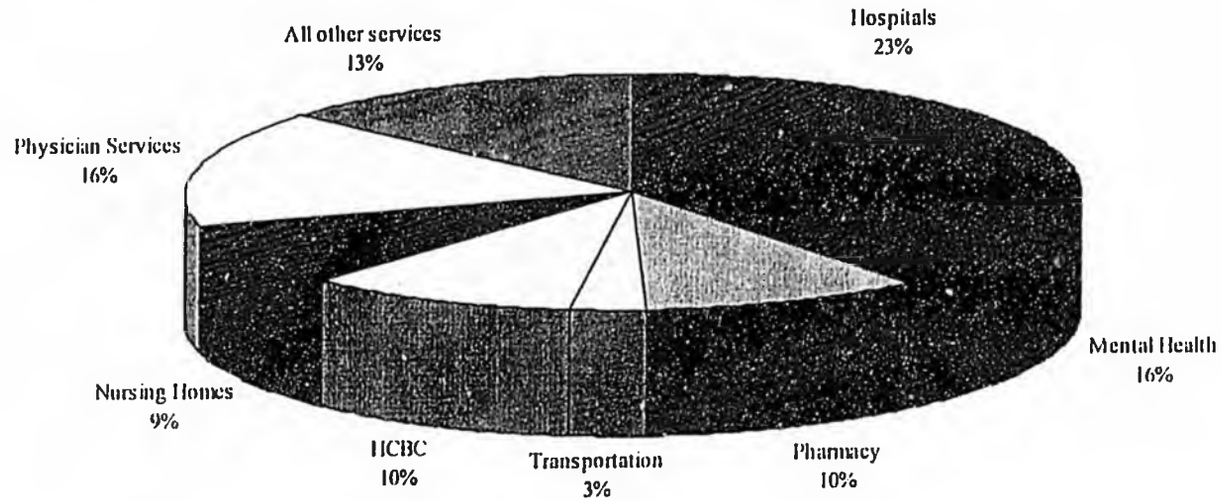


	Expenditure (in millions)	Eligibles
Children	$158.9	72,204
Disabled	163,6	11,108
Elderly	74.8	6,665
Adults	70.1	21,106
Total	$467.4	111,083

*Rounded

Source: DMA FY00 Annual Report

FY2000 Medicaid Expenditures by Category of Service

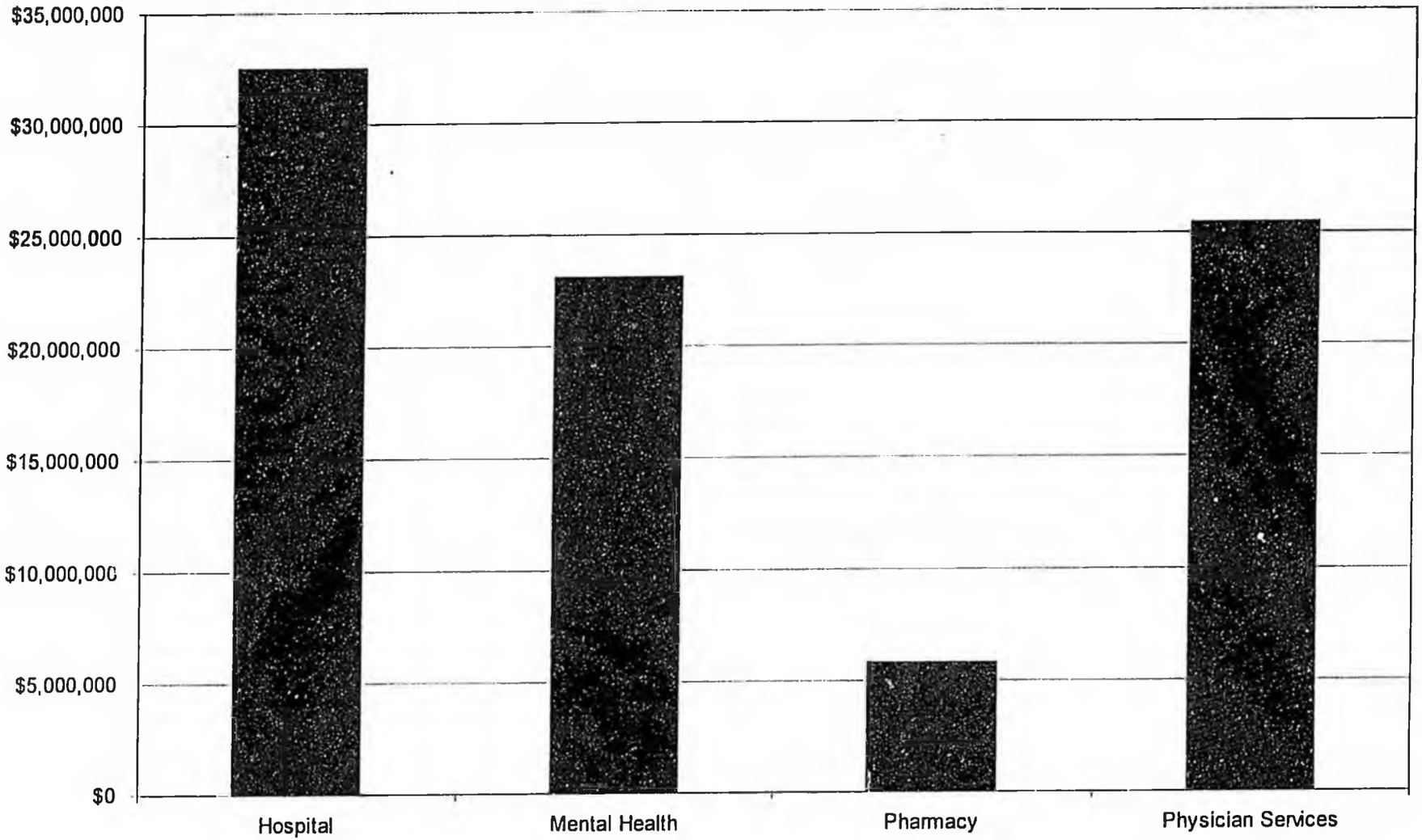


Category of Service	FY00 Expenditures (in millions)	FY99	FY98
Hospitals*	$108,312	$97,854	$98,353
Mental health	76,044	64,698	61,149
Pharmacy	46,311	37,288	30,781
Transportation	13,726	15,144	12,383
Home & Community	45,907	34,225	25,035
Nursing homes	40,153	43,282	41,799
Physician services	74,388	67,906	55,943
All other services	62,582	29,010	47,278
Total all services	467,423	389,407	372,721

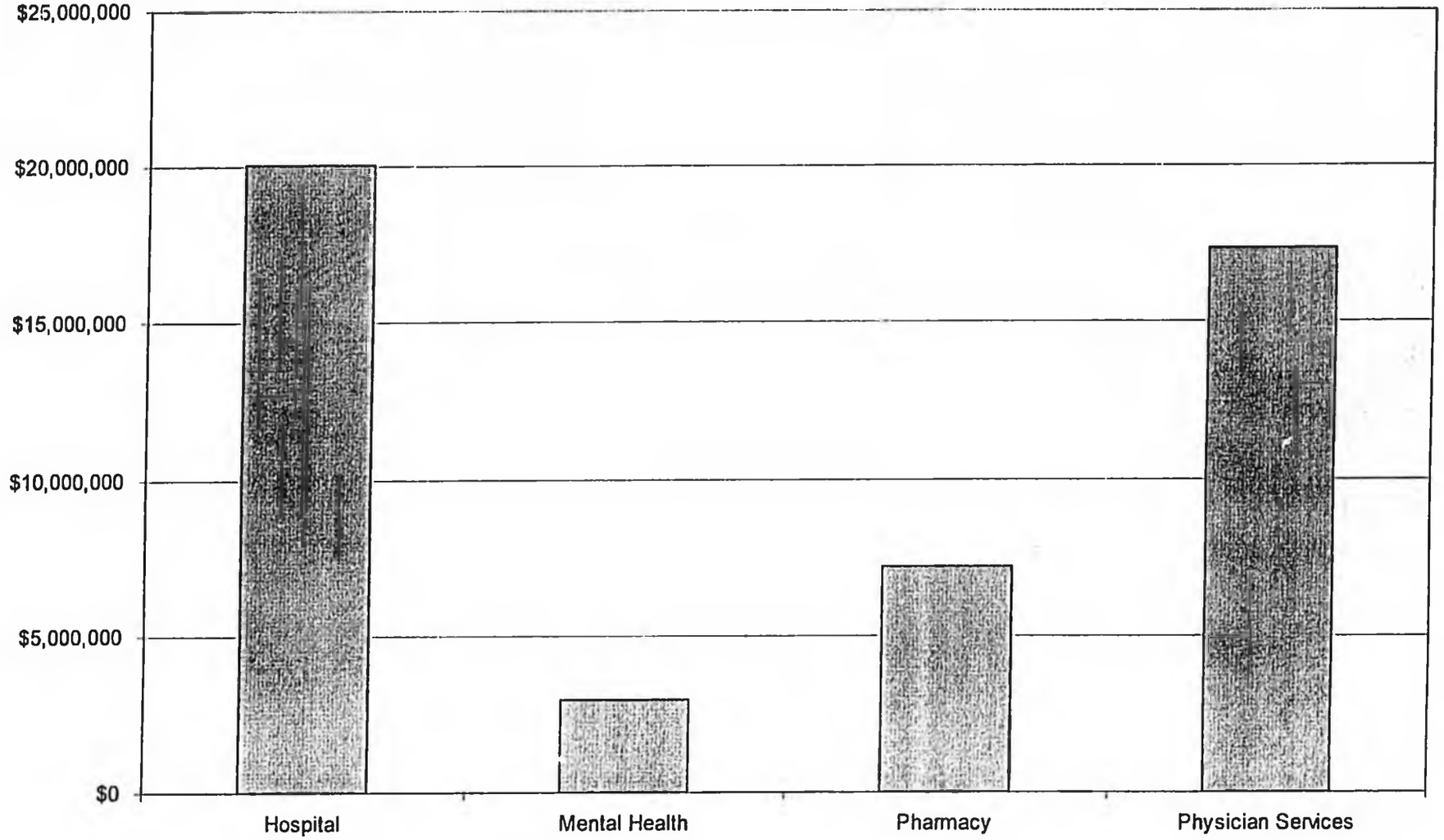
*Includes IHS facilities

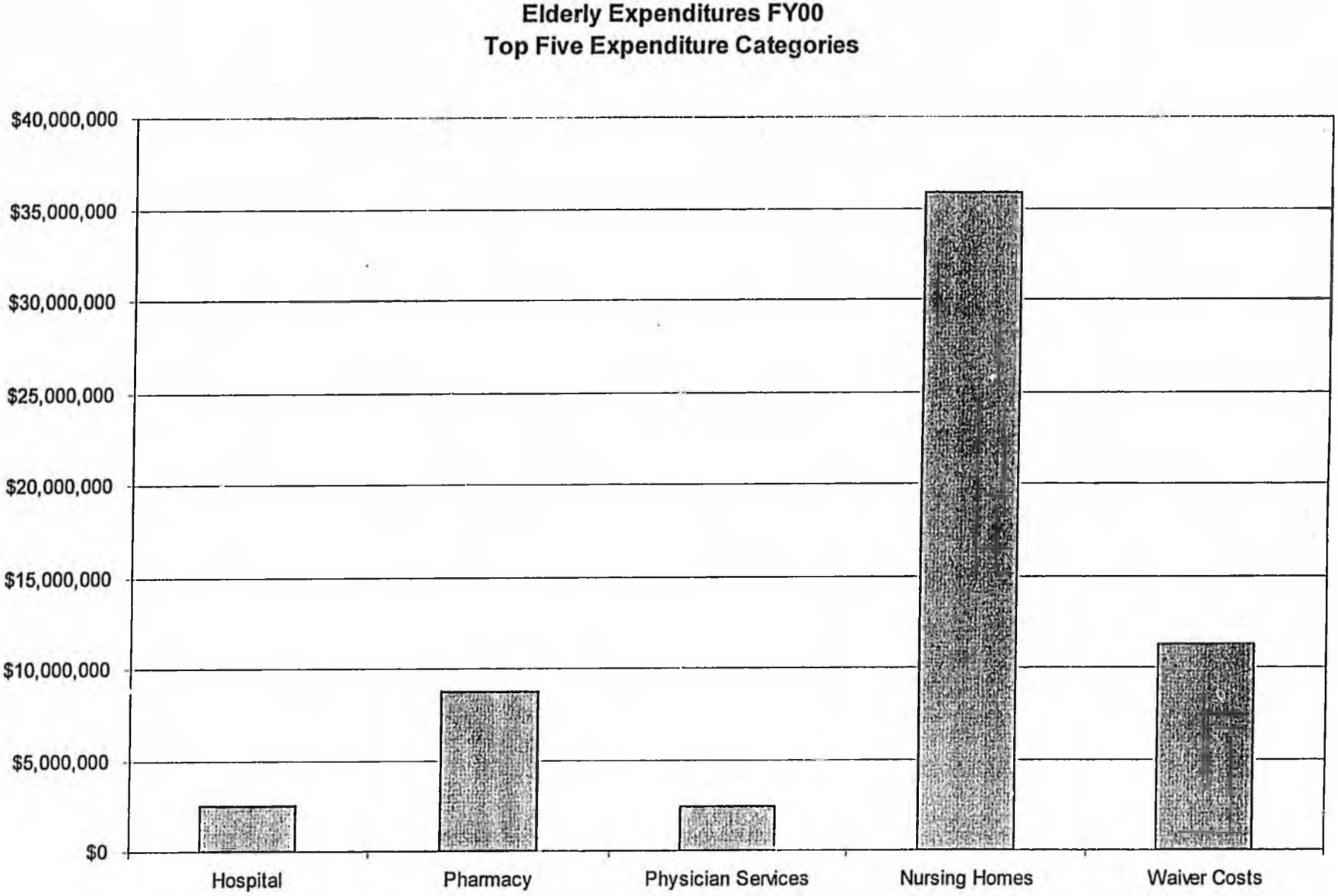
Source: DMA Annual Reports

Children Expenditures FY00
Top Four Expenditure Categories

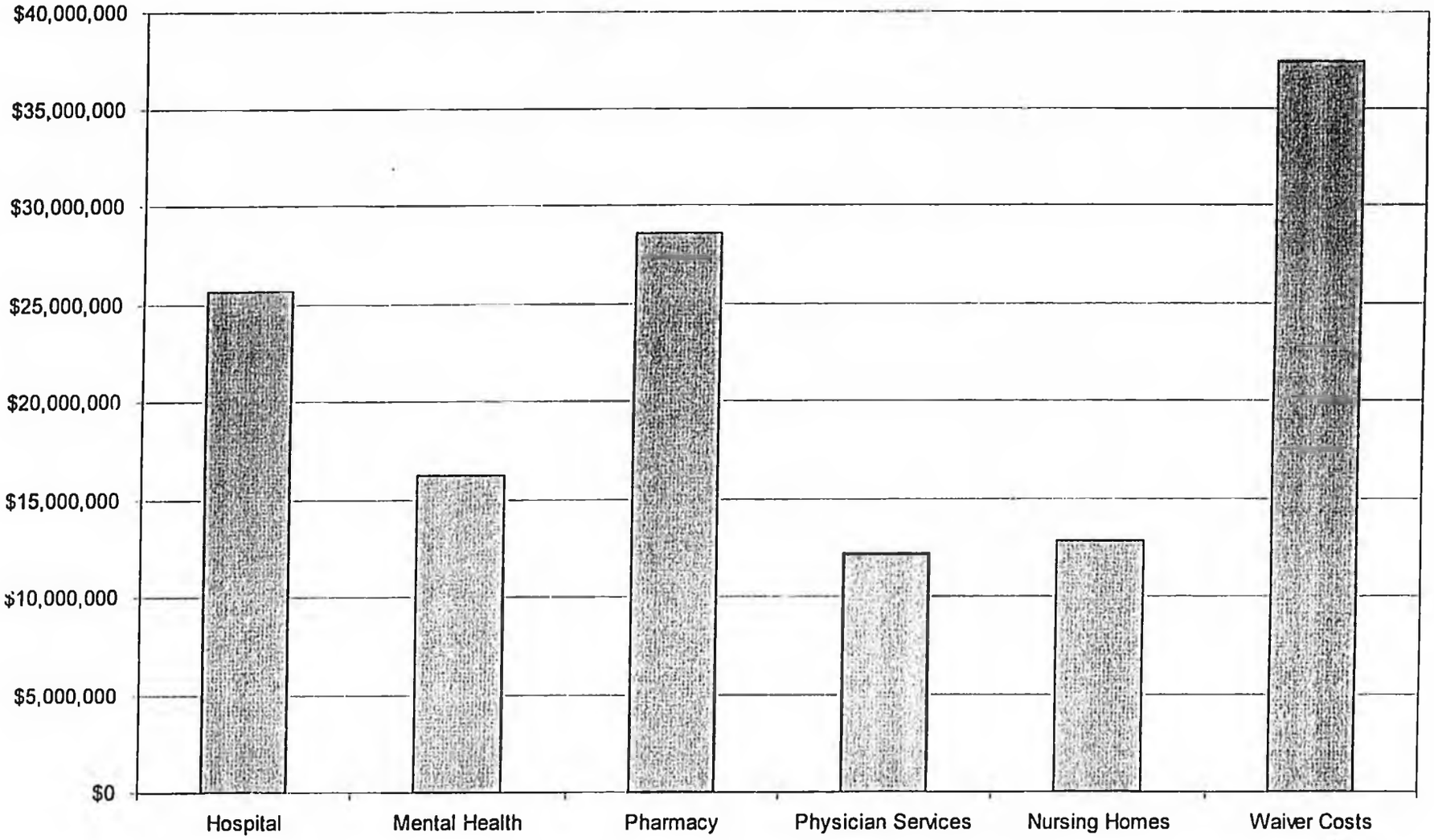


Adults Expenditures FY00
Top Four Expenditure Categories

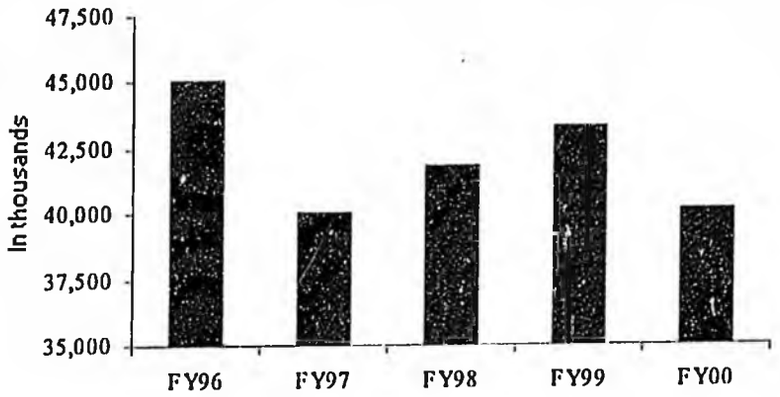



Elderly Expenditures FY00
Top Five Expenditure Categories
$40,000,000
$35,000,000
$30,000,000
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$0
Hospital
Pharmacy
Physician Services
Nursing Homes
Waiver Costs

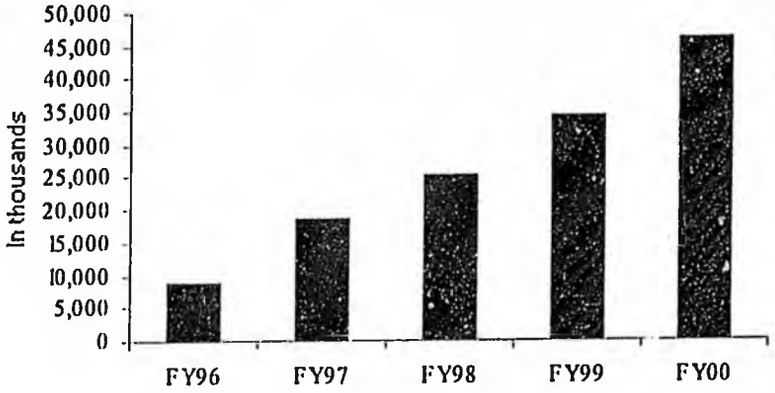
Disabled Expenditures FY00
Top Six Expenditure Categories



