FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

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

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)
Jay Livey, Deputy Commissioner, Alaska Department of Health and Social Services
for Karen Perdue, Commissioner

Date: _____

Reporting Period: 3/1/99 through 9/30/99

Contact Person/Title:

Robert Labbe
Director, Division of Medical Assistance
Department of Health and Social Services
P. O. Box 110660
Juneau, AK 99811-0660
Phone: (907) 465-3355
Fax: (907) 465-2204
Email: bob_labbe@health.state.ak.us

Deborah K. Smith
SCHIP Program Coordinator
Department of Health & Social Services
P. O. Box 110601
Juneau, AK 99811-0601
Phone: (907) 465-1696
Fax: (907) 465-3068
Email: deborah_smith@health.state.ak.us

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR SCHIP PROGRAM

This section is designed to highlight the key accomplishments of your SCHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the SCHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

The baseline is the number of children under 19 years of age in families with incomes below 200 percent of the Alaska Federal Poverty Level and without health insurance. The baseline number developed during the 1998 Alaska Legislative session in the request to expand the Medicaid program to include these children was 11,600 children.

Alaska did not submit a 1998 annual report to HCFA as the Title XXI Medicaid expansion was not implemented until March 1999.

1.1.1 What are the data source(s) and methodology used to make this estimate?

The data source used to develop the estimate was the March Supplement of the Current Population Survey (CPS) for the years 1994, 1995, and 1996 (data collected in March 1995, March 1996, and March 1997). These years were the most recent three available at the time the proposal to expand Medicaid coverage under Title XXI was first developed in Alaska. The 3-year merged sample was created by the Employee Benefits Research Institute under contract with the Alaska Department of Health and Social Services. Three-year merged samples have been used by many states as well as HCFA in order to improve the reliability of the estimates. In states such as Alaska, where a relatively small number of households are surveyed annually, the reliability of the state-level CPS estimates can be improved by merging three years of data. Using three years of March CPS data doubles the sample size. In a given March survey, half of the households were interviewed the previous year and half of the households will be interviewed again the next year. To ensure independence of observations, households are included only once in a 3-year merged sample.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Like most small states, Alaska relies on the CPS data because it is too expensive to collect our own data. However, Alaska and all small states have serious concerns about the reliability of the CPS March Supplement data even when three-year merged samples are used to make estimates.

At the request of HCFA, the Census Bureau created three-year merged samples and published baseline estimates for all states. For the same years (1994, 1995, and 1996) that we used to generate our estimated baseline number above, (see 1.1), the Census Bureau estimated that there were 12,000 uninsured Alaskan children under 19 years of age in families with incomes at or below 200 percent of the Federal Poverty Level. They also provided a standard error of 2,700 which means that the Census Bureau has 90 percent confidence that the Alaska's baseline estimate is between 9,300 and 14,700 children. However, the data used for estimating the baseline of uninsured children for implementation of the Title XXI Medicaid expansion under-estimated both the number of children with existing Medicaid coverage and the number of children with coverage through the Indian Health Service.

It is also important to note that at no point in the CPS are respondents asked if any members of the household were uninsured for either part or all of the previous year. Estimates of the uninsured from the CPS reflect the number of persons for whom none of the specified types of coverage are reported for the year. Therefore, if survey respondents are answering the questions as intended, a person reported as uninsured on the CPS is without insurance for the entire year. When respondents answer the questions accurately, the CPS captures any type of coverage held for even part of the year, but only capture as uninsured those who were without insurance for the entire year.

In addition, there is concern that persons responding to the CPS may be reporting their coverage at the time of the interview, rather than their status during the previous calendar year as requested. Experts on the CPS acknowledge that it is likely that there is a mix of responses among respondents to the CPS, some reporting their current coverage while others are reporting coverage during the previous year as requested.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

At this time, the best source of information on changes in the number of uninsured children is the state's Title XIX and Title XXI program data. With the extent of outreach and the resulting enrollment, it is assumed the combined program has made a major impact in reducing the number of children without health coverage in Alaska, however it is difficult

to list a change in uninsured rate in the state. Evidence of rising health care costs, low metal prices in the mining industry, and regional economic downturns in seafood processing and lumber make assumptions regarding the number of families losing health coverage difficult.

There is not a good process for tracking annual changes on the uninsured in Alaska. If we rely on the CPS March Supplement data, we will not see that data relevant to FFY99 (when we first implemented the SCHIP program) until October 2000 at the earliest. Even then, a three-year merged sample will reflect health care coverage status in 1997, 1998, and 1999.

We know from Medicaid enrollment data that the number of children with health coverage through Medicaid increased substantially in the year when SCHIP was implemented. The total number of individuals under age 21 enrolled in Medicaid in FFY98 (prior to CHIP implementation) was 58,266. In the next year, FFY99, there were 7,130 more individuals under age 21 enrolled: 57,363 were eligible for Title XIX and 8,033 were in the Title XXI Medicaid SCHIP expansion program.

1.2.1 What are the data source(s) and methodology used to make this estimate?

CPS, March Supplement – 3 year average
Program data (Title XIX and XXI)

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The reliability of the CPS, March Supplement data is poor. The sample size for Alaska is small (approx. 160 families). The data used for estimating the baseline of uninsured children for implementation of the Title XXI Medicaid expansion under-estimated both the number of children with existing Medicaid coverage and the number of children with coverage through the Indian Health Service. The Department of Health and Social Services is looking at developing estimates of uninsured children using the CDC-sponsored Behavioral Risk Factor Surveillance Survey (BRFSS). The BRFSS still may not establish an accurate estimate of the number of uninsured children in Alaska, however the larger sample size may provide better estimates of year-to-year trends in the health coverage of children.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its SCHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the SCHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
I. Reduce the number of uninsured children in Alaska by providing health care coverage through the expanded Medicaid Children's Health Insurance Program (SCHIP).	*I.1 Market the Children's Health Insurance Program.*	*1. Number of applications distributed through non-traditional sites.* *Baseline: 0 Target: 10,000* *2. Number of clients enrolled through mail-in applications.* *Baseline: 0 Target: 2,758* *3. Number of targeted outreach initiatives.* *Baseline: 0 Target: 3* Data Sources: *Division of Public Assistance Denali KidCare office and Division of Public Health outreach staff.* Methodology: *Compare performance to baseline and to targets.* Numerator: Denominator: Progress Summary: *Performance exceeded the targets for all measures. Approximately 54,000 applications were distributed through non-traditional sites. More than 95% of the 8,033 children enrolled in SCHIP were enrolled through the mail-in process. Forty-five (45) targeted outreach initiatives were conducted by community-based organizations throughout the state.*

OBJECTIVES RELATED TO SCHIP ENROLLMENT		
	I.2 De-link SCHIP eligibility determination from public assistance programs and simplify eligibility process.	1. *Create separate SCHIP eligibility determination unit.* 2. *Create mail-in application process and shorten application.* 3. *Implement policy for continuous eligibility for children and eliminate asset test.* 4. *Eliminate face-to-face interview.* Data Sources: Methodology: Numerator: Denominator: Progress Summary: *All four of the performance measures were completed and implemented. This goal is accomplished.*
	I.3 Enroll targeted low income children in the Children's Health Insurance Program (SCHIP).	*Percent of targeted low income children enrolled in SCHIP.* *Baseline: 0 Target: 45.5% or 2,758* Data Sources: *quarterly reports to HCFA (data from MMIS)* Methodology: *unduplicated number of enrollees* Numerator: Denominator: Progress Summary: *Total unduplicated number of children enrolled in SCHIP between 3/1/99 (program start date) and 9/30/99 was 8,033. This goal is accomplished and exceeded.*

