

**MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Effective Date:

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Approval Date:

**MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: ALASKA
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

**William J. Streur, Deputy Commissioner, Health Care Policy and Medicaid, Alaska
Department of Health and Social Services, March 3, 2009**
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: **William J. Streur** Position/Title: **Deputy Commissioner, Health Care Policy and Medicaid**

Name: **Barbara F. Hale** Position/Title: **CHIP Administrator – Health Care Policy and Medicaid**

Name: Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Section 2103); **OR**

1.1.2 Providing expanded benefits under the state's Medicaid plan (Title XIX); **OR**

1.1.3 A combination of both of the above.

1.2 Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the state has legislative authority to operate the State Plan or Plan Amendment as approved by CMS. (42 CFR 457.40(d))

Alaska assures that expenditures for child health assistance were not claimed prior to the time that the state had legislative authority to operate the State Plan or Plan Amendment as approved by CMS.

1.3 Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Since program inception, every effort has been made in Alaska to comply with all applicable civil rights requirements, including Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR – Parts 80, 84, and 91, and 28 CFR – Part 35.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date

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Model Application Template for the State Children's Health Insurance Program

services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date of Title XXI State Plan: **March 1, 1999 is the date that the State of Alaska began to incur costs to implement its State Plan.**

Implementation date: **March 1, 1999**

Effective Date of State Plan Amendment in Section 2.3 of this document: **July 1, 2007.**

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

- 2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

Background on Alaska – Program Inception

The State of Alaska is different than other states in the country due to its geography, extreme climatic conditions, and low population density. The Alaska population is younger, has proportionately fewer females, more Native people, and fewer African Americans than the United States as a whole.

Alaska is one-fifth the size of the U.S., and larger than the states of Texas, California and Montana combined. Over 70% of the population lives in urban areas, with 41.7% of all inhabitants residing in the largest city, Anchorage. Forty-eight percent of the Alaska Native population lives in areas of the state where natives make up over one-half of the population. The largest number of Alaska Natives, 20,083, lives in Anchorage but they comprise only 7.8% of the population there. In 1997, the population density of the state was 1.07 persons per square mile, compared with 75.68 persons per square mile in the U.S. Compounding the problems related to the sheer size and climate of the state, is the lack of a road system, which makes airplane travel the necessary means of transportation to most areas of the state.

The economy in Alaska has always been characterized by cycles of boom and bust, and a higher percentage of Alaskans are employed in seasonal jobs than in other states. World markets dictate demand for the products of the local economies: oil, timber, mining, fishing and tourism. Major transitions in military presence in the state have also had dramatic effects on the population in regions of Alaska. The result of cyclical economies has been major in and out migrations related to people searching for employment. Alaska's personal income increased four percent during the 1990s compared with five percent for the United States.

Health Care in Alaska – Program Inception

A unique health care delivery system has evolved in the state to serve Alaska's

ethnically-diverse and geographically scattered population. Major tertiary services are located only in Anchorage where the majority of residents live. Community hospitals are located in smaller urban communities, and two military hospitals are located in Anchorage and Fairbanks. The tribal health care delivery system is virtually the only provider of health care services in rural Alaska, where five hospitals in hub communities serve specific regions that in turn refer Native Alaskan patients to the Native hospital in Anchorage. The twelve Native Health corporations, funded by the Indian Health Service under 638 compact agreements, manage the health care services delivered to Alaska Natives in more than 200 villages in the state. Primary care and emergency services are rendered in the community by community health aides who are trained residents of the village with telephone guidance provided by a physician of the health corporation. Community health aides are unique to Alaska under federal law. The state, through Public Health Nurses, also provides for the direct delivery of health care services in medically underserved areas of the state, focusing on maternal and child health. Managed care is making only minor inroads in the health care delivery in the state with some preferred provider arrangements; there are no HMOs in the state.

Alaska Population Information – Program Inception

According to *Population Overview: 1997 Estimates* (Alaska Department of Labor), there were 611,300 residents in Alaska during that year; 74% of the population was white, 16.7% was Alaska Native, and around 5% each were African American, Asian/Pacific Islander, and Hispanic. In 1997, 46.2% of households in Alaska had related children; of these, 71.1% were married couple households, and 29% were single parent households, of which one-third were male headed. Two hundred one thousand seven hundred thirteen (201,713) of the total population in 1997 (33%) were children from birth through age 18. Twenty-two percent of all children up through age 18 were Alaska Native, and 67% were white; this is accounted for by the higher birth rate of Alaska Natives who have a crude birth rate of 23.8 per 1,000. There are 2.4 children per family in Alaska, but 3.2 children in Alaska Native families.