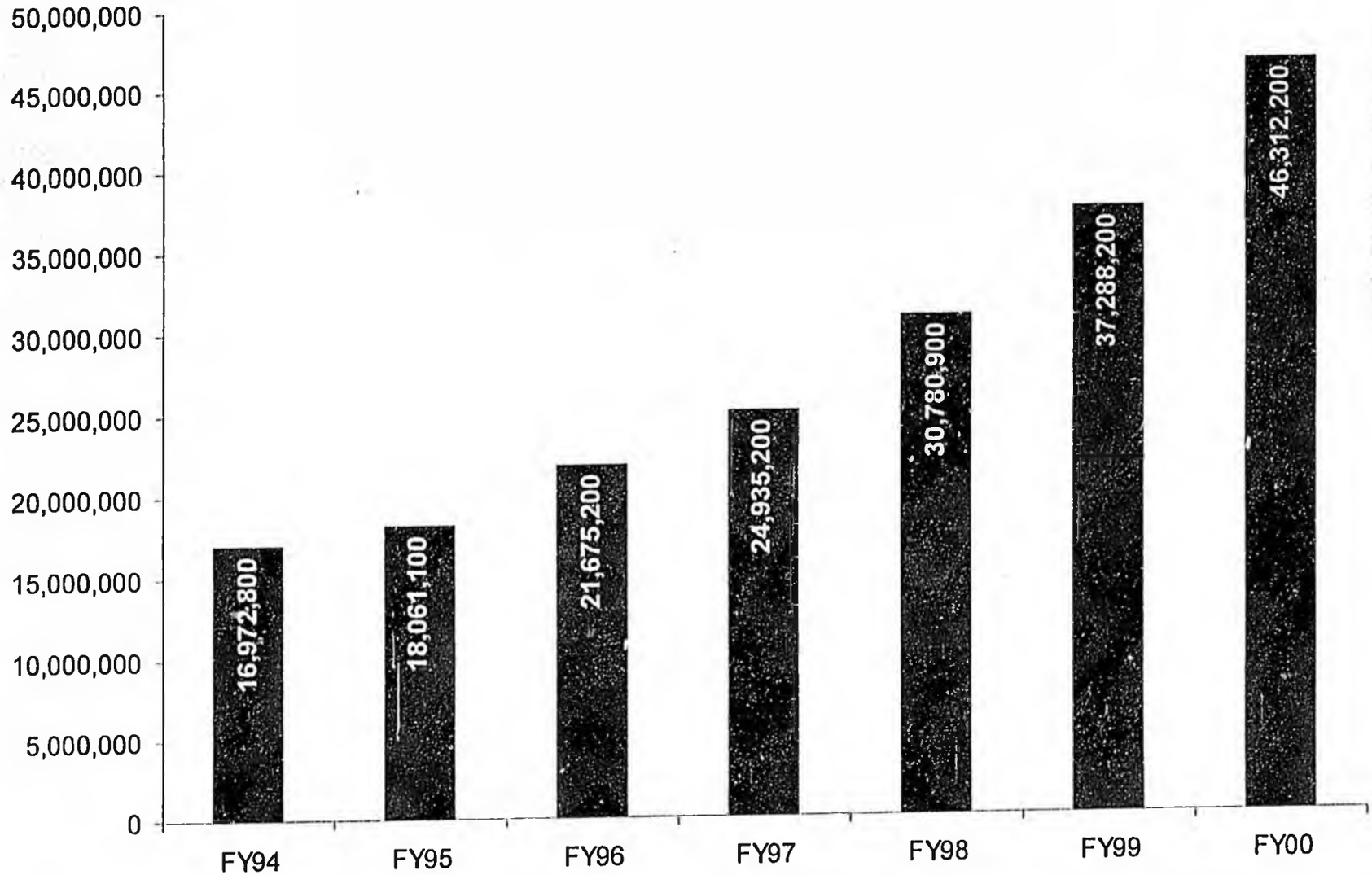
Nursing Homes



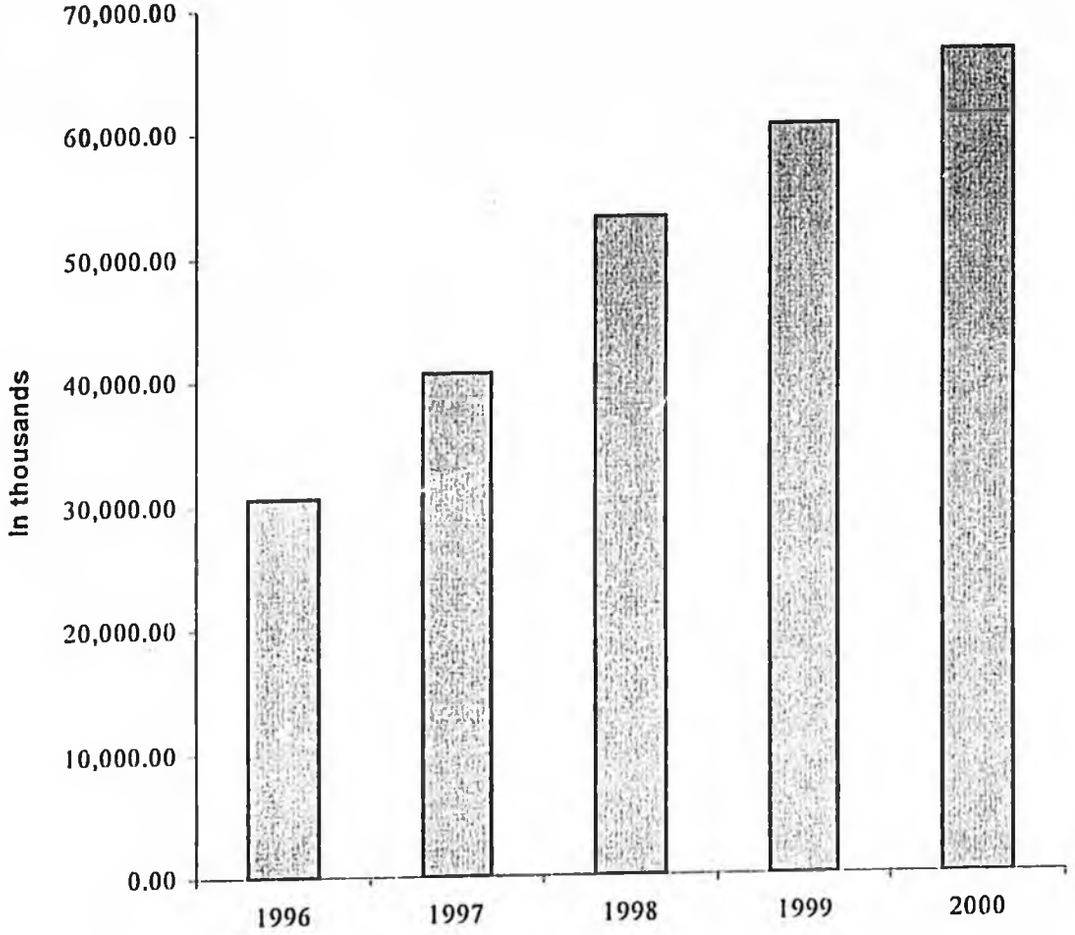
Waiver Services



FY94 to FY00 Pharmacy Expenditures



Medicaid IHS Expenditures (100% FFP)



FY00 Medical Assistance Payments by Election District (Eligibles)

Senate District	Area Represented	Number of Eligibles	FY00 Expenditures
A	Wrangell	4,533	$22,314,941
B	Juneau	3,776	$21,248,902
C	Kodiak/SE	4,842	$15,043,684
D	Soldotna	6,204	$33,317,859
E	Kenai	3,864	$16,866,777
F	Anchorage	4,322	$24,438,460
G	Anchorage	4,028	$15,567,429
H	Anchorage	12,488	$52,655,170
I	Anchorage	2,723	$10,340,730
J	Anchorage	4,850	$31,913,215
K	Anchorage	4,576	$22,992,284
L	Eagle River	3,397	$18,556,648
M	Chugiak	4,754	$17,255,005
N	Wasilla	9,272	$31,112,985
O	Fairbanks	3,291	$11,923,244
P	Fairbanks	4,007	$23,266,175
Q	North Pole	2,678	$7,433,915
R	Rampart	7,251	$20,432,895
S	Kotzebue	11,245	$27,606,930
T	Bethel	8,203	$23,174,847

FY00 Medical Assistance Payments by Election District (Providers)

Senate District	Area Represented	Number of Providers	FY2000 Expenditures
A	Wrangell	428	$20,963,128
B	Juneau	371	$20,055,837
C	Kodiak/SE	253	$8,153,014
D	Soldotna	400	$28,258,920
E	Kenai	176	$9,368,821
F	Anchorage	203	$23,269,0
G	Anchorage	112	$4,247,85
H	Anchorage	230	$22,957,1
I	Anchorage	123	$2,987,45
J	Anchorage	771	$74,987,1
K	Anchorage	841	$93,788,0
L	Eagle River	52	$7,396,99
M	Chugiak	270	$16,829,951
N	Wasilla	300	$12,658,767
O	Fairbanks	127	$5,594,693
P	Fairbanks	430	$39,831,288
Q	North Pole	34	$811,788
R	Rampart	190	$5,413,397
S	Kotzebue	172	$6,896,992
T	Bethel	324	$18,685,055

Potential Expansion of Persons Covered and/or Additional Services

- Women diagnosed with breast or cervical cancer under the CDC program
  - House Bill 65
  - Senate Bill 38
- TB infected individuals
- Home and Community Based Care for persons with Alzheimer's and related disorders
- Children aging out of foster care
- Working disabled individuals to higher income levels
- Coverage of parents whose children are eligible through Denali KidCare (SCHIP)
- Adult preventable and restorative dental services
- Home and Community Base Care for children under age 21 with psychiatric disorders

gible for Medicaid. The Task Force acknowledges the value of home and community-based long-term care services and recommends this legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail.) ❖

MEDICAID COVERAGE FOR ALZHEIMER'S PATIENTS

The Task Force requests the Departments of Administration and Health and Social Services review all options available to the state, including Medicaid, to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and Related Disorders.

Alzheimer's Disease and Related Disorders (ADRD) refers to cognitive impairments that are progressive and degenerative in nature. As a result of these impairments, effected adults require supervision and cueing from other individuals in order to adequately and routinely perform activities of daily living and instrumental activities of daily living.[30] People whose sole diagnosis is Alzheimer's Disease and Related Disorders do not typically require daily supervision by medical professionals.

"To be eligible for Alaska's Medicaid long-term care waiver programs, applicants must require skilled nursing services."

To be eligible for nursing home care and home and community-based services from Alaska's Medicaid program, applicants must be low-income and require skilled nursing or intermediate care. Persons whose sole diagnosis is ADRD typically do not meet the criteria for skilled nursing or intermediate care and consequently, the Alaska Medicaid program will not pay for nursing home placement or home and community-based services.

Alaska is only one of two states whose Medicaid eligibility standards for nursing home and home and community-based services require that the patient needs "professional-level medical supervision."[31] This requirement, as determined by the Department of Health and Social Services, effectively eliminates eligible Medicaid ADRD-only patients from the state's major long-term care services.

Persons with ADRD may have great difficulty living without assistance.[32] Currently for many people who suffer from ADRD, respite service for their families is the only long-term care service available. [1] The Task Force recognizes the desire for additional assistance for this particular group of Alaskans and understands that

the temporary relief provided to the family caregivers is not enough to adequately address the pressing long-term care needs of an ADRD individual.

However, modifying the Medicaid eligibility requirement for ADRD-only patients may have budget implications for the state.[34] Approximately 40 percent of the cost for qualified Medicaid patients is paid from the state's General Fund. Some states have reduced the budget impacts by requiring that all long-term care patients receive universal care plan counseling. (Please see recommendation 20) The effect of this requirement has been to place residents in the least restrictive long-term care setting, which often is also the lowest-cost setting. The effect has been to prolong the time that residents can pay for their own care, and therefore, reduce the potential cost to the Medicaid program.[35]

"Persons with ADRD may have great difficulty living without assistance."

In addition to the budget concerns, the Division of Senior Services may not have the capacity to serve the additional clientele who may apply for home and community-based waiver services if ADRD is included as an eligible diagnosis.

Even though changing the Medicaid eligibility requirement to include ADRD-only patients raises serious concerns, 48 other states offer Medicaid programs to patients suffering from only Alzheimer's Disease. Alaska should too.

The Task Force requests the Department of Administration and the Department of Health and Social Services review all options available to the state, including Medicaid, to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and Related Disorders. Also, the Task Force requests that a preliminary report outlining the departments' findings be submitted to the President of the Senate and Speaker of the House by April 30, 1999. ❖

INCREASE MEDICARE ACCESS

RECOMMENDATION 15

The Task Force requests the Department of Health and Social Services conduct a review of Medicare patients' access to medical services within the state and, if warranted, explore options to increase their access to health care.

The Task Force heard testimony regarding individuals covered by Medicare who were having difficulty accessing health care services. General concerns were ex-

OPTIONS FOR REACHING PEOPLE WITH DEMENTIA AND OTHER COGNITIVE IMPAIRMENTS

Option 1. Change nursing facility level of care regulations to include people with serious cognitive impairments. Because it uses the nursing facility level of care as an eligibility criterion, this allows the Medicaid Home and Community-Based Services waiver to serve people with dementia and other cognitive impairments.

Option 2. Add Medicaid Home and Community Care for Functionally Disabled Elderly Option – this option allows state to provide services to people age 65 and older who do not meet nursing home level of care, but do meet separate functional impairment criteria, as defined in federal law. It includes people with cognitive impairments such as dementia. It does not cover people who would only qualify for Medicaid using the more generous financial eligibility requirements for people who meet nursing home level of care.

	1. Expand Waiver	2. Add Option
Who is categorically eligible?	Any person who is disabled or age 65+ who meets NF level of care.	Individuals who are age 65+ who meet separate criteria for functional impairment.
Implementation	Requires regulation change, training of NF and HBC provider staff.	Requires statute change, implementing regulations, EIS and MMIS computer system changes, and training of HCB staff.
Financial Eligibility	$1,536/month for an individual. Spouse's income not counted. $2,000 countable resource limit. Spouse may retain up to $84,120 in countable resources.	$951/month for individual, $1410/month for couples. $2,000 countable resource limit. No spousal resource provision.
Service Package	All regular Medicaid services plus special HCB waiver services defined by state.	All regular Medicaid services plus special services defined by state (can be different from waiver).
Spending Restrictions	Average cost of people on waiver cannot exceed the average cost of serving people in institutions.	Average cost of people in option cannot exceed 50 percent of average cost of Medicare NF services.
Care Coordination	Assessment can be performed by private care coordinator who may be affiliated with a nursing home or HCB provider (except assisted living provider if client is in assisted living).	Assessment must be performed by public or nonprofit entity that is not affiliated with a nursing home or HCB provider.
Impact on Nursing Homes	People who meet expanded criteria are eligible for Medicaid coverage of nursing home.	No expansion of Medicaid nursing home coverage.

Prepared by Division of Medical Assistance, 4/01

Option 1

Expanding Nursing Facility Level of Care Criteria

Percent Served on Waivers	66%
Percent Served in Nursing Homes	34%
Percent Already on Medicaid	68%

Per Person Costs:

Waivers	
FY 02 Waiver Services	$ 14,616
FY 02 Other Services	$ 8,512
Nursing Facility	
FY 02 Nursing Facility	$ 81,528
FY 02 Other Services	$ 2,936

Total Costs:

	FY 02	FY 03	FY 04	FY 05	FY 06
Total Number of Recipients	75	150	200	250	300
Waiver Recipient Costs	$ 429,159	$ 1,716,634	$ 2,288,846	$ 2,861,057	$ 3,433,268
Nursing Recipient Costs	$ 1,051,463	$ 4,205,853	$ 5,607,803	$ 7,009,754	$ 8,411,705
Total	$ 1,480,622	$ 5,922,487	$ 7,896,649	$ 9,870,811	$ 11,844,973
General Fund	$ 631,041	$ 2,524,164	$ 3,365,552	$ 4,206,940	$ 5,048,328

Assumptions:

Approximately 100 people currently qualify for service, 50 people would be added each year.
In the first year, 75 people would enter service 1/2 year. The remaining 25 people would be added in the second year, along with the 50 additional people.

Option 2
Add Medicaid Home and Community Care for Functionally Disabled Elderly Option

Percent of Target Population Served 68%

Per Person Costs:

FY 02 Service Cost $ 14,616

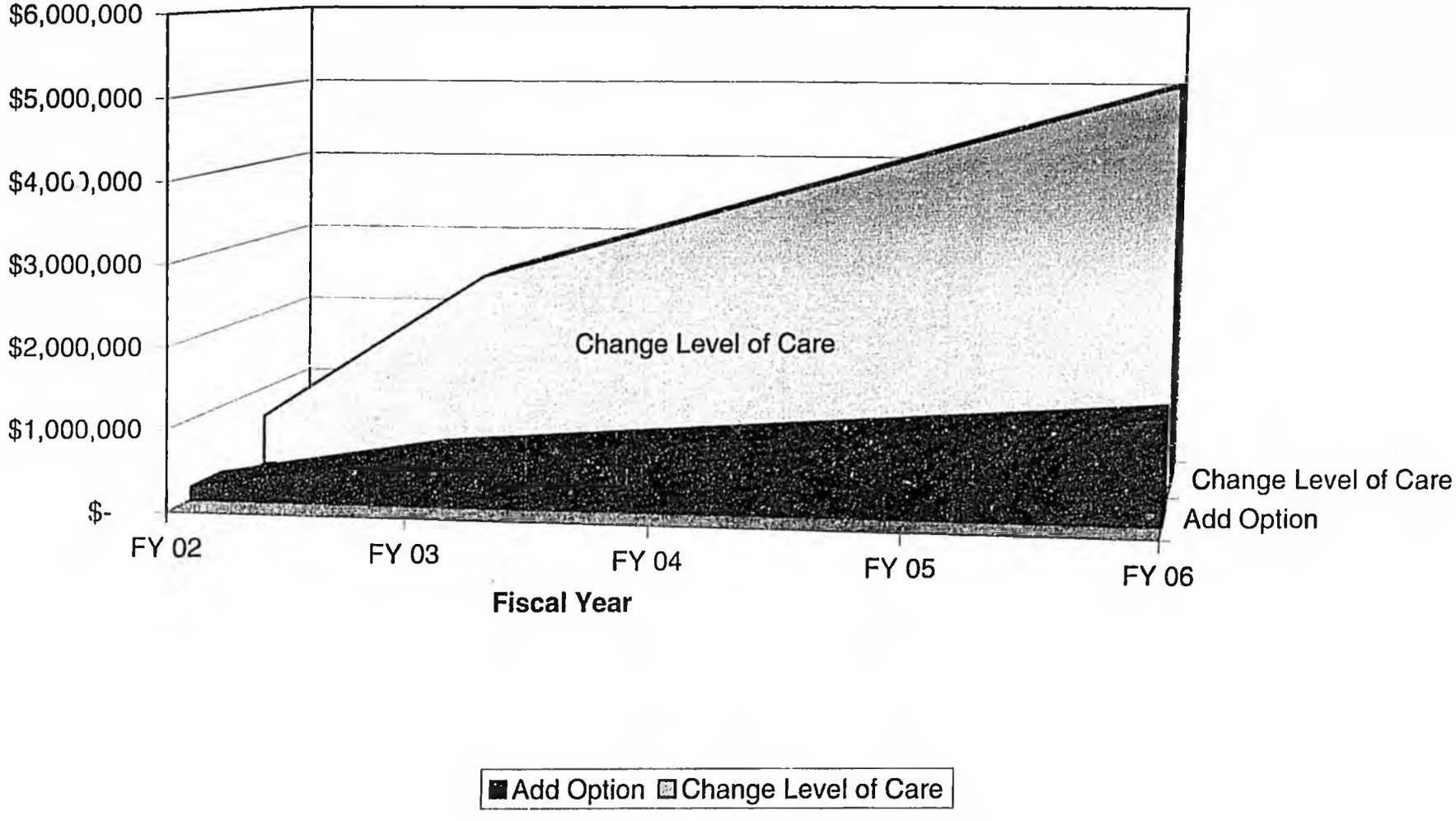
Total Costs:

	FY 02	FY 03	FY 04	FY 05	FY 06
Total Number of Recipients	51	102	136	170	204
Option Service Costs	$ 372,703	$ 1,490,811	$ 1,987,748	$ 2,484,685	$ 2,981,622
General Fund	$ 158,846	$ 635,384	$ 847,178	$ 1,058,973	$ 1,270,767

Assumptions:
Approximately 68 people currently qualify for service, 34 people would be added each year.
In the first year, 51 people would enter service for 1/2 year. The remaining 17 people would be added in the second year, along with the 34 additional people.

32 percent of the target population would not be served by the option because they failed to meet Medicaid financial eligibility criteria for people who do not meet institutional level of care.

General Fund Costs of Options



STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

TONY KNOWLES, GOVERNOR

P.O. BOX 110510
JUNEAU, ALASKA 99811-0610
PHONE: (907)465-3090
FAX: (907)586-1877

MEMORANDUM

DATE: March 28, 2001

TO: Elmer Lindstrom, Special Assistant
Office of the Commissioner
Department of Health & Social Services

FROM: Karen Pearson, Director
Division of Public Health

SUBJECT: SB38

The Centers for Disease Control (CDC) Breast and Cervical Cancer Early Detection Program is designed to reduce breast and cervical cancer morbidity and mortality. Women who do not receive regular screening and early detection are more likely to die than women who receive regular screening and have their cancers detected early. Because of this, CDC requires states to make an extra outreach effort to bring women in for screening who are the least likely to receive screening without this extra effort. However, all eligible women, regardless or race, ethnic or cultural minority status receive services from the program and receive outreach to bring them into the program. The Young Women's Christian Association in Anchorage has an outreach grant to help women with transportation needs, or other barriers to service, get in to see a provider for their annual exam. Other outreach grantees are located in Fairbanks, Soldotna and Homer which bring women into screening, and the State anticipates awarding an additional outreach grant in the Mat-Su Valley for FY02. Posters, flyers, and door to door campaigns are used to inform women about the program in these areas with low screening rates and encourage them to seek annual screening services.

At the enrolled provider's office, women are screened for age and income eligibility and other payment sources. If no other payment sources are available, women sign an enrollment form stating that they are eligible for the program and meet income guidelines. Alaska has selected the CDC recommended guideline of 250% of the poverty level as the upper income guideline for breast and cervical cancer screening. This allows more women in Alaska to be screened. The Health Care Finance Administration will not accept a State Plan for the federal breast and cervical cancer treatment program with an income guideline that is different than the screening income guideline.

Women Screened in the State Program in FY2000

Asian/Pacific Islander	265
Black/African American	238
Native Alaskan/American Indian	59
Other	88
Unknown/Undisclosed	235
White	3,466

There are four CDC Breast and Cervical Cancer Early Detection Program grantees operating in Alaska: the State of Alaska; SouthCentral Foundation (tribal grantee/Anchorage); Southeast Regional Health Consortium (tribal grantee/SE Alaska); and Arctic Slope Native Association (tribal grantee/North Slope Borough.) While all women diagnosed through one of these four CDC screening programs may eventually benefit from the treatment program, state general funds are needed only for those women who are not Indian Health Service Beneficiaries. The federal government pays 100% of the Medicaid costs for Alaska Natives. In 2000, 72 Alaskan women were diagnosed with breast or cervical cancer through one of the four CDC programs. Of those, 30 were Alaska Native, and 42 were not. Therefore, while the numbers of women who will benefit from the treatment program has sometimes included Alaska Native women (30), state general funds will only be needed for a portion of the cost of services for those women who are not Indian Health Service beneficiaries (42).

The fiscal note was based on the actual Medicaid expenditures for FY2000 for all services for women with a diagnosis of breast and cervical cancer. The average expenditures for these cancers was $17,500 for breast and $12,100 for cervical. Medicaid pays for services at a set fee schedule and the providers agree to accept that payment as payment in full except for required co-payments. Again, the costs are only for those women who are not Indian Health Service beneficiaries. Because the women will be eligible for Medicaid only for the duration of their breast or cervical cancer treatment, the enrollment numbers are not cumulative. Women lose their Medicaid eligibility once their treatment is complete.

Alaska Breast and Cervical Cancer Early Detection Program

Eligibility for Screening Program	Eligibility for Treatment Program
Income less than 250% of poverty	Income less than 250% of poverty
Has insurance but deductible too high to meet (e.g. $1,000 deductible)	Not eligible for the Medicaid treatment option under SB38-private insurance will pay for treatment
Has insurance but it doesn't cover preventive services (pap smear)	Not eligible for the Medicaid treatment option under SB38 -private insurance will pay for treatment
Alaska Native/American Indian and income below 250% of poverty	Not eligible for the Medicaid treatment option under SB38 if treatment is available at an IHS facility
Income and insurance eligibility checked every year	Eligibility for the Medicaid treatment option under SB38 is limited to the duration of treatment for the cancer that was diagnosed in the screening program
No cost sharing requirement for screening services	Cost sharing required at the maximum amount allowed under federal law. Inpatient: $50/day with a maximum of $200/admission Outpatient: 5% of allowable outpatient hospital charges; $3 /physician service day; $2/prescription filled or refilled. Cost sharing amounts are deducted from the payment to the provider
No asset testing required	Asset testing is prohibited for the treatment option per HCFA/CDC. States do not have authority to impose income and resource limitations

MEDICAID ELIGIBILITY PROCEDURES

A woman screened under the CDC Breast and Cervical Cancer Early Detection Program (BCCEDP) would apply for Medicaid at her local Division of Public Assistance office.

The Eligibility requirements will consist of:

- Documentation of screening by a BCCEDP provider;
- Medical diagnosis of cancer;
- Documentation of no creditable coverage; and
- Under age 65.

Length of eligibility:

Eligibility for this category exists through treatment for cancer. At this time, we are looking at physician certification that treatment is complete to terminate eligibility for each individual woman. The Division of Medical Assistance may use case managers to monitor the treatment of these women in order to secure physician certification that treatment has ended. The division currently has case managers on contract through the Professional Review Organization/West (PRO-W) voluntarily available to Medicaid recipients with certain high cost conditions; case managers under this contract could be required by the division to monitor the treatment of the women eligible for Medicaid under this option. There are nationally accepted clinical practice guidelines available through the Agency for Health Care Research and Quality.

DHSS
4/11/01

Released 3/29/01
HCFA/CDC

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000

On January 4, 2000, the Health Care Financing Administration (HCFA) provided initial guidance to State Health Officials to assist with implementing the provisions of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). The new option allows states to provide full Medicaid benefits to uninsured women under age 65 who are identified through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer.

