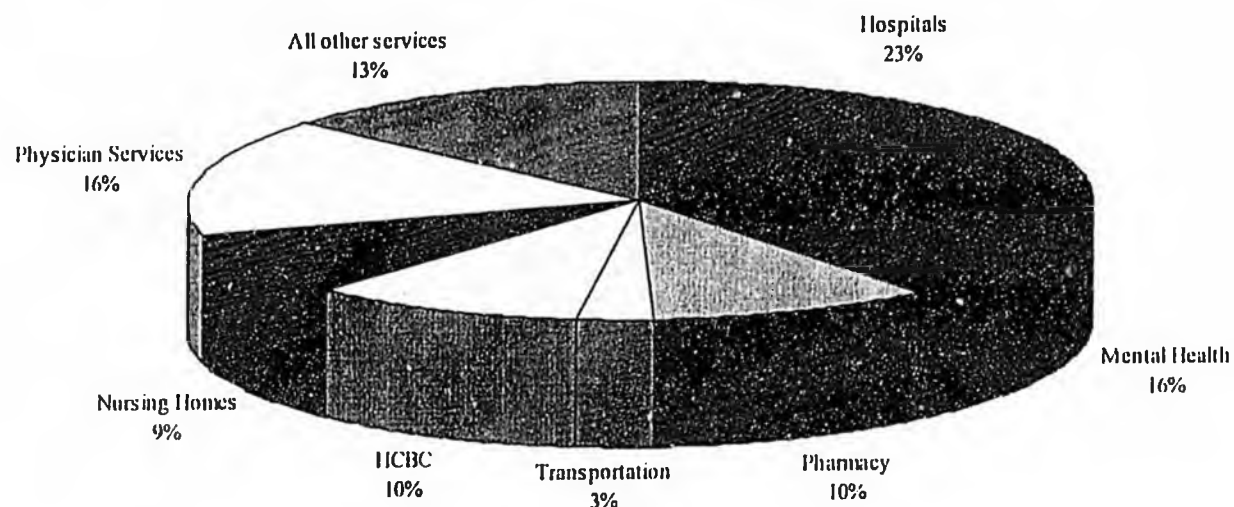


ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10521 SENATE HEALTH EDUCATION & SOCIAL SERVICES

FY2000 Medicaid Expenditures by Category of Service

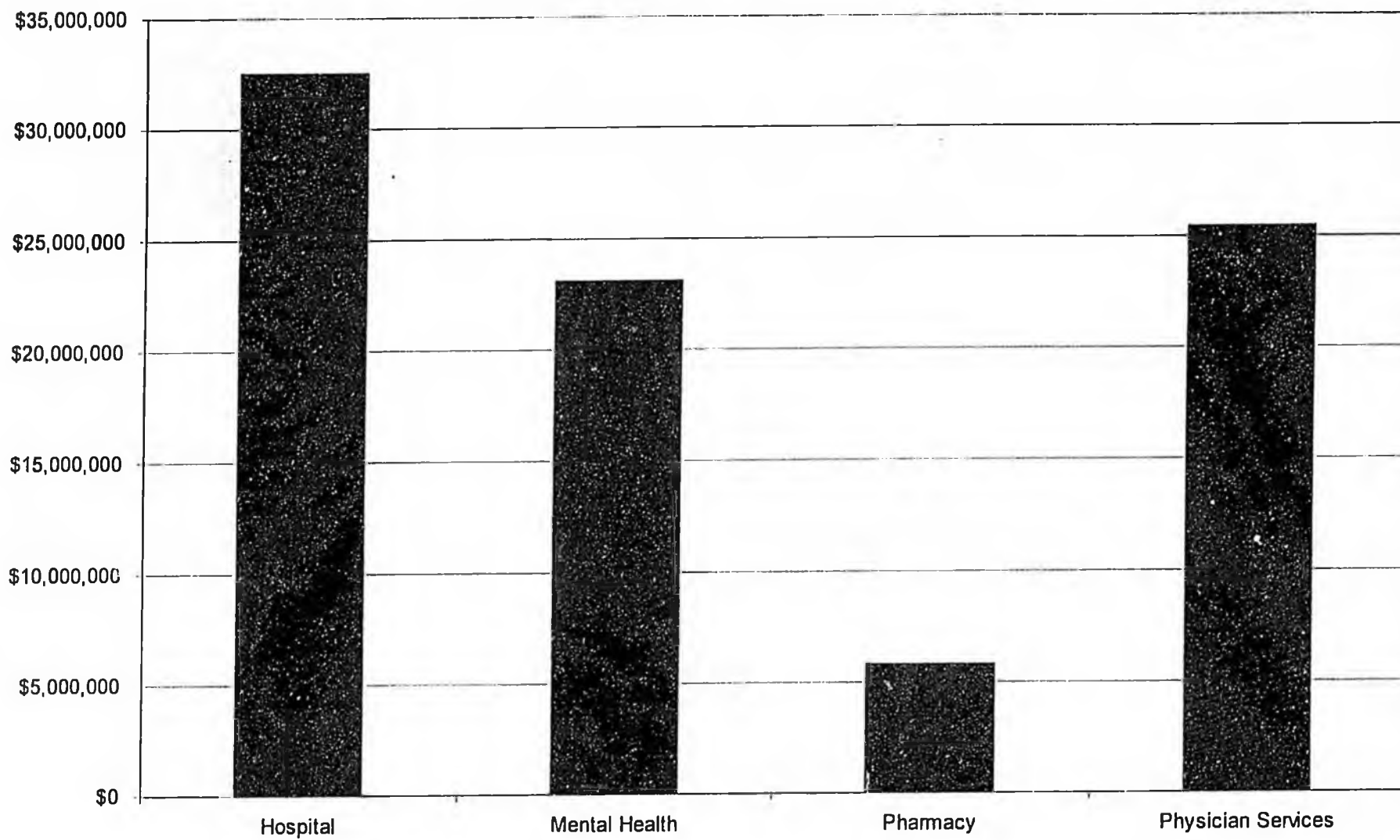


| Category of Service | FY00 Expenditures (in millions) | FY99 | FY98 |
|---------------------------|------------------------------------|----------------|----------------|
| Hospitals* | \$108,312 | \$97,854 | \$98,353 |
| Mental health | 76,044 | 64,698 | 61,149 |
| Pharmacy | 46,311 | 37,288 | 30,781 |
| 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 |
| <u>All other services</u> | <u>62,582</u> | <u>29,010</u> | <u>47,278</u> |
| Total all services | 467,423 | 389,407 | 372,721 |