Alaska’s total population increased by 11.1% from 1990 to 1997; however, the numbers of children under age five decreased 7.5%. Children ages 5 to 13 represent the peak of the echo boom (children of the last Baby Boomer born in the late 50s and 60s); their numbers increased during the 90s although their proportion of the population increased only 1.3%. The cohort of children aged 14 to 17 have increased steadily since 1990 from 5.5% of the population to 6.6% in 1997. In 1997, 52,202 children ages birth through 18 were eligible for Medicaid – 26% of the children in the state. Thirty-nine percent of Medicaid eligible persons are Alaska Native; however, Alaska Native children constitute 41.1 percent of Medicaid eligible children. The state and the tribal health

organizations believe Alaska Native children are under-enrolled in Medicaid due to a combination of factors that need to be addressed by targeted outreach efforts designed for this population. (See outreach information in Section 5).

The distribution of children in Alaska by selected ages is as follows:

AGE	TOTAL	MALE	FEMALE
Under 1	10,029	5,134	4,895
1-2	20,333	10,361	9,972
5	11,229	5,502	5,527
6	11,449	5,986	5,553
10-11	22,193	11,351	10,842
12-13	21,656	11,078	10,578
15	10,086	5,259	4,827
16	10,067	5,226	4,481
17	9,487	4,990	4,497
18	8,503	4,473	4,030

Information on geographic, racial, income, and insured status distribution of children in the state is not readily available through any sources.

The state hired Employee Benefits Research Institute (EBRI) to analyze the CPS data, and although the state remains concerned about the small CPS sample size for Alaska, the EBRI estimated that 55% of children in Alaska had private insurance coverage, 35% had public coverage (including Medicaid) and 9% of children were uninsured.

Conclusion – Program Inception

The State of Alaska can make only basic assumptions about the number, distribution and insured status of children residing in the state from the data briefly outlined above. Baseline information will need to be developed in order to evaluate the success of the Medicaid expansion for Title XXI.

- 2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))
 - 2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

The Division of Medical Assistance in the Department of Health and

Social Services (single state agency) has an agreement with the Division of Public Health, Maternal Child Family Health, Child Health Unit, to conduct outreach to children in the state who may be eligible for Medicaid. Through the state public health nurses, who conduct clinics in many locations in the state with an emphasis on maternal and child health, children seen in the communities are encouraged to enroll in Medicaid if the child appears eligible. The public health nurses and Section of Maternal Child Family Health also coordinate with HeadStart, Infant Learning Programs and the Handicapped Children's Program to promote enrollment in Medicaid.

The Division of Public Assistance, responsible for eligibility determinations for all assistance programs including Medicaid, pays Fee Agents in rural areas of the state to assist individuals in completing the Medicaid application.

The Division of Medical Assistance also meets regularly with tribal health staff in a group called the Medicaid Task Force to share information and address problems of mutual concern. A subcommittee of the Task Force has formed to develop innovative ideas for promoting Medicaid enrollment of Alaska Natives. Because Alaska Natives receive free health care through the Indian Health Service-funded tribal health delivery system, the challenges of Medicaid enrollment for this population are significant. Under-enrollment of Alaska Natives in Medicaid is a real problem for tribal health care entities, and has been documented to be as high as 40% in some areas of the state. Additionally, the tribes remain concerned that Welfare Reform is reducing the number of Medicaid-covered Alaska Natives because of confusion over the meaning of the five year benefit limit, and the fact that cash assistance and Medicaid are no longer linked.

- 2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

There are no programs in Alaska involving a public-private partnership to provide health insurance for children.

- 2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with

other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (*Previously 4.4.5.*)
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Alaska's initial effort for utilizing Title XXI funding expanded Medicaid eligibility for children up to age 19 to those children whose family incomes did not exceed 200% of the Federal Poverty Guidelines (FPGs) for Alaska. Effective September 1, 2003, Alaska reduced the upper limit of the FPGs from 200% to 175% for the optional group of persons under 19 years of age. This optional group of children was considered eligible if the following family monthly income amounts were not exceeded for family size indicated. These monthly income amounts were held constant through June 30, 2007:

