

**HB**

**107**

# ALASKA STATE LEGISLATURE

*Vice Chair:*

Joint Armed Services Committee

*Member:*

Military and Veterans Affairs Committee

Labor and Commerce Committee

State Affairs Committee

Economic Development, Trade, &

Tourism Committee



*Session:*

Alaska State Capitol

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## REPRESENTATIVE NANCY DAHLSTROM

ELMENDORF AFB • FORT RICHARDSON • WIRCHWOOD • FIRE LAKE • GOVERNMENT HILL • MULDOON

Representative\_Nancy\_Dahlstrom@legis.state.ak.us

To: Representative Peggy Wilson, Chairman, House Health, Education and Social Services

From: Representative Dahlstrom *ND*

Date: February 19, 2003

Re: House Bill 107

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Please schedule House Bill 107 "An Act relating to an optional group of persons eligible for medical assistance who require treatment for breast or cervical cancer; relating to cost sharing by those recipients under the medical assistance program; and providing for an effective date" for a hearing in House Health, Education and Social Services Committee as soon as possible.

Included with the request is:

- 1) Sponsor Substitute for HB 107
- 2) Sponsor Statement
- 3) Alaska State Statutes 47.07.020 and 47.07.042
- 4) Background information

Thank you for your consideration.

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### Sponsor Statement

#### HB 107

**An Act relating to optional group of persons eligible for medical assistance who require treatment for breast or cervical cancer; relating to cost sharing by those recipients under the medical assistance program; and providing for an effective date.**

In 1990, Congress passed the Breast and Cervical Cancer Mortality Prevention Act, which authorized the Centers for Disease Control and Prevention to provide screening services through the National Breast and Cervical Cancer Early Detection Program for low-income women nationwide.

While the federal program was enacted with the intention of reducing breast and cervical cancer mortality, it lacked a critical aspect – funding of the treatment for women diagnosed with breast or cervical cancer. As a result, many women found themselves without means to pay for their treatment.

In October 2000 Congress, with strong bipartisan support, enacted the Breast & Cervical Cancer Treatment Act that completed the “screen-diagnose-treatment” loop. This federal legislation allowed individual states to extend Medicaid coverage for treatment to women diagnosed with cancer through the federally funded screening programs. In response to this federal action, the Alaska State Legislature passed legislation in May 2001. This legislation extended Medicaid coverage to women diagnosed with cancer by one of the five federally funded screening programs operating in Alaska. That legislation included a two-year sunset clause that will terminate medical treatment for all women in June 30, 2003.

HB 107 will remove the sunset provision and ensure treatment will continue for women diagnosed with breast or cervical cancer under the 2001 legislation. This program covered 44 women in 2002. The federal government picked up 70% of the bill; leaving only 30% or \$175,835 as the states' share. For many of the women these benefits meant the difference between life and death.

I would point out that we are not singling out a particular group with HB 107; we are taking advantage of federal funding options for healthcare coverage. While AS 47.07.042 outlines recipient cost-sharing, this bill also clearly defines the sliding scale options that are identical to the provisions put in to statute by the Denali KidCare program that was overwhelmingly passed by the legislature in 1998.

The number of women affected by this legislation is small; our ability to assist is immense. Together we can ensure that women in Alaska receive the care and coverage they need.

I urge your support of HB 107.



Sec. 47.07.020. Eligible persons.

(a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the Aid to Families with Dependent Children program;

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 - 25.23.220;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them;

(12) disabled persons, as described in 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under applicable federal regulations or guidelines, is less than 250 percent of the official poverty line applicable to a family of that size according to the federal Office of Management and Budget, and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is not eligible under another provision of this section shall pay a premium or other cost-sharing charges according to a sliding fee scale that is based on income as established by the department in regulations;

(13) persons under age 19 who are not covered under (a) of this section and whose household income does not exceed 200 percent of the federal poverty guideline as defined by the federal office of management and budget and revised under 42 U.S.C. 9902(2);

(14) pregnant women who are not covered under (a) of this section and whose household income does not exceed 200 percent of the federal poverty line as defined by the federal office of management and budget and revised under 42 U.S.C. 9902(2).

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) Additional groups may not be added unless approved by the legislature.

(e) Notwithstanding (b)(4) of this section, a person is not eligible for Medicaid benefits until a final determination is made on the eligibility of that person for benefits under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act).

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

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

(2) otherwise meets the requirements of 42 U.S.C. 1396p(d)(4).

(g) A person's eligibility for medical assistance under this chapter may not be denied or delayed on the basis of a transfer of assets for less than fair market value if the person establishes to the satisfaction of the department that the denial or delay would work an undue hardship on the person as determined on the basis of criteria in applicable federal regulations.

(h) A person who meets the eligibility requirements of (a) or (b) of this section, except that the person is a qualified alien as defined in 8 U.S.C. 1641, is eligible for medical assistance unless the person is not eligible under the limited eligibility provision of 8 U.S.C. 1613.

(i) The department may allow a person under 19 years of age who is determined to be eligible for benefits under this chapter to remain eligible for those benefits for up to 11 calendar months following the month that the person is determined eligible for benefits or until the person is 19 years old, whichever occurs earlier.

Sec. 47.07.042. Recipient cost-sharing.

(a) Except as provided in (b) - (d) of this section, the state plan developed under AS 47.07.040 shall impose deductible, coinsurance, and copayment requirements on persons eligible for assistance under this chapter to the maximum extent allowed under federal law and regulations. The plan must provide that health care providers shall collect the allowable charge. The department shall reduce payments to each provider by the amount of the allowable charge. A provider may not deny services because a recipient is unable to share costs, but an inability to share costs imposed under this section does not relieve the recipient of liability for the costs.

(b) The state plan developed under AS 47.07.040 shall impose a copayment requirement for inpatient hospital services in an amount that is the lesser of

- (1) \$50 a day, up to a maximum of \$200 per discharge; or
- (2) the maximum allowed under federal law and regulations.

(c) If the department has clear and compelling reason to believe that application of the maximum allowable charges under (a) of this section to a specific service would not reduce state expenditures or would generate savings to the state that are insignificant in relation to the total cost containment possible, then the department may waive the charges otherwise required under (a) of this section as to that specific service.