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
II. Increase access to preventive care for SCHIP enrolled children.	*II.1 Deliver EPSDT services to children enrolled in SCHIP at the same rate as children enrolled in regular Medicaid.*	*Percent of SCHIP and regular Medicaid children ages 6-18 eligible for screening who receive recommended EPSDT screenings.* Data Sources: *MMIS claims system and EPSDT subsystem* Methodology: *HCFA 416 methodology was applied to the subgroup of Medicaid recipients who were eligible for SCHIP at any time between 3/1/99 and 9/30/99. Rates of service usage were adjusted to reflect only 7 months of SCHIP program operation in FFY99.* Progress Summary: *SCHIP recipients ages 6-18 accessed EPSDT screenings at more than twice the rate of Title XIX Medicaid recipients. SCHIP recipients age 6-18 received both preventive dental and dental treatment services at rates higher than the rates for Title XIX Medicaid recipients in those age groups.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:
OTHER OBJECTIVES		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:

SECTION 2. BACKGROUND

This section is designed to provide background information on SCHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

_X_ Providing expanded eligibility under the State's Medicaid plan (Medicaid SCHIP expansion)

Name of program: ___Denali KidCare_____

Date enrollment began (i.e., when children first became eligible to receive services): _____3/1/1999_____

Denali KidCare incorporates three groups of Medicaid recipients:

- *SCHIP eligibles*
- *Individuals age 18 and under eligible under other "poverty level" Medicaid programs*
- *Women eligible for Medicaid due to pregnancy. Eligibility for this group was expanded to 200% FPL at the same time SCHIP was implemented.*

___ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed SCHIP program)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP programs.

NO FAMILY COVERAGE OFFERED

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP programs.

NO BUY-IN PROGRAM OFFERED

2.2 What environmental factors in your State affect your SCHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your SCHIP program(s)?

The Alaska Medicaid program served a large number of low-income children and is generally well accepted by Alaska health care providers. Effective eligibility and claims processing systems already existed to support a Medicaid expansion through Title XXI.

Alaska Native tribal health organizations that compact with the Indian Health Service have a statewide presence. This is the principal health care delivery system in most of rural Alaska and serves a significant number of low-income Alaskans in both rural and urban settings. The IHS system and the State of Alaska have worked hard over the years to develop the infrastructure to make effective use of Medicaid funding to supplement IHS funding for Alaska Native health care. The State of Alaska has an incentive to encourage the use of IHS services by eligible Medicaid recipients as the federal government provides 100 percent federal matching funds for these services.

Because these two health care funding/delivery systems were well established and have

developed good cooperative relationships, and because of the funding incentives, implementation of a Title XXI program through a Medicaid expansion was chosen. Also, the outreach components of our Title XXI program were designed to integrate the Alaska Native tribal health organizations to the greatest extent possible.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

_X_ No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into SCHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your SCHIP program.

_x_ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
_x_ Provision of continuous coverage (specify number of months _6_)
___ Elimination of assets tests
_x_ Elimination of face-to-face eligibility interviews
_x_ Easing of documentation requirements

Continuous eligibility and elimination of the face-to-face interview requirement are self-explanatory. Documentation of income for verification purposes was reduced through policy clarification. Note that both coverage of SSI children and elimination of the assets test for poverty-level categories already applied to the Alaska Medicaid program prior to the Title XXI expansion.
As a result of the 6-month continuous eligibility, preliminary data indicates that the ratio of monthly enrollment of children to annual unduplicated enrollment of children has increased.

_X_ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)_____

The TANF program was implemented in Alaska on July 1, 1997. Between that date and June 30, 1999 the welfare caseload decreased by 35% with more than

4,000 families leaving welfare for jobs. Most of these families remained eligible for Medicaid for 6 months after leaving welfare; if their family income remained below 185% of the Alaska Federal Poverty Level at the end of the six months, they were eligible for an additional six months of coverage.

A study is currently underway to gather information on the current economic circumstances – including health insurance status -- of former welfare recipients. Because the Alaskan economy in the past decade has moved increasingly toward service and retail sales jobs, we suspect that many former welfare recipients remain at an income level that would qualify the children for Medicaid or SCHIP coverage. In spite of the dramatic drop in the number of families receiving cash assistance since welfare reform, the following table shows that rather than decreasing, the number of children on Medicaid grew slowly over a 5-year period until a substantial increase occurred in FFY99, the year in which SCHIP was implemented.

FFY94	*FFY95*	*FFY96*	*FFY97*	*FFY98*	*FFY99*
55,202	56,051	56,927	57,763	58,266	65,396

_X_ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- _X_ Health insurance premium rate increases
- ___ Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- _X_ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____

Health insurance premium rates are increasing for both public and private sector employers. The trend in state employment and non-profit organizations is toward passing at least part of the increased premiums along to employees and/or decreasing benefits (e.g., increasing deductibles and co-payments, requiring employees to pay part or all of the cost of family coverage).

_X_ Changes in the delivery system

- ___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- ___ Changes in hospital marketplace (e.g., closure, conversion, merger)
- _X_ Other (specify) *Indian Health Service compacting to Alaska Native tribal health organizations has increased the potential for local self-determination in the type and amount of health care services available in many parts of the state. Compacting is a government-to-government agreement between the United States government*

(through the Indian Health Service) and the tribal organizations. To effectively use the potential presented by compacting, tribal health organizations must increase their recovery of third party reimbursement through Medicaid and insurance.

___ Development of new health care programs or services for targeted low-income children (specify) _____

___ Changes in the demographic or socioeconomic context

- ___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____
- ___ Changes in economic circumstances, such as unemployment rate (specify) _____
- ___ Other (specify)_____
- ___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid SCHIP Expansion Program	**State-designed SCHIP Program**	**Other SCHIP Program*** _____
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	*Statewide*		
Age	*Age 18 and under*		
Income (define countable income)	*200 percent of the federal poverty guidelines for Alaska and lower. Countable income includes the child's income as well as income of any natural or adoptive parent living in the household. Deductions to income include an earned income deduction of $90 and a monthly deduction of documented dependent care expenses up to a set limit.*		

Resources (including any standards relating to spend downs and disposition of resources)	*No resource test is applied.*		
Residency requirements	*Present in the state with an intent to remain indefinitely or temporarily absent from the state.*		
Disability status	*No disability criteria is applied.*		
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	*Cannot have creditable health insurance coverage or, if income is at or above 150% of the FPL, cannot have dropped such coverage in the last 12 months without good cause.*		
Other standards (identify and describe)			

**Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here **9** and indicate who you passed it along to. Name_____, phone/email_____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	____Gross	_X_Net	____Both
Title XXI Medicaid SCHIP Expansion	____Gross	_X_Net	____Both
Title XXI State-Designed SCHIP Program	____Gross	____Net	____Both
Other SCHIP program_____	____Gross	____Net	____Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups

133% of FPL for children under age 6 without insurance

100% of FPL for children up to age 18 born on or after 9/30/83 without insurance

71% of FPL for children up to age 18 born before 9/30/83 without insurance

150% of FPL for children with insurance who would otherwise be SCHIP eligible

Title XXI Medicaid SCHIP Expansion *200% of FPL for children aged 18 and under*

____% of FPL for children aged _____

____% of FPL for children aged _____

Title XXI State-Designed SCHIP Program ____% of FPL for children aged _____

____% of FPL for children aged _____

____% of FPL for children aged _____

Other SCHIP program_____ ____% of FPL for children aged _____

____% of FPL for children aged _____

____% of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3

Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Child, siblings, and legally responsible adults living in the household	D	D		
All relatives living in the household	N	N		
All individuals living in the household	N	N		
Other (specify): *Child and parent (but not stepparent) if counting sibling or stepparent income causes child to be over-income*	D	D		

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded. ***Enter "C" for counted, "NC" for not counted and "NR" for not recorded.***

Table 3.1.1.4

Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	C			
Earnings of dependent children	C	C		
Earnings of students	C	C		
Earnings from job placement programs	C	C		
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	C	C		
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NC		
Education Related Income Income from college work-study programs	NC	NC		
Assistance from programs administered by the Department of Education	NC	NC		
Education loans and awards	NC	NC		
Other Income Earned income tax credit (EITC)	NC	NC		
Alimony payments received	C	C		
Child support payments received	C	C		

Roomer/boarder income	NR	NR		
Income from individual development accounts	C	C		
Gifts *in excess of $30*	C	C		
In-kind income	NC	NC		
Program Benefits Welfare cash benefits (TANF)	NC	NC		
Supplemental Security Income (SSI) cash benefits	NC	NC		
Social Security cash benefits	C	C		
Housing subsidies *see AFDC 364-2*	NC	NC		
Foster care cash benefits	NC	NC		
Adoption assistance cash benefits	NC	NC		
Veterans benefits	C	C		
Emergency or disaster relief benefits	NC	NC		
Low income energy assistance payments	NC	NC		
Native American tribal benefits *after $2,000 annual exclusion*	C	C		
Other Types of Income (specify): *Alaska Permanent Fund Dividend payments*	NC	NC		

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes ____ No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	$ 90	$ 90	$	$
Self-employment expenses	$ actuals	$ actuals	$	$
Alimony payments Received	$ N/A	$ N/A	$	$
Paid	$ N/A	$ N/A	$	$
Child support payments Received	$ actuals	$ actuals	$	$
Paid	$ N/A	$ N/A	$	$
Child care expenses *under age 2* *Age 2 or over*	$ 200 175	$ 200 175	$	$
Medical care expenses	$ N/A	$ N/A	$	$
Gifts	$ 30	$ 30	$	$
Other types of disregards/deductions (specify)	$	$	$	$

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups	_X__No	____Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program	_X__No	____Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program	____No	____Yes (complete column C in 3.1.1.7)
Other SCHIP program_____	____No	____Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Alaska applies no asset test for these categories

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XXI State-designed SCHIP Program (C)	Other SCHIP Program* _____ _____ (D)
Countable or allowable level of asset/resource test	$	$	$	$
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*				
What is the value of the disregard for vehicles?	$	$	$	$
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*				

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes _X_ No

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program* _____
Monthly			
Every six months	X		
Every twelve months			
Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

_x_ Yes ° Which program(s)? *Medicaid expansion*

For how long? *Six Months*

___ No

3.1.4 Does the SCHIP program provide retroactive eligibility?

_x_ Yes ° Which program(s)? *Medicaid Expansion*

How many months look-back? *Three Months*

___ No

3.1.5 Does the SCHIP program have presumptive eligibility?

___ Yes ° Which program(s)?

Which populations?

Who determines?

_x_ No

3.1.6 Do your Medicaid program and SCHIP program have a joint application?

_x_ Yes ° Is the joint application used to determine eligibility for other State programs? If yes, specify.

One of two applications may be used. The primary application used for Title XXI (a short form developed specifically for Title XXI) may be used for Medicaid coverage for children and pregnant women in Title XIX categories for which there is no resource test. Eligibility workers will also accept applications for Title XXI on the State's multi-program application used for Medicaid, TANF, Food Stamps, the State Supplement to SSI (the Adult Public Assistance program), General Relief, and the Chronic and Acute Medical Assistance program.

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Alaska's eligibility determination process offers applicants a brief, easy-to-read application available from a wide variety of sources, including many health providers and the Internet. Applications can be submitted by mail from anywhere in the state. Almost all will be processed within two working days of receipt. Documentation and verification is the minimum necessary to reasonably ensure that factors of eligibility are met. Applicants do not have to have any direct contact with a Division of Public Assistance office. However, toll-free support from the single statewide Denali KidCare office is available and easily accessible.

The only possible weakness is that with a single, statewide office handling the applications, clients must either rely on the support of the state's outreach partners or take more initiative in seeking support from the statewide office. While substantial efforts are made to develop skilled outreach partners throughout the state, the possibility that someone may not find the support they need to apply does exist.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

The redetermination process differs very little from the initial eligibility process except that a review form is automatically mailed to recipients and income is generally the only factor of eligibility that must be verified. Otherwise, the strengths and weaknesses are the same.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your SCHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 3.2.1 SCHIP Program Type Medicaid Expansion			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T	*For 18 year olds*, $50 per day up to $200 per stay*	
Emergency hospital services	T	*N/A*	
Outpatient hospital services	T	*For 18 year olds*, 5% of charges*	
Physician services	T	*For 18 year olds*, $3/visit*	
Clinic services	T	*N/A*	
Prescription drugs	T	*For 18 year olds*, $2/prescription*	
Over-the-counter medications		*N/A*	
Outpatient laboratory and radiology services	T	*N/A*	
Prenatal care	T	*N/A*	
Family planning services	T	*N/A*	*Abortions are covered only when the mother's life is threatened or the pregnancy is a result of rape or incest*
Inpatient mental health services	T	*N/A*	
Outpatient mental health services	T	*N/A*	
Inpatient substance abuse treatment services	T	*N/A*	
Residential substance abuse treatment services	T	*N/A*	
Outpatient substance abuse treatment services	T	*N/A*	
Durable medical equipment	T	*N/A*	

* *applies only to 18 year olds who are not pregnant and who are not Alaska Native*

Table 3.2.1 SCHIP Program Type ____Medicaid Expansion__			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Disposable medical supplies	T	*N/A*	
Preventive dental services	T	*N/A*	
Restorative dental services	T	*N/A*	
Hearing screening	T	*N/A*	
Hearing aids	T	*N/A*	
Vision screening	T	*N/A*	
Corrective lenses (including eyeglasses)	T	*N/A*	*Required to use a state-contracted provider*
Developmental assessment	T	*N/A*	
Immunizations	T	*N/A*	
Well-baby visits	T	*N/A*	
Well-child visits	T	*N/A*	
Physical therapy	T	*N/A*	
Speech therapy	T	*N/A*	
Occupational therapy	T	*N/A*	
Physical rehabilitation services	T	*N/A*	
Podiatric services		*N/A*	
Chiropractic services	T	*N/A*	
Medical transportation	T	*N/A*	