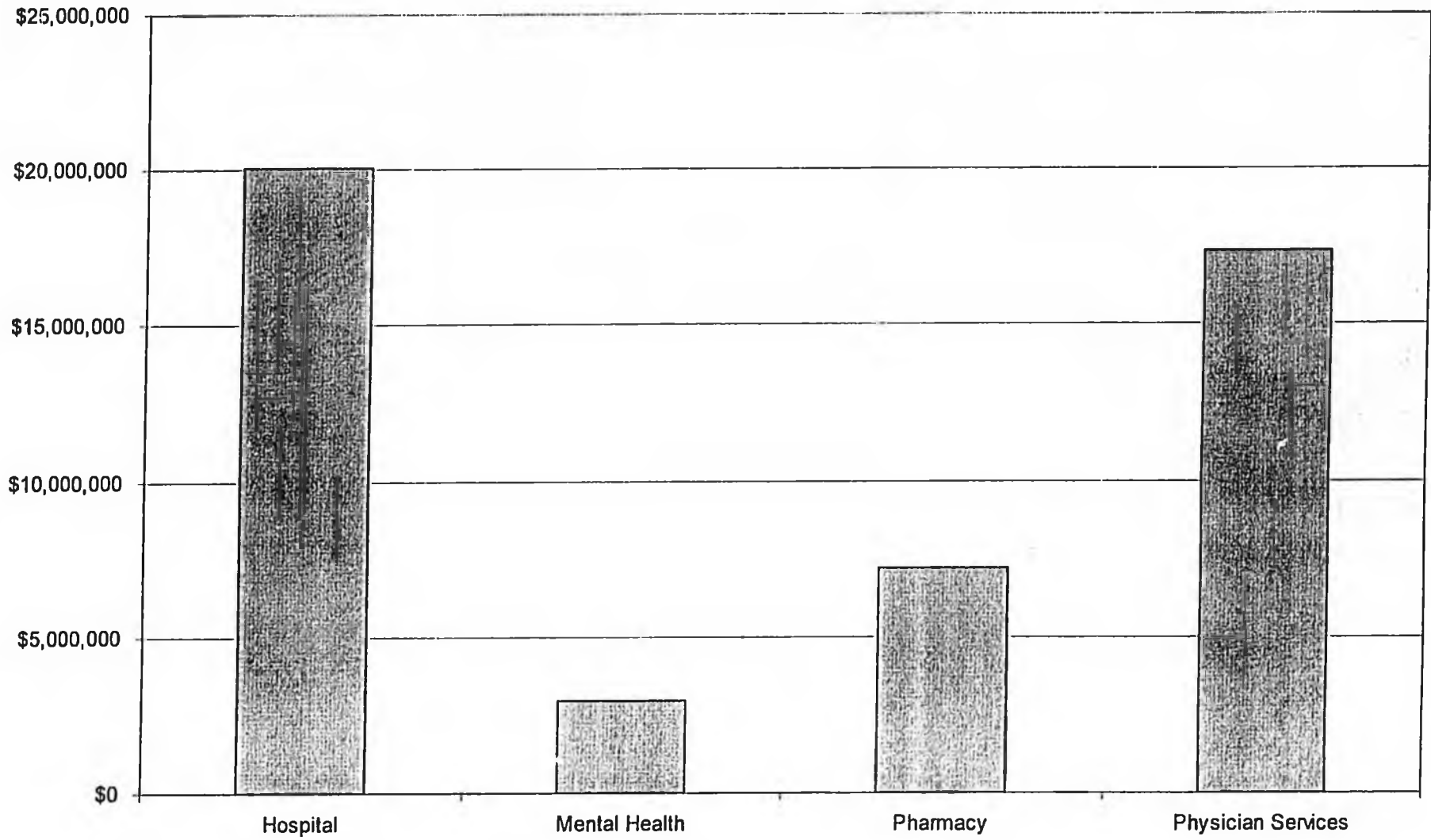
*Includes IHS facilities

Source: DMA Annual Reports

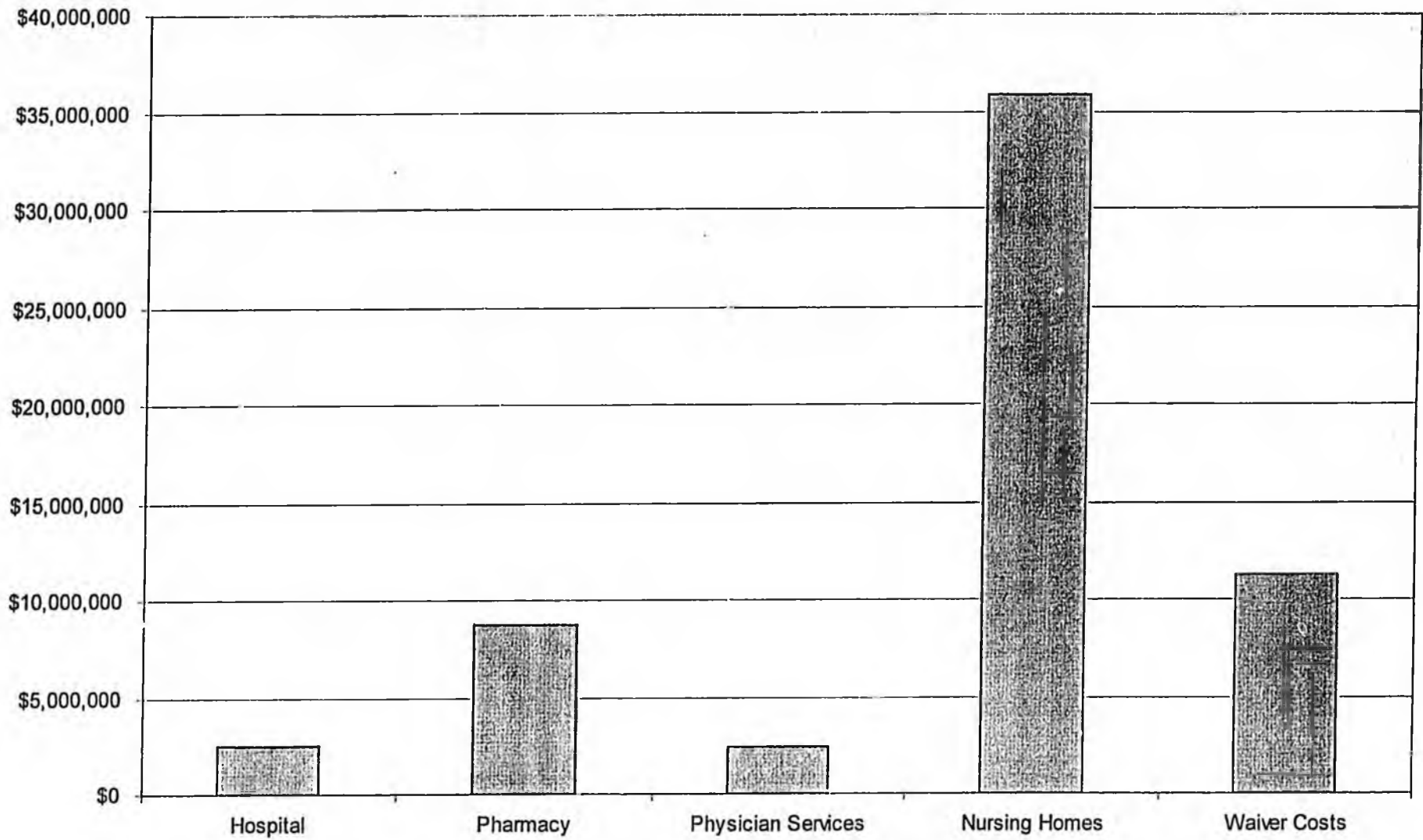
**Children Expenditures FY00
Top Four Expenditure Categories**