(d) In addition to the requirements established under (a) and (b) of this section, the department may require premiums or cost-sharing contributions from recipients who are eligible for benefits under AS 47.07.020(b)(13) and whose household income is between 150 and 200 percent of the federal poverty guideline. If the department requires premiums or cost-sharing contributions under this subsection, the department

- (1) shall adopt in regulation a sliding scale for those premiums or contributions based on household income;
- (2) may not exceed the maximums allowed under federal law; and
- (3) shall implement a system by which the department or its designee collects those premiums or contributions.

## Breast/Cervical Cancer Medicaid Eligibility Fact Sheet

### Background

Since 1990, the Center for Disease Control and Prevention (CDC) has conducted the National Breast and Cervical Cancer Early Detection Program, which provides funding for breast and cervical cancer screening in all 50 states. During the years that followed, it was discovered that many women who had been diagnosed with cancer could not afford treatment and could not purchase health insurance once the cancer had been diagnosed. To encourage more women to seek treatment following the diagnosis, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act of 2000, which gave states the authority to provide Medicaid coverage to women who were shown to need treatment as the result of the CDC screening program. In 2001, the Alaska Legislature established this new Medicaid eligibility category beginning July 1, 2001.

### Basic Eligibility

To be eligible for this Medicaid category, a woman must:

1. be age 18 to 64;
2. have been screened under the CDC National Breast and Cervical Cancer Early Detection program and determined to need treatment for breast or cervical cancer; and
3. have no health insurance coverage for breast or cervical cancer treatment.

Although men also suffer from breast cancer, they are not included in the CDC screening program and, therefore, are not eligible for this Medicaid category.

### What Coverage is Available?

Under this eligibility category, women remain eligible as long as they are undergoing treatment for breast, cervical, or a directly related cancer. When a woman's treating health care provider determines that her course of treatment has ended, her Medicaid eligibility under this category ends. While eligible, all Medicaid covered services are available, not just cancer-related services.

### How Do Women Get Screened?

The Division of Public Health (DPH) operates the Breast and Cervical Health Check (BCHC) program to screen individuals. This program uses 25 different health care providers in 15 communities throughout the state. There are also three tribal grantees who provide screening services: Southcentral Foundation; Southeast Regional Health Corporation; and Arctic Slope Regional Health Corporation. The Division of Public Health determines eligibility based upon three factors: 1) age (18-64); 2) insurance status (uninsured or have insurance that does not cover preventative screening services); and income (must be below 250% of the Federal Poverty Guideline for Alaska). Here are the monthly income limits for 2002:

Family Size	1	2	3	4	5	6	7	Each Add'l
250% FPG	\$2,309	\$3,111	\$3,913	\$4,715	\$5,517	\$6,319	\$7,121	\$803

### MEDICAID COST SHARING

In 1994, Medicaid put regulations in place to require the following cost sharing for services:

- \$50 per day for inpatient hospital services to a maximum of \$200 (this limit is in statute, we are actually allowed to charge 50% of the cost of the first day of admission);
- 5% of the payment made for outpatient hospital services;
- \$3 for a physician visit; and
- \$2 for each prescribed drug.

Under federal rules, cost sharing is prohibited for:

- Services for pregnant women
- Services for children age 18 and younger
- Services for institutionalized persons (they are already required to pay any income except the personal needs allowance toward their cost of care; this includes HCB waiver clients)
- Family planning services
- Persons receiving hospice care
- Dual Medicare-Medicaid eligible persons

We also exempt American Indians and Alaska Natives receiving care at a tribal facility since they cannot charge their beneficiaries for these services under federal law.



**ALASKA'S**  
**MEDICAL ASSISTANCE PROGRAMS**  
Medicaid ♦ Denali KidCare ♦ CAMA



*Providing health coverage for Alaskans in need.*

*July 2000*

July 2000

Dear Reader,

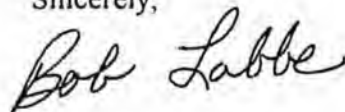
As Director of the Division of Medical Assistance, I am pleased to provide you with this booklet of information regarding health care programs for Alaskans in need.

The purpose of this booklet is to help you understand available programs and, if you are eligible, how to use the coverage effectively. If you have questions regarding any aspect of the programs, please call the Division of Medical Assistance Hotline, toll free at 1(800)211-7470 (statewide); if you live in the Anchorage area, you may call 562-3671.

It is important to understand that this is only a guide and is not intended to determine eligibility. Each person's situation is different and there are many factors which must be taken into consideration. Final determination of eligibility will be made by the Division of Public Assistance (please see the back page of this booklet for the nearest office).

Our programs help you take responsibility for your own health by paying for a wide variety of services. To get the most benefit, you should follow the guidelines, use the services wisely, and most importantly, lead a healthy lifestyle. By doing these, you will help to maintain the integrity of Alaska's medical assistance programs.

Sincerely,



Bob Labbe, Director  
Division of Medical Assistance

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The information in this booklet gives you an overview of Alaska's medical assistance programs and serves as a guideline to help you determine if you should apply. If you do qualify for a program, please keep this booklet for reference purposes and to help answer any questions you may have. The actual determination of your eligibility will be made by the Division of Public Assistance.



This booklet is published by the State of Alaska, Department of Health and Social Services, Division of Medical Assistance.

# Medicaid

## WHAT IS MEDICAID?

Medicaid is like health insurance but it is available only to certain low income individuals and families who fit into an eligibility category recognized by federal and state law. Medicaid does not pay money to you, instead, it sends payments directly to your health care providers.

**Medicaid** is often confused with **Medicare**. The basic difference is that eligibility for Medicaid is based on financial need. Medicare is not based on financial need but is available to almost anyone who has been determined disabled by the Social Security Administration or who is age 65 or older. For more information on Medicare, please call the Alaska Medicare Helpline toll free at 1-800-478-6065.

## WHO IS ELIGIBLE FOR MEDICAID?

To be eligible for Medicaid you must fit into an eligibility category. Generally, the categories of eligibility are children, pregnant women, families with dependent children, disabled adults, or persons age 65 or older. This leaves out many people, such as single adults who are not disabled and who do not have children at home. These people cannot qualify for Medicaid even if they are low income and have large medical bills.

You must be financially eligible for the Medicaid program. The rules for counting your income and assets vary from category to category and can get rather complex. Your caseworker will evaluate your financial eligibility for you. There are special rules for those who live in nursing homes and for disabled children living at home.

If you have been denied eligibility for a medical assistance program offered by the state Division of Medical Assistance you may request a hearing to appeal this denial. Please contact the Division of Public

Assistance (DPA) caseworker who evaluated your application for information on how to request a hearing.