Table 3.2.1 SCHIP Program Type ____Medicaid Expansion_____			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Home health services	T	*N/A*	
Nursing facility	T	*N/A*	
ICF/MR	T	*N/A*	
Hospice care	T	*N/A*	
Private duty nursing	T	*N/A*	
Personal care services	T	*N/A*	
Habilitative services			
Case management/Care coordination	T	*N/A*	
Non-emergency transportation	T	*N/A*	*Not authorized for weekends.*
Interpreter services			
Other (Specify)			
Other (Specify)			
Other (Specify)			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to SCHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Scope and range of benefits provided under SCHIP is exactly the same as under Title XIX. Because our SCHIP program is a Medicaid expansion, we cover a wide range of preventive services, rehabilitative services, and treatment as well as two health care needs seldom covered by commercial insurance: non-emergency travel (including travel for preventive care) and care for pre-existing medical conditions.
Preventive care offered under the program includes well-child exams, immunizations, dental exams, eye exams, and diagnostic procedures such as developmental assessment, mental health and substance abuse evaluations, and laboratory tests. Families receive outreach notices for well-child exams based on the state's EPSDT periodicity schedule. Public health nurses conduct additional local targeted outreach for EPSDT and either perform well-child screenings or provide assistance with scheduling appointments with private providers enrolled in the Medicaid program and securing transportation to appointments. The back of the mailer used to send plastic Denali KidCare cards to new recipients contains a prominent message highlighting coverage of dental and vision exams and immunizations.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3

Type of delivery system	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	___ Yes _x_ No	___ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	___ Yes _x_ No	___ Yes ___ No	___ Yes ___ No
Number of MCOs	0		
B. Primary care case management (PCCM) program	*None*		
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	*None*		
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	*None*		
E. Other *Fee-for-service*	X		
F. Other (specify)			
G. Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.3 How much does SCHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

_X_ Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program*_____
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**	*For 18 year olds only**		
Other (specify) _____			

** applies only to 18 year olds who are not pregnant and who are not Alaska Native*

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".
**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

NA -- No premiums

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

NA -- No premiums

___ Employer
___ Family

___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

NA – No enrollment fee

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

NA – No deductibles

3.3.6 How are families notified of their cost-sharing requirements under SCHIP, including the 5 percent cap?

Notification of cost-sharing for 18 year olds is included in program brochures and promotional material. Individuals subject to cost-sharing are notified by providers at the time of service. Cost sharing is minimal and applies only to in-patient hospitalization, outpatient hospital services, physician services, and prescriptions.

3.3.7 How is your SCHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

_x_ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your SCHIP program was implemented? (If more than one SCHIP program with cost sharing, specify for each program.) *0 percent*

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?
No

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your SCHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your SCHIP program(s). Specify which approaches are used (**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid SCHIP Expansion		State-Designed SCHIP Program		Other SCHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards	*N/A*					
Brochures/flyers	T	5				
Direct mail by State/enrollment broker/administrative contractor	*N/A*					
Education sessions	T	5				
Home visits by State/enrollment broker/administrative contractor	T	4				
Hotline	T	5				
Incentives for education/outreach staff	*N/A*					
Incentives for enrollees	*N/A*					
Incentives for insurance agents	*N/A*					
Non-traditional hours for application intake	T	3				
Prime-time TV advertisements	*N/A*					
Public access cable TV	T	4				
Public transportation ads	*N/A*					

Table 3.4.1						
Approach	Medicaid SCHIP Expansion		State-Designed SCHIP Program		Other SCHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Radio/newspaper/TV advertisement and PSAs	T	5				
Signs/posters	T	5				
State/broker initiated phone calls	*N/A*					
Other: Simple, customer friendly application and promotional materials	T	5				
Other: Newsletter articles provided to non-profits/associations	T	3				
Other: Radio PSA text provided to Native organizations for live radio translations	T	4				
Other: Community telephone book listings of 888 or local number	T	5				
Other: Community-based grantee projects for targeted outreach	T	4				
Other: Training manuals and packets for access points	T	5				
Other: Point of Service brochure and poster holders	T	5				
Other: Table top displays for health fairs/conferences	T	5				
Others: CB radio announcements	T	4				
Other: Denali KidCare Website	T	5				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Table 3.4.2

Setting	Medicaid SCHIP Expansion		State-Designed SCHIP Program		Other SCHIP Program* _____	
	✔ = Yes	Rating (1-5)	✔ = Yes	Rating (1-5)	✔ = Yes	Rating (1-5)
Battered women shelters	T	4				
Community sponsored events	T	5				
Beneficiary's home	T	3				
Day care centers	T	4				
Faith communities	T	4				
Fast food restaurants	T	3				
Grocery stores	T	3				
Homeless shelters	T	5				
Job training centers	T	5				
Laundromats	T	4				
Libraries	T	3				
Local/community health centers	T	5				
Point of service/provider locations	T	5				
Public meetings/health fairs	T	5				
Public housing	T	4				
Refugee resettlement programs	T	5				

Table 3.4.2						
Setting	Medicaid SCHIP Expansion		State-Designed SCHIP Program		Other SCHIP Program* _____	
	✔ = Yes	Rating (1-5)	✔ = Yes	Rating (1-5)	✔ = Yes	Rating (1-5)
Schools/adult education sites	T	5				
Senior centers	T	4				
Social service agency	T	5				
Workplace	T	4				
Other: Public health centers	T	5				
Other: Alaska Native health organizations and clinics	T	5				
Other: Hospitals	T	5				
Other: Physicians' and other health care providers' offices	T	5				
Other: Public and private elementary, middle and high schools	T	5				
Other: State home school program	T	4				
Other: Headstart and other pre-school programs	T	5				
Other: State agencies such as child protection and juvenile justice systems	T	5				
Other: WIC program offices	T	5				
Other: Community mental health centers	T	4				
Other: Community alcohol and drug treatment programs for teens	T	4				
Other: Local youth shelters and programs	T	4				

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Applications received are tracked and caseload data are updated on a weekly basis. A survey is included in the application packet to evaluate the success of outreach efforts and to provide information on client demographics; staff were aware there would be difficulties getting this information in a timely fashion from the eligibility system and Medicaid Management Information System, since both of these systems were going through programming changes for Y2K compliance. Monthly reports from the survey provide information on how clients hear about the program and where they obtain the program applications, as well as on family size, community of residence, and income. Copies of sample reports from the outreach survey have been provided as an attachment.

The survey illustrated that initially applicants heard about the program from state agencies, numerous access points, and the media. The early media efforts were related to press coverage and the Governor's press releases about the program. Over the months the survey illustrated that new applicants were increasingly hearing about the program through friends, family and neighbors.

The survey indicated that initially most applicants received applications through the mail and this remains the most common source for the receipt of applications. However, the survey has shown clients increasingly report receiving applications from their health care providers (private physicians or Native health corporations). This information was used early in the program to develop strategies to decrease the number of applications submitted without required documentation. To remedy the problem, outreach specialists increased training/education to access points including providers on what supporting information needed to be included with the applications. In addition, when survey results indicated that most applications were not being completed in provider offices, but received through the mail, it was also decided to provide a check-list with the application packet.