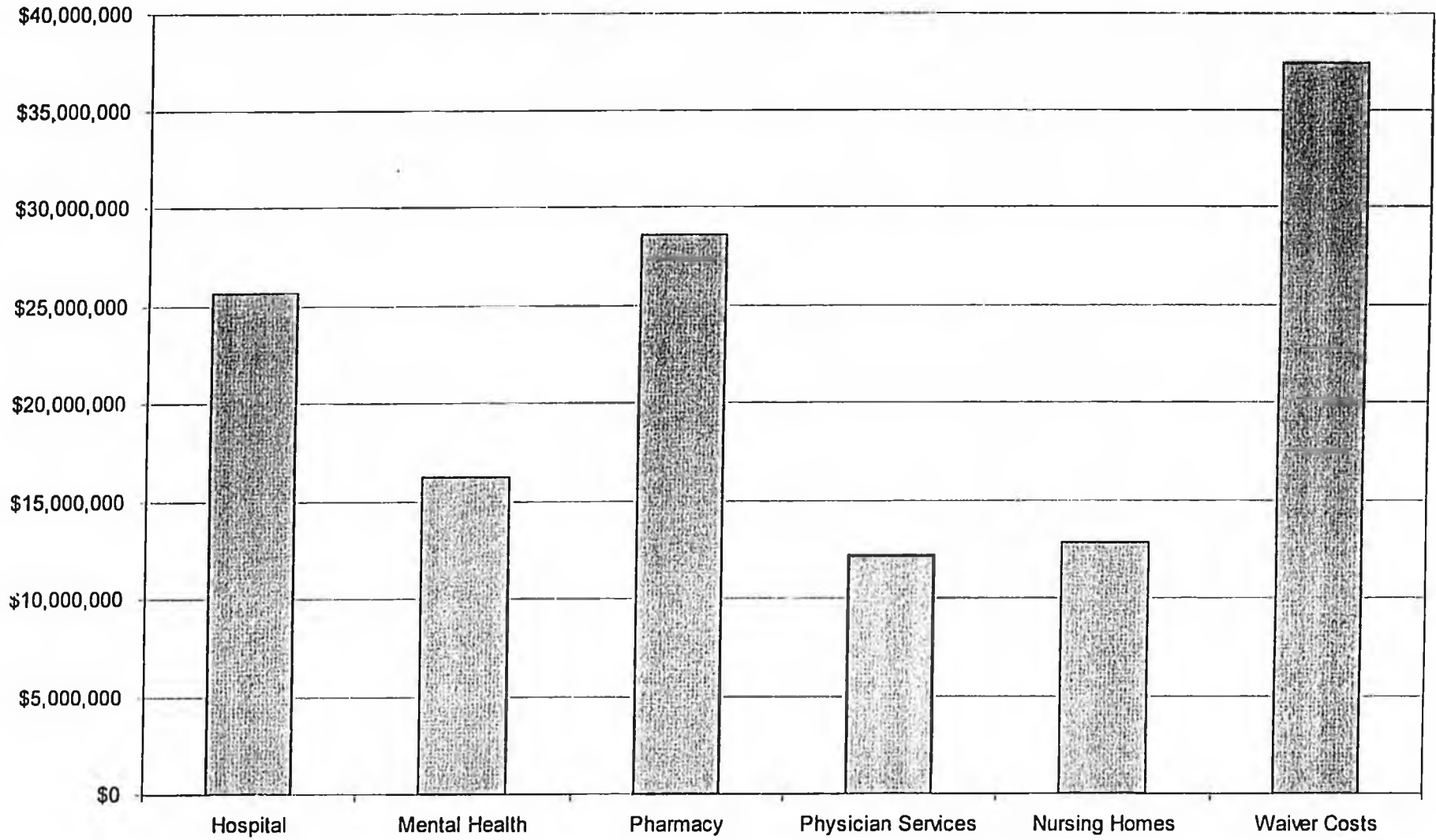
**Adults Expenditures FY00
Top Four Expenditure Categories**



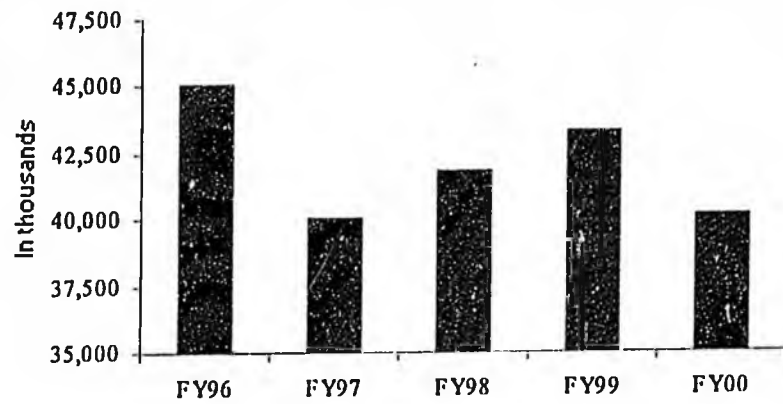
**Elderly Expenditures FY00
Top Five Expenditure Categories**



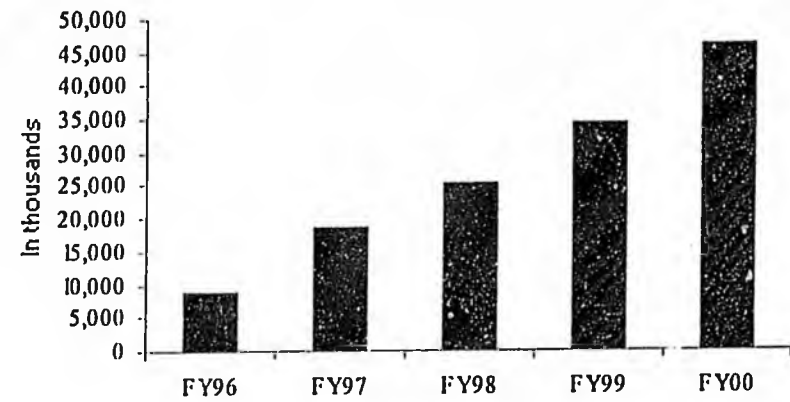
**Disabled Expenditures FY00
Top Six Expenditure Categories**