Below are the first series of answers that respond to some of the questions about the BCCPTA. HCFA and CDC are committed to providing timely responses to important issues and will release additional guidance as needed and as it becomes available.

ELIGIBILITY

Question 1. What are the eligibility requirements for the new optional eligibility group for women who need treatment for breast or cervical cancer?

Answer. In order to qualify under this new optional category, a woman must meet the following eligibility requirements:

1. The woman must have been screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service (PHS) Act, and found to need treatment for either breast or cervical cancer (including a precancerous condition);

2. She does not otherwise have creditable coverage, as the term is used under the Health Insurance Portability and Accountability Act (HIPAA) (§2701(c) of the PHS Act (42 U.S.C. 300gg(c)); and she must not be described in any of the mandatory Medicaid categorically needy eligibility groups; and

3. She is under age 65. (As mandated by PL 106-354.)

Question 2. Must a woman be uninsured for a specific length of time before she may be found eligible for Medicaid under this new option?

Answer. No. There are no requirements imposed by federal law that there be a waiting period of prior uninsurance before a woman can become eligible for Medicaid under this new option, and no authority for states to impose such requirements. In addition, if she were insured but her creditable coverage were to end, the woman could become immediately eligible for coverage under Medicaid assuming she satisfied all other eligibility criteria.

Question 3. What is meant by the term "creditable coverage"?

Answer. The term "creditable coverage" is defined under the new Act to have the same meaning as "creditable coverage" for purposes of HIPAA. A woman having the following types of coverage would be considered to have creditable coverage and would, therefore, be ineligible for the new Medicaid option:

- A group health plan
- Health insurance coverage - *benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.*
- Medicare
- Medicaid
- Armed forces insurance
- A medical care program of the Indian Health Service (IHS) or of a tribal organization
- A state health risk pool

Question 4. Are there any circumstances where a woman with creditable coverage could be eligible for the new Medicaid option?

Answer. Yes. While the new option requires that a woman is "not otherwise covered under creditable coverage," we read that requirement to refer to creditable coverage for treatment of breast or cervical cancer (in light of the immediately preceding requirement referring to that treatment). There may be limited circumstances where a woman has creditable coverage, as defined above in Question 3, but she is not actually covered for treatment of breast or cervical cancer. For example, if a woman has creditable coverage but is in a period of exclusion (such as a preexisting condition exclusion or an HMO affiliation period) for treatment of breast or cervical cancer, she is not considered covered for this treatment. If a woman who has creditable coverage exhausts her lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer, she is not considered covered for this treatment. In these types of circumstances, the woman may be eligible for the new Medicaid option, assuming that she meets all other eligibility criteria.

(NOTE: The reference to "not otherwise covered" in the eligibility criteria for this new group is different than under the State Children's Health Insurance Program (SCHIP) eligibility criteria. While the statute also provides that a child is ineligible for SCHIP if covered by a group health plan or health insurance coverage, unlike the new Medicaid option the SCHIP eligibility exclusion is not connected to coverage for a specific condition.)

(Question 37 addresses the treatment of creditable coverage that may be available/unavailable to American Indians and Alaska Natives (AI/AN) through a medical care program of the IHS or AI/AN tribal organization.)

Question 5. Is a woman who has limited coverage, such as limited drug coverage or limits on the number of outpatient visits or high deductibles, eligible for the new Medicaid option?

Answer. No. In order to qualify for this new Medicaid option, a woman must not be otherwise covered under creditable coverage. According to the HIPAA rules defining creditable coverage, most health insurance, including insurance that may have limits on benefits or have high deductibles, is considered creditable coverage. However, there are certain types of coverage that are not considered creditable coverage. A woman who may have one of these types of coverage may be eligible for the new Medicaid option assuming that she meets all other eligibility criteria:

- Limited scope coverage such as those which only cover dental, vision, or long term care.

- Coverage for only a specified disease or illness.

Question 6. What does it mean that an individual not have "attained age 65"? What if she turns age 65 during her period of coverage?

Answer. The statute uses the term "attained age 65". A woman attains age 65 on the date of her 65th birthday. If the woman turns age 65 during her period of coverage her eligibility will terminate as of the date of her birthday. Her coverage may continue to the end of the month or quarter to the extent that it is the usual and customary practice of the state to pay for coverage through a capitated payment on a monthly or quarterly basis. Similarly, to the extent that it is usual and customary for payment to be due at the onset of a particular service, such as payment for inpatient hospital services upon admission to the hospital, she is entitled to the full service. Further, at attainment of age 65, the state must explore other categories of Medicaid coverage and should assist the individual to continue coverage under Medicare.

Question 7. Who is considered to have been "screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program?"

Answer.

1. Women are considered screened under the CDC program if their clinical services were provided all or in part by CDC Title XV funds. CDC Title XV grantees are those entities receiving funds under a cooperative agreement with CDC to support activities related to the National Breast and Cervical Cancer Early Detection Program.

In addition, CDC allows Title XV grantees the flexibility to extend the definition of screened under the CDC program to include one or both of the following two options:

2. Women who are screened under a state Breast and Cervical Cancer Early Detection Program in which their particular clinical service was not paid for by CDC Title XV funds, but the service was rendered by a provider and/or an entity funded at least in part by CDC Title XV funds, and the service was within the scope of a grant, sub-grant or contract under that state

program and the CDC Title XV grantee has elected to include such screening activities by that provider as screening activities pursuant to CDC Title XV.

3. Women who are screened by any other provider and/or entity and the CDC Title XV grantee has elected to include screening activities by that provider as screening activities pursuant to CDC Title XV. For example, if a family planning or community health center provides breast or cervical cancer screening or diagnostic services to low-income women, but does not receive funds from the CDC Title XV grantee to support these services, the CDC Title XV grantee would have the option of including these providers' screening activities as part of their overall screening program. The CDC Title XV grantee may require any provider deemed part of the overall screening program to follow program guidelines.

The programs operating in states under the CDC program will provide Medicaid agencies with verification that a woman was screened under the CDC program. A list of state contacts for the CDC National Breast and Cervical Cancer Early Detection Program can be found at web site: http://www.cdc.gov/cancer/nbccedp/contacts.htm.

Question 8. Does a woman have to have been screened for both breast and cervical cancer and found to be in need of treatment before she can be found eligible for Medicaid?

Answer. No. A woman does not have to have been screened for both breast and cervical cancer as a condition of eligibility for Medicaid. Either screen would satisfy the screening requirement.

Question 9. What is meant by the term "need treatment"?

Answer. The term "need treatment" means that, in the opinion of the woman's treating health professional that the diagnostic test following a breast or cervical cancer screen indicates that the woman is in need of cancer treatment services. These services include diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Based on the physicians plan-of-care, women who are determined to require only routine monitoring services for a precancerous breast or cervical condition (e.g., breast examinations and mammograms) are not considered to need treatment.

Question 10. Is there any income test under Medicaid for women under this new eligibility group?

Answer. No. There are no Medicaid income or resource limitations imposed by federal law for this new Medicaid eligibility group, and no authority for states to impose such limitations.

Question 11. Can a state impose Medicaid asset /eligibility standards on women whose eligibility is based on this new option?

Answer. No. Asset related questions would be appropriate as part of the Medicaid application process only to the extent necessary to determine if the individual is otherwise eligible for Medicaid.

Question 12. Can a state limit Medicaid eligibility to certain subcategories of women (e.g., women of a certain age, certain geographic residences, or with certain types of cancers or disease severity)?

Answer. No. States must cover all eligible women and may not limit coverage to sub-populations.

ELIGIBILITY PERIOD

Question 13. If a state elects to expand Medicaid eligibility to include this new optional group, what is the effective date of the coverage available to this group?

Answer. Medicaid eligibility can be effective as early as the first day of the quarter in which the state Medicaid agency submits an approvable state plan amendment to HCFA and the state implements the expansion or a later date specified in the state plan amendment.

Question 14. When does a woman's eligibility under this new option begin?

Answer. A woman's eligibility for coverage under this new option begins up to three months prior to the month in which she applied for Medicaid, if as of this earlier date, she would have met relevant eligibility requirements under the state plan (including having been screened and diagnosed).

Question 15. When would a woman's eligibility under this new option end?

Answer. A woman determined eligible under this option would continue to be eligible as long as she is receiving treatment for breast or cervical cancer, is under age 65, and is not otherwise covered under creditable insurance coverage. A state may presume that a woman is receiving such treatment during the duration of the period established by her treating health professional in her plan of care. If that period extends beyond a year (or a shorter period at state option), the state must confirm eligibility consistent with standard Medicaid redetemination requirements. Care and services under this new option should be consistent with optimal standards of practice for items and services available under the state plan. The state may use utilization management techniques such as prior approval to monitor care and ensure that it is medically necessary and used efficiently.

Question 16a. Is a woman limited to one period of eligibility? What happens if a woman goes through treatment for breast or cervical cancer, and then two years after treatment is completed has a recurrence and needs treatment for breast or cervical cancer again?

Answer. No. A woman is not limited to one period of eligibility. A new period of eligibility and coverage would commence each time a woman is screened under a CDC program and found to need treatment for breast or cervical cancer, and meets all other eligibility criteria.

Question 16b. If a woman is treated for breast or cervical cancer during her first period of eligibility and is subsequently determined to have cancer that has spread to other parts of her body, would she be covered?

Answer. Yes. If the recurrent metastasized cancer is either a known or presumed complication of breast or cervical cancer, and the women is still in her first period of eligibility, i.e., she is still receiving treatment for the initial breast or cervical cancer diagnosis, she would continue to be eligible for additional treatment. If, however, her first treatment period is over and her Medicaid eligibility has been terminated, she must be recertified as eligible for the CDC program to renew her Medicaid eligibility for the treatment of recurrent breast or cervical cancer.

COVERAGE

Question 17. What is the scope of coverage under this option?

Answer. During the period of eligibility, a woman is entitled to full Medicaid coverage as specified in the state plan. Coverage is not limited to treatment of breast or cervical cancer (including a precancerous condition).

Question 18. Can states employ utilization management techniques to determine coverage limits and if so, are there relevant practice standards that can be used to assist states to carry out utilization management activities?

Answer. Yes. As is the case with Medicaid coverage in general, states may use administrative methods, such as prior review and approval requirements, to ensure that care and services furnished to women under this new option are medically necessary. Care and services furnished under this new option should be, to the maximum extent possible, consistent with optimal standards of practice. Such practice guidelines are located at the National Guideline Clearinghouse, Agency for Health Care Research and Quality: http://www.ahrq.gov.

Question 19. May a state cover experimental treatments?

Answer. Yes. States may cover experimental treatments although they are not required to do so. Routine covered costs associated with the experimental intervention may also be covered.

PRESUMPTIVE ELIGIBILITY

Question 20. What is presumptive eligibility?

Answer. Presumptive eligibility is a Medicaid option that allows states to enroll women in Medicaid for a limited period of time before full Medicaid applications are filed and processed, based on a determination by a Medicaid provider of likely Medicaid eligibility. States have the option to use the presumptive eligibility procedure to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical

cancer. Election of presumptive eligibility provides states the opportunity to offer immediate health care coverage to women likely to be Medicaid eligible, before there has been a full Medicaid eligibility determination.

Question 21. Is presumptive eligibility mandatory for this group?

Answer. No. Presumptive eligibility is a state option.

Question 22. When does presumptive eligibility begin?

Answer. Presumptive eligibility begins on the date that a qualified entity determines that the woman appears to meet the eligibility criteria for this new Medicaid option. Federal financial participation (FFP) is allowed for services provided during this presumptive eligibility period regardless of whether the woman is later found eligible for Medicaid.

Question 23. When does presumptive eligibility end?

Answer. Presumptive eligibility ends on the earlier of the following two dates: the date on which a formal determination is made on the woman's application for Medicaid; or, in the case of a woman who fails to apply for Medicaid following the presumptive eligibility determination, the last day of the month following the month in which presumptive eligibility begins.

For example, if a woman is found presumptively eligible on April 1 and files her application before May 31, her presumptive eligibility would continue until her eligibility is determined. If the woman fails to apply, her eligibility would cease on May 31.

Question 24. Which types of entities can be a qualified entity for purpose of presumptive eligibility?

Answer. State Medicaid agencies can certify entities that are eligible for payments under the state's Medicaid program that the state determines are capable of making presumptive eligibility determinations. A certified entity can enroll women who appear to be eligible in Medicaid on a temporary basis.

Question 25. What if the entity does not participate in Medicaid as a health provider or on some other basis? For example, what if a community volunteer group wants to make presumptive eligibility services?

Answer. If the entity receives payment as either a provider or administrative contractor under the state Medicaid plan, the entity could be qualified as long as the Medicaid agency also determines that the entity is capable of making presumptive eligibility determinations.

Question 26. Can presumptive eligibility determinations be performed at outstationed eligibility locations? Can the full application be filed at an outstationed site?

Answer. Yes. States are generally required to have outstation locations at federally qualified health centers and disproportionate share hospitals. At its option, a state may expand the types of entities that are used in its outstationing program. Outstation activities may be performed by state eligibility workers, by employees of a provider or contractor, or by volunteers.

If a state that arranges with an entity to perform outstation functions determines that the entity is capable of making presumptive eligibility determinations, the state can expand its agreement with the entity to make presumptive determinations for women applying under this new category. In addition, the state can use the outstation location to accept full Medicaid applications from presumptively eligible women. Outstation workers who are not public employees of the agency that makes eligibility determinations can only do initial processing of full Medicaid applications.

For example, a state has an agreement with its federally qualified health centers (FQHC) to conduct outstationing activities. The health centers also are part of the state's early detection coalition under Title XV and offer both cervical cancer and breast cancer screening. A state that adopts presumptive eligibility may enter into an agreement with the FQHCs to make presumptive eligibility determinations and perform outstationed enrollment activities for presumptively eligible women.

Question 27. Must a full Medicaid eligibility determination be completed in order to establish presumptive eligibility?

Answer. No. Presumptive eligibility is designed to permit temporary Medicaid coverage while a complete eligibility determination is conducted. Presumptive eligibility permits rapid access to health care for women found through screening to need cancer treatment. To streamline this process, at the point that presumptive eligibility is being determined, a presumptive eligibility provider need to determine only that the woman has been screened under the state's breast and cervical cancer detection program (as defined by the state) and needs treatment, is under age 65, and has neither Medicaid nor any other form of individual or group health insurance. For women who meet these rapid criteria, coverage on a presumptive basis can begin. The state will provide qualified entities with application forms and information on how to assist such individuals in completing and filing such forms. This will enable the qualified entity to assist a presumptively eligible woman in applying for formal coverage and to help her collect and provide the state agency with needed information to determine eligibility, including income and resource information, and other information related to residency and legal status.

Question 28. Are state administrative expenditures for a presumptive eligibility program eligible for a federal match?

Answer. Yes. Expenditures for presumptive eligibility activities, including payments to the qualified entity for the administrative costs of making presumptive determinations and providing application assistance would be allowable administrative costs under Medicaid and federal financial participation would be available at the 50% rate. Expenditures for providing services to presumptive eligibles under this category are eligible for the enhanced federal matching rate.

Question 29. Can provider taxes or donations be used to support the state share of a presumptive eligibility program?

Answer. Provider taxes that meet the requirements of §1903(w) of the Social Security Act may be used to support the state share of a presumptive eligibility program. Furthermore, §1903(w) of the Act provides an exception to the otherwise restrictive rules governing provider-related donations, by considering as permissible provider donations made by a hospital, clinic, or similar entity for the direct costs of state or local agency personnel who are stationed at the facility to determine eligibility of individuals for Medicaid or to provide outreach services to eligible Medicaid individuals. Thus, under the statutory exception, donations made by a hospital, clinic, or similar entity to cover the direct costs of a state or local agency worker stationed at such facility could be used to support the state share of a presumptive eligibility program. It must be noted that this exception applies to the costs of state or local agency workers (i.e., outstationed state employees) and is not applicable to costs incurred by provider personnel. Under the latter arrangement, an in-kind donation made by the provider would be subject to the very restrictive bona fide provider-related donation statutory provisions and would more than likely not be considered a permissible source of state share." Donations by health providers to cover the direct costs associated with presumptive eligibility would be permissible as a form of Medicaid outreach in accordance with the requirements of 42 C.F.R. §433.66 (b)(2). A state could report these provider donations as a state expenditure for purposes of claiming the federal administrative match.

Question 30. Must a state enter into presumptive eligibility agreements with all entities that are eligible to receive federal payments under Medicaid and are capable of carrying out presumptive eligibility services?

Answer. No. A state may select among qualified presumptive eligibility providers. However, HCFA and the CDC encourage states to elect presumptive eligibility as a means of promoting access to rapid coverage, which is essential to treatment. Furthermore, we encourage states that elect to use presumptive eligibility to make decisions about presumptive eligibility sites through closely coordinated efforts among the state Medicaid agency, the state agency that administers the early detection program, and community breast and cervical cancer coalitions. This will best ensure the availability of presumptive eligibility and enrollment assistance at a sufficient number of locations to ensure that the purposes of this Act are achieved.

Question 31. Were a state to offer presumptive eligibility, would the state be required to do so on a statewide basis?

Answer. Yes. Presumptive eligibility is part of the state plan and must be made available on a statewide basis.

CITIZENSHIP AND ALIENAGE

Question 32. Does this new eligibility option amount to a "federal means tested public benefit"?

Answer. Yes. Medicaid is a federal means tested public benefit.

Question 33. Are qualified aliens and non-qualified aliens eligible for the new Medicaid option?

Answer. The usual rules which govern citizenship and alienage apply to the new optional Medicaid eligibility group. In general, to be eligible for Medicaid an individual must either be a citizen or a qualified alien (See the web site at http://aspe.hhs.gov/hsp/immigration/restrictions-sum.htm for a definition of "qualified alien" and a discussion of the restrictions on immigrants receiving federal public benefits, including Medicaid, and for a list of exceptions to these restrictions). Many qualified aliens who arrived in the United States after August 21, 1996 are barred from receiving Medicaid for 5 years beginning with their date of entry with a qualified alien status. The 5-year bar does not apply to certain refugees, asylees, and certain other groups. Otherwise eligible qualified aliens who are subject to the 5-year ban as well as otherwise eligible non-qualified aliens may receive Medicaid coverage for treatment of an emergency medical condition but not including organ transplants and transplant-related services.

Women who do not meet the immigration-related eligibility criteria may still be able to receive Medicaid coverage related to an "emergency condition", other than services related to an organ transplant. Section 1903(v) of the Act permits states to obtain federal match for services related to an "emergency medical condition" when furnished to an otherwise eligible individual.

Question 34. What does the term "emergency medical condition" mean?

Answer. The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (A) placing the patient's health in serious jeopardy; (B) serious impairment of bodily functions, or (C) serious dysfunction of any bodily part.

Question 35. Would treatment for breast and cervical cancer (including treatment for a precancerous condition) be classified as coverage for an "emergency medical condition?"

Answer. Breast or cervical cancers may be identified at various stages. Some women in need of treatment for breast or cervical cancer will have an emergency condition. As with other examples of emergency medical conditions, medical judgement and the facts of a particular case will form the basis for identifying those conditions in screened women that amount to an emergency medical condition.

TREATMENT OF TERRITORIES

Question 36. Does the new law apply to the United States territories?

Answer. Yes. Territories that operate Medicaid programs (Puerto Rico, Virgin Islands, American Samoa, Guam and the Northern Marianas Islands) may choose this new option. However, federal payments to those territories are capped by statute. To the extent that these territories already receive the maximum federal payment permitted, the new law would not result in any additional federal funding. If the cap on federal payments has not been reached, federal funds at the enhanced matching rate could be available for the new eligibility group.

TREATMENT OF AMERICAN INDIAN AND ALASKA NATIVE (AI/AN)WOMEN

Question 37. Since medical care furnished by the Indian Health Service (IHS) or AI/AN tribal organizations is treated as "creditable coverage" under the PHS Act, how does this affect AI/AN women?

Answer. Medical care programs of the IHS or of a tribal organization is creditable coverage under §2701(c) of the PHS Act; however not all AI/AN women are covered under such programs (in this case, for breast or cervical cancer treatments). Some AI/AN women may not have access to coverage under such programs at all: for example, women who do not live on a reservation or near an IHS facility. States are encouraged to work with IHS and tribal organizations to ensure that AI/AN women screened under the CDC program who lack such coverage are enrolled in Medicaid.

Furthermore, some AI/AN women who have creditable coverage through IHS may not be covered under that creditable coverage *(refer to questions 3 through 5 for a detailed explanation of creditable coverage)* with respect to treatment for breast or cervical cancer. If the State eligibility worker (or the qualified entity that performs presumptive eligibility) determines that the AI/AN woman lacks coverage for breast and cervical cancer treatment through the IHS or tribal organization, that AI/AN woman can be included in the new Medicaid eligibility group. Such a determination should be based on a documented refusal or inability by IHS or tribal organization to provide (or continue to provide) treatment for breast or cervical cancer. States should consult and work with IHS and tribal organizations to understand when such a determination is appropriate, and to streamline documentation requirements.

Question 38. What type of coordination should states engage in with the IHS and tribes and tribal organizations?

Answer. States should ensure that the IHS and tribal health programs that participate in the CDC early detection program are fully involved in the planning process regarding implementation and coordination between the state's early detection program and the expanded Medicaid eligibility option.

Question 39. Are the IHS or tribal health programs administered by Indian tribal organizations eligible to receive Medicaid payments for the breast and cervical cancer treatment they furnish to Medicaid-eligible women?

Answer. Yes. IHS and tribal health programs would be eligible for payment for covered services to the same extent as they would be eligible for payment for any other covered Medicaid service.

FEDERAL FINANCIAL PARTICIPATION

Question 40. What level of enhanced FFP is available to states that elect to add coverage under this option? How can a state find out what its enhanced match rate will be?

Answer. The federal matching rate for the new eligibility group is equal to the enhanced federal medical assistance percentage (FMAP) used in the State Children's Health Insurance Program (SCHIP) (described in §2105(b) of the Act. That rate is published annually in the Federal Register, and is posted on the web site at http://aspe.os.dhhs.gov/health/fmap.htm.

Question 41. When is the enhanced federal matching rate available for Medicaid expenditures on the new eligibility group?

Answer. The new law has an effective date of October 1, 2000. In order to be eligible for payment under this new Act, a state or territory must submit a state plan amendment (SPA) electing this optional categorical needy eligibility group and/or to provide presumptive eligibility. A SPA can be effective back to the first day of the quarter in which it is submitted. Funding for this group would be available back to the effective date of the SPA. Attached is a state plan preprint that should be used by states electing these new options.

Question 42. What level of FFP is available to States for providing case management as a medical service under the BCCPTA? What level of FFP is available to States for providing case management as an administrative activity?

Answer. State Medicaid expenditures are generally claimed under two categories: medical assistance (that is, medical services) and administrative expenditures. The federal matching rate for medical assistance expenditures, referred to as the federal medical assistance percentage (FMAP), is generally the same for all types of medical services, but varies by state in accordance with a statutorily prescribed formula. The FFP for States' administrative expenditures is the same for all States, but varies by the type of administrative expenditure.

Under the BCCPTA, covered medical services provided to the new eligibility group, including services case management, are matched at an enhanced FMAP. That rate is published annually in the Federal Register, and is posted on the web site at http://aspe.os.dhhs.gov/health/fmap.htm.

Question 43. Is there any aggregate upper limit on the availability of federal funds for this new eligibility group?

Answer. No. This is a Medicaid benefit and there is no aggregate upper limit on the federal funds available to furnish coverage to individuals eligible under this new eligibility group.