## HOW DO I APPLY FOR MEDICAID?

You can pick up an application at your local DPA office or its representative in your community, called a "fee agent." Some hospitals and doctors' offices also have applications available. The completed application must be submitted to the nearest Division of Public Assistance office or fee agent. Arrangements will be made for an interview, if necessary. Both the application and interview are confidential.



Using eligibility rules established by the federal government and the state Division of Medical Assistance, a DPA caseworker will determine whether you and/or your family are eligible for coverage. For some eligibility categories other state agencies and medical organizations will also review your application. Your caseworker will be looking at many things when determining your eligibility, including:

- income
- what kind of personal assets you have (such as bank accounts, vehicles, and property)
- citizenship or alien status
- Alaska residency
- age of everyone in the household
- special health care needs

As the caseworker reviews your application, you may be asked to provide more information. If you qualify for Medicaid coverage you will be notified by mail and sent a Medicaid Recipient Card. If you do not qualify you will be notified by mail explaining why. You may apply again for Medicaid at any time.

### HOW COULD I LOSE MY ELIGIBILITY?

It is possible for a person to lose his/her Medicaid eligibility for a variety of reasons. Here are some of the common ones:

- ◆ you lose your status as a resident of Alaska
- ◆ your income or assets increase
- ◆ your household composition changes
- ◆ you lose your disability status
- ◆ you fail to cooperate with the Child Support Enforcement Division (CSED) when required
- ◆ you do not provide your caseworker with your current or a forwarding address
- ◆ your age makes you ineligible for certain Medicaid categories

If you are unsure about your eligibility or what may cause you to become ineligible, contact your caseworker.

### WHAT IF I HAVE MEDICAL INSURANCE OR HEALTH COVERAGE?

Generally, Medicaid is the "payer of last resort." This means that if you have other health insurance or belong to other programs that can pay a portion of your medical bills, payment will be collected from them first. Medicaid may then pay all or part of the amount that is left. When a person is covered under the Indian Health Service (IHS), the IHS is the payer of last resort.

**This is very important:** When you apply for Medicaid, you **MUST** indicate if you have any other type of health care insurance or benefits. If you fail to tell your caseworker about your other health care coverage, you may be responsible for part of your medical bill. Your Division of Public Assistance caseworker can help you determine if you have any other type of health care coverage.

Other sources of health coverage include, but are not limited to:

- Private health insurance
- Veterans Administration (VA) benefits
- Medicare
- TRICARE (CHAMPUS)

- medical support from absent parents
- court judgments or liability settlements for accidents or injuries
- workers' compensation
- long-term care insurance
- Fisherman's Fund (for commercial fishermen in Alaska)

### WILL I HAVE TO PAY ANYTHING FOR SERVICES?

You may be required to share the cost for some services that you receive. Your "co-pay" amounts may include:

- ◆ \$50.00 a day up to a maximum of \$200.00 for inpatient hospital services
- ◆ \$3.00 for each visit to a doctor or clinic
- ◆ 5% of the allowed amount for outpatient hospital services
- ◆ \$2.00 for each prescription drug that is filled or refilled

You pay the co-payment amount directly to your health care provider when you receive services. If you cannot pay at that time you will still receive services. Your provider will bill you for the co-pay amount.

Children under 18, pregnant women, and people in nursing homes are not required to share in the cost of services. Certain services such as family planning services and supplies, emergency services, and hospice care do not require a co-pay payment. If you are pregnant, notify the Division of Public Assistance office right away. They can have your coupons changed to show that you are pregnant so that you will not have to pay the co-pay amount.

### HOW DOES MEDICAID WORK?

For each month you are eligible for Medicaid, you will receive a Medicaid Recipient Card. On this card are small peel-off stickers (sometimes called "coupons"). You must show your recipient card to your doctor or other health care provider each time you receive medical treatment. The health care provider may remove one of the small stickers with your number on it, photo copy your card, or just write down your Medicaid number on the bill. Your provider will send the bill directly to Medicaid for payment. For some services,

Medicaid may require you to share the cost. You should not pay your provider for the full cost of services you receive because Medicaid cannot pay you back.

### SHOWING UP FOR APPOINTMENTS

It is very important to show up to your appointment several minutes before it is scheduled. If you are unable to make it to your health care provider's office on time, you need to call as soon as you can (at least 24 hours beforehand) and let them know that you are not going to be able to keep your appointment. Your provider has put aside time for you in order to treat you.

#### APPOINTMENTS

Please be courteous to your provider and either show up several minutes before your scheduled appointment or give at least a full day's notice if you must cancel.

### WHEN YOU USE MEDICAID, YOU SHOULD:

- tell the Division of Public Assistance and your provider if you have any other type of health care coverage
- make sure your health care provider will accept Medicaid as a health coverage program
- make sure the service you receive is covered by Medicaid
- show your health care provider your current Medicaid Recipient Card each time you receive medical treatment
- report to your caseworker any change in your income, assets, place of residence, if anyone has moved into or out of your home, or anything else that could affect your eligibility for Medicaid coverage
- pay co-pay amounts for some Medicaid services and drugs
- pay for your medical care if you get services from someone who is not approved by Medicaid, or services that are not covered by Medicaid
- talk to your health care provider about any problems you have with your medical bills

If you knowingly break Medicaid rules, or are untruthful about any aspect of your application, you could lose all your Medicaid coverage.

### WHAT IS "PRIOR AUTHORIZATION?"

Some services covered under Medicaid must be "prior authorized." This means that you must receive approval from Medicaid before using a service. Your health care provider is responsible for requesting prior authorization for services he/she will perform. Transportation must also be prior authorized. It is the provider's responsibility to get authorization for the travel and to give vouchers to the person traveling. It is the beneficiary's responsibility to make all travel arrangements. The appointment to which the beneficiary is traveling must be with an Alaska Medicaid provider at a specific time and date.



For more information regarding travel, please see "Traveling on Medicaid and How it Works" on page 17.

### YOUR MEDICAID HEALTH CARE PROVIDER IS RESPONSIBLE FOR:

- ◆ accepting your stickers as your payment for covered services
- ◆ getting payment from Medicaid or your health insurance company
- ◆ accepting only the Medicaid rates for your health care; Medicaid will only pay a certain amount of money for each health care service; your provider cannot charge you or the state more money
- ◆ collecting the co-pay amount you are required to pay
- ◆ receiving prior authorization for some services

Health care providers who knowingly charge Medicaid for services that were not given, who neglect or abuse patients, or give poor quality care may be subject to legal action. If you believe this has happened, you may write the Division of Medical Assistance, 4501 Business Park Blvd., Suite 24, Anchorage, Alaska 99503-7167. You may also call the Medicaid Hotline toll free at 1-800-211-7470 (statewide) or 562-3671 (Anchorage area).