- 1. \$1,635 a month if the household consists of one person;**
- 2. \$2,208 a month if the household consists of two persons;**
- 3. \$2,782 a month if the household consists of three persons;**
- 4. \$3,355 a month if the household consists of four persons;**
- 5. \$3,928 a month if the household consists of five persons;**
- 6. \$4,501 a month if the household consists of six persons;**
- 7. \$5,074 a month if the household consists of seven persons;**
- 8. \$5,647 a month if the household consists of eight persons;**
- 9. \$5,647 a month, plus an additional \$574 a month for each extra person above eight persons who is in the household if the household consists of nine persons or more.**

Effective July 1, 2007, Alaska increased the FPGs from 154% to 175% for the optional group of persons under 19 years of age. This optional group of children is considered eligible if the family household income does not exceed 175% FPG as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2). The revisions will take place annually on or before April 1 in Alaska.

Insured children with incomes up to 150% of the Federal Poverty Level are eligible for Medicaid under Title XIX if third party coverage is the only eligibility factor preventing them from qualifying for Title XXI coverage. The single state agency, the Alaska Department of Health and Social Services, initiated a department-wide effort to develop and promote child health coverage that included separating Medicaid eligibility determination from public assistance programs, and an expanded outreach effort.

The state made some modifications to the simplified application form currently used for pregnant women and children up to age six. Separate Medicaid eligibility determination units have been established so that health care and cash

assistance programs are no longer linked. The state opened many avenues for the health care application so that the perception of Medicaid as “welfare” diminished. All applications are mailed in to the Medicaid eligibility determination unit, with any necessary follow-up done by phone with the families of children. Elimination of the asset test for all children as well as continuous eligibility simplified the process and provided some assurance that children remained on the program. This is especially important in Alaska, as a significant number of people are seasonally employed through industries such as tourism, fishing, and logging; additionally, these types of employment and traditional Native lifestyles mean that families move about the state to partake in various activities. It was hoped that continuous eligibility would minimize disruptions in coverage from fluctuations in family income and would promote continuity of care.

Since Denali KidCare program implementation in March 1999, six-months of continuous eligibility have been provided to children enrolled in the program. Beginning April 2009, the Department will begin providing 12-months of continuous eligibility for children enrolled in the program. This added simplification will help the state be consistent with requirements under the CHIPRA performance bonus payments provision. Not only should this provide better continuity of coverage and care for children with eligibility redeterminations being done every twelve months, but also the eligibility administration should become more efficient with the change in process. It is hoped that this will free up time for eligibility staff to focus on quality improvements to eligibility determinations and the added requirements of citizenship and identity documentation as well as PERM.

The state also has in place a system of Fee Agents in rural locations without access to eligibility offices. Fee Agents are people who live in the community who are trained in eligibility issues by the Division of Public Assistance, and who are paid on a per-application basis to assist individuals in completing application forms and assure that required documentary information is included so that applications are complete as submitted to the state for the final eligibility determination.

(DMA) response to 10/28/02 e-mail - CMS questions

Section 2.3 – Please describe the procedures that the State uses to accomplish coordination of SCHIP with relevant child health programs such as Title V as required at 42 CFR 457.80(c).

Denali KidCare, Alaska’s SCHIP, coordinates with child health programs such as Title V through its outreach effort. In Alaska, the Denali KidCare Program is administered by the Division of Medical Assistance who in turn contracts with the Division of Public Assistance to determine eligibility for the program and also contracts with the Division of Public Health to

conduct the outreach/marketing/training of the Denali KidCare Program. The Denali KidCare outreach staff members are housed in the Child Health Unit of the Maternal Child Family Health Section, Division of Public Health. It was felt that placing the outreach staff under the MCFH umbrella would be a natural fit for coordination with all of the Title V programs such as the Infant Learning Program (ILP); Women, Infant, Children Program (WIC); Children with Special Health Care Needs Program (CSHCN); etcetera. This would best be described as a top down approach where all the Title V state program coordinators are housed with the outreach arm of Denali KidCare insuring that they are apprised of the latest accomplishments and developments with the SCHIP including information on the application and renewal process, covered services, policy changes, and new collateral program materials. The Denali KidCare outreach staff is composed of a state outreach coordinator and five regional outreach specialists who cover the Southeast Alaska Region, South Central and the Aleutians Region, Anchorage and the Matanuska Susitna Borough Region, the Interior and Northern Region, and the Western Region of Alaska. Each specialist is responsible for culturally appropriate outreach efforts in their assigned region. Outreach Specialists conduct training for local organizations on the application and renewal process, on covered services, on policy changes, and provide collateral materials to more than 1,200 access points across the state. Additionally, they attend health fairs and other local events, and assist recipients with the application and renewal process if necessary. Efforts common to all regions include working with schools; Alaska Native health corporations; Women Infant and Children's Programs; Infant Learning Programs; public health nurses; social service agencies including Parents, Inc., Family Voices, and Alaska Family and Youth Network to name several CSHCN advocacy networks; providers; and other organizations as well as appropriate businesses. Denali KidCare has accomplished the goals pertaining to outreach and enrollment through planning, placement of outreach staff, and coordination of training with access points. From program inception major emphasis has been placed on MCFH, Title V programs.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))



Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

- 3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))
- 3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

- 4.1.1. Geographic area served by the Plan:
- 4.1.2. Age:
- 4.1.3. Income:
- 4.1.4. Resources (including any standards relating to spend downs and disposition of resources):
- 4.1.5. Residency (so long as residency requirement is not based on length of time in state) :
- 4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility):
- 4.1.7. Access to or coverage under other health coverage:
- 4.1.8. Duration of eligibility:
- 4.1.9. Other standards (identify and describe):

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

- 4.2.1. These standards do not discriminate on the basis of diagnosis.
- 4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

- 4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))
- 4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))
- 4.4.3. The state is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))
- 4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box.
(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))
- 4.4.5
- 4.4.4.1. Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.
- 4.4.4.2. Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.
- 4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.
- 4.4.4.4. If the state provides coverage under a premium assistance program, describe:
- The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.
- The minimum employer contribution.
- The cost-effectiveness determination.
- 4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

Applications are widely available in the state at all community locations where families with children commonly visit. Partnerships with state, local government, schools, health care providers, tribal entities, and non-profit corporations serving children have been established to ensure that child health coverage is promoted and families are assisted in applying. One advertising promotion and other promotional activities such as the Governor's press conference were conducted within the state in advance of the initiation of the Medicaid expansion to assure awareness of the program: these activities were linked with other state promotional activities such as childhood immunizations, Head Start enrollment, and school and sport physicals, to name a few. Information on child health coverage, applications, and renewals were made available on the department's home page and on the Internet as well.

The State applied and received a Robert Wood Johnson Foundation, Covering Kids grant in 1999. A coalition of state agencies, health care associations, community partnerships and Alaska Native organizations prepared two innovative outreach concepts for the grant proposal which became the two pilot projects under the RWJ grant. The first was AlaskaNet, designed to target all communities in which Alaska Native children reside and became known as the Alaska Native Tribal Health Consortium Pilot Project. The second concept was to target the fastest growing area of the state in Southcentral Alaska and this pilot project became known as the Mat-Su Agency Partnership. Because of geographic, cultural and other challenges of the state, these two initiatives demonstrated new ways to reach children and overcome resistance to enrollment in health care programs.

At program inception, Alaska Natives comprised 16.7% of the state's population, but due to a number of factors were disproportionately represented in most poverty and health indicators, and comprised 39% of the current Medicaid eligible population. Nearly one-half of all Alaska Natives lived in small, rural communities that were accessible only by small plane, boat in summer, or snow machine in winter, and relied on a subsistence lifestyle in largely non-cash economies. A significant number of eligible Alaska Native children were not enrolled in Medicaid, and the state and tribal health care delivery system believed the number was increasing with the effects of welfare reform. Because Medicaid reimbursement was and still is critical to the future development of the

tribal health care delivery system, a project to market Medicaid coverage in a culturally appropriate manner was very timely. Although the health care delivery system to rural Alaskan villages was/is impressive, given the climate, geography and distance from urban centers, the level of health care service availability remains well below the expectations of most Americans. The Alaska Native Tribal Health Consortium, a network of tribally owned and operated health care providers, designed objectives and statewide strategies to enroll Alaska Native children in the Medicaid Program in an effective, culturally sensitive manner that educated the community on the importance of Medicaid to the overall health care delivery system.

The other outreach pilot project, Mat-Su Partnership, a twelve-year old community-based consortium of organizations, targeted enrollment of children in Medicaid in the Matanuska-Susitna Borough. This 24,643 square mile area of the state has two communities in the core area of the borough and a growing number of people choosing a self-sufficient rural lifestyle. At program inception, the borough has a population density of only 1.6 persons per square mile, but the population is projected to triple in the next twenty years. Residents in the borough choosing to emulate the subsistence lifestyle distrust governmental intrusion, and many homestead land and home school their children; they also lack access to phones, media, and retail establishments. The Mat-Su Partnership utilized unique public awareness techniques, community access points, and tested electronic application submission.