Question 44. What financial obligations for medical assistance will a state incur under the Act?

Answer. A state is responsible for its share of covered medical assistance consistent with the enhanced federal matching rate. Because the enhanced federal matching rate is significantly higher than the standard Medicaid federal matching rate, a state's financial responsibility for expansions authorized by the BCCPTA will be significantly lower than under the standard program. States will be able to obtain access to the enhanced federal matching in advance of actual expenditures, pursuant to the normal Medicaid funding mechanism.

Question 45. Can Medicaid require cost sharing from women eligible in the new eligibility group?

Answer. Yes, for non-pregnant women over age 20, but cost sharing is limited to deductibles, coinsurance copayments or similar charges that do no exceed the nominal amounts set forth in federal Medicaid regulations. Under these requirements, for non-institutional services, any deductible cannot exceed $2.00 per month per family for each period of Medicaid eligibility, coinsurance may not exceed 5 percent of the payment the state makes for the services, and the maximum copayment for a single service would be $3.00. For institutional services, cost sharing may not exceed 50 percent of the payment made by the state for the first day of institutional care. Only one of these types of charges can be imposed for each service, and there must also be a cumulative maximum amount for all deductible, coinsurance or copayment charges.

Question 46. If a state were to impose cost-sharing requirements (to the extent permitted under Medicaid law and regulation) on individuals in this new eligibility group, would cost sharing amounts count toward the state share?

Answer. No. Beneficiary cost sharing is not considered part of the state match for expenditures under Title XIX but an applicable credit that reduces state expenditures. Beneficiary cost-sharing revenues collected by the state must be applied to offset, that is to reduce overall federally matchable Medicaid expenditures. Such revenues effectively reduce both the state and federal shares of allowable Title XIX expenditures, and both state and federal governments would be credited with their respective share of these cost sharing funds. Cost sharing collected and retained by providers would not count as expenditures or revenues to the state.

For example, if the total expenditure for a beneficiary is $20,500 and the state collects $500 in cost sharing, the expenditure allowable for Title XIX purposes would be $20,000. If the state's enhanced FMAP was 65%, the federal government would pay the state $13,000 and net state responsibility would be $7,000.

Question 47. How will states report their expenditures related to the new law?

Answer. HCFA is currently revising the form HCFA-64, Medical Assistance Expenditures by Type of Service for the Medical Assistance Program, to include a new Column (e) specifically dedicated to reporting these expenditures. We are currently reprogramming the MBES/CBES automated reporting system (Medicaid Budget Expenditure System/State Children's Health

Insurance Program Budget Expenditure System) to incorporate this change. We expect this change to be completed in time for the states to use this in reporting their first quarter fiscal year 2001 expenditure report which is due January 30, 2001. We will also be sending detailed reporting instructions to the states.

APPLICATION AND ENROLLMENT

Question 48. What are the basic elements of an application under this new option? How simple can it be?

Answer. The basic elements of an application under this new option can be simple. The individual must provide a social security number and information about her health insurance and citizenship/alienage status. The application must notify the individual about her rights and responsibilities and must be signed. No verification is required under federal law except alien status if the woman is not a citizen. The application must contain sufficient information to determine if an individual is described in the mandatory Medicaid categorical eligibility groups. However, the application could be structured to avoid asking for unnecessary information. If, for example, an individual is not pregnant, does not have dependent children, and is not disabled, no additional income or asset information needs to be collected, since the woman has no relationship to one of the mandatory categorical eligibility groupings. If the information on the application indicates that the individual is not likely to be in a mandatory Medicaid group, the state does not have to perform a full determination for those groups. However, if a short application that is expressly designed for this new option would not collect enough information to allow the state to actually determine her eligibility under all other mandatory Medicaid coverage groups, the application must say so and must inform the woman of her right to file a full application.

Question 49. Must there be a written application?

Answer. Yes. Medicaid requires that there be a written application and that the final determination be made by the agency which determines Medicaid eligibility. An outstationed enrollment provider that performs outstationing functions for this newly eligible category of women can receive and initially process applications but cannot make the final determination. However, the final determination can be made at the outstationed enrollment provider site if it is done by a State employee from the agency that makes Medicaid eligibility determinations.

Question 50. How quickly must the application be processed?

Answer. Applications must be processed within 45 days, barring unusual circumstances.

Question 51. What if a woman who applies is determined not to meet the qualifications of this new option?

Answer. If the information on the application is sufficient to determine her eligibility under some or all relevant categories, the state must make this determination before denying coverage.

If the application does not permit a determination under all relevant categories, the applicant must be notified and given the opportunity to submit the additional information required to make a determination under other categories.

GENERAL STATE IMPLEMENTATION

Question 52. Is the expansion of Medicaid eligibility authorized by the new law mandatory or optional for states?

Answer. The new Medicaid eligibility group is optional for states.

Question 53. If a state wishes to expand Medicaid eligibility to include the new eligibility group authorized by the new law, what is the state required to do? Must a state plan amendment be submitted? What must the state do to add presumptive eligibility for the group?

Answer. In order to be eligible for payment under this new Act, the state or territory must submit a state plan amendment electing this optional categorical eligibility group and/or providing presumptive eligibility. Attached is a state plan preprint that should be used by states electing these new options.

Question 54. Can states offer targeted case management for women with breast and cervical cancer?

Answer. Yes. A state can develop a targeted case management program under its Medicaid state plan for women with breast and cervical cancer. Such a program would be designed to assist the target population in accessing needed medical, social, educational, and other services. States can find additional information on targeted case management at §1915(g) of the Act and §4302 of the state Medicaid Manual. States also may wish to consult the National Association of Social Workers' Standards for Social Work Case Management, June, 1992, or the Case Management Society of America's Standards of Practice for Case Management, 1995.

Question 55. Can a state require a beneficiary under this benefit to enroll in a managed care organization or managed care entity?

Answer. Yes. By electing in its state plan to do so, a state may require beneficiaries to enroll in managed care arrangements to obtain coverage. To the extent consistent with usual and customary practices, a state could contract with full-service managed care organizations or managed care entities that specialize in the management of breast and cervical cancer patients and receive payments on a global basis. Those arrangements must ordinarily permit eligible individuals a choice of managed care entities. Furthermore, such arrangements must either include the full range of Medicaid coverage, or must be coordinated with other arrangements to furnish beneficiaries the full range of Medicaid coverage.

In the event that a state decides to use managed care arrangements for breast and cervical cancer patients, we urge state Medicaid agencies and state health agencies to collaborate in developing standards and contractual specifications for participation by either full service or specialty MCOs. At a minimum such standards should address the following issues: enrollment; scope of coverage; case management; provider network capabilities; geographic and service timeline access; cultural competence and language access; quality improvement; data; and external review. MCOs that participate in breast and cervical cancer treatment must meet all standards applicable to MCOs under the Medicaid program.

Question 56. Is breast reconstructive surgery a covered service under the new Medicaid option?

Answer. Reconstructive breast surgery may be provided as an optional service under the Medicaid program. If a state elects this option, women eligible for breast cancer treatment through the new Medicaid option can receive breast reconstructive surgery as defined in the state's Medicaid plan.

Question 57. Are men diagnosed with breast cancer eligible for this Medicaid benefit?

Answer. No. Title XV (Public Law 101-354) precludes men from being eligible to receive screening and/or diagnostic services through the CDC NBCCEDP; therefore, men may not be considered screened under the program.

Breast (female)

Data Definition: Incidence data were obtained from the Alaska Cancer Registry using primary site ICD-O-2 codes C50.0 - C50.9, and excluding morphology codes 9590-9989. Mortality data were obtained from Alaska State death certificates using the underlying cause of death ICD-9 codes 174.0 - 174.9.

1997 Alaska Residents
Incidence and Mortality Summary by Sex
rates per 100,000 population age-adjusted to 1970 U.S. population

Incidence	Female
In situ cancer	63
Invasive cancer	284
Incidence rate*	119.4
1997 U.S. rate*	115.4

*Excludes in situ cases

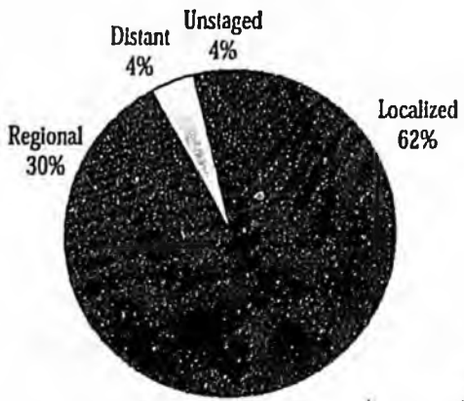
Mortality	Female
Deaths	41
Mortality rate	19.1
1997 U.S. rate	23.3

Invasive Breast Cancer by Borough/Census Area

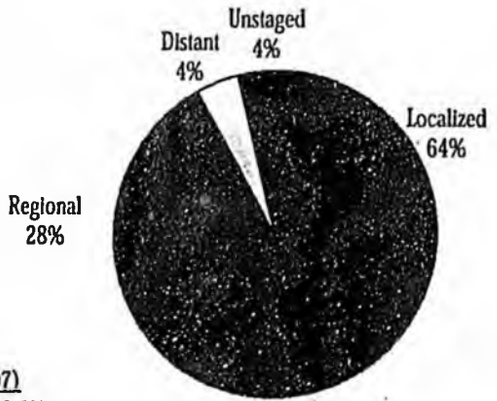
Aleutians East	0	Kenai Peninsula	27	Skagway-Hoonah-Angoon	1
Aleutians West	2	Ketchikan Gateway	3	Southeast Fairbanks	2
Anchorage	138	Kodiak Island	10	Valdez-Cordova	3
Bethel	4	Lake and Peninsula	0	Wade Hampton	0
Bristol Bay	0	Matanuska-Susitna	24	Wrangell-Petersburg	3
Denali	2	Nome	4	Yakutat	0
Dillingham	1	North Slope	1	Yukon-Koyukuk	2
Fairbanks North Star	31	Northwest Arctic	3	Unknown	0
Haines	3	Prince of Wales-Outer Ketchikan	2		
Juneau	17	Sitka	1		

Stage at Diagnosis

Alaska (n=284)



U.S.



5 year Survival (U.S., 1997)
All Stages 85.0% Localized 96.5%

Cervix

Data Definition: Incidence data were obtained from the Alaska Cancer Registry using primary site ICD-O-2 codes C53.0 - C53.9, and excluding morphology codes 9590-9989. Mortality data were obtained from Alaska State death certificates using the underlying cause of death ICD-9 codes 180.0 - 180.9.

1997 Alaska Residents
Incidence and Mortality Summary by Sex
rates per 100,000 population age-adjusted to 1970 U.S. population

Incidence	Female
Invasive cancer	26
Incidence rate	8.8
1997 U.S. rate*	7.5

*Excludes in situ cases

Mortality	Female
Deaths	4
Mortality rate	n/c**
1997 U.S. rate	2.6

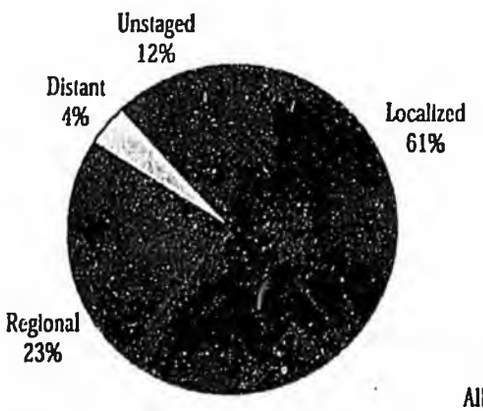
**n/c=rate not calculated if n<5

Cervical Cancer by Borough/Census Area

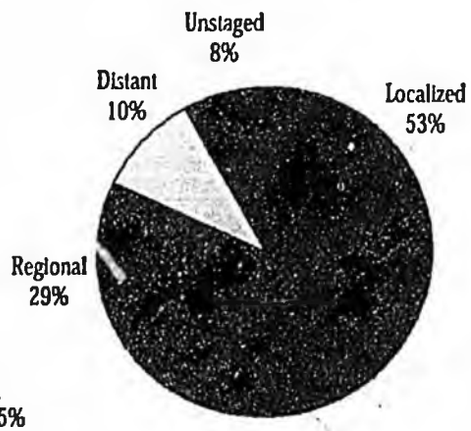
Aleutians East	0	Kenai Peninsula	3	Skagway-Hoonah-Angoon	0
Aleutians West	0	Ketchikan Gateway	1	Southeast Fairbanks	0
Anchorage	8	Kodiak Island	0	Valdez-Cordova	0
Bethel	0	Lake and Peninsula	0	Wade Hampton	0
Bristol Bay	0	Matanuska-Susitna	5	Wrangell-Petersburg	0
Denali	0	Nome	0	Yakutat	0
Dillingham	0	North Slope	1	Yukon-Koyukuk	0
Fairbanks North Star	5	Northwest Arctic	0	Unknown	0
Haines	1	Prince of Wales-Outer Ketchikan	0		
Juneau	1	Sitka	1		

Stage at Diagnosis

Alaska (n=26)



U.S.



5 year Survival (U.S., 1997)
All Stages 69.9% Localized 91.5%

AVERAGE COST PER RECIPIENT PER YEAR BY CANCER SITE DIAGNOSIS
ALL Paid Claims For Recipients With Cancer Diagnosis

DOP FY98

Site	Sum of Payment	# Undup Recips	Avg Cost/Recip
Breast	$2,862,057	160	$17,888
Cervix	$619,591	94	$6,591
BOTH DX	$157,459	8	$19,682
Totals	***$3,639,108***	***262***	***$13,890***

DOP FY99

Site	Sum of Payment	# Undup Recips	Avg Cost/Recip
Breast	$2,226,622	172	$12,945
Cervix	$748,652	91	$8,227
BOTH DX	$125,439	8	$15,680
Totals	***$3,100,714***	***271***	***$11,442***

DOP FY2000

Site	Sum of Payment	# Undup Recips	Avg Cost/Recip
Breast	$3,552,029	203	$17,498
Cervix	$1,236,591	102	$12,123
BOTH DX	$204,486	7	$29,212
Totals	***$4,993,105***	***312***	***$16,004***

Diagnoses Searched On

DX	DX Desc
174	MALIG NEO FEMALE BREAST
1740	MALIG NEO NIPPLE
1741	MAL NEO BREAST-CENTRAL
1742	MAL NEO BREAST UP-INNER
1743	MAL NEO BREAST LOW-INNER
1744	MAL NEO BREAST UP-OUTER
1745	MAL NEO BREAST LOW-OUTER
1746	MAL NEO BREAST-AXILLARY
1748	MALIGN NEOPL BREAST NEC
1749	MALIGN NEOPL BREAST NOS
17490	MALIGN NEOPL BREAST NOS
180	MALIG NEOPL CERVIX UTERI
1800	MALIG NEO ENDOCERVIX
1801	MALIG NEO EXOCERVIX
1808	MALIG NEO CERVIX NEC
1809	MAL NEO CERVIX UTERI NOS
19881	SECOND MALIG NEO BREAST
2330	CA IN SITU BREAST
23300	CA IN SITU BREAST
2331	CA IN SITU CERVIX UTERI
23310	CA IN SITU CERVIX UTER
2393	BREAST NEOPLASM NOS
6221	DYSPLASIA OF CERVIX

In the Senate of the United States,

October 4 (legislative day, September 22), 2000.

Resolved, That the bill from the House of Representatives (H.R. 4386) entitled "An Act to amend title XIX of the Social Security Act to provide medical assistance for certain women screened and found to have breast or cervical cancer under a federally funded screening program, to amend the Public Health Service Act and the Federal Food, Drug, and Cosmetic Act with respect to surveillance and information concerning the relationship between cervical cancer and the human papillomavirus (HPV), and for other purposes.", do pass with the following

AMENDMENT:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Breast and Cervical Cancer Prevention and Treatment Act of 2000".

SEC. 2. OPTIONAL MEDICAID COVERAGE OF CERTAIN BREAST OR CERVICAL CANCER PATIENTS.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVI), by striking "or" at the end;

(B) in subclause (XVII), by adding "or" at the end; and

(C) by adding at the end the following:

"(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);".

(2) GROUP DESCRIBED.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following:

"(aa) Individuals described in this subsection are individuals who—

"(1) are not described in subsection (a)(10)(A)(i);

"(2) have not attained age 65;

"(3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection

program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and

"(4) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)).".

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking "and (XIII)" and inserting "(XIII)"; and

(B) by inserting ", and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer" before the semicolon.

(4) CONFORMING AMENDMENTS.—Section 1905(a) of the Social Security Act (42 U.S.C.

1396d(a)) is amended in the matter preceding paragraph (1)—

(A) in clause (xi), by striking "or" at the end;

(B) in clause (xii), by adding "or" at the end; and

(C) by inserting after clause (xii) the following:

"(xiii) individuals described in section 1902(aa),".

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920A the following:

"PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL CANCER PATIENTS

"SEC. 1920B. (a) STATE OPTION.—A State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(aa) (relating to certain breast or cervical cancer patients) during a presumptive eligibility period.

"(b) DEFINITIONS.—For purposes of this section:

"(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

"(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(aa); and

"(B) ends with (and includes) the earlier of—

"(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

"(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

"(2) QUALIFIED ENTITY.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

"(i) is eligible for payments under a State plan approved under this title; and

"(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

"(B) REGULATIONS.—The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

"(C) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

"(c) ADMINISTRATION.—

"(1) IN GENERAL.—The State agency shall provide qualified entities with—

"(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

"(B) information on how to assist such individuals in completing and filing such forms.

"(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

"(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

"(B) inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

"(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

"(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

"(1) is furnished to an individual described in subsection (a)—

"(A) during a presumptive eligibility period;

"(B) by a entity that is eligible for payments under the State plan; and

"(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).".

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: "and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section".

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking "or for" and inserting ", for"; and

(ii) by inserting before the period the following: ", or for medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section".

(c) ENHANCED MATCH.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended—

(1) by striking "and" before "(3)"; and

(2) by inserting before the period at the end the following: ", and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII)".

(d) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance for items and services furnished on or after October 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date.

Attest:

Secretary.

106TH CONGRESS
2D SESSION

H. R. 4386

AMENDMENT

WELFARE REFORM: WHAT'S NEXT?

Final Report on the 2001 Community Meetings

January 2001

STATE of ALASKA
Department of Health and Social Services

TABLE OF CONTENTS

Welfare Reform: What's Next?

Final Report on the Community Meetings
January 2001

EXECUTIVE SUMMARY

In January 2001, the Department of Health and Social Services presented information and entered into dialogue on welfare reform in five Alaskan communities. Partners from the Department of Education and Early Development and the Division of Child Support Enforcement joined them. This summary provides a snapshot of the meetings - those who participated, the ideas and information shared, the questions and discussions that occurred and general findings.

The purpose of the meetings was to provide background to welfare reform in Alaska, present the major challenges facing welfare recipients in future years, suggest solutions to meet those challenges and solicit community comments and support for those solutions. The meetings were also planned as an opportunity to hear comments from members of the public about how welfare reform has been received in their community.

The meetings were held in five communities: Mat-Su Valley (37 attendees), Anchorage (78), Fairbanks (68), Kenai (36) and Juneau (31).

Summary of Presentation

Background on the history of welfare reform in Alaska included implementation of the Alaska Temporary Assistance Program (ATAP), the "work first" philosophy, job development strategies, devolution and local control (community provider contracting, agency collaboration), WorkStar, creation of one-stop job centers and support for Native TANF programs.

The **outcomes** presentation covered the result of welfare reform in Alaska so far including data on the large statewide caseload decline from 1994 (13,164) to 2000 (6,847). The UAA Leaver Study completed in January 2001 provided some additional information about leavers - 75% of those leaving Temporary Assistance were working, though 30% returned to Temporary Assistance within two years; 30% used community supports such as family, food banks or faith-based organizations; 88% said they would rather work than receive financial assistance. Information was also provided about the benefit savings realized by the state ($51 million comparing FY97 to FY00) and the reinvestment of these dollars in child-care, work services and Native TANF programs.

The **challenges** included the issue of the 60-month limit on ATAP. Although caseloads are declining, there are families who will need continued support after receiving 60 months of assistance. Federal and state laws cap the number of these extensions at 20% of the current caseload. As the caseload declines sharply, so has the number of possible exemptions under the

20% rule. Less than half the families eligible for an exemption when ATAP passed are now eligible. In future years, the number of families receiving greater than 60 months of assistance will exceed the number of exemption slots available. The Division of Public Assistance (DPA) and community providers share a mutual view that the number of people who are challenged by undiagnosed learning disabilities, social barriers and those who, despite authentic efforts to stay in work, return to the caseload will be harshly affected if cut off assistance, most particularly, their children.

Child-care challenges include the reversal of the trend from licensed care to legally exempt care and assuring quality in legally exempt care. Child support enforcement challenges are maintaining good customer service while increasing collections particularly for former recipients to ensure they do not return to ATAP.

"Next steps" included proposed budget and policy solutions

Possible budget solutions:

- Help keep families still on welfare from hitting the 60-month limit by providing intensive services: reinvest $2.8 million in federal savings in the "Families Work!" initiative which will provide intensive family services and identify those families that should be eligible for an exemption from the 60-month limit.
- Help families who are working to keep their jobs, advance in employment and avoid returning to welfare: reinvest $1.8 million in savings into the "Success at Work" initiative to provide services for job retention and advancement, job related training and supportive services.

Possible policy solutions:

- Ensure that needy families are not arbitrarily cut off Temporary Assistance by the 20% cap on exemptions.
- Keep 60-month limit on cash benefits, but make changes to state law governing ATAP to remove the 20% cap.
- Exemptions would be based on strict and objective criteria.
- Grant extensions to all families who meet those criteria.

Community Panels and Participant Input

Invited community service providers participated on a panel to talk about the progress and impacts associated with the implementation of ATAP in their community. The panels were developed to include representation from key fields of practice that interact with families receiving ATAP: employment and case management, child care, food banks, family services, Native TANF programs and substance abuse treatment programs. The following items reflect a compilation of comments during the discussions in all five communities.

- There was an expressed need to have more complete data on the families who are approaching the 60-month limit so that targeted approaches (multidiscipline) could be designed for them.

- The Leaver Study does not explain reasons people were having trouble keeping jobs.

- The private (faith community) and non-profit agencies don't have a 60-month limit on benefits like DPA. They may have to be prepared to support those families when their 60 months is up. Are they going to be prepared?

- The OFFER program, placing a substance abuse assessment counselor in the DPA office has worked very well. DPA hopes to expand this program in other.

- Young teen parents are not choosing ATAP and instead are moving from place to place because they don't feel safe living with their parents (stepfathers). There was concern about no financial support to teen parent thus their babies are put at risk.

- Transportation problems continue to plague ATAP clients in all communities. Love Inc. donated rides and donated car programs are working well in Fairbanks.

- Much concern was expressed about 60-month limit creating indigent families in the community and children without supports. There are some families who have done everything they've been asked to do, and are sincerely trying to work and get off welfare.

- The needs of personnel working with hard-to-serve clients were raised. There is a work-force problem keeping staff in jobs. This is big burnout work. More dollars are needed for staffing to reduce caseloads and provide long-term, intensive case management.

- The "churning" issue (people cycling in and out ATAP) was raised. It was suggested that the cause might be a matter of type of education recipients receive. We need to reinvest in vocational/technical schools.

Findings

- Attendees at all five community meetings fully supported the DPA proposed solutions. They also felt it essential that there be community provider involvement in the implementation of the possible new resources if approved by the Legislature.