## WHAT SERVICES WILL MEDICAID PAY FOR?

Following is a brief description of the services covered by Medicaid for those eligible for the program. In addition to those listed below, children receive additional and/or expanded services (please see page 14). Some services have limits and others must be prior authorized before they are provided.

**Audiology & Treatment of Speech, Hearing and Language Disorders.** Services of a speech therapist to improve a person's ability to speak, or an audiologist to test a person's hearing. Medicaid will also pay for hearing aids, which are limited to a certain model. Batteries and repairs are covered.

**Dental.** Services are very limited for adults and include the relief of pain and infection, which usually means fillings and/or extractions. Crowns, root canals, and dentures are not included.

**Dialysis.** Services provided as treatment of kidney disease which causes kidney failure. Covered whether received in a hospital or free standing agency.

**Doctor's Services.** Doctor's services provided to you in the doctor's office or the hospital. If your doctor sends you to a consultant or specialist, Medicaid may also pay for their services.

**Emergency Services.** Immediate medical care that cannot be delayed for an office visit may be covered. If the services do not meet the definition of emergency services you will be required to pay the co-pay amount for physician services and hospital outpatient care. Ambulance services must only be used in the event of a true medical emergency. If use of an ambulance is determined not to be an emergency, Medicaid might not pay the bill and the beneficiary may be held responsible for the amount due.



**Family Planning Services and Supplies.** Family planning, medical counseling services, and the cost of birth control for men and women. Many over-the-counter birth control items such as contraceptive creams, gels, foams, and condoms, will be paid for by Medicaid if your doctor writes a prescription for them. These supplies are also available free from family planning clinics in larger towns.

**Home and Community Based Care Services.** If you need nursing care for a long time, you may be able to get that care at home through the Home and Community Based Care Services programs. These programs, also called "waivers", are for people who need a high level of care such as that provided in a nursing home. If you have questions about this program, you may contact one of the following offices:

For people with mental or developmental disabilities:

Division of Mental Health and Developmental Disabilities  
phone (907)269-3600 or toll free (800)770-3930  
for the hearing impaired, TDD (907)269-3624

For people over age 65 or for adults with physical disabilities:

Division of Senior Services  
phone (907)269-3666

**Home Health Care.** Short-term nursing care in a person's home that is ordered by a doctor may be paid by Medicaid. Home health care must be prior authorized by Medicaid before care starts.

**Hospice Care.** Special services for persons who are terminally ill can be given at home through a hospice care agency. These services must be ordered by a doctor. The patient or family must sign an agreement with the hospice to receive care at home.

**Hospital Care.** The care you receive at a hospital must be for a Medicaid approved service and some surgeries must be prior authorized. This care may be for both inpatient and outpatient care. If you must stay in the hospital (inpatient), Medicaid will pay for a semiprivate room. Payment is made for a private room only if your

doctor says you need it and it has been approved by Medicaid. Telephone calls, television, and other personal items are not paid for by Medicaid. If you must receive treatment at a hospital but do not have to stay in the hospital (outpatient), Medicaid will pay for the treatment. Your doctor must schedule this care with the hospital.

**Inpatient Psychiatric Facility Services.** Services are only for people who are under age 21, or 65 and over. Prior authorization is needed.

**Laboratory and X-ray Services.** Diagnostic tests and procedures such as laboratory tests, examinations, and X-rays when they are ordered by your doctor.

**Mammography Screening.** Breast X-rays to detect problems when ordered by your doctor.

**Medical Supplies and Equipment.** Medically necessary supplies and equipment ordered by your doctor and approved by Medicaid.

**Mental Health Services.** Psychotherapy services from a psychiatrist. Also services from a psychologist or clinical social worker when in a community mental health clinic.

**Nurse Practitioner Services.** The services of a nurse practitioner who specializes in family practice, pediatrics, or who is a nurse midwife.

**Nursing Facilities Services.** Care in a nursing home. Your doctor must get approval from Medicaid before you move into a nursing home.

**Occupational Therapy.** Covered when medically necessary to correct a physical defect.

**Personal Care Services in a Beneficiary's Home.** Personal care attendant who comes into your home to perform nonmedical tasks. These services must always be ordered by a doctor and prior authorized by Medicaid.

**Physical Therapy.** Services of a physical therapist to rehabilitate and restore body functions following an illness or accident if ordered by a doctor. Subject to limitations.

**Prenatal and Postpartum Care (for pregnancy).** Regular checkups and other services provided by a physician, clinic, nurse midwife, or direct entry midwife during pregnancy and for two months after the baby is born. Medicaid also covers hospital care for the birth.

**Prescribed Drugs.** Most prescription drugs. Some over-the-counter drugs may be paid for if they are prescribed by your doctor such as birth control, prenatal vitamins, drugs for yeast infections, laxatives, etc. Check with your doctor about drugs that will be paid for by Medicaid. Except for children and pregnant women, a \$2.00 co-payment is applicable.



**Prosthetic Devices.** Prosthetics (artificial limbs) and orthotic devices (body braces) when medically necessary for your care and ordered by a doctor.

**Speech Therapy.** Evaluations and therapy are covered. Evaluation and treatment for swallowing dysfunctions is also covered.

**Substance Abuse Rehabilitative Services.** Enrolled substance abuse treatment providers may be reimbursed (in accordance with their certification) for the following services:

- assessment services which determine the nature of the substance abuse problem
- outpatient counseling services which allow a substance abuse client to live at home while receiving outpatient services
- residential treatment during which the substance abuse client resides at a substance abuse treatment center while receiving services
- medical services, including detoxification & methadone maintenance

Substance abuse treatment is available for adults, teens, and pregnant women. Certain substance abuse treatment facilities have programs where young children may stay with their mothers at the facility while their mother receives treatment. Ref. to 7AAC 43.740

A provider of services must be certified by the Division of Alcoholism and Drug Abuse (ADA) and receive funding from ADA or the DHSS. Treatment services must be medically necessary. Travel to enrolled treatment providers must be approved by ADA (tel. 1-800-478-7677).

**Surgery.** Medically necessary surgery ordered by a physician can be covered whether performed in a hospital or a surgery center. Some surgical procedures require prior authorization.