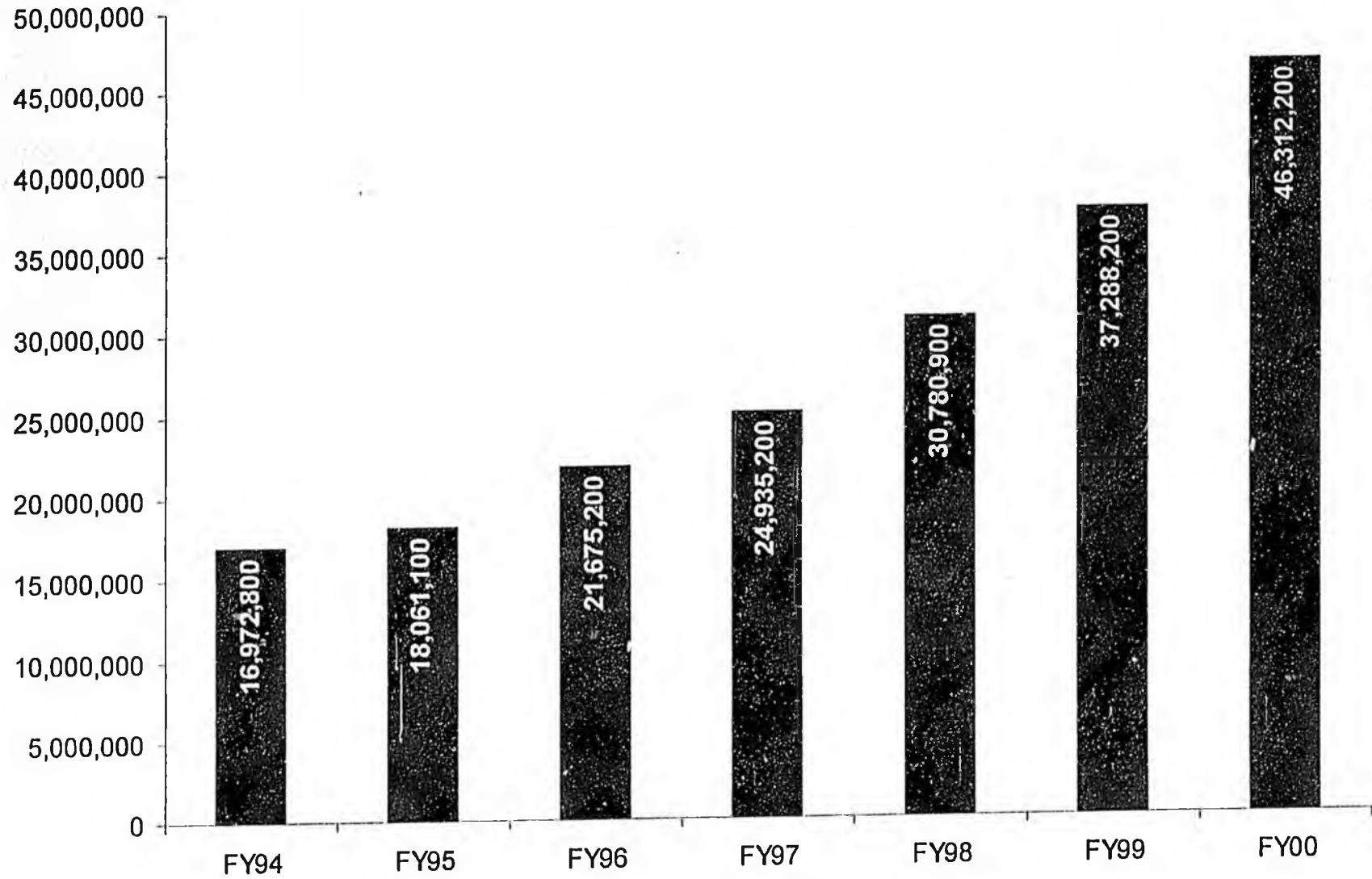
Nursing Homes



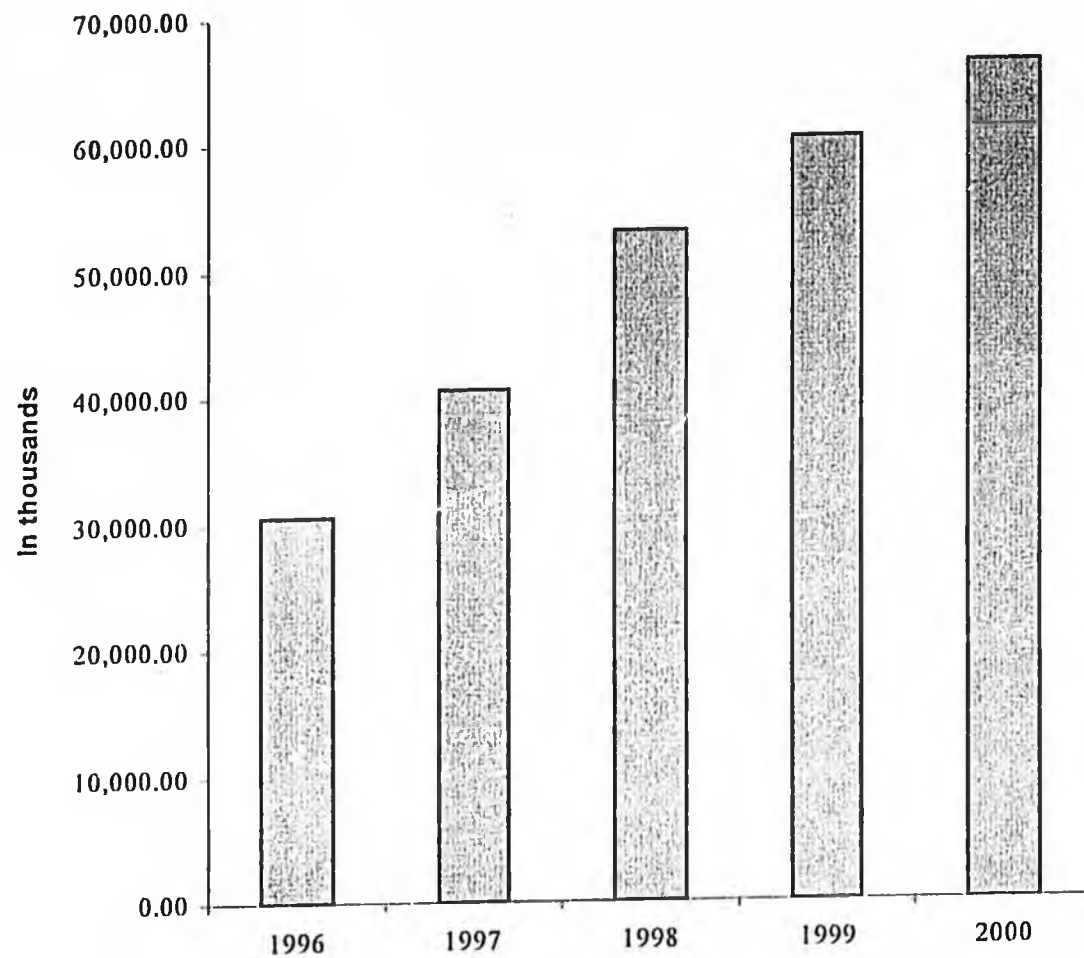
Waiver Services



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.