- Partnerships between non-profit providers, faith community and DPA have been working. Now with more challenging clients left on caseloads, these partnerships need new resources. There was consensus that some type of individualized, intensive case management would be necessary for clients with multiple barriers to employment.

- Many providers expressed concern that the UAA produced Leaver Study represented the success of those leaving the ATAP program, but that leaving was not the best measure of success. There was real concern about the quality of life for those families, particularly their children.

- Every community had grave concerns about families with challenges who remain on ATAP. There were consistent reports of large increases in use of the Food Banks, serious difficulties with child care due to non-traditional work hours of parents and limited quality care, the need for intensive supports/case management, concerns about future downturns in the economy i.e., fewer jobs, lower wages for leavers and those still on ATAP and major transportation limitations in every community.

- In childcare, there is universal lack of infant/toddler care and particularly quality care. Many people raised the point that it made more sense to support these parents caring for their own infants rather than try to create a infant child care resource that is nearly impossible to recruit given non-traditional hours, the labor intensity of infant care and very poor pay.

INTRODUCTION

In January 2001, the Department of Health and Social Services presented information and entered into dialogue on welfare reform in five Alaskan communities. Partners from the Department of Education and Early Development (DEED) and the Division of Child Support Enforcement (CSED) joined them. This is a report of those meetings; their goals, the demographics of those who participated, the information presented by the Division of Public Assistance, DEED and CSED, the ideas and information shared by selected community provider panelists, the questions and discussions that occurred, and finally the general findings.

The meetings were held in the Mat-Su Valley on January 12th, in Anchorage on January 13th, in Fairbanks on January 22nd, in Soldotna on the Kenai Peninsula on January 23rd and in Juneau on January 31st. United Way of Alaska joined tne Department in co-sponsoring these meetings, with the United Way director in each community helping to facilitate location, invitation lists, logistics and introductions during the meetings.

Goals of the Meetings

The goals of the meetings were to:

- Provide background to welfare reform in Alaska by reviewing the history, client demographics and outcomes of the Alaska Temporary Assistance Program (ATAP) for the past five years.
- Present the major challenges facing welfare recipients in future years, particularly regarding ATAP as well as childcare and child support.
- Suggest solutions to meet those challenges and to solicit community comments and support for those solutions.
- Hear comments from participants about how welfare reform has been received by the community, provider organizations and clients.

Presentation Content

Commissioner of DHHS Karen Perdue spoke on the purpose of the meetings and welcomed special guests. Jim Nordlund, Director, made the presentation for DPA, Yvonne Chase, Deputy Commissioner spoke for DEED and select staff made the presentation from CSED.

Most of the content of the meeting was presented though a PowerPoint slide show. This presentation included a background on welfare reform including milestones in Alaska's welfare reform program, community responses from the 1995 welfare reform meetings and demographics on who is receiving Temporary Assistance. A section on the outcomes of welfare reform included information on the decline in caseload, family outcomes including the UAA

Leavers Study, federal performance measures, budget savings, reinvestments in work services, and reinvestments in Native TANF Programs. A section on the remaining challenges of welfare reform includes challenges in childcare and child support, and challenges in the Temporary Assistance Program dealing with the five-year limit and in helping recipients succeed in the workforce.

The "what's next" for welfare reform included both budget and policy solutions to these challenges. The proposed budget solutions by DHSS were designed to help keep families from reaching the 60-month limit, to provide intensive services to those families approaching 60 months, and to help identify those families that would get an extension beyond 60 months. A $2.8 million reinvestment from welfare benefit savings due to caseload reductions was proposed for the "Families Work!" initiative that will provide intensive services to families experiencing family violence, learning disabilities, problems with substance abuse, mental health and other barriers to success in the workplace.

Another reinvestment was proposed to help families who are working to keep their jobs, advance in employment and avoid returning to welfare. $1.8 million in savings was proposed for the "Success at Work" initiative to provide services for job retention and advancement, and job related training and supportive services.

The proposed policy solution was designed to ensure that needy families are not arbitrarily cut off Temporary Assistance by the 20% cap on exemptions by keeping the 60-month limit on cash benefits, but making changes to state law to remove the 20% cap. Extensions would be based on strict and objective criteria that would be granted to all families who meet the criteria.

The PowerPoint presentation was tailored to each community in two areas: 1) responses from community members who attended the first welfare reform community meetings in 1995; and 2) changes in the ATAP caseload during the period of 1997-2000. For more detail of the content, please see the complete PowerPoint presentation in the Appendix.

DEMOGRAPHICS OF THE MEETINGS

The following table totals both letters of invitation sent to community members as well as the actual number who attended. Community DHSS employees (DFYS, DPA, Public health nurses) were generally notified by email so are not represented in the number of invitations. In a given community this most likely only adds another 3-6 people. The actual sign-in sheets from the meetings are included in the Appendix.

Community	Invitations Sent	Attendees
Mat-Su	31	37
Anchorage	89	78
Fairbanks	63	68
Kenai	31	36
Juneau	39	31
TOTAL	253	250

COMMUNITY PANELS PRESENTATION

The providers listed below participated on panels formed to discuss the progress and impacts associated with the implementation of ATAP in their community. They were also asked to respond to the challenges and solutions presented by DPA Director, Jim Nordlund and Commissioner Perdue. The panels were developed to include representation from key fields of practice that interact with ATAP families: employment and case management (often a contractor with DPA), child care, food banks, family services, Native TANF programs and substance abuse treatment programs.

This section will be divided by community with a list of panelists followed by key points of content presented and United Way representative.

Mat-Su

Panel Members
Dorene Ekman - Valley Women's Resource Center-Child Care local administrator
Laura Kelly - Human Resources Company, President
Sheila Walker - Mat-Su Recovery, Program coordinator
Kristen Vernola - Mat Su Family Services, Health Families program manager
Henry Guinotte - Palmer Food Bank & Mayor.

The Mat-Su providers who agreed to present are listed below with the agencies they represented. Sammye Pokryfki of United Way opened the meeting. The comments made are grouped and synthesized from all panelists.

- The **health of the Alaskan economy has been instrumental in the increase** in employment and thus reduction in ATAP caseload. Salaries in the Mat-Su Valley have been inching up and there are concerns that an economic downturn will upset the fragile balance for many families who have left ATAP.

- When a parent/family has **many risk factors in their lives, they do not and cannot put work first.** Need a broad variety of services and systems approach. DHSS has taken a good step in this direction with welfare reform.

- **Smaller employers have been most helpful** since they tend to have more of a family attitude and provide more informal support to new workers.

- Up until last year **transportation was number one issue in the Mat-Su Valley** for people attaining and retaining jobs. With four new buses in the Valley, this barrier is not removed but merely dented.

- **DPA** has taken the lead on **establishing a model of client-centered collaboration** between the State and community agencies including joint efforts on planning and collecting data. Clients have really benefited from this approach.

- The **OFFER** (Offering Families a Future Recovery) program was described; the Mat-Su Recovery Center provides a staff person on site in the DPA office to **do assessments, evaluations and mental health screenings** and work directly with clients and DPA caseworkers. Seven hundred, sixteen applicants were screened. Of those, **42 were referred for further assessment.** Those in treatment need mandates to stay in treatment. There are also formal referral systems with DFYS in place.

- The combined trainings with other community agencies have been beneficial; there are particular concerns about families with substance abuse, family violence or mental illness issues. **Healthy Families has found in a control study that a very large percentage of families** have one or more of these issues.

- **Denali KidCare** is a major factor in promoting work stability and availability of health care for children. Increase the concept of "medical home" and reduce emergency room care.

- An increase in **childcare assistance funds** that reduced waiting list has made significant difference in the past several months.

- Continuing issue: there are not enough entry-level jobs that pay enough for family to survive.

- There are a number **of minors with small children becoming homeless** because they cannot live with parents, sometimes due to family dysfunctions and lack of safety.

- The Food Bank has seen an **increase in the number of out of state people looking for food** as a holdover until they can get on ATAP. Concern about their motive for coming to Alaska and the drain on local systems. General usage of food banks has gone up.

- **Welfare reform is working and people are going to work.** Success is best defined as people getting their own life going, not being dependent.

- Use of childcare funding through PASS (Parents Achieving Self-Sufficiency) II has gone up by 35%; coverage is available for 12 months post benefits. **Those on PASS III are struggling the most.** Many ATAP clients have become "registered" providers as a work-first activity. Registered providers do help provide child-care for non-traditional hours of care.

- Thirty-nine licensed centers and 75 legally exempt (registered) in 1998. In 1999, there were 42 **licensed and 226 were legally exempt.**

Anchorage

Panel Members
Cynthia Hull-Child Care Connection, Executive Director
Sandra Hefern-JobReady, Director
Molly Meritt-Duren- CITC transitional services case management Manager
Karlene Jackson-Catholic Social Services, Executive Director
George Hieronymous- Beans Café, Director
Jewel Jones-Municipality of Anchorage, Dept Health and Human Services, Director

The Anchorage meeting was held in the Northeast Community Center one-stop service center which houses the Department of Labor Job Center, Head Start. Boys and Girls Club, and the Anchorage Center for Families, among others. Dennis McMillan of United Way began the meeting, reflecting on the similar meeting in 1995 and the coalition called Anchorage's Response to Welfare Reform (ARWR) that formed following that meeting. All the panelists have worked as a part of that coalition. The following is a synthesis of their comments.

- The government and non-profit agencies **are working together in new and better ways.**
- **Housing continues to be a big challenge**-too few affordable options for people with new jobs, poor rental history and low paying jobs. One crisis occurs and family has to choose between medicine and rent.
- In childcare, many people are **not aware they are eligible for PASS III.**
- **Transportation**- complicated by many stops before arriving at work if kids at different child care. Buses are dependable but distances require many hours on the bus.
- **Health care access** is a big problem for non-legal permanent residents.
- **Family Pathfinders,** a family mentoring collaboration between DPA, Lutheran Social Services and Catholic Social Services works well as support teams for clients.
- In order to **support the most challenging clients, must recognize substance abuse, victimization,** thus low self-esteem, **undiagnosed learning disabilities** and undiagnosed FAS/FAE. Need smaller caseloads.
- Transitional case management services have served over 3,000 people in past 31/2 years. Those who are "churning" (coming on and off ATAP) earn low pay and have poor life skills. **Need more sheltered work environments** to assist them. Job shadowing and more flexibility for caseworkers with clients.
- Success of client employment is **directly related to the array of support services available.** It is a balance and losing any segment of service may impact family success.

- The state of the economy in Anchorage has had a major contributing effect. **Surprise at the "Leaver Study" showing $10.52 per hour average wage of leavers.** In FY 00 110 people moved to self-sufficiency and **96 got jobs averaging $9.60 per hour.**

- **Big wish list** – 1) a way for clients to access vehicles, purchased or donated; 2) do away with caps on spending for support services; especially need post-ATAP supports like childcare and transportation for 6 months to year after leaving ATAP; 3) extend health insurance to the adults as well as children (Denali KidCare).

- A lot of people start at an **entry-level job but need lots of support to advance**, which may be part of why people end up back on ATAP (Leaver Study shows that 30% return within 2 years).

- In childcare the Resource and Referral agency provides a **key link** between childcare referrals and **potential to increase quality of care.**

- The **drop-in childcare center at the Anchorage Job Center** is great model and represents the type of support needed for ATAP families. Need more of these around state.

- Commissioner Holloway of DEED set a **hopeful note at Anchorage Association for the Education of Young Children conference** opening with three points of focus for early care and education: 1) Increasing the attention in the Department and state to integrating quality early care and education into existence systems; 2) Implementation of the childcare professional development system. 3). Establishment of the Early Development Collaborative Council to guide the Division of Early Development.

- UAA is establishing a **Bachelors' degree in Early Childhood** to begin in the fall of 2001.

- National hunger and food studies show requests for **emergency food have risen 32% in '98** and '99. This fits Anchorage as well. Many are families with young children and elderly. The amount of food available, one box each month, is too small for a family.

- Need to **support the Hunger Relief Act** that did not pass in this state. Sixty agencies have signed on as supporting such legislation. Needs to be fully funded.

- The **elderly** are in a tough spot, as have trouble actually getting out of the house to pick up food boxes. When forced to pick between **spending their limited money on food or medications, they choose medications.**

- Is the **movement from welfare to work really working for families**? Yes, it is the reality of what must happen but there are questions about the quality of life for these families and the cost to their young children - from little contact with working parents, stress from minimal incomes, transportation limitations, lack of health insurance, poor quality childcare, non-traditional work hours. Yes, we are meeting the goals but what harm is being done?

- **Housing is major barrier.** Most pay low rent, but have to move frequently, change schools for kids each time, generate first, last month rent etc. Becoming a homeowner is an important goal. Develop more capacity and visibility for AHFC programs to support first time homeowners.

- **Domestic violence is escalating** not decreasing or holding. Safe City program just completed study with APD (10 years) shows this increase and shows it is not socio-economically based.

- **Faith community has become much more active,** need more support from them.

- The complexion of Anchorage is changing; many more cultures and languages are represented.

Fairbanks

Panel Members
Cheryl Keepers-Fairbanks North Star Borough Child Care Local Administrator
Traci Nero-Adult Learning Programs of Alaska, Work First program manager
Terry Reichardt – Love, Inc, Executive Director
Don Shircel -Tanana Chiefs Conference, Family Services Director
Sam Castle-Fairbanks Community Food Bank Services, Executive Director
Tori Foote- Fairbanks Native Association, Director Ralph Perdue Center

The Fairbanks meeting was attended by 68 people and was held at the Fairbanks Community Food Bank. Terry Sterle of United Way opened the meeting. The following represents the main points presented by the panelists listed below.

- Many people are not keeping their jobs, **need to do better job of connecting them like walking them from DPA office to Job Center.**

- The **population is changing,** adults have many more challenges, unable to work, fear of failure contributes to this. Need community mentoring approaches to role model how to manage life skills.

- Reach out more to kids from **generational welfare families to learn a value of working.**

- There is still an **active childcare coalition operating.** Started as result of '95 welfare reform meeting in Fairbanks.

- There has been a large **increase in use of childcare assistance,** particularly **non-traditional hours.** See less licensed care and more registered. Serious concerns about this movement. If a parent using registered care has a concern about the quality of the care, no one can investigate non-licensed homes. No background checks are required.

- Child Care funding stream has increased with reduced benefit payments. FY97-$158,000, FY99-$248,600, FY00- $400,000. This has **finally ended childcare assistance wait list.**

- Quality of care is essential. Analogy made between early childhood education and higher education. **Tuition for college is cheaper than paying for childcare. Yet staff pay is shockingly different between college instructors and childcare providers.** One system is heavily subsidized by the state while the others in minimally supported. Reflects the values our culture holds for young children.

- Hunger is solvable; though the status of economy has been good we're beginning to see it drop in Fairbanks. It's a very charitable community. **If economy drops, there is a concern about having enough resources to provide food.**

- Presently providing **1.5 million pounds of food a year**. Peak was four years ago, now its lower as people moved into work. Last year the Food Bank assisted 22,000 people, not all related to welfare reform. Sixteen percent were people new to the community. See these numbers as barometer of what's to come. Fifty percent of those served are children. When families begin to reach their 5-year limit, fear higher increases than four years ago.

- There are **100 groups delivering food to** needy people.

- National statistics show welfare to work clients getting $10.00 per hour. Sometimes, **people working on social services (child care, Head Start) are earning less than this**. Low pay effects morale.

- Many **women getting into substance abuse treatment because they're pushed to do so by welfare reform.** This has been helpful since it has pushed them past their fears.

- Ralph Perdue Center for **Substance abuse treatment** sees mostly single men (but also fathers). Most with substance abuse, domestic violence involvement, low self esteem, and getting sabotaged by loved ones. Very hard to treat or teach life skills. **Need to reduce worker to client ratio, which is at 100 cases per worker right now.**

- Most **clients can't relate to 60-month limit, just worried about tomorrow.** Some parents worried their kids will come in shooting at them when they can't get assistance anymore.

- **Need better link** between **work and treatment.** Need onsite substance abuse counselors at Job Centers. Need DPA staff in substance abuse treatment locations.

- **Women in treatment are very fragile**. Their children are often very difficult, angry, hard to manage, raised in chaotic environments and thus childcare workers are not prepared to care for them in group settings. Get bounced out of childcare.

- **Need supportive living system for FAS, FAE adults**. Many have mental health issues and criminal records.

- **Love, Inc. is a coalition of 46 churches** in the area focused on meeting needs where there are holes in support for struggling families. They offer a telephone clearinghouse and the AIM program. AIM 1) provides rides from 7:30 am to 9:00 pm in Fairbanks and North Pole. 2) Classes on living skills. 3). Vehicle donation program- help repair clients vehicles and take donated cars/ make ready for clients. In '97 provided 1,000 rides, in 2000 provided 8,000 (not all welfare to work clients).

- Team efforts needed to get people off welfare. Means working together on each client, **more individualized focus**. Recognize this group requires much more time to reach work success.

- Church resources will continue to be available when families reach their 60-month limit.

- **Tanana Chiefs Council (TCC) Tribal TANF** is just 3 years in operation. Originally, half of TANF caseload resided in Fairbanks the rest in villages. Now 58% are in Fairbanks, 42% in villages. Caseload is reducing from 460's to 370's.

- **TCC** intends to **complete a leaver study**. Reference made to Children's Defense Fund survey tool entitled "Families Struggling in the Workplace". Suggests caseload reduction doesn't mean much, really the question should be what is the effect on the children.

- Tribal TANF program finds most who leave assistance do so voluntarily. Why is this?

Kenai Peninsula

On the Kenai Peninsula, the meeting structure was more informal, there was no panel. The attendance was higher than expected with a total of 36 people from Kenai, Soldotna, Homer and Seward. Some of the points listed below reflect issues of the entire Peninsula while others are specific to Kenai/Soldotna. Evy Gephardt of United Way opened the meeting, which was held in the Soldotna Council Chambers. During the course of the meeting, the following people were asked to make comments to give perspectives on childcare, food programs, employment and case management, family services and substance abuse treatment. Shannon Spaarts-Department of Labor, Norm Casagrande-AVTEC, C'lest Jensema-child care local administrator, Mg Mitchell-Community Mental Health in Homer, Henry Novak-Cook Inlet Council on Alcohol and Drug Abuse, James Fischer-Food Bank, Kristin Lambert-CARTS, Jane Stine-Soldotna Assembly member and Jane Urbanovsky, DPA.

The following reflects comments from this group:

- Biggest barrier in **childcare is non-traditional hours and infant/toddler care**. No one wants to work nights and weekends and disrupt their own families with family home childcare, particularly at the rates of pay.

- Childcare is really limited in Homer and Seward.

- On the Peninsula, the big issue is so few available jobs. AVTEC discussed limited resources for families, the seasonal economy as good place to start getting skills. They need a vocational rehabilitation-type counselor in Seward. **The most difficult clients have been "back-burnered".**

- There was a suggestion that other models be considered as they deal with much harder to reach families/adults. **Consider a vocational rehabilitation model instead of Work-first.** The former DPA regional manager suggested she had worked in both systems. Felt voc rehab was useful but DPA Work-first is outcome based and needs to be kept. Suggested a move from group model to individual work-based model is a combination of both.

- For individuals with diagnosed or undiagnosed learning disabilities, **the Adult Basic Education requirement to complete a GED in 3 month is not always possible** and makes client feel like failure. Need flexibility in these cases.

- **Eighty percent of people do not go to college.** Need to return and reaffirm vocational education. Kenai Borough School District is about to release a plan regarding **vocational education** in the next week.

- The **caseload of teen parents** is getting more manageable. There are ten to fifteen on the caseload right now, which is down from past years.

- PASS II childcare usage remains pretty steady on Peninsula though **PASS III not fully utilized. Local administrator gets lists of eligible people from DPA** but number who come seeking childcare assistance is very low. Could do more in this area.

- In Kenai, **childcare licensing is almost non-existent**. There are 113 registered care providers, 12-14 licensed. No local licensing office – it all comes out of Anchorage DEED office. Suggest redefine registered care as relative care only and give financial incentive for getting licensed. Also used to need licensing to get food reimbursement, not so anymore.

- To increase quality, **training is big issue for childcare providers**. There is a need for childcare for special needs children. The new Frontier Community Services (recent recipient of FAS community coordinating grant) can assist.

- **Pay for childcare** providers needs to be **increased.**

- With this client population, group suggested **personalized contract services** to work with individuals to **build life skills and coach toward work as a part of the process.** Kenai received one of the FAS coordination grants and wants to improve the individualized services, voc-ed, skill building.

- **Food needs continue to rise** and becoming more regional. Now increasing in Homer, Ninilchik and Seward. Transportation to food or food to people is big gap.

- Already **need more food for distribution** - concerned about what will happen after families reach 60 months of ATAP. The Food Pantry in Homer draws on the Food Bank in Kenai. Seward draws on Anchorage Food Bank. Serving a higher number of 15-18 year olds.

- Central Area Rural Transportation Services (CARTS) works closely with DPA, provided some matching funds. **Transportation on the Peninsula is a huge barrier** for welfare to work clients. Success story is hiring a former ATAP client as dispatcher, helps folks waiting for rides by calling an hour earlier than needed to encourage them to "get ready for work".

- **Denali KidCare has made a huge difference** in parents succeeding in work activities by getting health care provided easier and earlier.

- Kenai interagency group meets once a month. Helps them keep coordinated.

Juneau

Panel Members
Joy Lyon-NAEYC – R & R Child Care, Director
Carin Smolin-SERRC, Executive Director
Bob Starbard-Central Council of Tlingit and Haida TANF –cancelled
Rosemary Hagevig-Catholic Community Services, Executive Director
Joan Decker-Glory Hole, Director

The Juneau Welfare reform meeting ended the series of community meetings. It occurred during the Legislative session, which affected the participation somewhat. Thirty-one people attended the meeting held at the Gruening Park Community Center. The meeting was opened by Marsha Riley of Juneau United Way. Larry Persily, Deputy Commissioner of the Department of Revenue presented the CSED material and added some additional statewide information. He reminded participants that CSED was originally created to recover government revenues from non-custodial parents with court requirements to pay child support. It has expanded over the years to collect and distribute child support payments between custodial and non-custodial parents. There are 48,000 CSED cases in Alaska and most cases are related to public assistance clients. Forty percent are former DPA clients.

The following summarizes the panelist's main points.

- Concern was expressed about **pressure on GED students to complete by pre-designated date.** Sometimes unrealistic based on literacy skills, learning disabilities. The GED testing exam will be changed January 2002. If students have not completed their GED by that time, they will have to begin again. Please alert people

- In employment and job training, staff is seeing **significant increase in individuals with special needs and barriers such as learning disabilities, substance abuse, and mental health issues**. Suggest **a model somewhat like IEP** for special needs children that will assess and develop a plan that all players, including individual and all providers agree to.

- **Denali KidCare has been a godsend** for those moving into jobs. Health concerns still play into success for children and parents. Non-traditional work hours create many problems.

- Many 16-17 year old parents served. As teens with children, extenuating circumstances make the **GED the best option but they cannot apply until 18 yrs.**

- **Staff burnout with this population is big issue** and needs to be addressed. Reducing caseload size is likely improvement.

- **Work-search – first two years 60% obtained jobs with placement rate of 70%.** In Ketchikan doing training for dislocated workers, added basic skills training and computer skills.

- Many homeless have very **limited incomes; can choose food or shelter but not both.** Most single men making $7-8 per hour and have child support requirements for their children. Willing to take jobs but amount so small, after CSED nothing really left to live on.