**Transportation.** Transportation to another city to get medical care if your doctor says it is necessary. Your travel must be prior authorized and you must travel on a commercial carrier such as an airplane, ferry, taxi, etc. Medicaid may also pay for the cost of hotels, meals and taxis while you are away from home. For more information, please see "Traveling on Medicaid and How it Works" on page 17.

**Vision Services and Eyeglasses.** One vision examination per calendar year by an optometrist or an ophthalmologist to determine need for glasses and for the treatment of diseases of the eye. Medicaid will pay for one pair of Medicaid approved glasses per calendar year. Additional vision coverage may be authorized if medically necessary. Tinted lenses and contact lenses are only covered for those with certain medical conditions.

#### **ADDITIONAL SERVICES FOR CHILDREN**

In addition to services provided for adults, the following Medicaid services are available only to children and youth under the age of 21.

**Chiropractic Services.** Twelve visits per child per year. Visits for children under 6 must be approved in advance by Medicaid. Services are limited to manual manipulations of the spine to correct a

dislocation that can be verified by X-ray. Medicaid will pay for one X-ray per person per year.

**Dental Services Including Dentures.** Preventive dental care and treatment of cavities, pain and infection. Medicaid will also pay for the cost of dentures and orthodontia in extreme cases of malformation if prior authorized.

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT).** EPSDT services are available to all Medicaid eligible children under age 21. Children can get all the regular Medicaid services and the following special services:

- ◆ preventive health checkups and health screening to detect health problems or concerns
- ◆ immunizations (shots) to prevent disease
- ◆ dental checkups for children age 3 and up
- ◆ diagnosis of illness or medical problems
- ◆ treatment of any illness or medical problems
- ◆ assistance with scheduling appointments and with transportation
- ◆ follow-up with families on health checkups and treatment

Please see page 16 for more information regarding the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT).

**Nutrition Services for High Risk Children and Pregnant Women.** Services of a dietitian for high risk pregnant women, and children who have a growth problem, a chronic disease, low weight at birth, or for an adolescent girl who is pregnant or breast feeding.

**Podiatrists Services.** Services of a podiatrist (a doctor who specialize in conditions of the ankle or foot) if the child is referred by a doctor.

## **EPSDT: Taking Care of Alaska's Children**

Expanded services are available to babies, children and teens enrolled in Medicaid and Denali KidCare. The following services are covered until an individual is 21 years of age.

### **Well-child exams**

Even healthy babies, children and teens need to go to their health care provider every so often. Children go through many changes as they grow – it is important to make sure that your child is doing well.

Denali KidCare/Medicaid pays for well-child exams that should include: a head to toe physical exam; a health and developmental history; hearing and vision checks; blood tests or other tests, if needed; health education/guidance for parents; immunizations (shots), if needed; referral to a dentist starting at age 3 (or earlier, if needed), and; referral to WIC, if needed

Take your child for a well-child exam often, especially when they're small. Regular visits will help make sure that your child gets his or her shots on time. These visits also give you (and your child) a chance to ask any questions you might have about your child's health. We suggest the following schedule:

**Infants** – exams at birth, then at 2, 4, 6, 9 and 12 months

**Toddlers** – exams at 15 months, 18 months and at age 2

**Preschool/kindergarten children (ages 2 – 6)** – an exam every year

**School-aged children/teens (ages 7 – 20)** – an exam every two years

### **Dental health care**

Medicaid pays for dental health care services for children and teens. Covered services include regular dental exams, teeth cleaning, and treatment of identified oral health problems.

### **Local transportation and other assistance**

Local transportation assistance is available if you need help getting to your child's medical, health screening, treatment, or dental appointments. Help is also available if you need to find a medical or dental health care provider or need to make an appointment. For more information, call the Medicaid Services Unit.

276-0606 (in Anchorage) or 1-888-276-0606 (toll free within Alaska)

465-2845 (in Juneau) or 1-888-465-2845 (toll free within Alaska)

## **WHAT ARE SOME SERVICES WHICH MEDICAID DOES NOT COVER?**

Medicaid covers most medical services for those eligible for the program but there are some services which the program does not cover. These include, but are not limited to: dentures for adults; smoking cessation products and services; experimental procedures; infertility, obesity and baldness drugs, procedures and services; heart transplants for adults; cosmetic surgery; and educational type services. If you need to have a procedure or service but are not sure if Medicaid will cover it, please call the Medicaid Hotline toll free instate at 1-800-211-7470, or if you live in the Anchorage area, you may call 562-3671.

## **TRAVELING ON MEDICAID AND HOW IT WORKS**

When your health care provider decides that you need to go to a different community for health care they will ask Medicaid for approval. However, it is the beneficiary's responsibility to make all travel arrangements. The appointment to which the beneficiary is traveling must be with an Alaska Medicaid provider at a specific date and time. If the travel is for a child under 18, an escort's travel will also be requested.

An escort may be requested for adults traveling to or from a medical appointment. It may be necessary to have an escort due to the physical or mental limitations of the adult. Medical training is not needed

for a person to be an escort. The escort's transportation,

lodging and food will be covered,

provided that the escort is prior

authorized for the travel. The

escort is not paid by Medicaid for

his/her time during the escort. The escort's responsibility is to make sure the adult needing medical care is well taken care of and that he/she meets all appointments while traveling.

Once your trip is approved, you will be given a travel voucher. Be sure to have several copies of your travel voucher as you must give one copy of the voucher and one Medicaid sticker from your Medicaid Recipient Card to each airline, ferry, taxi, or hotel that you use. Not all airlines, hotels, or taxis will take your Medicaid coupons. Before



you travel ask your medical provider for a list of who will accept Medicaid.

On overnight trips, Medicaid will pay up to \$36.00 for food each day. You must pay any amount over that. It is highly recommended that you stay at a Medicaid approved hotel which has a restaurant so that your room and meals can be paid for at the end of your stay with your voucher and stickers. When making reservations, be sure to ask the hotel and restaurant if they will accept Medicaid as payment for services.

Medicaid will not pay for:

- your food or lodging if you stay with friends or family
- travel expenses that have already been paid by you
- travel expenses that are not approved before you travel unless it is really an emergency
- hotel and hospital expenses for the same time period (be sure to check out of your hotel before you check into the hospital)

If you are traveling for medical care outside of Alaska you may want to ask your Division of Public Assistance caseworker for extra stickers before you travel. If you are traveling at the end of the month and expect to be gone into the next month, be sure to ask for extra stickers for the next month.