The survey information has shown that the greatest percentage of applications are received from "urban" Alaska, especially the Anchorage area and the rest of Southcentral Alaska, the most populous area of the state. (Much of Southcentral Alaska outside Anchorage – such as the Kenai Peninsula and the Matanuska-Susitna valley -- would be considered "rural" in other areas of the U.S.) However, the survey also shows significant numbers of applications from the "bush" areas of the state (remote or frontier/wilderness areas by most U.S. standards).

One of the analyses conducted on survey results sorts the results by Alaska Native health corporation regions as a means to provide feedback to the Alaska Native Tribal Health Consortium and health corporations on their outreach efforts for the program.
Examples of reports generated from the surveys are attached.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

All promotional materials including brochures, posters, flyers, and table top displays used photographs of children and teens that depict the ethnic diversity of Alaska's children and teens.
We collaborated with Alaska Native health corporations and other tribal entities to enhance enrollment of Alaska Natives in Denali KidCare. We provided training and educational materials to numerous Alaska Native health organizations and non-profit associations statewide. We also provided radio and television public service announcement copy and press releases to these organizations for their staff and volunteers to translate into Native languages and read live on local radio stations statewide.
The state-level outreach staff collaborated very closely with the outreach staff of the Robert Wood Johnson Foundation-funded outreach project conducted by the Alaska Native Tribal Health Consortium to facilitate their educational materials and other outreach communication needs. Alaska Native Tribal Health Consortium outreach staff were included in weekly state outreach staff meetings, as well as in all of the state program staff's strategic marketing planning and in program update communications and formal training.
The state funded 26 diverse community-based outreach project grantees to provide targeted outreach in their local community. Many of these projects are in rural areas where the population is primarily Alaska Native. Since most Alaska Natives do not read their Native dialects (because they are oral languages and frequently no written language exists), local phone number labels were added to state-produced posters to direct people to local organizations for application assistance.
Some grantees in urban centers translated program brochures and flyers into other languages for targeted outreach to ethnic groups in their areas including Hispanic, Samoan, Korean, Thai, and Russian people, and with state grant awards they have provided translators to serve these populations with direct application assistance.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

The success of our outreach and program enrollment is due not only to the program design and delivery system that eliminated or minimized barriers to enrollment, but also is due to the strategic marketing planning and marketing mix that was used to reach every Alaskan with simple, strong publicity and enrollment messages. All promotional materials were simple, colorful, respectful and non-governmental looking to de-link Denali KidCare from the negative stigma of welfare and "typical" government programs. All materials contained photographs of children and teens representing the ethnic diversity of Alaskan children. Key "retail" motivator messages such as "It's easy to apply"—"Short mail-in application"—"At no cost to eligible families" –and "No interview" were used to reach every Alaskan family, parent, grandparent, teen, friend and neighbor. A marketing mix of these key benefit messages was delivered through PSA's statewide, in the press, and in trainings and presentations made to the more than 1,000 community access points or partner organizations across the state.

Hands-on training and frequent follow up by state Outreach Specialists proved most successful in working with some rural and Native health organizations and entities, and gave these organizations a higher comfort level with the program information and eligibility guidelines.

Informal feedback from trainings delivered to these organizations, from grantee trainings and from working in partnership with the Alaska Native Tribal Health Consortium resulted in some modifications to trainings delivered to Native organizations and entities. To better meet the needs they expressed and their learning styles, Outreach Specialists developed a step-by-step, "hands-on" approach to teaching them application assistance that, we believe, better facilitated enrollment of Alaska Native children in Denali KidCare.

3.5 What other health programs are available to SCHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among SCHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between SCHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	Medicaid*	Maternal and child health WIC	Other (specify) Free & reduced price school lunch program	Public health centers	Headstart programs	Mental health centers
Administration						
Outreach		X	X	X	X	X
Eligibility determination						
Service delivery				X	X	X
Procurement						
Contracting						
Data collection						
Quality assurance						
Other (specify) Application assistance or referral for assistance		X		X	X	X
Other (specify)						

*Note: This column is not applicable for States with a Medicaid SCHIP expansion program only.

PLEASE NOTE: *The state's SCHIP outreach staff networked with community-based entities including social service organizations, child and adult education programs and institutions, health care providers, and retail establishments (such as grocery stores) to develop more than 1,000 Denali KidCare "access points" throughout the state. Each access point chooses its level of involvement: information only (display brochures), information and applications (maintaining a supply of applications for public distribution), or actively assisting potential applicants to complete and mail the application.*

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your SCHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

x___Eligibility determination process:

_x_ Waiting period without health insurance (specify) *12 months*
_x_ Information on current or previous health insurance gathered on application (specify) *Information on current and previous 12 months health insurance requested*
_x_ Information verified with employer (specify) *If worker has reason to question applicant statement. Eligibility workers are familiar with the benefit packages offered by major employers in a local area.*
___ Records match (specify)
___ Other (specify)
___ Other (specify)

___ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing (specify)
___ Other (specify)
___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Alaska's SCHIP program was implemented on 3/1/99 and operated for the last 7 months of the FFY99. During this reporting period, enrollment was the priority activity. For the next reporting period we are developing a process to take a closer look at crowd-out issues, including a post-enrollment quality assurance project to verify insurance coverage information on a random sample of SCHIP enrollees.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your SCHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your SCHIP program?

4.1.1 What are the characteristics of children enrolled in your SCHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your SCHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

TABLE B
Alaska
M-SCHIP Enrollment Statistics FFY 1998 and FFY 1999[a]

Table 4.1.1 in NASHP Framework for State Evaluations						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Year end enrollees as percentage of unduplicated enrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	0	8,033	-	4.4	-	97.9%
Age						
Under 1	0	129	-	4.8	-	98.4%
1-5	0	1,448	-	4.4	-	99.4%
6-12	0	3,383	-	4.5	-	99.0%
13-18	0	3,073	-	4.4	-	95.8%
Countable Income Level*						
At or below 150%	0	5,671	-	5.2	-	97.4%
Above 150% FPL	0	2,362	-	2.5	-	98.9%
Age and Income						
Under 1						
At or below 150%	0	59	-	7.6	-	100.0%
Above 150% FPL	0	70	-	2.5	-	97.1%
1-5						
At or below 150%	0	609	-	7.0	-	99.7%
Above 150% FPL	0	839	-	2.5	-	99.3%
6-12						
At or below 150%	0	2,438	-	5.2	-	99.0%
Above 150% FPL	0	945	-	2.5	-	98.9%
13-18						
At or below 150%	0	2,565	-	4.8	-	95.3%
Above 150% FPL	0	508	-	2.5	-	98.4%
Type of plan						
Fee-for-service	0	8,033	-	4.4	-	97.9%
Managed care	0	0	-	-	-	-
PCCM	0	0	-	-	-	-

a. Alaska began reporting enrollment data for its M-SCHIP program in Quarter two, FFY 1999; FFY99 are only partial year.

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many SCHIP enrollees had access to or coverage by health insurance prior to enrollment in SCHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

We have no automated method of collecting and reporting information on coverage by health insurance prior to SCHIP. Applications from families with income above 150% FPL who respond affirmatively to the question on the application regarding health insurance coverage for the child are denied eligibility for SCHIP; however, we are not able to identify on the database the number of applications denied for this reason.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

No other such programs exist.