- These are **splintered families, mother on ATAP struggling** with family issues and work-first. **Father making poor wages, living in shelters** and eating at the Glory Hole soup kitchen. Need to be thinking about how to get these families support again. The Glory Hole is absorbing what welfare is not. Very concerned about what will happen at the end of 60 months. 30 churches presently involved in supporting Glory Hole.

- Childcare Resource and Referral is co-located with the Job Center, which really helps parents looking for care. **Need to address quality issues.** Many people on work-first are trying out family childcare as employment.

- About **50** referral calls per month for childcare - **half for infant care and half for non-traditional hours/weekends and for families without a car.**

- There could be more consideration of **"exemption for lack of appropriate child care".** Many women with infants would do better to care for their own child than to place them in nearly non-existent childcare and work for low wages.

- There are **10 licensed centers in Juneau, 22 licensed homes and 96 registered homes.** National Association for the Education of Young Children, Southeast Alaska-R&R provides lots of incentives to get licensed, also training, mentoring, mobile toy library, but not having any affect in increasing licensing. Need financial incentives. It's very unsafe for children to go into homes where not even a background or safety checks are done.

- **Caring for infants is a financial loss for centers.** No incentive to provide this care. Higher turnover rate in unlicensed care. Full day care within Head Start is the ideal.

- **State is setting market rate,** but the study is based on rates already set by the state so doesn't reflect real costs. **Flawed design.**

- The **childcare field** has a **40% turnover rate** and pays an average $8.04/hr. entry level.

- In family services and partnerships with DPA, there is good collaboration but high caseloads. Catholic Community Services consider themselves a wall-less agency. The non-profit agencies in Juneau work very well together and **want to continue close relationship with DPA in designing systems changes needed to address the harder to serve families.**

SUMMARY OF COMMUNITY COMMENTS

This section reflects a compilation of comments from all five communities since many similar themes arose. Where appropriate, the community that generated the comment is shown. All others reflect comments made in two or more communities.

- There was some dialogue on the need to **have more complete data on the families who are within the 60-month limit** so that targeted approaches (multidiscipline) could be designed for them. (Mat-Su and Kenai)

- **Leaver Study**
  - There were questions about the Leaver Study asking what were the **reasons people were having trouble keeping their jobs**. The study does not address this.
  - The Leaver study **does not address housing needs** central to staying off welfare. Generally, AHFC has long waiting lists. Wonder if housing assistance is even available in the Valley.

- AHFC Jim Gurkie stated **2,000 ATAP families are receiving housing assistance**. WTW vouchers must be attached to the workforce requirements. There is still some resistance in landlord community to "Section 8" housing. (Anchorage)

- The **private and non-profit agencies don't have a 5-year limit like DPA.** They may have to be prepared to support those families when 60 months is up. Churches can do so much, are they going to be prepared along with agencies?

- There was some discussion about **people from out of state showing up at the Food banks and other agencies,** would it make sense to reestablish the old one-way "blue ticket" back to where they came from? One person commented that they didn't have anywhere to go back to. Could intakes be done on these folks to get better idea of their circumstances? (Mat-Su)

- There has been an **influx of single fathers avoiding child support payments** in the homeless and nearly homeless groups. (Mat-Su)

- Questions to OFFER program re: inpatient or outpatient capacity. Program referrals for residential treatment resource are very limited, mostly outpatient and short term. Note: Jim Nordlund said **DPA hoped to expand the OFFER program in other communities** through the Success at Work initiative if budget reinvestment proposals are approved by the Legislature.

- In the "Healthy Families" program, staff is seeing **young teen parents not choosing ATAP, moving from place to place because they don't feel safe living with their parents** (stepfathers). Very concerned about no financial support puts babies at risk.

- Discussion about **transportation problems** in the Valley and Kenai, cited improvement with new buses but still a huge problem. The Commissioner told the group about the Love, Inc donated rides and donated car program in Fairbanks. This could be started in other communities too. Churches are leading this effort in Fairbanks and Kenai.

- Much concern expressed about 60-month limit creating indigent families in the community and children without supports. **There are some families who have done everything they've been asked to do, sincerely trying to work and get off welfare,** who will be cut off without other means of support.

- Cook Inlet Tribal Council is working closely with other agencies to-serve adults with barriers such as learning disabilities; also **consider substance abuse treatment as an approved work activity**. They hope for more collaboration with DFYS. (Anchorage)

- The Nubian Sisterhood was represented at the meeting and raised issues of system's **capacity to identify and assess women with educational needs.** (Anchorage)

- **Needs of personnel working with challenged families** was raised. There is a workforce problem keeping these staff on the jobs. **This is big burnout work.** Perhaps funding for additional staff to reduce caseloads, provide long-term intensive case management.

- **Huge need for infant/toddler child-care and non-traditional hours**. Sending mothers with infants/toddlers to work when there is no child-care seems ludicrous.

- The **"churning" issue** of people cycling on and off ATAP was raised. May be a matter of education, **what happened to the community college system and vocational education.** Need to reinvest in this type of education

- Commissioner Holloway (DEED) spoke about the **exit exams and need to put pressures on schools not on the students at this point**. Need more time for kids with disabilities, military and non-English speakers. (Anchorage)

- Many ATAP **clients don't believe the state will cut them off at 60 months** even when told emphatically this is what will happen (Kenai).

- **Timelines for self-sufficiency set by DPA are not realistic** for hard to serve clients.

- The new **Family Development Credentialing** (through UAF) training has been extremely **helpful to staff across disciplines** in improving their skills for empowering families. Consider increasing its availability. Now in Juneau, Anchorage, Fairbanks, Mat-Su and Bethel. Running on a shoestring at this time.

FINDINGS

- **All five community-meeting attendees fully supported the DPA proposed solutions.** They also felt it essential that there be community provider involvement in the implementation of the possible new resources through reinvestment.

- **Partnerships** between non-profit providers, faith community and DPA **have been working.** Now with more challenging clients left on caseloads, these partnerships need new resources. There was consensus that some type of individualized, intensive case management would be necessary for clients with multiple barriers to employment.

- Many providers expressed **concern** that the UAA-produced Leaver Study represented the success of those leaving the ATAP program, but **that leaving was not the best measure of success.** There was real concern about the quality of life for those families, particularly their children.

- Every community had **grave concerns about the remaining families on ATAP.** There were consistent reports of large increases in use of the Food Banks, serious difficulties with child care due to non-traditional work hours of parents and limited quality care, the need for intensive supports/case management, concerns about future downturns in the economy i.e., fewer jobs, lower wages for the tenuous balance of leavers and those still on ATAP and major transportation limitations in every community.

- **In child-care, there is universal lack of infant/toddler care and particularly quality care.** Many people raised the point that it made more sense to support these parents caring for their own infants rather than try to create a infant child care resource that is nearly impossible to recruit given non-traditional hours, the labor intensity of infant care and very poor pay.

APPENDIX

WELFARE REFORM: WHAT'S NEXT

Co-sponsored by Department of Health and Social Services & United Way

Juneau - January 31, 2001
1:30-4:30
Gruening Park Community Center
1800 Northwood

Agenda

I. Welcome – Marsha Riley, United Way

II. Purpose of meeting and introductions - Commissioner Karen Perdue, DHSS

III. Welfare Reform: What's next? - Jim Nordlund, Director of Public Assistance

A. Background of welfare reform
B. Demographics of the Temporary Assistance caseload
C. Outcomes: the results of welfare reform
D. Challenges and next steps
Temporary Assistance
Child care - Yvonne Chase, Deputy Commissioner EED
Child support – Barbara Miklos, CSED

BREAK

IV. Community panel discussion:
Joy Lyon-NAEYC – Child Care
Carin Smolin-SERRC
Bob Starbard-Central Council of Tlingit and Haida TANF
Rosemary Hagivig-Catholic Community Services
Joan Decker-Glory Hole

Facilitator: Sally Mead

V. Questions and Answers

Welfare Reform: What's Next

Presented by Alaska DHSS, EED & CSED
Juneau community meeting
January 31, 2001

Slide show topics

Background
Demographics
Outcomes
Challenges and Next Steps

Background

Milestones in the History of Welfare Reform in Alaska

Background
March 1995 – Blueprint for Welfare Reform

Five stated objectives:

- Double AFDC parents working, training or in education
- Reduce welfare expenditures by helping families find work
- Require single mothers under 18 on to live with parents or other adult supervised living arrangements
- Increase child support collections
- Complete a public welfare reform planning process

Background
Fall 1995 Community Welfare Reform Meetings

What Alaskans said was important for successful welfare reform in 14 community meeting across the state

- Community responsibility for managing welfare – especially case management
- Encourage and reward work
- Foster responsible behavior, penalize irresponsible behavior
- Holistic case management
- Job development is essential
- Quality, affordable childcare
- Stronger child support enforcement

Background
Juneau

1995 Community Meeting Responses
What are the five most important parts of a welfare program for your community?

- Creation of jobs with a decent wage
- Emphasize prevention activities
- Housing
- Food
- Education

Background
Juneau Responses (cont)

Should every able-bodied adult be required to work in exchange for benefits?

- Exempt recipients who are not receiving child support that is due to them
- Only the disabled should be exempt
- Exempt where child care is not available
- School should count as work
- Exempt victims of abuse

Background
Juneau Responses (cont)

What shall we do when families use up their five years of welfare and don't have work?

- Maintain food and housing programs
- State should continue programs, even if Feds do not
- Consider on a case-by-case basis
- Encourage private agencies to provide services
- State should remove children from the home for program violations

Background
March 1996 – "Blueprint Two"

Established the overall goal of welfare reform:

Move Alaskans from welfare into jobs so they can support their families, and maintain a safety net for those truly in need.

Core principles:

- Emphasize work
- Limit benefits
- Maintain a safety net
- Promote responsibility

Background
June 1996 – State law (SB 98) signed

Key components:

- Alaska Temporary Assistance Program established
- Five-year limit on benefits
- Mandatory work activities
- Minor parent education and living arrangements
- Benefit reductions – shelter, second parent, seasonal
- Policies to "make work pay"
- Child support provisions
- Family self-sufficiency plan

Background
August 1996 Federal law (PRWORA) signed

Personal Responsibility and Work Opportunity Reconciliation Act of 1996

- Repealed the AFDC and JOBS programs
- Established the Temporary Assistance for Needy Families (TANF) program
- Established time limited benefits and work requirements
- Removes entitlement to public assistance, established "block grant" funding
- Maximized state flexibility

Background
July 1997 - ATAP begins

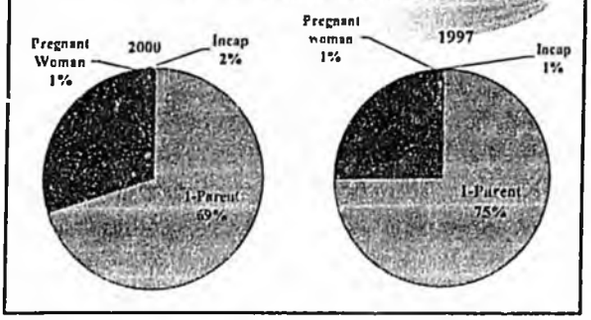
Implementation measures:

- Reinvestment of savings
- Community contracting
- "Work First" philosophy
- Agency collaboration
- Job development
- WorkStar
- One Stop Job Centers
- Devolution and local control
- Native TANF programs

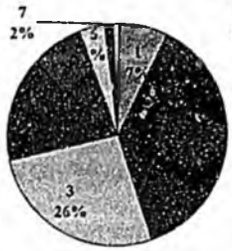
Demographics

Who is receiving Temporary Assistance?

Demographics
Family Type

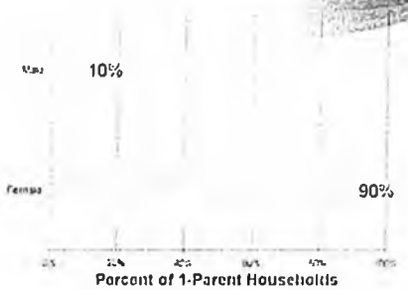


Demographics
Family Size



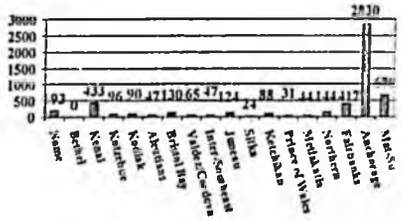
ATAP Family Size, Oct. 2000

Demogr.phics
Gender- single parent families



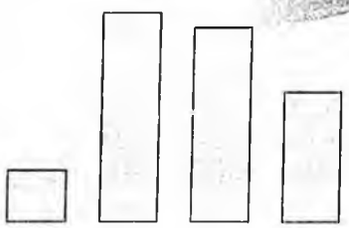
Demographics
Residence

November 2000 caseload

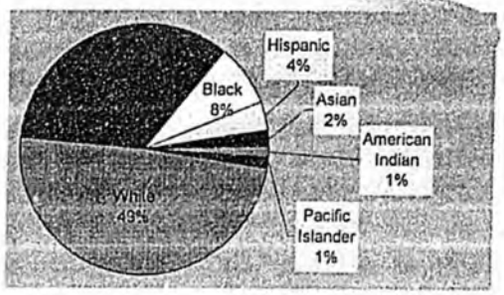


Demographics
Age of Adult on ATAP

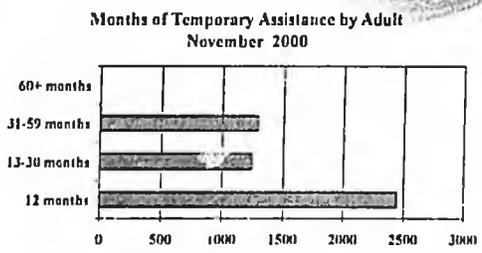
Demographics
Age of Children on ATAP



Demographics
Ethnic Origin



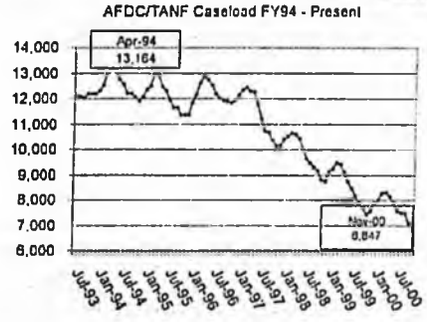
Demographics
Months of ATAP by Adult



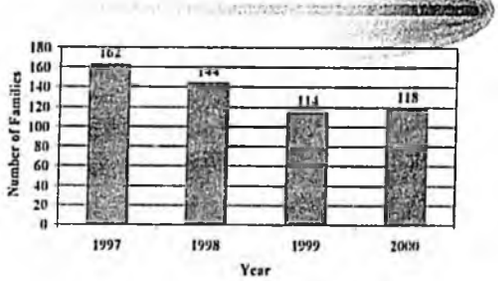
Outcomes

What has been the result of welfare reform in Alaska so far?

Outcomes
Statewide ATAP caseload decline



Outcomes
Juneau ATAP caseload decline



Outcomes

UAA "Leavers" Study: Preliminary results

Family Outcomes: Tracking families who have left ATAP

- 75% of leavers are working
- About 30% of leavers returned within two years
- The average wage - $10.52
- More than a third of leaver families had a second working adult
- 30% used community supports such as family, food banks, or from faith-based organizations

Outcomes

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Outcomes

"Leavers" Study (cont)

- Alaska Native families are leaving at the same rate
- 88% agreed they would rather work than receive welfare
- 55% agreed that their lives were better while off ATAP
- 46% worried that they would not be eligible for benefits
- 71% agreed that there should be a time limit

Outcomes

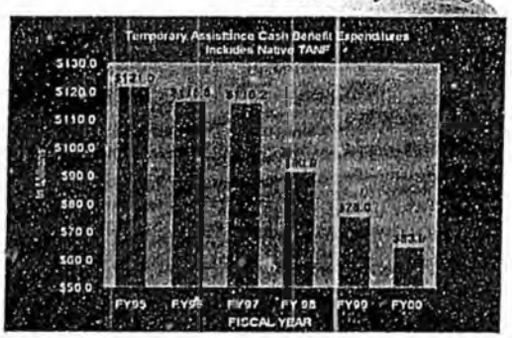
Performance measures

How we rank with other states:

- 8th in percent of adults in employment
- 7th in average hours in employment
- NO state ranks higher in both measures
- 15th in percent of adults in all work activities
- 6th in average hours of adults in all activities
- No state ranks higher in both measures

Outcomes

Cash Benefit Savings



Outcomes

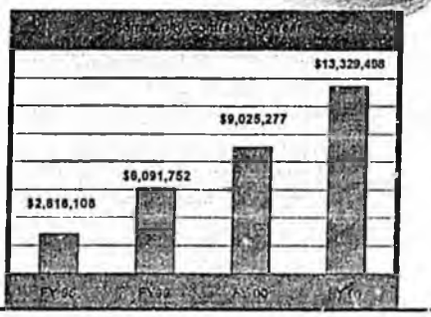
Reinvestments

Reinvesting savings into services for clients

- Child Care
- Work Services
- Native TANF programs

Outcomes

Reinvestments in Work Services



Outcomes

Reinvestments in Native TANF programs

Three Alaska Native regional non-profit organizations are now running Native TANF programs:

- Tanana Chiefs Conference began in October, 1998. In FY02 will be funded $2.2m GF, $.2m CS and $2.4m Fed for approximately 368 families
- Tlingit & Haida began in July, 2000. In FY02 will be funded $2.3m GF, $.3m CS and $2.4m Fed for approximately 375 families
- Association of Village Council Presidents began in October, 2000. In FY02 will be funded $3.2m GF, $.4m CS and $5.4m Fed for approximately 758 families

Challenges and Next Steps

What must be done to continue the success of welfare reform in Alaska?

Outcomes

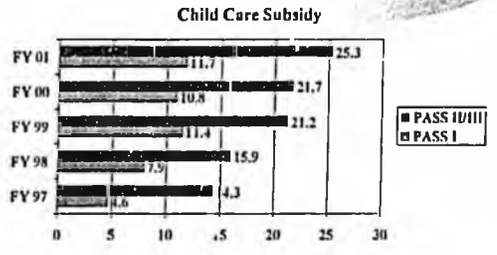
Child care

Outcomes for child care:

- Funding has shifted dramatically since the beginning of welfare reform, previously state dollars primarily funded child care
- FY99 state dollars were replaced with federal funds
- EED became lead agency for child care programs in July, 1999
- Child care licensing was transferred from DHSS to EED in July, 2000

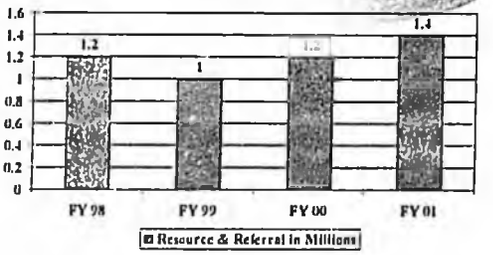
Outcomes

Child care

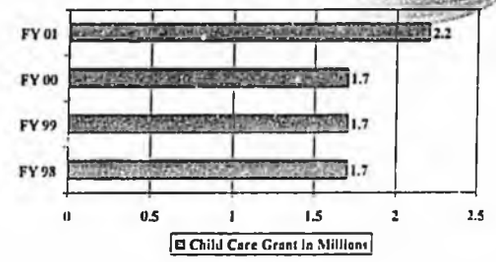


Outcomes

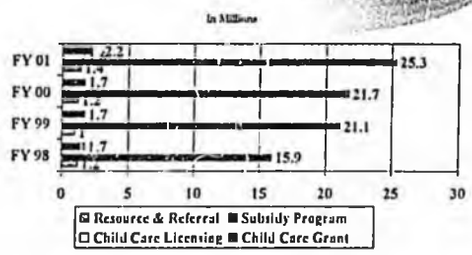
Child Care



Outcomes
Child Care



Outcomes
Child Care



Challenges and Next Steps
Child care

Challenges for child care:

- Reversal of the current trend: movement from licensed child care to legally exempt care
- Institution of tiered quality monetary incentive system for licensed facilities
- Assuring quality in legally exempt care
- Developing adequate departmental capacity to address licensing issues
- Child care registry

Challenges and Next Steps
Child care

Next steps for child care:

- Reinvestment of dollars into the expansion of child care licensing
- Elimination of wait list for Child Care Assistance Program (subsidy)
- Expanded resource and referral services to increase quality of child care
- Increased funding to the Child Care Grant program to enhance quality in licensed child care facilities

Outcomes
Child support

The Division of Child Support Enforcement outcomes:

- Increased collections: FY99/$81m, FY00/$85m and FY01/expected to exceed $90m
- Distribution to Alaskan families has increased 14% from $49m/FY99 to $59m

Challenges and Next Steps
Child support

Challenges for child support:

- Maintaining good customer service while increasing collections
- Collecting for disbursement to families vs government reimbursement
- Serving the ever increasing number of former recipients to ensure they do not return to ATAP

Challenges and Next Steps
Child support

Next steps for child support:

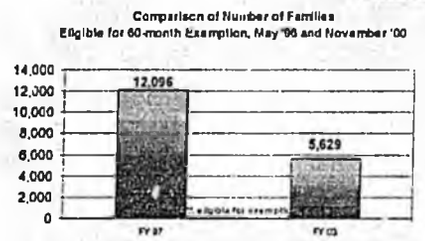
- Ensuring the sunset provisions of welfare reform are passed during this legislative session. Some of the tools that CSED uses are:
- Financial Institution Data Match both multi-state and in-state
- New Hire Reporting to National Directory of New Hires and Alaska employers reporting New Hires to CSED
- CSED is bringing on line a new distribution system.

Challenges and Next Steps
The five-year limit

The Challenge

- First families exceed limit in July 2002 - 349 estimate
- By July 2003, an estimated 1103 families will exceed limit
- 20% of the current caseload is eligible for exemption
- Caseload in May1996 was 12,752 in Nov 2000 5,428
- Families eligible for exemption reduced by 57%
- In future years the 20% cap will cause some families to be cut off despite their best efforts to work

Challenges and Next Steps
The five year limit



Challenges and Next Steps
The five-year limit

Proposed budget solutions:

- Reinvest federal savings to provide intensive work services for families approaching 60 months
- Reinvest federal savings for intensive services to address social barriers and identify families eligible for extension

Possible policy solutions:

- In legislation, modify the 20% cap on exemptions
- In regulation, establish strict and objective hardship criteria for extensions beyond 60 months
- Require self-sufficiency plans for all families, including disabled adults

Challenges and Next Steps
Success at Work

The Challenge

- Many recipients are working, but have trouble advancing to better jobs and off welfare
- Some current recipients have trouble keeping their jobs
- Many former recipients (30% over 2 years) lose their jobs and come back on welfare
- Many recipients have barriers that prevent them from getting a job

Challenges and Next Steps
Success at Work

Proposed solutions: Reinvest federal savings

- Improve the chances of job retention and advancement by establishing the Alaska Post-Employment Exchange
- Enable more recipients to receive job training through an expanded work-study program
- Expand social service partnerships to identify and treat substance abuse, mental health, domestic violence and other barriers to employment
- Provide additional work related support services to keep workers on the job

Alaska Temporary Assistance Program: Success at Work Initiative

Division of Public Assistance
January 8, 2001

ISSUE

With welfare reform's concerted focus on moving welfare recipients into the workforce, there is greater need to help individuals with low skills, a lack of work history and other barriers to move from welfare to work. The **Success at Work Initiative** will provide services to improve the employability of clients, enhance job retention and advancement, and address the more complex challenges that impede job entry and success in the work place.