### **WHERE DO I GO TO APPLY FOR MEDICAID?**

You may go to any Division of Public Assistance office listed on the back page of this booklet to apply for Medicaid. If you live in a community not listed, there may be a fee agent available to help you apply. To find out if you have a fee agent, contact the nearest Division of Public Assistance office.

### **WHERE CAN I ASK QUESTIONS ABOUT MEDICAID?**

For questions related to Medicaid services, such as

billing errors, services provided, and eligibility, you may call the Medicaid Hotline toll free at 1-800-211-7470 (statewide) or 562-3671 if you live in the Anchorage area. If you have internet access, you may view the Division of Medical Assistance homepage at <http://www.hss.state.ak.us/dma/table.htm> for more information regarding possible health care options for Alaskans in need.



# Denali KidCare

## WHAT IS DENALI KIDCARE?

Denali KidCare is a medical assistance program to ensure that children and teens of both working and nonworking families can have the health insurance they need. The program provides comprehensive health insurance coverage for children and teens through age 18, and for pregnant women who meet income guidelines, which are higher than for those applying for regular Medicaid. Please see the charts on the following page to see if your children may be eligible for the program.

## WHAT ARE THE SERVICES AND BENEFITS?

Well care for your child or teen is important to prevent disease, find and treat problems early, and maintain good health. Denali KidCare children and teens receive all of the prevention and treatment services listed on pages 10 to 16.

All medically necessary services are covered for pregnant women, including prenatal care, medication, diagnostic tests, and delivery costs. Over-the-counter prenatal vitamins are covered if you get a prescription for them from your provider. Nutrition services are

covered for certain pregnant women. Prenatal and delivery services can be received from physicians, nurse midwives, and direct entry midwives enrolled with Medicaid. If you live in a community without delivery services, Medicaid will pay for your travel for prenatal care services and to stay in the community where you will deliver as

you get closer to your due date (see "Traveling on Medicaid and How it Works" on page 17).

Medicaid coverage continues for two months following delivery so

new mothers can receive follow-up care and family planning services. Newborns receive Medicaid for their first year of life automatically. Remember to notify Denali KidCare when the baby is born so a card can be issued.

## IS THERE ANY COST?

There is no cost for eligible children, teens and pregnant women. However, youth who are 18 years-old may be required to share a limited amount of the cost for some services.

## WHO IS ELIGIBLE?

You will have to apply for the program to know for sure. Generally, a person may be eligible if:

- ◆ you are a child or youth age 18 or younger, or you are pregnant and can provide proof of pregnancy from your health care provider, and
- ◆ you live in Alaska, and
- ◆ your family income meets the guidelines

## HOW MUCH MONEY CAN MY FAMILY MAKE AND STILL BE ELIGIBLE?

Denali KidCare gross income standards are based on family size. If your family income is at or below the amount on the following chart according to your family size, pregnant women and uninsured children may qualify for Denali KidCare.

CHART 1

Family Size	Monthly Income	Annual Income
1	\$1,739	\$20,860
2	\$2,344	\$28,120
3	\$2,949	\$35,380
4	\$3,554	\$42,640
5	\$4,159	\$49,900
6	\$4,764	\$57,160
7	\$5,369	\$64,420
8	\$5,974	\$71,680
Each additional	\$605	\$7,260

*Incomes above reflect 200% of federal poverty guideline.  
Effective April 1, 2000. May change without notice.*

An unborn child of a pregnant woman is counted in the family size.



Standard deductions per month for dependent care and work expense may be allowed. It is best to apply to see if you are eligible.

If you have health insurance and your monthly income is less than or equal to the amounts below, your children may qualify for Denali KidCare according to the following chart.

CHART 2

Family Size	Monthly Income	Annual Income
1	\$1,304	\$15,645
2	\$1,758	\$21,090
3	\$2,212	\$26,535
4	\$2,665	\$31,980
5	\$3,119	\$37,425
6	\$3,573	\$42,870
7	\$4,027	\$48,315
8	\$4,480	\$53,760
Each additional	\$454	\$5,445

*Incomes above reflect 150% of federal poverty guideline.  
Effective April 1, 2000. May change without notice.*

#### WHICH HOUSEHOLD MEMBERS' INCOME COUNTS FOR CHILDREN'S ELIGIBILITY?

Denali KidCare only counts the income of the child and the child's parent(s). The income of a grandparent, stepparent, aunt, uncle, boyfriend or girlfriend is not counted.

#### DO ASSETS COUNT FOR ELIGIBILITY?

No. Your family car, house, and other property assets do not affect your eligibility.

#### WHAT IF MY CHILDREN OR I AM COVERED BY THE INDIAN HEALTH SERVICE (IHS)?

Children, teens and pregnant women covered by the Indian Health Service may still be eligible.

#### WHAT IF MY CHILDREN ALREADY HAVE HEALTH INSURANCE?

This program is primarily for individuals without health insurance. However, if your family income is quite low your children with health

insurance may still be eligible for Denali KidCare (see Chart 2 on page 22). You must declare current health insurance on the Denali KidCare application. There is a 12-month waiting period for most children whose family voluntarily becomes uninsured.

#### HOW LONG DOES IT TAKE TO GET COVERAGE?

Once the application is received in the Denali KidCare office, every effort is made to determine eligibility within 30 days.

#### HOW WILL I BE NOTIFIED IF MY CHILDREN OR I AM ELIGIBLE?

Each child enrolled will receive a Denali KidCare Card in the mail with instructions. Pregnant women will receive peel-off stickers in the mail with instructions. You will be notified by mail if your children are not eligible.

#### IS THE APPLICATION PROCESS SIMPLE?

Yes. An interview is not required and the application is short. If you have any difficulty, call the Denali KidCare office for assistance.

#### HOW DO I APPLY FOR MY CHILDREN OR MYSELF?

Simply fill out a Denali KidCare application, sign it, attach the required documentation, and mail it to the Denali KidCare office.

#### WHERE CAN I ASK QUESTIONS OR REQUEST AN APPLICATION?

If you live in the Anchorage area, you may call 269-6529. Statewide, you may call toll free 1-888-318-8890. You may also access the Denali KidCare website at <http://www.hss.state.ak.us/dma/denali.htm> where you can view Frequently Asked Questions and view and/or download an application for the program.

# CAMA

## WHAT IS CAMA?

Chronic and Acute Medical Assistance, or CAMA, is a state funded program designed to help needy Alaskans get the urgent medical care they need. It is a program for people who need immediate medical treatment but who do not qualify for Medicaid benefits, have very little income, and who have inadequate or no health insurance.