4.2 Who disenrolled from your SCHIP program and why?

4.2.1 How many children disenrolled from your SCHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do SCHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

Due to a combination of the 3/1/99 start date for our SCHIP program and the six-month eligibility period, only a very small number of children disenrolled during this reporting period.

The six-month enrollment period was instituted for all children on Title XIX Medicaid programs on 1/1/99. Disenrollment for these eligibility groups was higher due to the earlier start date; failure of the parent/guardian to re-apply for coverage at the end of the six-month period was the most common reason for disenrollment of Title XIX children during this reporting period.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left SCHIP?

Seventy-five children did not re-enroll at renewal. We have no information about the insurance coverage status of children who leave SCHIP.

4.2.3 What were the reasons for discontinuation of coverage under SCHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid SCHIP Expansion Program		State-designed SCHIP Program		Other SCHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	75	100				
Access to commercial insurance						
Eligible for Medicaid						
Income too high						
Aged out of program						
Moved/died						
Nonpayment of premium						
Incomplete documentation						
Did not reply/unable to contact						
Other (specify)						
Other (specify)						
Don't know	75	100				

NOTE: Due to the March 1 start date of our SCHIP program and the six-month eligibility period, we did not have enough program history in FFY99 to conduct a meaningful analysis of disenrollment.

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Prior to the end of the six-month SCHIP eligibility period, a family receives three notices advising of the end of coverage and the process for renewing; renewal forms are also mailed to the family with a return envelope. Renewal forms are accepted for up to 30 days after the child's eligibility end date.
Training provided to outreach grantees and to volunteer "access points" includes information about the six-month eligibility period and the process for re-enrollment.

4.3 How much did you spend on your SCHIP program?

4.3.1 What were the total expenditures for your SCHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 _____*no expenditures*_____

FFY 1999 _____$4,767,160_____

Please complete Table 4.3.1 for each of your SCHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

100% -- purchasing direct services

Table 4.3.1 SCHIP Program Type Medicaid expansion

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures		4,767,160		3,425,679
Premiums for private health insurance (net of cost-sharing offsets)*				
Fee-for-service expenditures (subtotal)				
Inpatient hospital services		393,485		282,758
Inpatient mental health facility services		968,279		695,806
Nursing care services				
Physician and surgical services		760,692		546,633

Table 4.3.1 SCHIP Program Type Medicaid Expansion				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures				
Outpatient hospital services		288,796		207,529
Outpatient mental health facility services		595,468		427,903
Prescribed drugs		220,641		158,552
Dental services		784,500		563,741
Vision services		111,793		80,334
Other practitioners' services		11,284		8,108
Clinic services		51,746		37,185
Therapy and rehabilitation services		33,006		23,718
Laboratory and radiological services		6,617		4,755
Durable and disposable medical equipment		23,223		16,688
Family planning				
Abortions				
Screening services				
Home health		2,809		2,019
Home and community-based services		3,000		2,156
Hospice				
Medical transportation		387,937		278,771
Case management				
Other services		123,884		89,023

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Outreach and administration

What role did the 10 percent cap have in program design?

None. The decision was made early in the design phase of the program to allocate resources needed to conduct outreach and administer the program wihtout regard to the 10% cap.

Table 4.3.2

Type of expenditure	Medicaid SCHIP Expansion Program		State-designed SCHIP Program		Other SCHIP Program* _____	
	FY 1998	FFY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach						
Administration						
Other *Outreach and administration*		529,684				
Federal share						
Outreach						
Administration						
Other *Outreach and administration*		380,631				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 What were the non-Federal sources of funds spent on your SCHIP program (Section 2108(b)(1)(B)(vii))

_X_State appropriations
___ County/local funds
___ Employer contributions
_X_Foundation grants
___ Private donations (such as United Way, sponsorship)

_X_ Other (specify) __*In-kind contributions*_____

4.4 How are you assuring SCHIP enrollees have access to care?

Prior to SCHIP implementation, we convened a work group comprised of state health program administrators and planners (from both Medicaid and public health programs) as well as tribal and private sector health care providers to identify potential access issues. As Medicaid enrollment increased during FFY99, access issues were monitored. The only significant access problem noted is a shortage in some areas of the state of dentists willing to take new Medicaid patients; this was also an issue prior to SCHIP. Interventions are planned to address this problem in FFY00.

The process for assuring SCHIP enrollees have access to care on a day-to-day basis is the same as it is for the rest of the Medicaid program. Beyond providing health coverage for services and enrolling providers, the Medicaid program also covers transportation for accessing services; in Alaska this is a significant component since many communities are not on a connected road system.

4.4.1 What processes are being used to monitor and evaluate access to care received by SCHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

During this reporting period program staff relied on feedback from outreach workers, public health centers, the Medicaid help-line and other contacts from enrollees for input on access issues. Transportation and dental access issues were the most frequent access problems reported to the program during this period. In response the department has initiated work groups to address these issues and come up with recommendations for action. The dental access issue is being addressed involving the state dental society and the Medical Care Advisory Committee (provider and consumer advisory committee to Medicaid). During the next fiscal year more work is intended on monitoring utilization of services from claims data and comparing utilization of Title XXI and XIX clients.

Table 4.4.1			
Approaches to monitoring access	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program* _____
Appointment audits			
PCP/enrollee ratios			
Time/distance standards			
Urgent/routine care access standards			
Network capacity reviews (rural providers, safety net providers, specialty mix)			
Complaint/grievance/ disenrollment reviews			
Case file reviews			
Beneficiary surveys			
Utilization analysis (emergency room use, preventive care use)			
Other (specify) _*Feedback from outreach workers and grantees*	X		
Other (specify) _*Feedback from enrollees on the toll-free help line*	X		
Other (specify) _*Feedback from public health clinics*	X		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.2 What kind of managed care utilization data are you collecting for each of your SCHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

Type of utilization data	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program* _____
Requiring submission of raw encounter data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by SCHIP enrollees in your State? Please summarize the results.

At this time we do not have a statewide/regional monitoring system for access to care for SCHIP or other Medicaid enrollees. The Medicaid program updates reimbursement rates annually and looks at provider enrollment in Medicaid as the main monitoring tools. While expenditure data indicates generally that our enrollees have access to services, we have no specific information about areas of service in which enrollees experience access problems.

4.4.4 What plans does your SCHIP program have for future monitoring/evaluation of access to care by SCHIP enrollees? When will data be available?

During FFY00 state agency staff will do more monitoring of utilization of services by Title XXI and XIX enrollees. The department is also planning on utilizing the Consumer Assessment of Health Plans Survey (CAHPS) to get information on enrollees' perceptions of access issues in the programs. Preliminary data from these efforts should be available by the end of FFY00.

4.5 How are you measuring the quality of care received by SCHIP enrollees?

Quality of care is measured much as it has been in the Medicaid program. There are peer review components built into the program, however much of the focus in Medicaid has been on well-child screenings and appropriate referrals for medical conditions. The program also relies on oversight by professional associations/boards to address issues related to "sub-standard" care or provider negligence. At this time those remain the main features for Alaska's Medicaid and SCHIP (Medicaid-expansion) program. This quality of care monitoring is limited by provider billing practices which often do not make use of preventive health codes or provide information on the referrals being made for additional diagnosis or treatment.