BACKGROUND

- Many Temporary Assistance recipients are working, but have trouble advancing to better jobs and off welfare. Some current recipients have trouble keeping their jobs, and many have barriers that prevent them from getting a job.

- To sustain their independence from welfare, some clients who have recently worked their way off Temporary Assistance also need help in maintaining employment, finding better jobs and advancing in their careers.

- Preliminary data from DPA records and the University of Alaska Anchorage study of families leaving Temporary Assistance indicates that over a two-year period approximately 30% of families who leave Temporary Assistance return.

PROPOSED SOLUTIONS

- **Continue to Reinvest Savings.** The Success at Work Initiative proposes to use savings from reductions in ATAP benefits to finance job retention and advancement services that will decrease the rate of return and promote economic independence. $1.8 million in federal TANF funding will finance the following new services:

  * **Services to Enhance Job Retention.** The Alaska Post-Employment Exchange (APEX) Call Center will be the primary post-employment service for clients who are working their way off Temporary Assistance, or who have left assistance for employment. As an adjunct to traditional case management services, APEX staff contact participants after they start working to make sure they are aware of and connected to job retention or other needed services such as child care, skill enhancement, career advancement, and continuing education and training opportunities. The call center will make work supports, referrals an information about retention and advancement services available to clients in their own homes in the evening and on weekends. Clients needing assistance can also contact APEX using a toll-free number.

* **Job-Related Training.** A State Work-Study Program will help current and former clients move from "a job" to "a better job" and become more able to fully support their families. A work study program provides an opportunity for parents seeking post-secondary education to fulfill their mandatory work requirements while getting the education needed to advance in the job market.

* **Social Services Partnerships.** Social Service Partnerships will place social service clinicians in the Fairbanks, Mat-Su, Anchorage, and Kenai Job Centers. Clinicians will provide Temporary Assistance clients with on-site assessment and rapid referral to services and treatment programs. Nationally, substance abuse, mental health disorders and domestic violence have been identified as the most pervasive and pernicious challenges to employment and self-sufficiency confronting welfare recipients. This strategy also increases capacity for services and treatment programs that emphasize work as a component of treatment.

* **Supportive Services.** Support Services include work-related expenses and are essential for the successful implementation of intensive case management, job related training, and job retention and wage progression services.

Alaska Temporary Assistance Program
60-Month Time Limit Issue Paper

Division of Public Assistance
January 29, 2001

ISSUE

July 2002, marks the first month families in Alaska will exceed the 60-month time limit for receiving Temporary Assistance.

Although the 5-year limit on Temporary Assistance is a key element of welfare reform, there are families who will need continued support after receiving 60 months of assistance. The original goal of welfare reform remains to move Alaskans from welfare to jobs so they can support their families while maintaining a safety net for those truly in need.

BACKGROUND

- There has been a 42% overall caseload reduction in ATAP since November 1996. The rate of caseload decline is slowing, however, and many clients who remain on the caseload have significant challenges to employment.
- In July 2002, an estimated 349 families will exceed the Temporary Assistance 60-month time limit.
- By July 2003, this number will increase to 1103 families who will have used up their 60-months of assistance.
- Some, but not all, of these families will be eligible for an exemption from the 60-month limit. Federal and state laws cap the exemptions at 20% of the current caseload and define eligibility criteria for the exemptions.
- As the caseload declines sharply, so has the number of possible exemptions under the 20% rule. Less than half the families eligible for an exemption when ATAP passed are now eligible. (*see attachment 1)*
- In future years, the number of families receiving greater than 60 months of assistance will exceed the number of exemption slots available. Many of these recipients will be unable to work despite their best efforts. (*see attachment 2)*
- The 20% cap in both federal and state laws, precludes the use of either federal or state funds to serve many families who are truly needy.

WHO ARE THESE FAMILIES?

As of June 2000, 618 of the families who are subject to the time limit, or 7% of the total caseload, had received Temporary Assistance for more than 35 months.

The 618 families rapidly approaching the 60-month time limit have these characteristics:

- **Long-term reliance on welfare.** The average length of time on AFDC/ATAP is 90 months.
- **Intermittent, short-term attachment to the workforce.** Over two-thirds of families have worked in the past three years, but less than one-third have worked for more than twelve months in that same time.
- **A variety of challenges to employment.** Estimated three-quarters of these families face at least one challenge to employment. Almost one-half face more than one barrier.
    - 20% had substance abuse issues
    - 32% had experienced domestic violence
    - 34% had mental health issues
    - 51% had a physical health problem

BUDGET SOLUTIONS

- **Continue to Re-Invest Savings.** Use savings from reductions in ATAP benefits to provide intensive services to families at risk of reaching the 60-month limit. $2.8 million in federal TANF funding will fund the new initiative called "Families Work!"

    ✓ **Families Work!** will reach out to families that are approaching the 60-month limit. These families face continued reliance on public assistance and the potential loss of services if they are not self-sufficient before they reach their 60-month lifetime limit on assistance. Services funded by this increase will provide intensive case management emphasizing a team approach. With focused, coordinated and intensified services, a portion of these families will gain the skills, self-esteem, work place experience, and connections to community resources that will enable them to successfully transition to employment. Families Work will also identify those families that should be eligible for an exemption from the 60 months.

POSSIBLE POLICY SOLUTIONS

- **Make changes to Alaska State Law governing the Alaska Temporary Assistance Program**

    ✓ Retain the 5-year limit on assistance, but allow the number of exemptions to exceed 20% of the caseload based on specific hardship criteria. Grant extensions to all families who meet the hardship criteria. This change is necessary to avoid placing families who meet hardship criteria on a waiting list for an extension, and meanwhile, deny supports for basic needs.

    ✓ Require incapacitated adults (physically or mentally unable to perform gainful activity) to participate in self-sufficiency activities to motivate them to plan for self-sufficiency.

Reaching for Independence:

A Study of Families That Have Left the Alaska Temporary Assistance Program

Pre-Publication

Executive Summary

January 18, 2001

Institute for Circumpolar Health Studies
University of Alaska Anchorage
3211 Providence Drive
Anchorage, Alaska 99508

January 2001

This project was supported by the State of Alaska
Division of Public Assistance
FY 1999 RSA 0600122 and FY 2000 RSA 0600017

Executive Summary

Background

A sweeping national welfare reform law, The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, established the federal Temporary Assistance for Needy Families (TANF) program. TANF replaced the Aid to Families with Dependent Children (AFDC) program, which had provided funding to states to operate cash welfare programs for needy families since the enactment of the Social Security Act during the Great Depression. States receive federal TANF funds based on congressionally established block grant amounts, unlike AFDC funding, which had been an open-ended entitlement.

This report assesses the characteristics and status of Alaskans who left Alaska's welfare rolls after the July 1997 implementation of the Alaska Temporary Assistance program, Alaska's version of TANF. Studies of this type (commonly called welfare "leaver" studies) are underway in many of the states. In general, leaver studies are designed to document the outcomes of families that left the welfare rolls after the states' implementation of welfare reform.

The Alaska Temporary Assistance program is administered by the Division of Public Assistance, an agency within the Alaska Department of Health and Social Services. The Division of Public Assistance commissioned the Institute for Circumpolar Health Studies (ICHS), an applied social welfare research unit within the University of Alaska Anchorage (UAA), to conduct the study. ICHS conducted the study in partnership with the UAA School of Social Work.

The Division of Public Assistance and the UAA evaluation team established the following objectives for this study:

- To assess the characteristics and status of families that left the welfare rolls ("leavers") after the July 1997 implementation of the Alaska Temporary Assistance program,
- To compare leaver families that returned to the welfare rolls after a period of absence ("returners") to non-returners,
- To identify factors that may impact the ability of former Temporary Assistance clients to stay off assistance, and
- To assist the Division of Public Assistance in using the evaluation findings to assess the effectiveness of its efforts.

The evaluation team used Division of Public Assistance administrative data and the results of a survey of a representative sample of 694 Alaskans who left the Temporary Assistance program rolls during the 24-month period ending in October 1999. Survey interviews were conducted during the spring of 2000. Statistical comparisons between the sample and the universe of all Temporary Assistance recipients who left the rolls during the study period established that the sample was representative of the population.

The study data were reviewed by Division of Public Assistance staff and an advisory and oversight committee appointed by the Commissioner of the Department of Health and Social Services. The results presented here include summaries of study data and interpretations of the meaning of the data.

The findings below are grouped according to the basic constructs or factors used in other states to assess the results of welfare reform on families that leave, and sometimes re-enter, the welfare rolls. As the title of this study suggests, most of the subject families were indeed "reaching for independence" with varying degrees of success.

Findings

Demographics and Family Characteristics

Most recipients who left the Temporary Assistance programs were younger, high-school-educated females with small families.

Alaska Native families left the caseload at about the same rate as non-Native families.

The presence in "one-parent" households (cases that included only one eligible adult) of a second adult who was not eligible for Temporary Assistance related positively with success in staying off the Temporary Assistance rolls.

Getting off welfare is not the same as staying off welfare. Three out of ten families returned to the Temporary Assistance rolls during the 24-month study period. This phenomenon of leaving and returning to welfare is often called caseload "churning." The occurrence of such repeated interactions with the welfare system highlights the need for steady employment and strong support services to people leaving welfare as they strive to maintain their independence.

Specifically, the study found that:

- Eighty-eight percent (88%) of recipients who left Temporary Assistance were female.
- The average age of Temporary Assistance leavers was 34 years.
- The typical family included two children.
- Although the proportion of Alaska Native families in the Temporary Assistance caseload (37%) is greater than the proportion of Alaska Natives in the state population, Native families left the caseload at about the same rate as non-Native families.
- The presence in "one-parent" households (cases that included only one eligible adult) of a second adult who was not eligible for Temporary Assistance related positively with success in staying off the Temporary Assistance rolls.
- Eight out of ten (81%) people who left Temporary Assistance had at least a high school education or equivalent.
- Three out of ten (30%) of the cases that left the Temporary Assistance caseload during the study period returned to the Temporary Assistance rolls at least once during the study period.
- Consistent with the overall geographic distribution of the Temporary Assistance caseload, significantly more respondents with two-parent families lived in rural Alaska (52%) than lived in urban Alaska (20%).

Employment and Earned Income Opportunities

Employment is a crucial factor in a family's ability to leave welfare. Numerous indicators point toward the importance of quality jobs to becoming independent of Temporary Assistance. Study participants who did not return to the Temporary Assistance rolls were more likely than returners to have held permanent, non-seasonal, full-time jobs and had higher hourly wages than returners did. As expected, people with less than a high school education or who had serious health problems or disabilities had more trouble maintaining independent employment.

Specifically, the study found that:

- Over half (51%) of the respondents cited employment as their reason for leaving Temporary Assistance.
- Two-thirds (65%) of the respondents were employed at the time of the interview.
- Three in ten (29%) of the respondents were back on Temporary Assistance at the time they were interviewed.
- Thirty-eight percent (38%) of the respondents who were back on Temporary Assistance at the time of the interview were employed.
- Three-quarters (75%) of the respondents who were off Temporary Assistance at the time of the interview were employed.
- The average wage for people interviewed who had worked was $9.73 per hour in 1998 and $10.52 per hour in 1999.
- Respondents with a high school diploma or equivalent were significantly more likely to be employed and off Temporary Assistance than those with less education.
- Health problems, disabilities, and problems with child care were the most frequently mentioned challenges to employment.

Unearned Income

Cash income from non-employment sources may contribute significantly to a family's total income and ability to leave and stay off the Temporary Assistance rolls. Unearned income that is received on a regular basis may be especially important in meeting a family's ongoing financial needs.

While many Alaskans believe that the Permanent Fund Dividend is an important way of reducing the need for Temporary Assistance, many people who left Temporary Assistance had their Permanent Fund dividends garnished to pay off their debts, suggesting that they were having trouble meeting their financial obligations. We also found that regular child support payments were available to few families that left the Temporary Assistance rolls and almost as many families paid out child support as received it.

Specifically, the study found that:

- Fewer than one out of five respondents (18%) reported that their household received child support payments. The average payment amount was $282 per month.
- Twelve percent (12%) of respondents reported that their household paid out child support, averaging $318 per month.
- Thirty-seven percent (37%) of respondents reported that a household member's 1999 Permanent Fund dividend was garnished.
- Sixteen percent (16%) reported that at least one member of the household received Adult Public Assistance payments.

Use of Transitional Services and Community Help
Getting off Temporary Assistance cannot be equated with no longer needing public services. Former Temporary Assistance recipients relied on government health insurance, food stamps, or community resources to help them stay off the Temporary Assistance rolls. These services must be available if the Temporary Assistance caseload is expected to continue to decline.

Specifically, the study found that:

- The most frequently cited government service used by respondents after they left the Temporary Assistance rolls was government health insurance, including Medicaid, tribal health care, and Denali KidCare.
- One-third (34%) of respondents said they were not receiving food stamps at the time of the interview. Most of those not using food stamps reported that they did not need or want food stamps, or believed that they were not qualified.
- Some respondents (30%) used food banks, faith-based organizations, family support, or some other form of community support while they were off the Temporary Assistance rolls.

Services Received by Temporary Assistance Recipients
Well trained and responsive Public Assistance caseworkers are a crucial element in helping people stay off Temporary Assistance. They are instrumental in helping people plan for the transition from welfare to work, prepare themselves for work, find jobs, and maintain employment. Temporary Assistance clients are also an important source of volunteer community service labor.

Specifically, the study found that:

- Sixty-two percent (62%) of respondents indicated their Public Assistance caseworker had required them to work, look for a job, or go to some kind of job training.
- An average of 13% of respondents indicated they had participated in some form of volunteer or unpaid work between 1998 and 1999.

Child Care
All families with children must address their child care needs in order to balance family life with employment. This is also true with Temporary Assistance recipients who leave the rolls. Subsidized child care is an essential welfare-to-work service. Survey respondents reported that they used subsidized child care less after they left the Temporary Assistance rolls than they did while they were receiving benefits. It is essential to maintain child care benefits and assure access to subsidized care as part of the welfare transitional package. Further study will be necessary to understand the subsidized child care utilization patterns of Temporary Assistance leavers.

Specifically, the study found that:

- One-third (33%) reported that a lack of child care had disrupted their work-related activities.
- One-third of the respondents (33%) reported that they used child care for preschool children in order to find or keep a job.
- One-fourth (24%) reported that they had used child care for school-aged children.

- Three in ten (31%) reported that they had received subsidized child care for training and other work-related reasons before they left the Temporary Assistance caseload, while only 18% said they had received subsidized care after leaving the Temporary Assistance rolls.
- Child care centers and family day care homes were the most frequently mentioned forms of child care used. Friends and relatives provided most of the remaining care.
- Almost nine out of ten (86%) of those who used child care were satisfied with the quality of child care they received.

Housing

Adequate shelter is one of the basic necessities of life. Without stable housing, it is difficult to maintain gainful employment. One in three survey respondents had trouble paying for this basic need. The data shows that people who returned to the Temporary Assistance rolls had more trouble than those who stayed off Temporary Assistance. Continued attention must be paid to basic housing as a crucial component of welfare reform.

Specifically, the study found that:

- Housing arrangements were stable for 70% of respondents in the year preceding the interview, with 30% reporting at least one move in the last year.
- The average housing cost for respondents was $430 per month, and their average utility cost was $133 per month.
- Twenty-eight percent (28%) of the respondents were living in either subsidized housing or a public housing project.
- Over one-third (36%) reported being unable to pay rent, housing or utility bills at least once in the past year, with people not on Temporary Assistance less likely to have this experience.

Transportation

There is a strong relationship between the availability of reliable transportation and people's ability to maintain employment and stay off the Temporary Assistance rolls. Three-quarters of the survey respondents had adequate transportation. This clearly helps people maintain stable employment. The data suggests that the liberalized Temporary Assistance policy on vehicle ownership is good public policy.

Specifically, the study found that:

- Three quarters (75%) of respondents reported having adequate transportation to get to work, training or child care.
- Personally owned vehicles were the most common form of transportation.
- People with reliable transportation were significantly more likely to be off Temporary Assistance and employed at the time of the interview.

Health Issues

While most former Temporary Assistance recipients are healthy, many recognize health problems and disability as a major challenge to stable employment. Lack of adequate health insurance affected the lives of one out of three families that left Temporary Assistance. This finding reinforces the need for continuing government-sponsored medical insurance as an important component of welfare-to-work strategy.

Specifically, the study found that:

- Nearly nine out of ten (89%) respondents reported their health status and the health of spouses and children as being fair or better.
- Thirty percent (30%) of respondents reported at least one family member with no medical coverage.
- Seventeen percent (17%) of respondents said that someone in their household had not received needed health care during the past year, most often due to financial constraints.

Client Perceptions and Attitudes

People who left Temporary Assistance agree with the welfare-to-work philosophy yet express reservations about their long-term ability to remain independent. During their quest for independence, many repeatedly move from welfare to work and back to welfare. Some people worry about the availability of Temporary Assistance benefits if they should need these services in the future. The impact of the new limits on welfare eligibility needs further investigation.

Specifically, the study found that:

- Almost nine out of ten (86%) people interviewed reported that they would rather work than receive Temporary Assistance.
- More than half (55%) of the respondents said that their lives were better after leaving the Temporary Assistance rolls.
- About seven out of ten (71%) respondents agreed with the appropriateness of Temporary Assistance time limits, with half of them (50%) strongly agreeing.
- Over eight out of ten (85%) respondents agreed that people on Temporary Assistance should be required to find a job and work.
- More than six out of ten (62%) people interviewed believed that their Temporary Assistance caseworker was interested in their well-being and gave them good advice and support.

Rural Issues

The availability of quality jobs in rural Alaska is going to affect the success of the welfare-to-work efforts in many areas of the state. Although benefit time limits do not apply in many small villages, the nature of temporary and seasonal employment in rural Alaska makes time limits on Temporary Assistance benefits a critical issue.

Specifically, the study found that:

- Almost nine out of ten (88%) rural Temporary Assistance recipients are Alaska Natives.

- There were significantly more respondents with two-parent families in rural Alaska (52%) than in urban Alaska (20%); this is consistent with the overall geographic distribution of the Temporary Assistance caseload.
- The higher cost of living and seasonal and temporary employment patterns probably offset higher wage levels in rural Alaska.
- Rural respondents believed that the available jobs were of lower quality and jobs were harder for them to find than their urban counterparts did.
- Rural residents were less willing than urban respondents to relocate to find employment.

Conclusions

Division of Public Assistance data show that both the Temporary Assistance rolls and the Temporary Assistance budgets have been shrinking since the Fiscal Year 1998 implementation of welfare reform in Alaska. The change to the "welfare-to-work" policy underlying Alaska's welfare reform efforts is generally recognized as a good public policy properly implemented. There is agreement, even among Temporary Assistance beneficiaries, that work is better than welfare. Many former Temporary Assistance recipients are now part of the workforce and appear to be successfully replacing benefits with earnings. They credit the caseworkers of the Division of Public Assistance and its affiliated agencies for helping them make the transition to independence.

However, the results of this study also suggest that these trends may not continue on their present course. The ability of former Temporary Assistance recipients to remain in the workforce is challenged by perceptions of shortages of quality jobs, problems with child care, and family problems. The inevitable economic downturns of the future are likely to affect this population strongly. A substantial proportion (30%) of those who left Temporary Assistance returned to the rolls during the study period, some repeatedly bouncing back and forth from welfare to work. The dynamics of this caseload "churning" phenomenon warrant further study. Many of those who remain off the Temporary Assistance rolls are working in the lower range of the wage scales. Many depend on seasonal and temporary work. Their situations seem to be economically fragile.

It is essential to provide the supports necessary to maintain the gains that Alaska has made in implementing its welfare-to-work policies. As the caseload falls, this may be increasingly difficult because the population remaining on Temporary Assistance may require more sophisticated and intensive interventions to help them prepare for independence, and to support their transition to work. More needs to be learned about the characteristics of the Alaskans who remain on the Temporary Assistance rolls in order to assure them the same opportunities to become stable members of the Alaskan workforce. Program strategies must be in place to support families that, despite their best efforts to achieve independence, exhaust their eligibility for Temporary Assistance when the 60-month time limit takes effect in mid-2002.

Alaska Medicaid Program

History Timeline for Services and Eligibility

April 10, 1972	Touche Ross and Company Begin Medicaid System Design.
April 18 - June 9, 1972	Departmental Presentation to Legislature.
July 6, 1972	Alaska Medicaid program enacted.
Sept. 1, 1972	Medicaid Program Implemented.
Sept. 28, 1972	First State Plan Submitted to Federal Department of Health, Education and Welfare.
April 4, 1973	Effective Date of Intermediate Nursing Home Care Option.
May 16, 1974	Effective Date of Inpatient Psychiatric Hospital Option for Eligible Persons over 64 and under 21.
May 16, 1974	Effective Date of Miscellaneous Minor Eligibility Groups (primarily needy children under 21 in foster care under supervision by Department of Health and Social Services).
Sept. 2, 1975	Effective Date of Intermediate Nursing Home Care for Mentally Retarded under 21 Who Meet AFDC Need Standards Option
March 12, 1976	Effective Date of Eye Glasses and Optometrist Service Options.
June 21, 1976	Effective Date of New Nursing Home Group of Eligibles (persons whose income while in the facility does not exceed 300 percent of the SSI benefit rate under title XVI of the Social Security Act but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility).
July 1, 1976	Effective Date of Limited Clinic Services Option (primarily community mental health centers and state operated mental centers).

July 1, 1976	Effective Date of Treatment of Speech, Hearing, and Language Disorders Option.
March 3, 1978	Effective Date for Coverage of Persons Under 21 Receiving Active Treatment in a Psychiatric Hospital who are Financially Eligible as Determined by the Standards of Part A of Title IV (AFDC) of the Social Security Act.
July 1, 1978	Effective Date for the Addition of Rural Health Clinics and Outpatient Surgical Care Centers.
1981	HCFA - IHS Agreement makes Medicaid a prior payer to IHS.
Sept. 22, 1981	Effective Date for the Addition of Nurse Midwives Services.
Oct 1, 1982	Medicare Part B Buy-in begins in response to federal mandate for Medicaid to purchase Medicare Part A and Part B premiums on behalf of dual eligible elderly and disabled.
June 25, 1982	Effective Date for the Addition of Persons Under 21 Who Would Be Eligible for Benefits under AFDC but Are Not Dependent Children and Pregnant Women as New Eligibles.
June 25, 1982	Effective Date for the Addition of Physical Therapy, Occupational Therapy, Prosthetic Devises, Medical Supplies and Long-Term Care Noninstitutional Services as New Services.
July 1, 1982	Effective Date for Indicating a Person is not Eligible for Medicaid Benefits Until a Final Determination is Made on the Eligibility of that Person.
1983	Medicaid Rate Commission established in statute, first facility payment rates established under new law July 1.
Oct. 21, 1984	Budget based prospective payment system established for hospitals and nursing facilities.
Jul 1, 1985	Contract w/Professional Review Organization of Washington to provide Utilization Review and Prior Authorization of inpatient hospital services

June 7, 1986	Effective Date for Addition that Medicaid will Cover all Mandatory Services required under 42 U.S.C. 1396-1396p and Personal Care Services in a Recipients Home, Emergency Hospital Services, Adult Dental Services, and Intermediate Care Facility Services for the Mentally Retarded as Optional Services.
Aug. 9, 1986	Cost based with inflation prospective payment system established for hospitals and nursing facilities.
Nov 1, 1988	Generic drug substitution for brand-name drugs required by regulation.
July 29, 1986	Effective Date for the Addition of Chiropractic Services as an Optional Service.
Feb 2, 1987	Contract w/ Touche Ross Company to recover payments from liable third parties
May 1, 1988	Contract w/The Computer Company to operate a federally- certified MMIS
May 1, 1988	Payment for outpatient laboratory services is limited to the Medicare fee schedule by federal law.
Sept. 5, 1988	Effective date for the addition of pregnant women, and children five years of age or younger, with a household income that does not exceed 100 percent of the federal poverty level as a new eligible group, required by federal law. Children were to be phased in one year at a time.
Sept. 5, 1988	Effective Date for the Addition of Case Management and Nutrition Services for Pregnant Women as a New Optional Service under state law.
July 1, 1988	Effective Date for the Addition of Prescribed Drugs as a New Optional Service for a One Year Period (I Y89). Added by state law, prescription drugs were previously covered with general funds under the GRM Program.