## WHAT MEDICAL SERVICES WILL CAMA PAY FOR?

CAMA pays for the following services:

- inpatient hospital care of up to eight days that is prescribed by a doctor
- nursing home care prescribed by a doctor
- transportation for hospital, pregnancy related, or nursing home care
- twelve doctor visits a year for a person who is receiving chemotherapy, is terminally ill, or who has one of the following chronic conditions: diabetes, seizure disorders, mental illness, or hypertension
- drugs and medical supplies prescribed by a physician for a person who is terminally ill, receiving chemotherapy, or who has one of the following chronic conditions: diabetes, seizure disorders, mental illness, or hypertension

## WHO IS ELIGIBLE?

To qualify for CAMA a person must meet all of the requirements below:

- ◆ You must be a United States citizen or a legal alien
- ◆ You must be a resident of the state of Alaska
- ◆ You must be between the ages of 18 and 65
- ◆ Your household income must be:
  - \$300 a month or less for one person
  - \$400 a month or less for two people
  - add \$100 for each additional person

- ◆ You must have no other resources you can use to pay your medical bills. Resources are things like:
  - medical or hospital insurance that pays 100%, including insurance payments for accidents
  - benefits from programs like Medicaid, Medicare, and the Veteran's Administration
  - help from a free health clinic

You must have less than \$500 in personal resources or property that could be used to pay medical bills. Personal resources include cash, bank/credit union accounts, or personal property. Your home, income producing property, property that is used for your job (boat, fishing gear), vehicles, or fishing permits are not counted.

You must have a major medical need. A doctor, physician's assistant, or advanced nurse practitioner must certify that you need immediate care for one of the services covered under CAMA.

## HOW TO APPLY

When you apply for CAMA your Division of Public Assistance office will first determine if you qualify for Medicaid.

You must apply for CAMA before you receive medical care unless you need emergency treatment. If you had emergency treatment at a hospital or clinic, you must apply for CAMA within 30 days of that emergency.

You must have an interview with a Division of Public Assistance employee or a fee agent in your community. For the interview you will need to bring the following papers along with your application:

- a doctor's statement that you need care
- papers that show your income such as tax forms, pay stubs, fish tickets, or a letter from the Internal Revenue Service saying that you do not pay taxes
- papers that show any other resources, like savings accounts

Your interview and your application are confidential. No one will give out information about your health or income without your permission.

Your application will be reviewed and a notice will be sent to you within 30 days.

If you do not qualify, you may ask for a hearing to review your application.

### How CAMA WORKS

Normally, CAMA eligibility is determined for only one month at a time. Before eligibility is determined, your DPA caseworker may have to make sure that your healthcare provider has documented that your pending treatment is medically necessary and that you have not already used the minimum days of coverage available to you. If eligible, you will receive a Recipient Identification Card in the mail, which indicates the scope of medical coverage available to you. You must show this card to your hospital, doctor, or pharmacist at the time of service. Your provider will either take the card, photocopy the card, or just write down your CAMA number on the bill. Your provider will send the bill directly to CAMA for payment. You should not pay your provider for the services you receive because CAMA cannot pay you back.

If you do qualify for a medical assistance program, please use this booklet as a handy reference guide to the program. Upon eligibility, you will be given case identification numbers that you may need in the future when talking to your case worker or another program person. Please record below information for each person eligible in your household.

Social Security #								
Medicaid ID #								
Public Assistance Case #								
Name								

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## Division of Public Assistance Offices

*(If your community is not listed here, please contact the nearest office.)*

### **Anchorage District Office**

400 Gambell Street, Suite 101  
Anchorage, Alaska 99501  
phone: (907)269-6599

### **Anchorage APA Office**

235 E 8th Ave., Suite 300  
Anchorage, Alaska 99501  
phone: (907)269-6000

### **Bethel District Office**

406 Ridgecrest Drive  
Bethel, Alaska 99559-0365  
phone: (907)543-2686 or  
(800)478-2686 (toll free)

### **Coastal Field Office**

3601 C Street, Suite 410  
PO Box 240249  
Anchorage, Alaska 99524-0249  
phone: (907)269-8950 or  
(800)478-4372 (toll free)

### **Denali KidCare Office**

PO Box 240047  
Anchorage, Alaska 99524-0047  
phone: (907)269-6529  
(888)318-8890 (toll free)

### **Eagle River Job Center**

11723 Old Glenn Hwy., #B-4  
Eagle River, Alaska 99577-7595  
phone: (907)694-7006

### **Fairbanks District Office**

675 7th Street, Station D  
Fairbanks, Alaska 99701  
phone: (907)451-2850 or  
(800)478-2850 (toll free)

### **Homer District Office**

270 W. Pioneer, Suite C  
Homer, Alaska 99603  
phone: (907)235-6132

### **Juneau District Office**

10002 Glacier Hwy., Suite 201  
Juneau, Alaska 99801  
phone: (907)465-3551 or  
(800)478-3551 (toll free)

### **Kenai Peninsula Job Center**

11312 Kenai Spur Hwy., #2  
Kenai, Alaska 99661  
phone: (907)283-2900 or  
(800)478-9032 (toll free)

### **Ketchikan District Office**

2030 Sea Level Drive, Suite 301  
Ketchikan, Alaska 99901  
phone: (907)225-2135 or  
(800)478-2135 (toll free)

### **Kodiak District Office**

307 Center Street  
Kodiak, Alaska 99615  
phone: (907)486-3783 or  
(888)480-3783 (toll free)

### **Kotzebue District Office**

PO Box 1210  
Kotzebue, Alaska 99752  
phone: (907)442-3451

### **Mat-Su District Office**

855 W. Commercial Drive  
Wasilla, Alaska 99654  
phone: (907)376-3903 or  
(800)478-7778 (toll free)

### **Muldoon One Stop**

1251 Muldoon Rd., Suite 111B  
Anchorage, Alaska 99504  
phone: (907)269-0000

### **Nome District Office**

PO Box 2110  
Nome, Alaska 99762  
phone: (907)443-2237 or  
(800)478-2236 (toll free)