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

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 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.³ 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 HCB 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 |

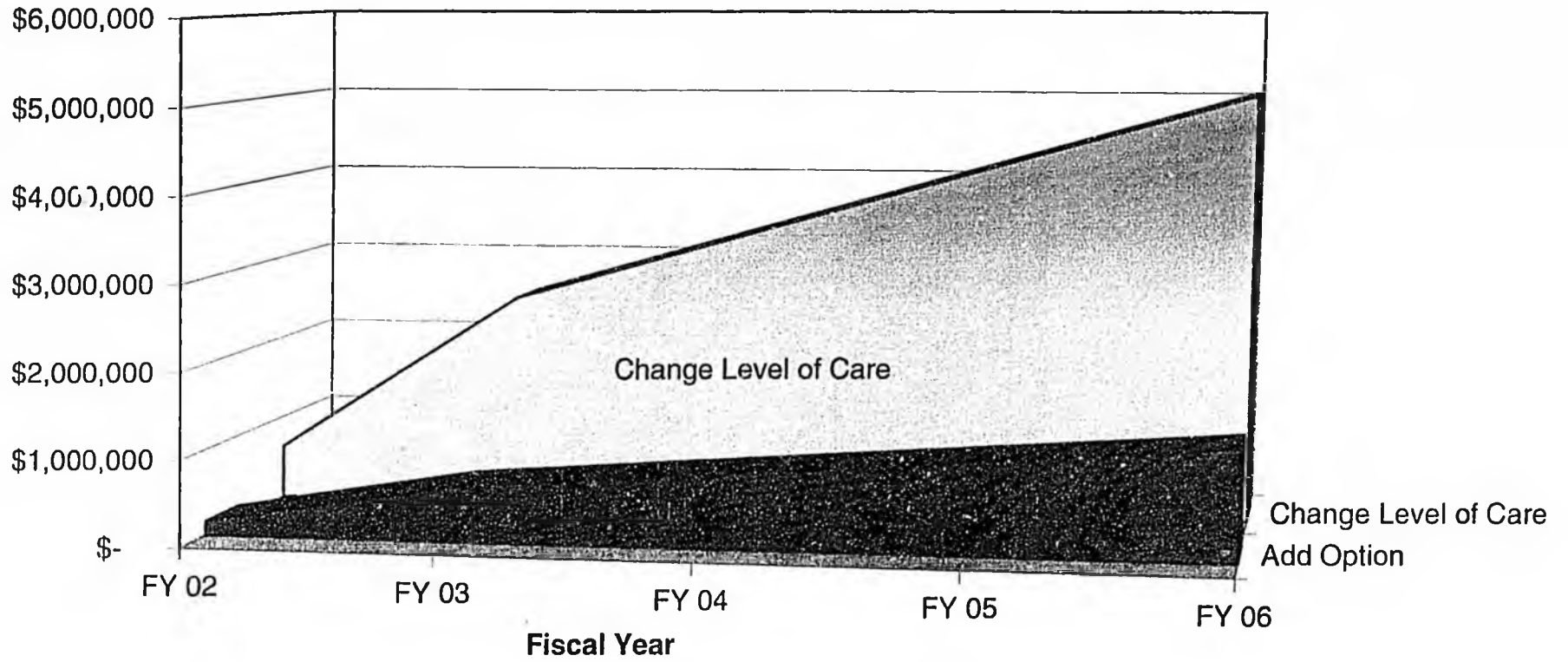
Total Costs:

| | <u>FY 02</u> | <u>FY 03</u> | <u>FY 04</u> | <u>FY 05</u> | <u>FY 06</u> |
|----------------------------|-------------------|---------------------|---------------------|---------------------|---------------------|
| 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 | \$ <u>631,041</u> | \$ <u>2,524,164</u> | \$ <u>3,365,552</u> | \$ <u>4,206,940</u> | \$ <u>5,048,328</u> |

Assumptions:

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

General Fund Costs of Options



■ Add Option □ Change Level of Care

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

COPY

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 of 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.

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 redetermination 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 woman 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 not 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

| <u>Incidence</u> | <u>Female</u> |
|------------------|---------------|
| In situ cancer | 63 |
| Invasive cancer | 284 |
| Incidence rate* | 119.4 |
| 1997 U.S. rate* | 115.4 |

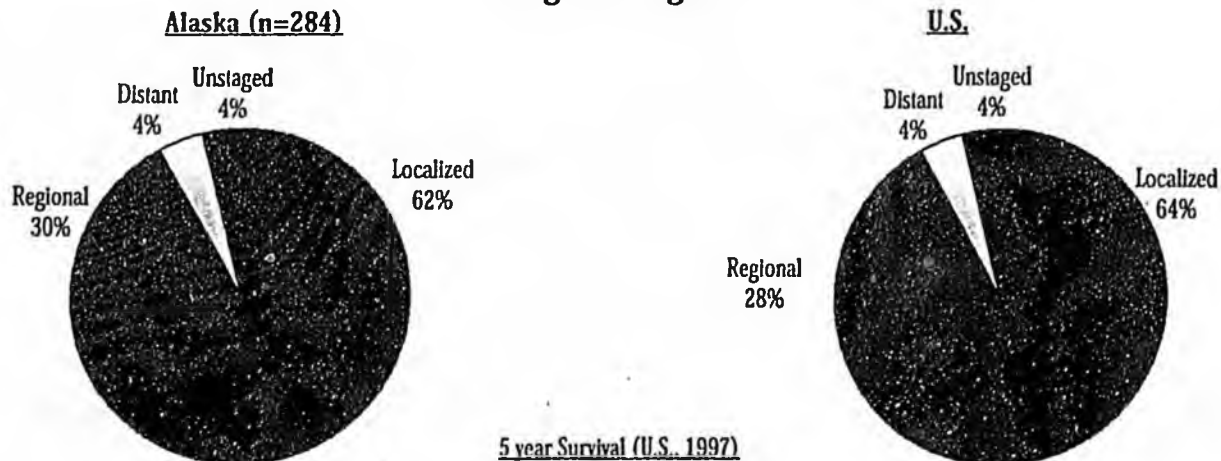
*Excludes in situ cases

| <u>Mortality</u> | <u>Female</u> |
|------------------|---------------|
| 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



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

| <u>Incidence</u> | <u>Female</u> |
|------------------|---------------|
| Invasive cancer | 26 |
| Incidence rate | 8.8 |
| 1997 U.S. rate* | 7.5 |