March 1, 1989	Executive Order 72 changed Medicaid Rate Commission to Medicaid Rate Advisory Commission.
March 25, 1989	Maximum cap on nursing facility payment rates established.
July 1, 1989	Effective Date for the Addition of Prescribed Drugs as an Optional Service.
July 5, 1989	Chiropractic Service Coverage Suspended for FY90.
Oct. 1, 1989	Effective date of "spousal impoverishment," federal statutory change allowing an institutionalized spouse to transfer up to $60,000 countable excess resources to the spouse at home. (Amount increases annually)
Nov. 1, 1989	Effective date of continuous eligibility, regardless of changes in income, for pregnant women.
Dec 1, 1989	Establish Electronic Verification System, 24 hour phone system, to improve provider access to client eligibility
April 1, 1990	Transitional Medicaid benefits under welfare reform: Changes the state existing 4 month/9 month work incentive plan to a 12 month plan for those individuals who lose AFDC eligibility because of increased earnings.
April 1, 1990	Coverage of pregnant women, infants and children up to age 6 at 133% of federal poverty level. This increases the current income standard from target group.
May 4, 1990	Enactment of CH 26 SLA 90, a temporary act, authorizing the establishment of home and community based waiver services.

July 1, 1990	Chiropractic benefits reinstated
July 1, 1990	Effective date of Medicaid payment of Medicare premiums for certain qualified disabled workers.
Oct. 1, 1990	UP Medicaid: Provides Medicaid benefits to intact families where the primary wage earner is unemployed or underemployed.
July 1, 1991	Effective date for coverage of children, born after 9/30/83 and over 6 years of age, at 100% of the federal poverty level.
Sept. 19, 1991	Effective date of HB 248, adding licensed clinical social workers' services and psychologists' services to Medicaid; not implemented due to finding of insufficient funds under AS 47.07.035. Funding was also not granted for these services in the FY 93 budget.
Nov. 1, 1991	Effective date of Division's decision to "unfreeze" fee profiles for physicians and dentists, frozen by the Legislature in 1985; resulted in first payment rate increase to many such providers since 1984.
Nov. 1, 1991	Effective date of federal pharmacy rebate program; rebates provided by drug manufacturers to states which reimburse for their drugs. Alaska had an existing pharmacy rebate program in place with pharmaceutical manufactures prior to the federal mandate. Estimated annual recovery income to Alaska: $500,000 to $600,000.
Nov. 1, 1991	Effective date of one-year period of continuous eligibility, regardless of income, resources, and some other family changes, for infants born to Medicaid mothers.
June 27, 1992	Personal Care Attendant Regulations become effective.

Dec., 1991	Implementation of the "Primary Care Program ", which identifies individual recipients who over-use Medicaid services and prescription drugs requires them to access all non-emergency services designated through a single physician.
Aug. 1, 1992	Chiropractic services coverage suspended for FY 93
Oct. 1, 1992	Effective date of the end of the Alaska Longevity Bonus Medicaid Hold Harmless Program, which provide state-only funds to continue Medicaid benefits to persons who lost eligibility because longevity bonus payments placed them over the Medicaid income qualifying standard. The Division used a special new provision in the Social Security Act to disregard longevity bonus payments as income. This change had no negative effect on elderly recipients, but it saved about $1,000,000 per year.
Nov. 28, 1992	Chiropractic services reinstated, when the Department found that the FY 93 total Medicaid appropriation was sufficient to reinstate this service.
Dec. 31, 1992	Effective date of HB 545, adding rehabilitative services for mental illness, alcoholism, and drug abuse to Medicaid. This addition allows grantees to claim federal Medicaid matching funds for services previously funded by state funds.
Dec. 31, 1992	Effective date of regulations adding podiatry, nutrition, private duty nursing, hospice care, and certain advanced nurse practitioner services to Medicaid , for children under 21.
Jan. 1, 1993	Prospective Drug Utilization Review (DUR) is implemented, as required by OBRA 90, to promote the safe use of prescription drugs by screening for adverse reaction before prescriptions are filled, establishing record keeping standards for pharmacies, and providing educational interventions.
Mar 1, 1993	Contract with Opticraft to provide all eyeglasses goes into effect in response to legislative budget reduction for eyeglass contract.

July 1, 1993	HB 178, adding children in subsidized adoptions and the TEFRA option to the Medicaid program becomes effective; the TEFRA option grants eligibility to disabled children age 18 and younger who need an institutional level of care, and would be Medicaid eligible in an institution, to attain Medicaid eligibility living in the community). SB 91, adding Direct Entry Midwives to the Medicaid Program becomes effective.
Dec. 19, 1993	Home and Community Based Waiver regulations become effective.
Dec. 28, 1993	State Plan Amendment adding TEFRA option becomes effective.
Jan. 1, 1994	HB 171, adding Hospice services to the Medicaid Program, becomes effective.
Feb. 1994	Claim Check, a claims processing software that evaluates billed procedures to determine any inappropriate billing of services. This software has been a significant cost avoidance mechanism for Medicaid.
Feb. 23, 1994	Substance Abuse Rehabilitation regulations become effective.
March 13, 1994	Cost containment regulations become effective, limiting payment for surgical assistants and transportation, the use of growth hormones and the number of annual chiropractic visits.
May 11, 1994	Disproportionate Share Hospital regulations are effective that significantly increase funding available for API.
July 3, 1994	Drug Use Review (DUR) regulations become effective.
Sept. 1, 1994	Regulations to eliminate chiropractic, dental, speech therapy, audiology, hearing aids, visual refraction, eyeglasses, and occupational therapy for adult recipients because of a budget reduction tied to the priority list in AS 47.07.035 are effective.

Sept. 7, 1994	SB 366 (CH 102, SLA 94) becomes effective implementing Medicaid Trust, estate recovery and child support enforcement amendments required by OBRA 93, and an additional requirement for recipient cost sharing.
Oct. 15, 1994	Regulations implementing recipient cost sharing for inpatient hospital, outpatient hospital, physician services and prescription drugs become effective.
Oct. 15, 1994	Emergency regulations delaying the implementation of recipient cost sharing for prescription drugs until January 1, 1995 become effective.
Dec. 31, 1994	Mental Health rehabilitation regulations become effective.
Jan. 1, 1995	Recipient cost sharing for prescription drugs becomes effective.
Jun 1, 1995	Point-of-sale processing for Pharmacy claims begins.
Sep 28, 1995	Effective date of Federally Qualified Health Center (FQHC) services; a federally mandatory service.
June 1996	Alaska Legislature passes Welfare Reform.
June 20, 1996	HB 393 (CH. 83 SLA 96) passes the Legislature, directing the division to implement at least two managed care pilot projects by June 30, 1997.
Aug. 1996	Congress passes Welfare Reform.
Aug. 7, 1996	Maximum cap on nursing facility payment rates repealed after litigation.
Oct. 1, 1996	The division implements school administration of the Medicaid State Plan through school-based claims implemented through time studies.

Dec. 27, 1996	Major revisions to hospital and nursing facility prospective payment system to re-base system and clarify processes.
Feb. 1, 1997	The Division implements the Resource Based Relative Value Scale (RBRVS) payment methodology for physicians and other providers who bill the division using physician procedure codes.
May 1, 1997	Adults with Physical Disabilities home and community based waiver administration moves from the Division of Mental Health and Developmental Disabilities to the Division of Senior Services.
May 1997	The division implements a Telephone Triage System in Fairbanks, Mat-Su and Kenai to assist Medicaid recipients in accessing medical care through a 24 hour, seven day a week nursing advice by phone. This is one of the managed care pilot projects.
June 1997	The division implements a voluntary care coordination program to manage the care of recipients with medically complex conditions. This program is contracted to the Professional Review Organization, West with nurse managers on-site in Anchorage. This is one of the case management pilot projects. The division implements a Memorandum of Agreement with the Yukon Kuskokwim Health Corporation in Western Alaska as a continuing care provider for children eligible for EPSDT. Under the MOA, the corporation took over the administrative requirements for EPSDT of outreach, informing parents and tracking the care of children, assistance with making appointments and transportation arrangements. This is also a managed care pilot project.
July 1, 1997	Welfare Reform is implemented, separating the link between AFDC cash assistance and Medicaid. Medicaid is required to use AFDC financial standards for families applying for Medicaid coverage.

Sept. 1997	The division contracts with First Mental Health to manage prior authorization of inpatient mental health services in response to FFY98 intent language.
Oct. 1, 1997	Alaska's Federal Medical Assistance Percentage (FMAP) is increased for three years to 59.8% through efforts of the Congressional delegation.
Oct. 15, 1997	The division restores emergency dental, speech therapy, occupational therapy, hearing services and vision services for adult Medicaid recipients in response to FY98 intent language.
Oct. 27, 1997	In response to budget intent language in the FY98 budget to initiate provider audits, the division enters into a contract with Deloitte and Touche to conduct audits of Medicaid providers.
Nov. 13, 1997	The division extends the TEFRA option for disabled children to seriously emotionally disturbed (SED) children under age 18.
Nov 29, 1997	Maternity LOS changed to 48 hours/96 hours
May 31, 1998	Federally mandated statewide limit on disproportionate share payments is effective.
June 22, 1998	HB 353 (CH 119, SLA 119), adopting a number of documents used in the administration of the Medicaid Program, by reference. This allows the division to adopt items, such as medical billing codes, without annually adopting regulations for changes and amendments to these standards.
June 25, 1998	HB 459 (CH 130, SLA 98) goes into effect, adding the new working disabled Medicaid option and coverage of direct entry midwives by moving them down the options list in AS 47.07.035.

July 1, 1998	HB 369 (CH 140 SLA 98), expanding Medicaid coverage for children and pregnant women with incomes up to 200% of the federal poverty level, and establishing continuous eligibility for children, goes into effect. The division implements detailed claims submission with the tribal health care providers in Alaska.
Jan. 1, 1999	The division implements six month continuous eligibility for children.
Feb. 12, 1999	Regulations adding coverage of direct entry midwife services go into effect.
March 1, 1999	Denali KidCare goes into effect, offering coverage of children and pregnant women with incomes up to 200% of the federal poverty level. Implementation includes a new streamlined application process, separate eligibility office, outreach component (required under federal law), and a new name denoting both Medicaid and SCHIP.
April 1, 1999	Regulations go into effect to implement the working disabled option, which allows disabled persons to earn up to 250% of the federal poverty level and still receive Medicaid; this group pays a premium for Medicaid coverage based on income.
Feb. 2000	The division initiates intergovernmental "Pro-Share" payments with public hospitals in Alaska under emergency regulations in response to legislative intent language under discussion in the budget process.
April 1, 2000	Regulations improving access to therapeutic mental health services for children go into effect.
Sept. 30, 2000	Federally mandated statewide limit on disproportionate share payments to institutions for mental disease.

Oct. 1, 2000	Mental health regulations, improving accountability for mental health services, go into effect.
Dec. 27, 2000	Congress passes the budget bill for FFY 01, which requires a reduction in the intergovernmental transfer program, and alters the Alaska FMAP formula with a 5% incremental factor.
Jan. 1, 2001	A new hospital and nursing facility rate system, that determines a daily inpatient rate, goes into effect.

Summary: Health Insurance Status of Alaskans

Estimates of sources of private health insurance coverage and for all Alaskans and Alaskans with no health insurance (uninsured), (1997–99), and actual counts of Medicaid Recipients (FY'99) and Medicare Beneficiaries (1999) (in thousands).

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Summary: The number of Alaskans with private health insurance was estimated at 402,000. Of those with employment-based coverage, the number of Alaskans with coverage in their own name (the employee) was 175,000 while 187,000 had coverage as a dependent. An estimated 41,000 had individually-purchased private coverage. The total number of uninsured Alaskans was 116,000. The actual count of Alaskans with Medicaid coverage was 94,509 in FY'99. The actual count of Alaskans Medicare beneficiaries 39,000 in 1999.

Notes:

Warning: Readers should keep in mind that some Alaskans have multiple sources of coverage so that some of the categories of insurance/coverage in the table are not mutually exclusive. For example, roughly half of all Alaskan seniors eligible for the Medicare program also have some private supplemental health insurance plan.

**These estimates were generated from a three-year merged sample (1997, 1998, and 1999) of the most recently available March Current Population Survey data.*

***These are actual administrative counts of the Alaskans with Medicaid coverage in FY'99 and Medicare beneficiaries in 1999.*

For more information, contact Jay Livey at 465-3030.

Introduction

Estimates of the sources of health insurance/coverage of Americans are compiled by the Bureau of the Census through the March Current Population Survey (CPS). The survey covers a representative sample of about 60,000 households including around 150,000 people. While the CPS was originally designed for national analyses of the population, it is increasingly used for state-level analysis. In states such as Alaska, where a relatively small number of households are surveyed, the reliability of the state-level estimates can be improved by merging three years of CPS data and thereby, increasing the sample size. While nearly all states rely on the March CPS for estimates of the uninsured, the data have significant limitations. For example, when respondents answer the questions accurately, the CPS captures any type of coverage held for even part of a year, but only capture as uninsured those who were without insurance for the entire year. Further, it appears that respondents answer the insurance questions with respect to a point in time rather than in reference to the entire year. In addition, Medicaid coverage is likely underreported.

This paper contains estimates of the health care coverage status of Alaskans as generated from a three-year merged sample (1997, 1998, and 1999) of the most recently available March CPS data. Estimates of the population have been rounded to the nearest thousand; percentages are based on the actual estimates and have been rounded to the whole number.

Estimates

Table A presents estimates of the sources of private health insurance coverage for all Alaskans.

Table A. Estimates of sources of private health insurance coverage and for all Alaskans and Alaskans with No health insurance (uninsured), 1997–99 (in thousands).

Sources of Private Health Insurance Coverage	1997-1999	
	Total	%
Total Population	619	100%
Total Private	402	65%
Employment-based	361	58%
Own name	175	28%
Dependent	187	30%
Individually Purchased	41	7%
Total Uninsured	116	19%

The number of Alaskans with private health insurance was estimated at 402,000. Of those with employment-based coverage, the number of Alaskans with coverage in their own name (the employee) was 175,000 while 187,000 had coverage as a dependent. An estimated 41,000 had individually-purchased private coverage. The total number of uninsured Alaskans was 116,000.

Experts on the CPS have observed that the CPS estimates of persons with Medicaid coverage have historically been lower than administrative data on Medicaid eligibles. The actual count of Alaskans with Medicaid coverage was 94,509 in FY'99. The actual count of Alaskans Medicare beneficiaries 39,000 in 1999.[1]

Table B presents estimates of the number of uninsured Alaskans by poverty status including Alaskans in families with incomes below 200 percent of the Federal Poverty Level (FPL) and Alaskans in families with incomes of 200 percent and above of the Federal Poverty Level as generated from the CPS sample.

Table B. Estimates of all uninsured Alaskans by poverty status, 1997–99 (in thousands).

Estimates of uninsured Alaskans	1997-1999	
	Total	%
Total uninsured population	116	100%
Total low-income uninsured population (under 200 % FPL)	54	46%
Total uninsured population with incomes 200% FPL and above	62	54%

More than 50 percent of all uninsured Alaskans are in families with incomes above 200 percent of the FPL.

Table C presents estimates of the number of Alaskan children 0 – 18 years of age and children with no health insurance as generated from the CPS sample.

Table C. Estimates of all uninsured Alaskan children, 1997–99 (in thousands).

Estimates of Alaskan children	1997-1999	
	Total	%
Total population (0-18 years)	218	100%
Total number of uninsured children	33	15%

Fifteen percent of Alaskan children are uninsured.

Table D presents estimates of the number of uninsured Alaskan children by poverty status including Alaskan children in families with incomes below 200 percent of the FPL and Alaskan

[1] American Association of Retired Persons Public Policy Institute. Reforming the Health Care System: State Profiles (for 1999). Washington, D.C.

children in families with incomes of 200 percent and above of the FPL as generated from the CPS sample.

Table D. Estimates of all uninsured Alaskan children by poverty status, 1997–99 (in thousands).

Estimates of uninsured Alaskan children	1997-1999	
	Total	%
Total uninsured children (0 –18 years)	33	100%
Total low-income uninsured children (under 200% FPL)	19	57%
Total uninsured children in families with incomes 200% of FPL and above	14	43%

Note: The small differences between these estimates and those available on the U.S. Census Bureau's web site are due to minor differences in the methodologies used to calculate the estimates.

Fifty-seven percent of all uninsured Alaskan children were in families with incomes below 200 percent of the FPL.

Table E presents estimates of the number of uninsured Alaskan adults 19 years and older and adults with no health insurance as generated from the CPS sample.

Table E.. Estimates of all uninsured adults, 1997–99 (in thousands).

Estimates of uninsured Alaskan adults	1997-1999	
	Total	%
Total adult population (19 years and older)	401	100%
Total uninsured adults	83	21%

Twenty-one percent of all Alaskan adults are uninsured.

Table F presents estimates of the number of uninsured Alaskan adults by poverty status including Alaskan adults in families with incomes below 200 percent of the Federal Poverty Level and Alaskan adults in families with incomes of 200 percent and above of the Federal Poverty Level as generated from the CPS sample.

Table F. Estimates of all uninsured adults by poverty status, 1997-99 (in thousands).

Estimates of uninsured Alaskan adults	1997-1999	
	Total	%
Total uninsured adults	83	100%
Total low-income adults (under 200% FPL)	35	42%
Total uninsured adults with incomes 200% FPL & above	48	58%

Fifty-eight percent of all uninsured Alaskan adults are in families with incomes above 200 percent of the FPL.

Table G presents estimates of the total number of uninsured Alaskans by the work status of the family head workers as generated from the CPS sample.

Table G. Estimates of all uninsured Alaskans by work status of the family head, 1997–99 (in thousands).

Estimates of uninsured by work status of family head	1997-1999	
	Total	%
Total uninsured population	116	100%
Full-time, full-year uninsured worker	63	54%
Part-time, full-year worker	10	8%
Full-year, some unemployment	20	17%
Part-year worker	12	11%
Nonworker	11	10%

Over half of all uninsured Alaskans are in families where the family head worked full time for the entire year. Only 10 percent of uninsured Alaskans were in families where the family head was unemployed.

Table H presents estimates of all Alaskans by work status of the family head, uninsured Alaskans by work status of the family head, and the percentage uninsured of Alaskans by work status of the family head as generated the CPS sample.

Table H. Estimates of the total number of Alaskans by work status of family head, total uninsured Alaskans by work status of family head, and the percentage of uninsured Alaskans by work status of the family head, 1997-99 (in thousands).

Total AKs, total and % uninsured by work status of family head	1997-1999		
	Total Aks by work status of family head	Total uninsured Aks by work status of family head	Percent un-insured
Total Population	619	116	19%
Full Time, Full Year	439	63	14%
Part Time, Full Year	31	10	31%
Full Year, SomeUn-employment	51	20	39%
Part Year Worker	42	12	29%
Nonworker	55	11	20%

Approximately 14 percent of Alaskans in families where the family head works full-time all year were uninsured. Over 30 percent of Alaskans in families where family head worked part-time for the entire year were uninsured, although this group included only 10,000 of the 116,000 uninsured Alaskans. Alaskans in families where the family head worked seasonally, either full-time for part of the year or part-time for part of the year, represented 32,000 uninsured Alaskans or 28 percent of all uninsured Alaskans.

Table I presents estimates uninsured Alaskan workers as generated from the CPS sample.

Table I. Estimates of uninsured Alaskan workers, ages 19–64, 1997 –99 (in thousands).

Estimates of uninsured Alaskan workers	1997-1999	
	Total	%
Total workers	325	100%
Uninsured workers	70	21%

Twenty-one percent of Alaskan workers were uninsured.

Table J presents estimates uninsured Alaskan workers by industry sector as generated from the CPS sample.

Table J. Estimates of uninsured Alaskan workers by industry sectors, ages 19-64 1997-99 (in thousands)

Estimates of uninsured Alaskan workers by industry sector	1997-1999	
	Total	%
Total uninsured workers	70	100%
Self-employed	12	18%
Retail/wholesale	16	23%
Services (including FIRE)	16	23%
Government	11	16%
All others	15	22%

Uninsured workers were in all industries. Twenty-three percent of the uninsured workers in Alaska were in the Services (including the Finance, Insurance, and Real Estate or the so-called FIRE) sector. The Retail/Wholesale sector also had 23 percent of the state's uninsured workers.

Table K presents estimates of the total workers, the total uninsured workers, and the percentage of uninsured workers by industry sector as generated from CPS sample.

Table K. Estimates of the Alaskan workers and uninsured workers by industry sector, and the percentage of uninsured workers in each industry sector, Ages 19–64,1997–99 (in thousands).

Total workers, total and % uninsured workers by sector	1997-1999		
	Total workers	Total uninsured workers	Percent uninsured
All sectors	325	70	21%
Self-employed	43	12	28%
Retail/ Wholesale	53	16	30%
Services & FIRE	80	16	20%
Government	80	11	14%
All others	68	15	22%

Twenty-eight percent of all Self-Employed and 30 percent of all Retail/Wholewhole sector workers were uninsured.

Table L presents estimates of the number of uninsured Alaskan Workers by public sector, self-employed sector, and firm size as generated from the CPS sample.

Table L. Estimates of uninsured Alaskan workers by public sector, self-employed sector, and firm size, Ages 18–64, 1997-99 (in thousands).

Estimates of uninsured workers by public sector, self-employed, and firm	1997-1999	
	Total	%
Total Uninsured Workers	70	100%
Public sector	11	16%
Self-employed	12	18%
Under 10 workers	15	22%
10 to 24 workers	9	13%
25 to 99 workers	6	9%
100 to 999 workers	7	10%
1,000 workers and over	10	14%

Twenty-two percent of uninsured Alaskan workers were employed in the smallest businesses (under 10 workers).

Table M presents estimates of the number of total workers, uninsured workers, and percentage of uninsured workers by public sector, self-employed sector, and firm size as generated from the CPS sample.

Table M. Estimates of total workers, uninsured workers, and percentage of uninsured workers by public sector, private sector, and firm size, Ages 18-64, 1997-99 (in thousands).

Estimates of total workers, uninsured workers, and percent of uninsured	1997-1999		
	Total workers	Total Uninsured workers	Percent uninsured of total workers
All workers	325	70	21%
Public sector	80	11	14%
Self-employed	43	12	28%
Under 10 workers	43	15	36%
10 to 24 workers	30	9	29%
25 to 99 workers	31	6	20%
100 to 999 workers	36	7	19%
1,000 workers +	60	10	16%

Thirty-six percent of Alaskans that worked in the smallest businesses (under 10 workers) were uninsured and 29 percent of Alaskans that worked in slightly larger businesses (10 to 24 workers) were uninsured.