### **SE APA/Specialized Medicaid**

10002 Glacier Hwy., Suite 105  
Juneau, Alaska 99801  
phone: (907)465-3537 or  
(800)478-3537 (toll free)

### **Sitka District Office**

201 Kallian Street, #107  
Sitka, Alaska 99835  
phone: (907)747-8234 or  
(800)478-8234 (toll free)

### Medical Assistance Standards

FAMILY MEDICAID 185% ELIGIBILITY TEST AND NEED STANDARDS					
2002			2003		
FAMILY SIZE	185%	NEED	FAMILY SIZE	185%	NEED
Adult Included			Adult Included		
1	1221	660	1	1237	669
2	1951	1055	2	1977	1069
3	2194	1186	3	2223	1202
4	2436	1317	4	2469	1335
5	2678	1448	5	2715	1468
6	2921	1579	6	2961	1601
7	3163	1710	7	3207	1734
Each Additional	242	131	Each Additional	246	133
Adult Not Included			Adult Not Included		
1	1071	579	1	1085	587
2	1313	710	2	1332	720
3	1555	841	3	1578	853
4	1798	972	4	1824	986
5	2040	1103	5	2070	1119
6	2282	1234	6	2316	1252
7	2525	1365	7	2562	1385
Each Additional	242	131	Each Additional	246	133

SSI PAYMENT STANDARDS		
SSI COLA	2.6%	1.4%
HOUSEHOLD TYPE	1/1/2002	1/1/2003
A Individual	545	552
B Individual	363.34	368
A Couple, Both Eligible	817	829
B Couple, Both Eligible	544.67	552.67
NH Personal Needs Allowance	30	30

LONG TERM CARE STANDARDS		
NH, HCB Waiver, TEFRA = 300% of SSI Payment Standard	1635	1656
Alaska NH Personal Needs Allowance	75	75
Alaska HCB Personal Needs Allowance	1635	1656
Maximum Community Spouse Resource Allowance	89,280	90,660
Community Spouse Monthly Maintenance Need Standard	2,232	2,266.50
Monthly Need Standard for Additional Household Members	744	755

2002 Monthly Federal Poverty Guidelines for Alaska								
Effective 4/1/2002								
FAMILY SIZE	QMB Working Disabled (premium level)	SLMB Base	SLMB Plus	Donall KidCare (limit for insured children)	SLMB Subsidy	Transitional Medicaid	Donall KidCare (uninsured children) Pregnant Women QDWI	Working Disabled (eligibility)
	100%	120%	135%	150%	175%	185%	200%	250%
1	\$924	\$1,108	\$1,247	\$1,385	\$1,616	\$1,709	\$1,847	\$2,309
2	\$1,245	\$1,493	\$1,680	\$1,867	\$2,178	\$2,302	\$2,489	\$3,111
3	\$1,565			\$2,348		\$2,896	\$3,130	\$3,913
4	\$1,886			\$2,829		\$3,489	\$3,772	\$4,715
5	\$2,207			\$3,310		\$4,083	\$4,414	\$5,517
6	\$2,528			\$3,792		\$4,676	\$5,055	\$6,319
7	\$2,849			\$4,273		\$5,270	\$5,697	\$7,121
8	\$3,170			\$4,754		\$5,863	\$6,339	\$7,923
Ea Addl	\$321			\$482		\$594	\$642	\$803

2001 Monthly Federal Poverty Guidelines for Alaska								
Effective 4/1/2001								
FAMILY SIZE	QMB Working Disabled (premium level)	SLMB Base	SLMB Plus	Donall KidCare (limit for insured children)	SLMB Subsidy	Transitional Medicaid	Donall KidCare (uninsured children) Pregnant Women QDWI	Working Disabled (eligibility)
	100%	120%	135%	150%	175%	185%	200%	250%
1	\$895	\$1,073	\$1,208	\$1,342	\$1,565	\$1,655	\$1,789	\$2,236
2	\$1,210	\$1,451	\$1,633	\$1,814	\$2,117	\$2,237	\$2,419	\$3,023
3	\$1,525			\$2,287		\$2,820	\$3,049	\$3,811
4	\$1,840			\$2,759		\$3,403	\$3,679	\$4,598
5	\$2,155			\$3,232		\$3,986	\$4,309	\$5,386
6	\$2,470			\$3,704		\$4,568	\$4,939	\$6,173
7	\$2,785			\$4,177		\$5,151	\$5,569	\$6,961
8	\$3,100			\$4,649		\$5,734	\$6,199	\$7,748
Ea Addl	\$315			\$473		\$583	\$630	\$788

2000 Monthly Federal Poverty Guidelines for Alaska								
Effective 4/1/2000								
FAMILY SIZE	QMB Working Disabled (premium level)	SLMB Base	SLMB Plus	Donall KidCare (limit for insured children)	SLMB Subsidy	Transitional Medicaid	Donall KidCare (uninsured children) Pregnant Women QDWI	Working Disabled (eligibility)
	100%	120%	135%	150%	175%	185%	200%	250%
1	\$870	\$1,043	\$1,174	\$1,304	\$1,522	\$1,608	\$1,739	\$2,173
2	\$1,172	\$1,406	\$1,582	\$1,758	\$2,051	\$2,168	\$2,344	\$2,930
3	\$1,475			\$2,212		\$2,728	\$2,949	\$3,686
4	\$1,777			\$2,665		\$3,287	\$3,554	\$4,442
5	\$2,080			\$3,119		\$3,847	\$4,159	\$5,198
6	\$2,382			\$3,573		\$4,407	\$4,764	\$5,955
7	\$2,685			\$4,027		\$4,966	\$5,369	\$6,711
8	\$2,987			\$4,480		\$5,526	\$5,974	\$7,467
Ea Addl	\$303			\$454		\$560	\$605	\$757

1999 Monthly Federal Poverty Guidelines for Alaska								
Effective 5/1/1999								
FAMILY SIZE	QMB Working Disabled (premium level)	SLMB Base	SLMB Plus	Donall KidCare (limit for insured children)	SLMB Subsidy	Transitional Medicaid	Donall KidCare (uninsured children) Pregnant Women QDWI	Working Disabled (eligibility)
	100%	120%	135%	150%	175%	185%	200%	250%
1	860	1,032	1,161	1,290	1,505	1,591	1,720	2,150
2	1,154	1,384	1,557	1,730	2,019	2,134	2,307	2,884
3	1,447			2,170		2,577	2,894	3,617
4	1,740			2,610		3,219	3,480	4,350
5	2,034			3,050		3,762	4,067	5,084
6	2,327			3,490		4,305	4,654	5,817
7	2,620			3,930		4,847	5,240	6,550
8	2,914			4,370		5,390	5,827	7,284
Ea Addl	294			440		543	587	734