Alaska's Medicaid and SCHIP programs are fee-for-service programs. Reimbursement rates are high enough that most health care providers in the state are enrolled in the Medicaid program. Enrollees can "vote with their feet" based on the availability of providers in their geographic area .

The state agency will be using CAHPS in FFY00 to get information on parents/guardians' perceptions of the quality of care their children receive. The state agency is also working toward establishing a process to monitor the immunization rate of 0-2 year olds enrolled in the Title XXI and XIX programs. Lastly, the state agency is discussing mechanisms to improve provider reporting in the EPSDT program.

4.5.1 What processes are you using to monitor and evaluate quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1			
Approaches to monitoring quality	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program
Focused studies (specify)			
Client satisfaction surveys *CAHPS*	X		
Complaint/grievance/ disenrollment reviews			
Sentinel event reviews			
Plan site visits			
Case file reviews			
Independent peer review			
HEDIS performance measurement			
Other performance measurement (specify)			
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.5.2 What information (if any) is currently available on quality of care received by SCHIP enrollees in your State? Please summarize the results.

There is little information on the quality of care received by SCHIP enrollees from either a health outcomes perspective or a patient satisfaction perspective during this reporting period.

4.5.3 What plans does your SCHIP program have for future monitoring/evaluation of quality of care received by SCHIP enrollees? When will data be available?

As mentioned previously, the department is looking at CAHPS to obtain information on enrollee perceptions of the quality of care provided in the program and is also looking at a process to monitor immunization rates of 0-2 year olds enrolled in Title XXI and XIX programs. Preliminary data should be available by the end of FFY00.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments

here.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its SCHIP program as well as to discuss ways in which the State plans to improve its SCHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your SCHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

Because of a perceived public stigma of Medicaid as a welfare program, the state's approach to the expansion from the time the funding request and proposed legislative changes were presented to the state legislature in January 1998 was to design a government program that looked and acted like private insurance. Accordingly, four specific goals were established for the development and implementation of Alaska's SCHIP. They were:

1. *Simplify the existing Medicaid eligibility criteria.*
2. *Simplify the application and enrollment process.*
3. *Design and conduct an effective community-based outreach program to inform all potentially eligible families.*
4. *Coordinate SCHIP with other Medicaid programs that provide coverage for low-income children.*

To attain these goals, we needed to draw on the expertise of various parts of state government as well as private sector health care providers, Alaska Native tribal health organizations, and community-based organizations throughout the state. The Department of Health and Social Services appointed a full-time project coordinator to oversee the planning and implementation of SCHIP and the integration of SCHIP and the existing income-based Medicaid coverage groups for children and pregnant women into the new Denali KidCare program.

A Statewide Coalition made up of many public and private sector partners including health care providers, non-profit agencies, Alaska Native health corporations, state agency representatives and others offered guidance to the Department in designing and implementing a customer-friendly delivery system, application, promotional outreach materials, and outreach approaches.

The Department also established interagency working committees for program development and implementation, including a Division Director's Steering Committee comprised of the administrators of the state agencies responsible for Medicaid, public assistance eligibility, and public health (which has the responsibility for SCHIP outreach); and separate committees to look at access, enrollment, training, evaluation and outreach issues. With SCHIP expected to increase the number of Alaskan children on Medicaid by about 15%, the access committee took a pro-active stance toward anticipating and addressing access issues. Committee members conducted focus groups and key informant interviews to gather current information about barriers to enrollment, access to service, transportation and other issues from parents of Medicaid children, community-based social service agencies, transportation vendors, primary care practitioners and their office managers, dentists and their office managers, and mental health providers.

5.1.1 Eligibility Determination/Redetermination and Enrollment

The decision to implement SCHIP as a Medicaid expansion provided the impetus to examine and improve the eligibility and enrollment processes used for children's poverty-level Medicaid programs. The intent was to remove the welfare stigma attached to Medicaid by refocusing these processes on the customer. This was achieved by:

- *Developing a shorter, more attractive application form*
- *Instituting a mail-in application process*
- *Reducing verification requirements*
- *Centralizing eligibility determination in one office which handles only Denali KidCare eligibility determination and redetermination (no other public assistance programs). The office was staffed with a mix of experienced eligibility workers and new employees who received training in customer service strategies as well as in the technical aspects of the job.*

Prior to SCHIP implementation, enhancements were made to the medical assistance case processing functions in the Eligibility Information System (EIS) which improved productivity and efficiency, including an automated process to streamline the renewal process.

We consider our SCHIP eligibility and enrollment best practices to be:

1. *our "customer first" philosophy emphasizing responsive and courteous service, and*
2. *the EIS enhancements which contribute to worker efficiency and to accurate and timely service to applicants and recipients.*

The two most significant problems encountered with eligibility and enrollment were the result of a highly successful outreach effort for SCHIP: we experienced a much higher volume of applications than was anticipated, and a much higher volume of telephone inquiries about the program. The high volume of applications, combined with the commitment to personalized customer service involving one-on-one customer contacts and verification contacts by phone in order to prevent pending of applications, created a backlog that was counter-productive to the customer service philosophy. Streamlining the process to ensure all customers received a response to their application within a week required a compromise: contacts had to be made by letter rather than by phone. To address the application backlog, additional personnel resources from other offices within the Division of Public Assistance were temporarily detailed to SCHIP and Denali KidCare. The extra staff coupled with intensive supervision, utilization of monitoring tools,and improved time management eliminated the backlog of applications.

To address the extremely high telephone call volume, the two in-coming lines were replaced by a multi-line telephone system and reception and switchboard duties were separated. These changes provided a higher level of customer service and created better efficiencies in workload management.

Both of these situations would have been improved by earlier planning and procurement of goods, services and staff. Some of the shortcomings in this area – such as delays in remodeling the office space needed for the new Denali KidCare office -- were beyond the control of the agency but nonetheless impaired the agency's ability to meet the high demand which occurred immediately upon SCHIP implementation.

5.1.2 Outreach

What worked:

The State used many approaches to ensure a customer-friendly program that actually delivered to the consumer the promises made by program outreach and promotion. The Division of Public Health (DPH) hired an experienced outreach coordinator to plan and implement strategic marketing campaigns and to write and produce professional marketing materials. The outreach coordinator supervises five regionally-based outreach specialists: three are funded by a Robert Wood Johnson Foundation outreach grant, one is funded through a grant from the Reuben E. Crossett Endowed Alaskan Fund (a Southeast Alaska-based foundation which assists with children's health care projects), and one is funded from the state's SCHIP administrative budget. The outreach specialists are responsible for providing information and training to the diverse partners in the communities in their assigned region. Outreach workers cultivated a statewide network of more than 1 ,000 voluntary "access points" – organizations and agencies that are willing to distribute to the public information about or applications for Denali KidCare. These access points include physician, dental and hospital health care providers; non-profit

agencies and associations; public and private schools; public health clinics, Division of Family and Youth Services and other state agencies; Headstart and WIC offices; Alaska Native tribal hospitals and clinics; community mental health centers; substance abuse treatment programs; local governments, employers and unions; unemployment insurance

offices and Job Centers; faith communities and others. Outreach specialists used a "Train the Trainer" model to educate organization staff about the program, as indicated by the interest of the local organization.