Section 6. Coverage Requirements for Children’s Health Insurance (Section 2103)



Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children:
(Check all that apply.) (42CFR 457.410(a))

- 6.1.1. Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)
 - 6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1))
(If checked, attach copy of the plan.)
 - 6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
 - 6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

- 6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430)
Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions.**
- 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania]
Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.
- 6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4) (42 CFR 457.450)
- 6.1.4.1. Coverage the same as Medicaid state plan
 - 6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
 - 6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
 - 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage
 - 6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage
 - 6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit-by-benefit comparison (Please provide a sample of how the comparison will be done)
 - 6.1.4.7. Other (Describe)

6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

- 6.2.1. Inpatient services (Section 2110(a)(1))
- 6.2.2. Outpatient services (Section 2110(a)(2))
- 6.2.3. Physician services (Section 2110(a)(3))
- 6.2.4. Surgical services (Section 2110(a)(4))
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. Prescription drugs (Section 2110(a)(6))
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Pre-natal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12. Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15. Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. Dental services (Section 2110(a)(17))
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. Hospice care (Section 2110(a)(23))

- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative,

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remedial, therapeutic, or rehabilitative services. (See instructions)
(Section 2110(a)(24))

- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
- 6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

- 6.3.1. The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**
- 6.3.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

- 6.4.1. **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. **Describe the**

cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

- 6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act.

Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

- 6.4.2. **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

- 6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

- 6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

- 6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 8.

- 7.1. Describe the methods (including external and internal monitoring) used to assure the

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quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) (42CFR 457.495(b))

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or**, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

Section 8. Cost Sharing and Payment (Section 2103(e))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. YES

8.1.2. **NO, skip to question 8.8.**

8.2. Describe the amount of cost sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(B)) (42CFR 457.505(b))

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. Cost sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3. No additional cost sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the state. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be

excluded from cost sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

- 8.8.1. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2. No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5)) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105(c)(7)(B)) (42CFR 457.475)
- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))
- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))
- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

A description of Alaska's strategic objectives, performance goals, and measures/indicators asked in 9.1, 9.2, and 9.3 is listed below:

STRATEGIC OBJECTIVE #1 – Reduce the number of uninsured children in Alaska by providing health care coverage through the expanded Medicaid child health insurance program known as Denali KidCare.

Performance Goal – Market the Medicaid child health insurance program

- **Number of enrollment forms distributed through outreach efforts**
- **Collaborative efforts with community entities serving children and families**
- **Public information campaign media exposure**

Performance Goal – Enroll targeted low income children in

- **Medicaid Measure the number of children enrolled in Medicaid in the base line year and compare enrollment growth in future years**

STRATEGIC OBJECTIVE #2 – Improve access for Medicaid enrollment of children

Performance Goal – De-link Medicaid eligibility determination from public assistance programs

- **Create separate Medicaid eligibility determination units**

Performance Goal – Simplify eligibility process

- **Create mail-in application process and shorten application**

- **Implement policy for continuous eligibility for children and eliminate asset test**
- **Eliminate face-to-face interview**

STRATEGIC OBJECTIVE #3 – Deliver EPSDT services to new children enrolled in Medicaid at higher income levels at the same rate as age-comparable groups of other children enrolled in Medicaid.

Performance Goal – Compare percentages of newly enrolled Medicaid children receiving EPSDT screenings to other Medicaid enrolled children

- **Measure data from EPSDT subset of MMIS**

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. Immunizations
- 9.3.7.2. Well-child care
- 9.3.7.3. Adolescent well visits
- 9.3.7.4. Satisfaction with care
- 9.3.7.5. Mental health
- 9.3.7.6. Dental care
- 9.3.7.7. Other, please list:
- 9.3.8. Performance measures for special targeted populations.

9.4. The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

The state will continue to comply and has complied with the required annual assessments. Alaska Department of Health and Social Services data and research staff will develop any reports required by CMS. If outside services are required to complete these assessments, evaluations or reports, the department will obtain professional services through the state's competitive procurement process.

9.6. The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

State legislation was required to obtain authority to expand Medicaid coverage and expend funding available under Title XXI. During the 1998 Legislative Session, public hearings were held in two committees in the House of Representatives and one committee in the Senate which were open for public comment. In advance of the session, the Governor of Alaska developed his Smart Start Initiative for children which included health coverage expansion under Medicaid. A blueprint for child health was developed and widely distributed

statewide to health care providers and organizations, child advocates, tribal leaders and others, as well as made available on the Department's Home Page. A concerted effort was made to develop grassroots support for the child health expansion in order to garner support for the legislation prior to session commencement in January.