*Excludes in situ cases

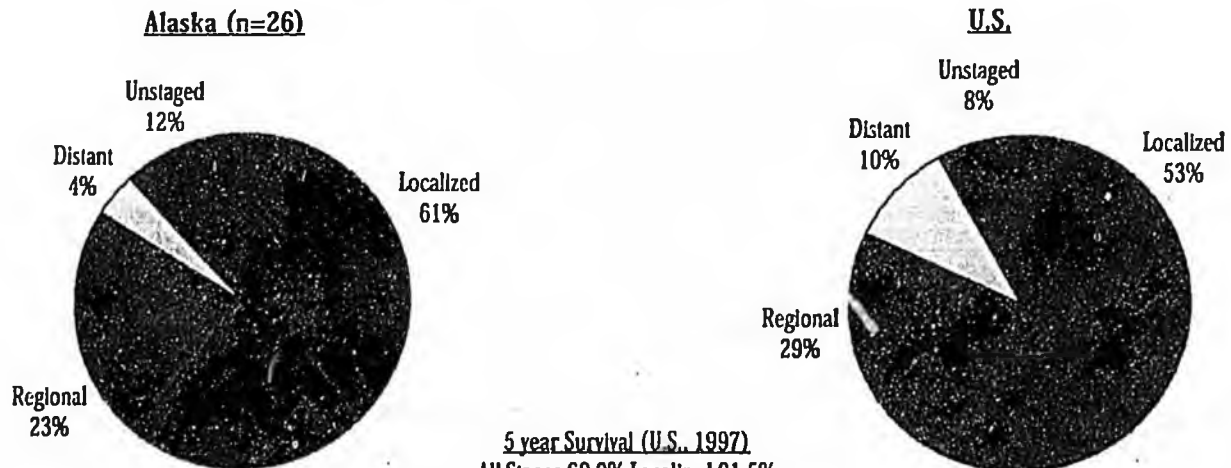
| <u>Mortality</u> | <u>Female</u> |
|------------------|---------------|
| Deaths | 4 |
| Mortality rate | n/c** |
| 1997 U.S. rate | 2.6 |

**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



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:

1 ***SECTION 1. SHORT TITLE.***

2 *This Act may be cited as the "Breast and Cervical*

3 *Cancer Prevention and Treatment Act of 2000".*

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

3 (a) *COVERAGE AS OPTIONAL CATEGORICALLY NEEDY*
4 *GROUP.—*

5 (1) *IN GENERAL.—Section 1902(a)(10)(A)(ii) of*
6 *the Social Security Act (42 U.S.C.*
7 *1396a(a)(10)(A)(ii)) is amended—*

8 (A) *in subclause (XVI), by striking “or” at*
9 *the end;*

10 (B) *in subclause (XVII), by adding “or” at*
11 *the end; and*

12 (C) *by adding at the end the following:*

13 “(XVIII) *who are described in*
14 *subsection (aa) (relating to certain*
15 *breast or cervical cancer patients);”.*

16 (2) *GROUP DESCRIBED.—Section 1902 of the So-*
17 *cial Security Act (42 U.S.C. 1396a) is amended by*
18 *adding at the end the following:*

19 “(aa) *Individuals described in this subsection are indi-*
20 *viduals who—*

21 “(1) *are not described in subsection*
22 *(a)(10)(A)(i);*

23 “(2) *have not attained age 65;*

24 “(3) *have been screened for breast and cervical*
25 *cancer under the Centers for Disease Control and Pre-*
26 *vention breast and cervical cancer early detection*

1 program established under title XV of the Public
2 Health Service Act (42 U.S.C. 300k et seq.) in accord-
3 ance with the requirements of section 1504 of that Act
4 (42 U.S.C. 300n) and need treatment for breast or
5 cervical cancer; and

6 “(4) are not otherwise covered under creditable
7 coverage, as defined in section 2701(c) of the Public
8 Health Service Act (42 U.S.C. 300gg(c)).”

9 (3) LIMITATION ON BENEFITS.—Section
10 1902(a)(10) of the Social Security Act (42 U.S.C.
11 1396a(a)(10)) is amended in the matter following
12 subparagraph (G)—

13 (A) by striking “and (XIII)” and inserting
14 “(XIII)”; and

15 (B) by inserting “, and (XIV) the medical
16 assistance made available to an individual de-
17 scribed in subsection (aa) who is eligible for
18 medical assistance only because of subparagraph
19 (A)(10)(ii)(XVIII) shall be limited to medical as-
20 sistance provided during the period in which
21 such an individual requires treatment for breast
22 or cervical cancer” before the semicolon.

23 (4) CONFORMING AMENDMENTS.—Section
24 1905(a) of the Social Security Act (42 U.S.C.

1 1396d(a)) is amended in the matter preceding para-
2 graph (1)—

3 (A) in clause (xi), by striking “or” at the
4 end;

5 (B) in clause (xii), by adding “or” at the
6 end; and

7 (C) by inserting after clause (xii) the fol-
8 lowing:

9 “(xiii) individuals described in section
10 1902(aa),”.

11 (b) *PRESUMPTIVE ELIGIBILITY.*—

12 (1) *IN GENERAL.*—Title XIX of the Social Secu-
13 rity Act (42 U.S.C. 1396 et seq.) is amended by in-
14 serting after section 1920A the following:

15 “*PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR*
16 *CERVICAL CANCER PATIENTS*”

17 “*SEC. 1920B. (a) STATE OPTION.*—A State plan ap-
18 proved under section 1902 may provide for making medical
19 assistance available to an individual described in section
20 1902(aa) (relating to certain breast or cervical cancer pa-
21 tients) during a presumptive eligibility period.

22 “(b) *DEFINITIONS.*—For purposes of this section:

23 “(1) *PRESUMPTIVE ELIGIBILITY PERIOD.*—The
24 term ‘presumptive eligibility period’ means, with re-
25 spect to an individual described in subsection (a), the
26 period that—

1 “(A) begins with the date on which a quali-
2 fied entity determines, on the basis of prelimi-
3 nary information, that the individual is de-
4 scribed in section 1902(aa); and

5 “(B) ends with (and includes) the earlier
6 of—

7 “(i) the day on which a determination
8 is made with respect to the eligibility of
9 such individual for services under the State
10 plan; or

11 “(ii) in the case of such an individual
12 who does not file an application by the last
13 day of the month following the month dur-
14 ing which the entity makes the determina-
15 tion referred to in subparagraph (A), such
16 last day.

17 “(2) QUALIFIED ENTITY.—

18 “(A) IN GENERAL.—Subject to subpara-
19 graph (B), the term ‘qualified entity’ means any
20 entity that—

21 “(i) is eligible for payments under a
22 State plan approved under this title; and

23 “(ii) is determined by the State agency
24 to be capable of making determinations of
25 the type described in paragraph (1)(A).

1 “(B) REGULATIONS.—The Secretary may
2 issue regulations further limiting those entities
3 that may become qualified entities in order to
4 prevent fraud and abuse and for other reasons.

5 “(C) RULE OF CONSTRUCTION.—Nothing in
6 this paragraph shall be construed as preventing
7 a State from limiting the classes of entities that
8 may become qualified entities, consistent with
9 any limitations imposed under subparagraph
10 (B).

11 “(c) ADMINISTRATION.—

12 “(1) IN GENERAL.—The State agency shall pro-
13 vide qualified entities with—

14 “(A) such forms as are necessary for an ap-
15 plication to be made by an individual described
16 in subsection (a) for medical assistance under
17 the State plan; and

18 “(B) information on how to assist such in-
19 dividuals in completing and filing such forms.

20 “(2) NOTIFICATION REQUIREMENTS.—A quali-
21 fied entity that determines under subsection (b)(1)(A)
22 that an individual described in subsection (a) is pre-
23 sumptively eligible for medical assistance under a
24 State plan shall—

1 “(A) notify the State agency of the deter-
2 mination within 5 working days after the date
3 on which determination is made; and

4 “(B) inform such individual at the time the
5 determination is made that an application for
6 medical assistance under the State plan is re-
7 quired to be made by not later than the last day
8 of the month following the month during which
9 the determination is made.

10 “(3) APPLICATION FOR MEDICAL ASSISTANCE.—

11 *In the case of an individual described in subsection*
12 *(a) who is determined by a qualified entity to be pre-*
13 *sumptively eligible for medical assistance under a*
14 *State plan, the individual shall apply for medical as-*
15 *sistance under such plan by not later than the last*
16 *day of the month following the month during which*
17 *the determination is made.*

18 “(d) PAYMENT.—Notwithstanding any other provision
19 of this title, medical assistance that—

20 “(1) is furnished to an individual described in
21 subsection (a)—

22 “(A) during a presumptive eligibility pe-
23 riod;

24 “(B) by a entity that is eligible for pay-
25 ments under the State plan; and

1 “(2) is included in the care and services covered
2 by the State plan,
3 shall be treated as medical assistance provided by such plan
4 for purposes of clause (4) of the first sentence of section
5 1905(b).”.

6 (2) CONFORMING AMENDMENTS.—

7 (A) Section 1902(a)(47) of the Social Secu-
8 rity Act (42 U.S.C. 1396a(a)(47)) is amended by
9 inserting before the semicolon at the end the fol-
10 lowing: “and provide for making medical assist-
11 ance available to individuals described in sub-
12 section (a) of section 1920B during a presump-
13 tive eligibility period in accordance with such
14 section”.

15 (B) Section 1903(u)(1)(D)(v) of such Act
16 (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

17 (i) by striking “or for” and inserting
18 “, for”; and

19 (ii) by inserting before the period the
20 following: “, or for medical assistance pro-
21 vided to an individual described in sub-
22 section (a) of section 1920B during a pre-
23 sumptive eligibility period under such sec-
24 tion”.

1 (c) *ENHANCED MATCH.*—The first sentence of section
2 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is
3 amended—

4 (1) by striking “and” before “(3)”; and

5 (2) by inserting before the period at the end the
6 following: “, and (4) the Federal medical assistance
7 percentage shall be equal to the enhanced FMAP de-
8 scribed in section 2105(b) with respect to medical as-
9 sistance provided to individuals who are eligible for
10 such assistance only on the basis of section
11 1902(a)(10)(A)(i)(XVIII)”.

12 (d) *EFFECTIVE DATE.*—The amendments made by this
13 section apply to medical assistance for items and services
14 furnished on or after October 1, 2000, without regard to
15 whether final regulations to carry out such amendments
16 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



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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.

WELFARE REFORM: WHAT'S NEXT?

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 the 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 through 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 3 1/2 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 DIISS, 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*

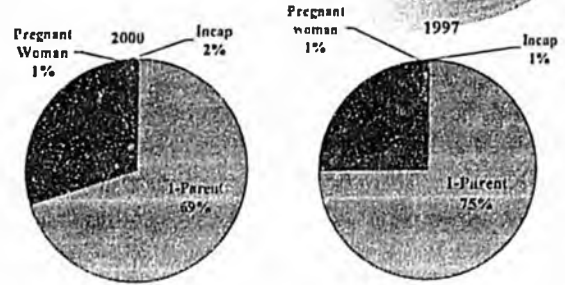
Implementation measures:

- ▶ Reinvestment of savings
- ▶ Community contracting
- ▶ "Work First" philosophy
- ▶ Agency collaboration
- ▶ Job development
- ▶ WorkStar
- ▶ One Stop Job Centers
- ▶ Devolution and local control
- ▶ Native TANF programs

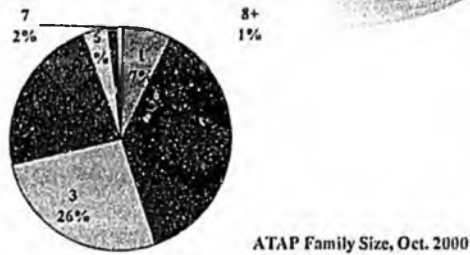
Demographics

Who is receiving Temporary Assistance?

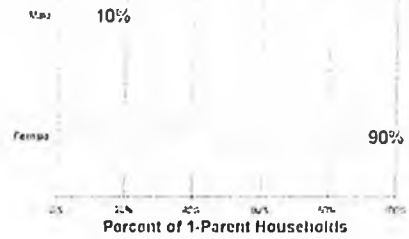
Demographics Family Type



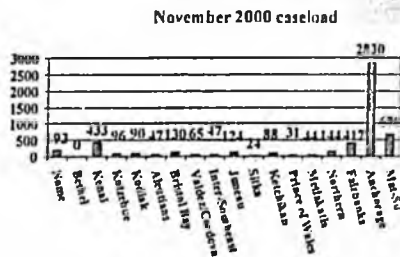
Demographics Family Size



Demographics Gender- single parent families

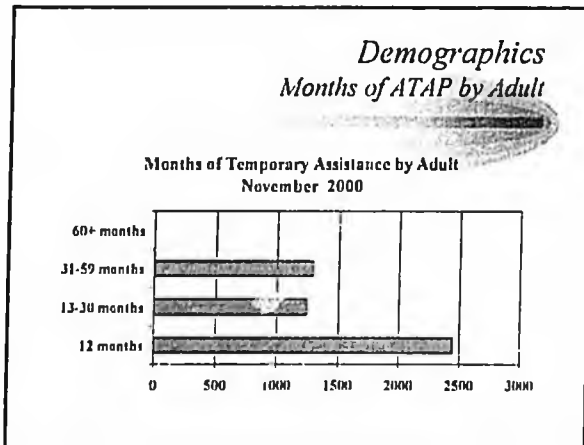
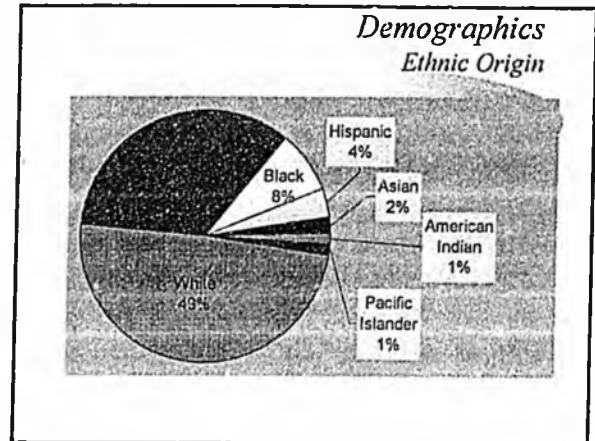
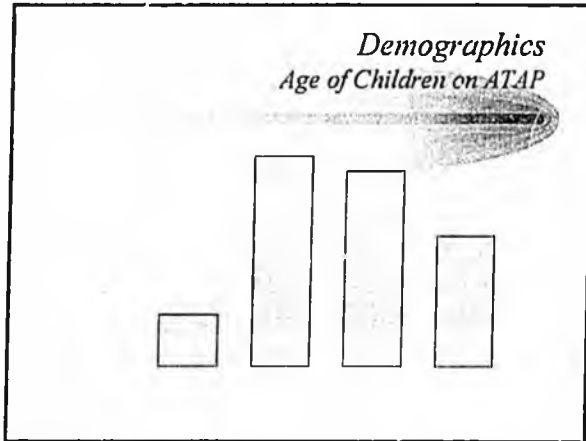


Demographics Residence



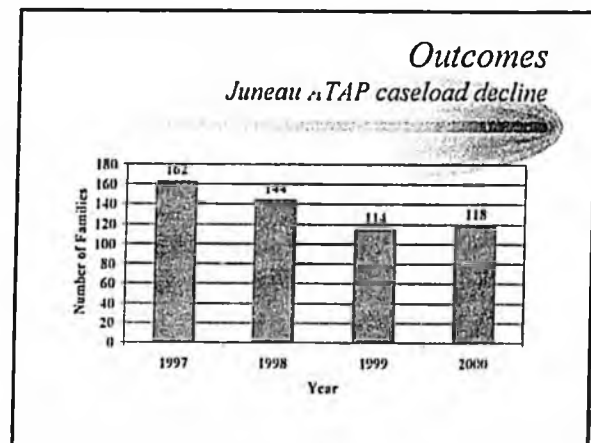
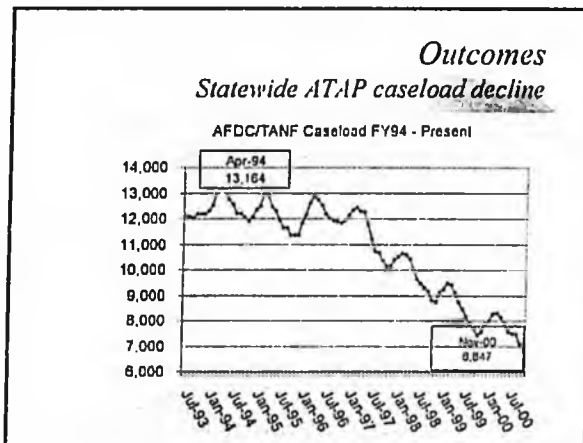
Demographics Age of Adult on ATAP





Outcomes

What has been the result of welfare reform in Alaska so far?



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

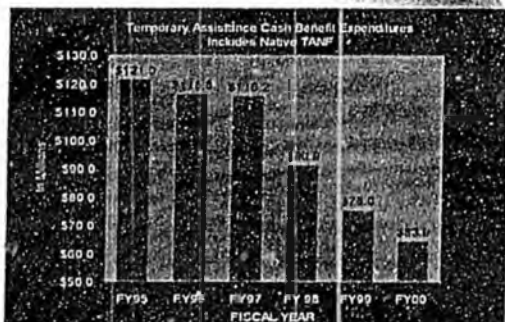
Outcomes

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

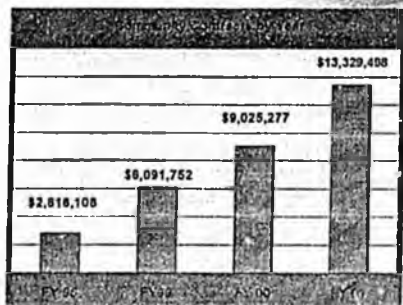


Outcomes
Reinvestments

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?

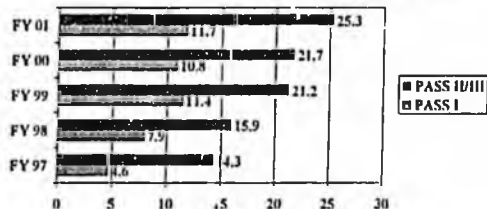
Outcomes
Child care

Outcomes for child care:

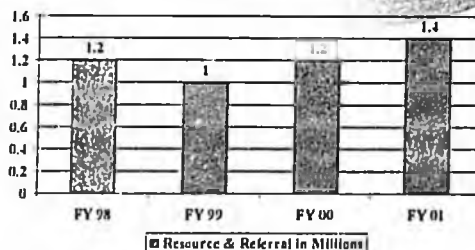
- ▶ Funding has shifted dramatically since the beginning of welfare reform, previously state dollars primarily funded child care
- ▶ FY99 state dollars were replaced with federal funds
- ▶ EED became lead agency for child care programs in July, 1999
- ▶ Child care licensing was transferred from DHSS to EED in July, 2000

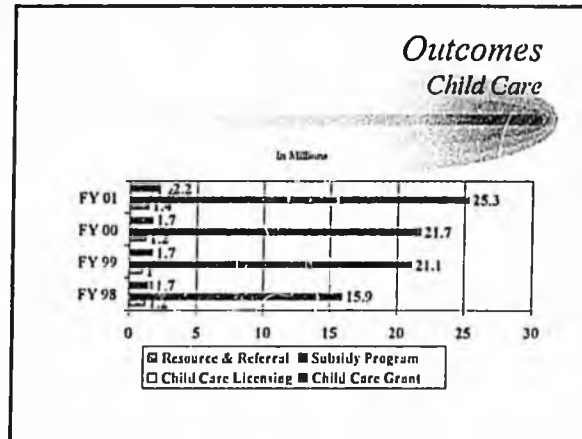
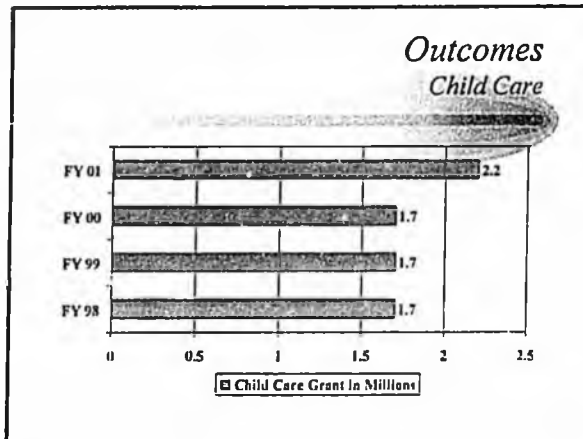
Outcomes
Child care

Child Care Subsidy



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.

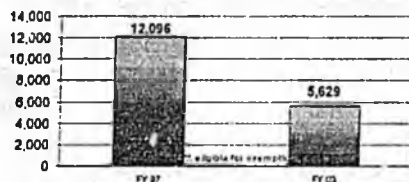
Challenges and Next Steps The five-year limit

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 May 1996 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

Comparison of Number of Families Eligible for 60-month Exemption, May '96 and November '00



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 solution: 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