Outreach specialists participated in community events such as health fairs and conferences to increase awareness of Denali KidCare. Six professional exhibit displays were produced for use statewide. Twenty-six community-based grantees received outreach grant awards of $5,000 to $17,500 from the state in response to our Request for Proposals for targeted outreach (including outreach to minority populations) in local communities.

The Division of Public Health outreach coordinator worked with the Governor's Office to coordinate his program announcement press conference which provided statewide positive press for Denali KidCare. A generic newsletter article about the program was produced and mailed to about 300 community organizations for inclusion in their newsletter. The outreach coordinator also provided materials and information to legislative staff.

Outreach strategies included marketing the ease of access to the program through: 1) access points where Alaskans can get applications, information and receive applicant assistance; 2) a mail-in application process, and 3) no need to go to a public assistance office or participate in an intake interview. An essential element of our initial outreach marketing mix was statewide broadcast of public service messages highlighting the benefit to families of enrollment of their children, and the easy application process.

Division of Public Health outreach workers implemented a strategic school-based outreach program, individualizing outreach to meet the needs of each school in the 53 districts in the state. More than 180,000 flyers directed at parents were distributed by the public schools. Outreach was also made to Headstart and day care programs, home schooled students, and university students.

Outreach staff collaborated with two pilot projects funded through a Robert Wood Johnson Foundation Covering Kids *grant – the Mat-Su Partnership project (serving a predominantly rural area in Southcentral Alaska near Anchorage) and the statewide Alaska Native Tribal Health Consortium project with 21 sites in rural and remote Alaska Native communities – by providing materials and technical assistance to their outreach pilot projects.*

The outreach coordinator worked with the Division of Medical Assistance (the state Medicaid agency) to develop the new application form, to produce attractive marketing and promotional materials, and to enhance technological outreach through a Denali KidCare web site (http://www.hss.state.ak.us/dma/denali.htm).

What we changed to make it work better:

Outreach Specialists modified their "Train the Trainer" presentation when working with some rural organizations including Native health organizations. By working closely with the Alaska Native Tribal Health Consortium staff, we found it most effective to go through the program application in a step-by-step process, giving these local access point staff more hands-on training experience rather than simply giving them program overview information. Our training program was modified to best meet the needs of the staff being trained, and to maximize their success as an outreach partner.

5.1.3 Benefit Structure

The discussion over alternative approaches of Medicaid expansion and separate child health insurance program did assist in reaching consensus that Medicaid offered a model of health benefits for children. It was also felt the dental benefits were a key service for the SCHIP expansion as staff believed more school-age children would be enrolled and dental services would likely be one of the highest needs for this population.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

There is limited co-payment in Alaska's SCHIP program (nominal co-pay for 18 year olds for some services). This approach in a Medicaid expansion avoids concerns with recipients' ability to pay even small amounts for health coverage, the cost of collecting premiums or co-payments by either providers or the department, and administrative procedures to ensure the 5% cap is not exceeded. However, it also stimulates conservative policymakers' concerns about expansion of an entitlement with little personal financial responsibility. These concerns increase as the program is expanded into higher income groups that likely have the ability to cover the some of the cost of the coverage and/or services.

5.1.5 Delivery System

Enrollment in the program was even faster than anticipated and the influx of new clients highlighted areas of the state that were already having problems with access to services in Medicaid. This was especially true of dental services. It appears the SCHIP enrollees were faster to access dental services than their lower-income counterparts. In some regions this led to dentists and/or their front office staffs changing from booking new Medicaid clients several months out to a message that they weren't accepting new Medicaid clients. However, this has also provided an opportunity to enter into discussions with the state dental society in an attempt to encourage broader dental participation in the Medicaid program. There were also areas of the state where private sector capacity for well-child exams were exceeded. State public health nursing in some urban areas had actively been referring clients to private providers, yet later had to

address increased demand for screenings as enrollees began to come back to the health centers due to long waiting periods for the exams.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

The program has been well coordinated with entities with which Medicaid has traditionally had a connection: state public health centers, WIC, Headstart programs, tribal health organizations, and Children with Special Health Care Needs programs operated by Maternal, Child and Family Health section of the Division of Public Health. SCHIP also augmented existing work with tribal health care providers toward more active participation in Medicaid and encouraging an increased emphasis on well-child exams and other preventive health services. Outreach for SCHIP also provided an inroad into more active participation with new partners in promoting children's health: school districts and the free/reduced school lunch programs, and a wide variety of social service agencies. The SCHIP program is well-integrated with other Medicaid poverty-level programs in the Denali KidCare program; the provider relations and claims processing aspects have been fully integrated into the existing Medicaid structure.

5.1.7 Evaluation and Monitoring (including data reporting)

Evaluation:

The workshops and materials provided by HCFA and the National Association for State Health Policy provided excellent overviews of data sources and evaluation alternatives for the SCHIP program. The development of the outreach survey in the application packet provided a good tool for evaluating outreach activities in the early implementation of the program. While other activities were desired in the first year of the program, the staff effort required for implementation of the program and information system issues related to Y2K programming changes precluded a higher level of oversight of utilization and access to services.

Another limitation for ongoing data evaluation efforts was the lack of a good baseline or understanding of the demographics and health needs of uninsured children, and limited understanding of the private insurance market in Alaska (e.g., how many employers are dropping or reducing health insurance coverage for employees and/or their dependents). When planning for SCHIP highlighted the need for information on health care coverage for children, we added questions to the Behavioral Risk Factor Surveillance System (BRFSS) survey to gather this information, but 1999 will be the first year for which it is available. These limitations make it difficult to assess the total impact of the SCHIP program on the issue of uninsured children.

However, the national SCHIP reporting agenda and past experiences with program implementation made the planning for an evaluation effort an integral part of the SCHIP

implementation. The department is implementing additional evaluation activities as they relate to the Medicaid and SCHIP programs in FFY2000.

Monitoring:

On-going monitoring of many aspects of SCHIP and Denali KidCare has been essential to maintain the level of responsiveness and customer service we want for this program. Monitoring which occurs on a weekly basis includes:

- *Number of applications received*
- *Number of renewal forms received*
- *Number of telephone calls received*
- *Number of telephone calls abandoned by the caller*
- *Caseload statistics for the expansion group (SCHIP and pregnant women)*
- *Timeframe for response to applications and application turn-around time*

5.1.8 Other (specify)

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

- *To continue to work with the Alaska Native Tribal Health Consortium and tribal health providers in utilizing Medicaid reimbursement to expand access to health services. The alliance with tribal health providers has also served as an impetus for greater attention on preventive health services in a health system that has historically been focused on meeting the demands for acute health care.*

- *The work to be done on addressing transportation issues in Medicaid as it relates to access to services*

- *Activities underway to increase dentist's participation in Medicaid*

- *Focus on retention of children already enrolled in SCHIP and Medicaid*

The assessment of the private health insurance market in Alaska has been limited - - little information is readily available. The department was unable to find any private insurance models for "child-only" insurance. The evidence we have is that Alaska's private health insurance premiums are increasing, which is likely to result in decreased dependent coverage - - as both employers drop coverage and/or employees self-select out of these benefits due to the cost.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

The major change, as discussed above, would be provisions in Title XIX of the Social Security Act that provide for charging for premiums and/or co-payments for Title XIX and Title XXI Medicaid expansion enrollees in state Medicaid programs.