State regulations were also required in order to implement changes to the Medicaid Program necessary to implement the child health expansion. The state regulatory process involves a written public notice published in newspapers of general circulation and the Alaska Administrative Journal that is mailed to interested parties on the departmental mailing list and provided to state legislators. A public hearing was also held on the regulations with statewide access through teleconferencing. Any changes to state Medicaid policy must similarly be accomplished through this public regulatory process.

- 9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

The Alaska Native Tribal Health Consortium served as one of two pilot project sites under the Robert Wood Johnson Foundation grant for the Covering Kids Initiative. There is ongoing discussion with the Medicaid Task Force that meets at least quarterly and includes representation from all of the Tribes and Regional Health Corporations. All aspects of the design and implementation of Denali KidCare were presented and discussed with the Medicaid Task Force through the legislative and regulatory processes in 1998. There is continuing dialogue with the Reaching Alaska's Children Statewide Coalition that consists of representation from the three state divisions responsible for the Denali KidCare Program under the Department of Health and Social Services, the Alaska Native Tribal Health Consortium, social service agencies, and others. Finally, there is ongoing outreach with the Native Tribal Health Facilities by state outreach staff.

(DMA) response to 10/28/02 e-mail - CMS questions

Section 9.9.1 – Please describe the method(s) used by the state to ensure ongoing public involvement in the design and implementation of the state plan.

To restate the paragraph under Section 9.9.1 of the state plan update in an alternative way, the following are the State's methods to ensure ongoing public involvement in the design and implementation of the state plan:

1. **The Division of Medical Assistance Medicaid Task Force holds quarterly meetings with the Tribes in different locations and includes representation from all of the Tribes and Regional Health Corporations to discuss policy and address issues of concern. An example of an issue that surfaced two years ago was the establishment of child support cases through the Child Support Enforcement Division (CSED) and perceptions of CSED actions as a serious problem in getting Alaska Native parents to agree to enroll their children in Denali KidCare. The Division worked with CSED to alter their process of order establishment, particularly as it applies to Alaska Natives, and succeeded in amending Alaska law to separate the establishment of cash and medical support orders. On-going dialogue as expressed in the prior paragraph is paramount to ensure public involvement in implementation of the state plan.**
2. **The Robert Wood Johnson, Reaching Alaska’s Children Statewide Coalition, whose membership includes representation from the Alaska Native Tribal Health Consortium; business leaders; social service agencies; family advocates; the three state divisions, Medical Assistance, Public Assistance, and Public Health; state health associations; and the state school board association meets quarterly to effect Medicaid policy and make recommendations to the Division of Medical Assistance.**
3. **Finally, Alaska’s Medical Care Advisory Committee (MCAC) is a public advisory group charged with advising the State's Medicaid agency, the Alaska Department of Health and Social Services, on policy and program changes to the Medicaid program. The MCAC also meets quarterly.**

These meetings are the methods used by the State to ensure ongoing public input into the design and implementation of the Alaska Medicaid State Plan.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

This State Plan Amendment to increase the FPGs to 175% does not restrict eligibility or benefits and therefore does not require public notice.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as

outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.

- Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

Based on CPS data available at the time of program inception, an estimated 11,600 children in the state were either uninsured with family incomes under 200% of the federal poverty level for Alaska, or were eligible for but not enrolled in Medicaid. At the time between 25 and 40 percent of these children were estimated to be Alaska Native. With the average annual per-child expenditure under Medicaid for children in Alaska projected at \$1,900 at the time, the state projected a full FY 99 cost for all newly eligible children at \$8.8 million total funds (including 10 percent administration). However, for state fiscal year 1999, the Legislature appropriated only \$1.9 million in state general fund match for a Medicaid expansion for child health, and to cover pregnant women under Title XIX with incomes up to 200% of the Federal Poverty Level. This funding level was thought to be sufficient to cover the program costs during the beginning fiscal year since the program startup was delayed until March 1, 1999 to develop the infrastructure necessary to expand the program.

See attached budget.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1 The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. Section 1128A (relating to civil monetary penalties)
- 11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.**

Eligibility and Enrollment Matters

- 12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

Health Services Matters

- 12.2 Please describe the review process for **health services matters** that comply with 42 CFR 457.1120.

Premium Assistance Programs

- 12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable.