Table of Contents

State/Territory Name: Alabama

State Plan Amendment (SPA) #: AL-23-0026-RIM2

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

April 20, 2023

Ms. Wanda Davis
Deputy Director, Children's Health Insurance Program
201 Monroe Street
Montgomery, AL 36104

Dear Ms. Davis:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number, AL-23-0026-RIM2, submitted on February 1, 2023, has been approved. This SPA has an effective date of May 1, 2023.

Through this SPA, Alabama expands its ALL Babies coverage to an additional 33 counties (for a total of 36 counties). ALL Babies provides CHIP eligibility for children from conception to the end of pregnancy (also known as the "unborn" option) with family incomes up to and including 312 percent of the federal poverty level (FPL) whose pregnant parents are not otherwise eligible for Medicaid or CHIP. Coverage will include pregnancy-related services including prenatal care for children from conception to the end of pregnancy. A copy of the approved CS9 state plan page is attached to be incorporated into the state's approved CHIP state plan. This page supersedes the previous CS9 that was approved on September 17, 2019.

Also through this SPA, Alabama expands its health services initiative (HSI), the ALL Babies Postpartum Initiative, to the same additional 33 counties (for a total of 36 counties) to provide 60 days of postpartum coverage for birth parents previously covered under the ALL Babies program.

The HSI approval is based on section 2105(a)(l)(D)(ii) of the Social Security Act (the Act) and 42 CFR §§ 457.10 and 457.618, which authorize use of title XXI administrative funding for HSIs that improve the health of children, including targeted low-income children and other low-income children. Consistent with section 2105(c)(6)(B) of the Act and 42 CFR § 457.626, title XXI funds used to support an HSI cannot supplant Medicaid or other sources of federal funding.

The state shall ensure that the remaining title XXI administrative funding, within the state's 10 percent limit, is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of this HSI to the administration of the CHIP program. The state shall report annually to CMS the expenditures funded by the HSI for each federal fiscal year.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (443) 934-2064. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

TEMPLATE FOR CHILD HEALTH PACWLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

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

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

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR 457.40(b))
Scott Harris, State Health Officer, Alabama Department of Public Health
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: Catherine Donald	Position/Title: Acting CHIP Director
Name: Shaundra B. Morris	Position/Title: Director, ADPH Financial Services
Name:	Position/Title:

*Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. ASPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90-day review period, or clock for CHIP Spas, that may be stopped by a request for additional information and restarted after a complete

response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101) ;(42 CFR 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance-** Regarding the required scope of

health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health

benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

- **Combination of Options-**CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101) (a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. ☐* Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both above. (Section 2101(a)(2))

*** Until October 1, 2002, Alabama's CHIP was a combination program. With the mandated gradual increase of Medicaid coverage at higher income levels for children born after September 30, 1983, the Medicaid expansion portion of CHIP was subsumed, on October 1, 2002, by the Alabama Medicaid SOBRA Program for Pregnant Women and Children.**

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

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

Alabama has not and will not claim expenditures for child health assistance prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by **CMS.**

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

Assurances are on file with DHHS. The Alabama Department of Public Health continues to assure that compliance with all applicable civil rights requirements.

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA(42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: February 1, 1998
Amendment 1 – Establishment of ALL Kids
Effective Date: February 1, 1998
Implementation Date: October 1, 1998
Amendment 2 – Establishment of ALL Kids PLUS
Effective/Implementation Date: October 1, 1999
Amendment 3 – Disregards
Effective/Implementation Date: June 1, 2001
Amendment 4 - Compliance
Effective/Implementation Date: August 24, 2001
Amendment 5 – Waiting List, Cost Sharing, Benefit Changes
Effective/Implementation Date: October 1, 2003
Amendment 6 – Discontinuance of the Waiting List and other Clean-Up changes

Effective/Implementation Date: November 23, 2004

Amendment 7 – Raise the upper income eligibility limit to 300% of FPL and other minor changes
Effective/Implementation Date: October 1, 2009

Amendment 8 – Include a private foundation grant as an additional source of state funding
Effective/Implementation Date: October 27, 2009

Amendment 9 – Establishment of a Prospective Payment System for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
Effective/Implementation Date: October 1, 2009;
Addendum on Dental Benefits Under Title XXI:
Effective/Implementation Date: October 1, 1998

Amendment 10 – Eligibility for children of employees of a public agency (state employees and public education employees)
Effective/Implementation Date: January 1, 2011

Amendment 11 – Provisions for Implementing Temporary Adjustments to Enrollment Determination and/or Redetermination Policies and Cost Sharing Requirements for Applicants/Renewals living in and/or working in FEMA or Governor declared disaster areas at the time of a disaster event. In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its enrollment and/or redetermination policies, the effective dates of such adjustments and the counties/areas impacted by the disaster.
Effective/Implementation Date: April 15, 2011

Amendment 12 – Increase premiums, increase co-pays and revise the methodology for determining annual aggregate cost-sharing
Effective/Implementation Date: May 1, 2012

Amendment 13 – Establishment of copayments for therapy services (physical, occupational, and speech), vision services and chiropractic services; and cleanup changes
Effective/Implementation Date: August 1, 2013

Amendment 14 – Alignment of ALL Kids fee groups with provisions of the Affordable Care Act (ACA) and other editorial changes to comply with previously approved ACA SPAs.
Effective/Implementation Date: January 1, 2014

Amendment 15 - AL-16-0015-MEXP – CHIP Medicaid expansion to cover Medicaid enrollees ages 14 years to 19 years with incomes above 18% FPL through 141% FPL.
Effective Date: October 1, 2015
Implementation Date: January 1, 2016

Amendment 16 – AL-18-0016-PAR - Attestation and documentation of Mental

Health Parity and Addiction Equity.
Submission Date: July 10, 2018
Effective Date: October 1, 2017*
Implementation Date: October 1, 2017*
***Note: Benefits were adjusted in October 2010 to be compliant with mental health parity; this amendment did not require any benefit changes**

Amendment 17 – AL-19-0017-RIM
- Reducing Infant Mortality (RIM) Health Service Initiative
Submission Date: July 17, 2019
Effective Date: July 1, 2019
Implementation Date: July 1, 2019

Amendment 18 – AL-19-0018-RIM
CS9 Eligibility – Coverage From Conception to Birth
Submission Date: July 17, 2019
Effective Date: July 1, 2019
Implementation Date: July 1, 2019

Amendment 19 – AL-20-0019-CEN
CS15 MAGI-Based Income Methodologies – Temporary Income
Submission Date: February 26, 2020
Effective Date: July 1, 2020
Implementation Date July 1, 2020

Amendment 20 – AL-20-0020-COVI
Allowing for Temporary Waiving of cost sharing requirements for enrollees who reside and/or work in a State or Federally declared disaster area.
Submission Date: July 29, 2020
Effective Date: March 1, 2020
Implementation Date: March 1, 2020

Amendment 21 - AL-20-0021-BH
Documentation of AL CHIP compliance with the SUPPORT Act.
Submission Date: July 29, 2020
Effective Date: October 1, 2019
Implementation Date: October 24, 2018

Amendment 22 – AL-21-0022-PP
Postpartum coverage Health Services Initiative for ALL Babies
Submission Date: May 13, 2021
Effective Date: July 1, 2021
Implementation Date: July 1, 2021

Amendment 23 – AL-22-0023-OBJ
Edits to align Strategic Objectives and Performance Goals with

CARTS
Submission Date: 3/30/2022
Effective Date: 10/1/2021
Implementation Date: 10/1/2021

Amendment 24 – AL-22-0024-ARP
Coverage of COVID-19 vaccine, testing, and treatment under American Rescue Plan Act
Submission Date: 3/30/2022
Effective Date: March 11, 2021
Implementation Date: March 11, 2021

Amendment 25 – AL-22-0025-CE
12-Month Postpartum Period Continuous Eligibility
Submission Date: August 18, 2022
Effective Date: October 1, 2022
Implementation Date: October 1, 2022

Amendment 26 – AL-23-0026-RIM2
CS9 Eligibility - Statewide Coverage from Conception to Birth
Submission Date: January 31, 2023
Effective Date: May 1, 2023
Implementation Date: May 1, 2023

Amendment 27 – AL-23-0027-CC
Amending AL-19-0017-RIM to discontinue HSI
Submission Date: January 31, 2023
Effective Date: October 1, 2023
Implementation Date: October 1, 2023

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
AL-14-0016 (Original: AL-14-0016 Effective/Implementation Date: January 1, 2014) AL-20-0019-CEN (affects only CS15) Effective Implementation Date: July 1, 2020	MAGI Eligibility & Methods	CS7 CS10 CS15	Eligibility – Targeted Low Income Children Children With Access to Public Employee Coverage MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Section 4.4.1: Supersedes only the information on dependents of public employees in this section; supporting documentation should be incorporated as an appendix to the current state plan Incorporate within a separate subsection under section 4.3
AL-23-0026-RIM2 (Original: AL-19-0018-RIM Effective/Approval Date: July 1, 2019)		CS9	Coverage from Conception to Birth	

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
(Original: AL-14-0014 Effective/Implementation Date: January 1, 2014) AL-16-0015-MEXP Effective/Implementation Date: October 1, 2015	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program CHIP Medicaid expansion to cover Medicaid enrollees ages 14 years to 19 years with incomes above 18% FPL through 141% FPL	Supersedes the current Medicaid expansion section 4.0
AL-14-0015 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
AL-14-0018 Effective/Implementation Date: January 1, 2014	Eligibility Process	CS24	Single, Streamlined Application Screen and Enroll Process Renewals	Supersedes the current sections 4.3 and 4.4
AL-14-0017 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20 CS21 CS27	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial – Social Security Number Substitution of Coverage Non-Payment of Premiums Continuous Eligibility	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
				Supersedes the current section 4.4.4 **Supersedes the current section 8.7** **Supersedes the current section 4.1.8**

1.4- TC **Tribal Consultation**(Section 2107(e)(1)(C))Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

In accordance with approved policies, on December 08, 2022, a certified letter explaining the changes proposed in AL-23-0026 and AL-23-0027 was mailed to the Tribal Chairman of the one federally recognized Native American tribe in Alabama, the Poarch Band of Creek Indians. The letter included the purpose for the proposed changes and a description of the changes. In the letter, the Tribal Chairman was also reminded that she had the opportunity to respond to the proposed changes within 30 days and was given contact information for any such response. The certified letter was signed by the CHIP Deputy Director.
TN No: Approval Date Effective Date: January 09, 2023

Section 2. **General Background and Description of Approach to Children's Health Insurance Coverage and Coordination**

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Prior to CHIP, the only two programs offering health insurance to low-income children

were Medicaid and the Alabama Child Caring Foundation (ACCF). Medicaid served children at the minimum income levels required by federal law. This meant that Medicaid coverage was available to children at three different levels of income and age:

- **Those under the age of six (6) years with incomes up to 133% FPL;**
- **Those children six (6) through 14 years of age who were born after September 30, 1983 with incomes up to 100%FPL; and,**
- **Those remaining children through the age of 18 years (middle and older teens) with incomes at the TANF assistance level (below approximately 13% FPL).**

The ACCF served children (birth through 18 years) with incomes from the Medicaid levels up to 200% FPL.

From February 2, 1998 through September 30, 2002, Phase I of CHIP, a Medicaid expansion was in existence. On October 1, 2002, Phase I of Alabama's CHIP was subsumed by the Alabama SOBRA Medicaid Program. Beginning October 1, 2015, however, children in this category (ages 14 to 19 with incomes between 13% FPL and 141% FPL) will again be enrolled in a CHIP Medicaid expansion.

Originally, CHIP used a baseline number of uninsured children derived from the Current Population Survey (CPS). This baseline including the following chart was derived from a study by Winterbottom et.al. based on a three year merged Current Population Survey, or CPS, (1990-92), which showed over 200,000 children, in Alabama, under 18 years to be uninsured.

	Employer	Medicaid	Other Coverage	Uninsured
Percent	59.3	17.2	5.1	18.4
Number	652,300	189,200	110,000	202,400

However, due to concerns about the CPS regarding potential problems with subjects' abilities to recall information, Alabama changed its baseline estimate to reflect data from the 1997 round of the Urban Institute's National Survey of America's Families (NSAF). The NSAF indicated that there were 173,012 uninsured children in Alabama. Of these, 91,209 were ≤ 100% Federal Poverty Level (FPL), 49,579 were above 100 up to 200% FPL and 32,223 were >200% FPL.

In its first 4 years of implementation (October 1, 1998 – September 30, 2002), Phase II, ALL Kids, enrolled over 80,000 children. It is estimated that 52,000 children have current enrollment in ALL Kids at the end of FY 2002.

ALL Kids PLUS, added as a third amendment to the CHIP State Plan (October, 1999), serves as a mechanism by which children with special health care needs/conditions (CSHCN/C), who are enrolled in ALL Kids, may receive health and health related services which are beyond the

scope of the basic ALL Kids package. ALL Kids PLUS was designed so that it serves as a funding source for CHIP state match and as a funding mechanism for state agencies who serve CSHCN/C with state funds. State agencies participating in ALL Kids PLUS supply the state match, provide the service, and receive full reimbursement. It was originally estimated that approximately 9% of these enrollees would also receive at least one service under ALL Kids PLUS. However because the basic benefit package is so comprehensive, a much lower percentage of children are receiving PLUS services. It is expected that this percentage will increase as more state agencies contract with CHIP to become ALL Kids PLUS providers.

With the advent of ALL Kids, the ACCF has changed its income eligibility criteria to serve children who are not eligible for Medicaid or ALL Kids and who have incomes up to 235% FPL. Because, the ACCF has no enrollment restriction regarding immigrants, this program has seen a dramatic increase in its Hispanic enrollment.

Guidance: Section 2.2allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives-**Describe if the State will use the health services initiative option as allowed at42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

~~**As permitted under section 2105(a)(1)(D)(ii) of the Social Security Act and federal regulations at 42 CFR 457.10, the State of Alabama is implementing a health services initiative (HSI) that will use CHIP funds, within the federal administrative expenditures cap allowed for states, to support the Reducing Infant Mortality (RIM) Health Services Initiative. The aim of this initiative is to reduce the infant mortality rate in selected counties within Alabama through the provision of a variety of evidence-based case management services for pregnant women and children. These case management services will target health, social, and behavioral health related high-risk factors which have been shown to impact pregnancy outcomes and infant health. Case Management services will connect patients, with high-risk factors, to appropriate services and case managers will follow-up to ensure that risk factors are being addressed satisfactorily. It is anticipated that the case manager will make a total of 6 face to face visits. Three visits would occur during the prenatal care, and three visits would be provided post-delivery.**~~

~~**The care coordination services provided postpartum including services to the infant include:**~~

~~**i. Make home visit within one month following delivery to complete the following:**~~
~~**1. Encourage patient to keep postpartum appointment including providing appointment reminders to help ensure completion of the postpartum appointment.**~~
~~**2. Encourage patient to choose a reliable birth control method. If the patient has chosen**~~

~~sterilization as her method, follow up with the patient to ensure the procedure is completed.~~
~~3. Ensure patient is established with a PMP for the infant.~~
~~4. Ensure infant has enrolled in WIC, if eligible.~~
~~5. Educate the patient on the importance of immunizations for the infant.~~
~~ii. Assist in scheduling appointments with infant's PMP up to the first year to ensure that well baby checkups are made and immunizations are up to date. Follow up after the appointments to verify that appointments were kept. Well Baby checkups are scheduled at:~~
~~a. 1 month~~
~~b. 2 months~~
~~c. 4 months~~
~~d. 6 months~~
~~e. 9 months~~
~~f. 12 months~~
~~iii. Promote the child's overall physical, cognitive, and emotional development through educating parents/caregivers about developmental milestones according to the child's age and developmental abilities.~~
~~iv. Complete an ASQ-3 (Ages and Stages Questionnaire, Third Edition, a developmental screening tool) as appropriate at face to face appointments.~~
~~v. Educate the parents about the importance of reading to the infant to promote cognitive development.~~
~~vi. Make referrals for the child, as appropriate, such as Early Intervention, Children's Rehabilitation Services, etc.~~
~~vii. Prior to the child's first birthday, ensure he/she is established with a dentist.~~
~~viii. Screen the mother for post-partum depression at each face to face visit and make referrals and follow up (as needed)~~

~~With the exception of providing necessary prenatal monitoring by a nurse in the home or health department setting, no HSI funds will be spent on direct care.~~

~~The high-risk factors that HSI will address include the following:~~

~~ACEs Score of ≥4~~	~~Depression[1]~~	~~Diabetes Mellitus~~
~~Current multiple births~~	~~Substance Abuse[2]~~	~~Maternal age[3]~~
~~Hypertension~~	~~Interpersonal safety~~	~~Transportation needs~~
~~Housing Instability~~	~~Food Insecurity~~	~~Utility needs~~
~~Abuse[4]~~	~~Enrollment in CHIP unborn coverage~~	
~~Prior poor pregnancy outcome[5]~~		

1 Depression noted at anytime during the pregnancy or postpartum period (90 days postpartum)
2 History of use or current substance use
3 <21 or >35
4 Emotional, physical, or sexual
5 Fetal Death – Stillbirth after 20 weeks; Infant death -first year of life; Preterm birth - <37 weeks gestation; Low Birthweight - <2500 grams; Very Low Birthweight - <1500 grams; Other serious chronic conditions (ex: heart disease, renal disease, chronic medical illnesses, etc.); and, Maternal Death (death of a woman while

~~To be eligible for the HSI, pregnant women and/or their infants in selected counties must have at least one of the high-risk factors cited above and have an income no greater than the upper CHIP limit (currently 312% FPL). HSI services will be offered whether or not the patient has health insurance coverage and regardless of the type of insurance. Case management services for individuals enrolled in Medicaid will be time-limited until the implementation of the case management services provided in the Alabama Coordinated Health Network (ACHN) scheduled to begin October 1, 2019. Individuals with other insurance that are provided case management services will not be provided case management services using HSI funds.~~

~~Patients will be enrolled in the HSI initiative during pregnancy, during the post-partum period, or by referral. Once enrolled, HSI services will continue, as appropriate, for one-year post-delivery with the exceptions noted in the paragraph above.~~

~~The HSI will be coordinated by the Alabama Department of Public Health and delivered through designated county health departments. Depending upon the needs of those participating in the initiative, services may be provided by public health nurses, public health social workers, community health workers, etc.~~

~~The proposed counties for initial implementation of the HSI include Montgomery, Macon and Russell counties. Services supported through this HSI will not supplant other federal, state or local funds allocated for similar services.~~

~~Outreach activities for the RIM HSI include providing education and information to pertinent providers, hospitals and programs serving the target population residing in the counties in which the expansion is implemented.~~

~~In monitoring/evaluating the progress and success of this program, the total number of women and children served will be captured and reported to ALL Kids on an agreed upon schedule but no less than a quarterly basis. Tracking and reporting of visits and birth outcomes (birth weight, mortality within the first year of life and maternal health indices) will also be included in reports to ALL Kids.~~

~~The cost of the HSI is budgeted to be $753,625 for FY 2019 (July – Sept).~~

~~Case Management Costs:~~
~~Initially, within the proposed three county area, approximately 500 women/families could be served in FY 2019. The number of case management hours per person/family is estimated to be 10 hours/quarter at an average cost of $135/hour. This hourly rate would account for salary~~

---

pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes).

~~cost of those providing/coordinating services. Additionally, it is estimated that staff will travel 25 miles per home visit and there will be two home visits/patient/quarter at the state mileage reimbursement rate of $0.545/mile.~~

	Annual	1st Quarter
~~Case Management: Enrollees X case management hours X $135.00/hour~~	~~$2,700,000~~	~~$675,000~~
~~Travel: # enrollees X miles/round trip X 2 trips/quarter X mileage reimbursement rate~~	~~$ 54,500~~	~~$ 13,625~~

~~Start Up/Outreach Costs:~~
~~As the HSI is being developed, costs are being allocated for personnel support to include up to two FTEs (one full-time project manager and other ancillary support staff as needed). Additionally, costs are included for the development of materials to promote and educate health care providers and community organizations throughout the implementation counties about the initiative and to garner support and participation of agencies/providers. Education and awareness materials to outreach to women will also be prepared. Expenses to conduct (as well as attend) meetings, conferences and/or trainings to share information about the program and generate participation are also included as part of the startup and implementation costs.~~

	Annual	1st Quarter
~~Personnel Costs (Salary, Fringe, Indirect costs)~~	~~$200,000~~	~~$50,000~~
~~Educational/training materials (providers/organizations and participants)~~	~~$ 10,000~~	~~$10,000~~
~~Costs for meetings (transportation/meeting fees)~~	~~$ 5,000~~	~~$ 5,000~~
~~Grand Total: (Personnel, Materials, Meeting costs, Case Management)~~	~~$2,969,500~~	~~$753,625~~

~~HSI II:~~ **ALL Babies Postpartum Initiative: As permitted under section 2105(a)(1)(D)(ii) of the Social Security Act and federal regulations at 42 CFR 457.10, the State of Alabama is implementing a health services initiative (HSI) that will use CHIP funds, within the federal administrative expenditures cap allowed for states, to support the ALL Babies Postpartum Initiative. This HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds. This HSI will assist in improving the health of children by ensuring their mothers have access to healthcare services during their postpartum period. The aim of this initiative is to provide full health insurance coverage during the postpartum period to enrollees who have been prenatally covered in the Reducing Infant Mortality Conception to Birth program known as ALL Babies. The length of the ALL Babies postpartum period is equivalent to Alabama Medicaid's current definition of the length of postpartum period "From delivery through the end of the month in which the 60th day postpartum falls, counting from the date the pregnancy ends either as a full term or as a miscarriage." ALL Babies participants will be enrolled automatically in the postpartum HSI**

initiative. Metrics used to measure the impact of the state's HSI program on the health of low-income children and their mothers will be included in the state's CHIP Annual Report.

Cost: The cost of the HSI is budgeted to be $360,000 for FY 2023. This figure is based on anticipated enrollment (870 enrollees) in 36 counties with an average enrollment of 2.5 months.

2.3-TC **Tribal Consultation Requirements**-(Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009)Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

ALL Kids provides a certified letter to the federally recognized tribe in the state when considering amendments to the State Plan or other program changes requiring CMS approval. The tribe is given 30 days to respond. In the event of an emergency, ALL Kids will submit a faxed letter to the tribe and give 10 days for response.

Section 3. Methods of Delivery and Utilization Controls

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

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the

State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to the CMS Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding.
If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

3.1. **Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Phase I - Medicaid Expansion

From February 2, 1998 through September 30, 2002, Phase I of CHIP, a Medicaid expansion was in existence. On October 1, 2002, Phase I of Alabama's CHIP was subsumed by the Alabama SOBRA Medicaid Program.

As of October 1, 2015, CHIP will again expand Medicaid by covering Medicaid enrollees ages 14 years to 19 years with incomes above 13% FPL through 141% FPL.

ALL Kids:

Program Operation–Administration

From inception of the program in 1998 through May, 2001, ALL Kids contracted with the State Employee's Insurance Board (SEIB) to serve as its enrollment and premium billing/receiving office. As enrollment grew, ALL Kids staff increased, and the need for data management grew, the ADPH CHIP unit and SEIB jointly decided to move the enrollment and premium billing/receiving functions to the CHIP unit. The Alabama Department of Public Health (Department) now manages all enrollment aspects of the ALL Kids program and utilizes other contractors to administer certain aspects of the ALL Kids program including, but not limited to, the following:

1. Providing all eligible persons involved in ALL Kids an individual policy or certificate that states the insurance protection provided, the method and place of filing claims, and to whom benefits are payable. The policy or certificate indicates that coverage was obtained through CHIP;
2. Maintenance of a claims database for the purpose of program management.
3. Management of evaluation surveillance procedures.
4. Consultation for actuarial services
5. Consultation for development of data systems
6. Consultation for development of specialized outreach plans

Program Operation-Benefits and Services

The ALL Kids program is a self-funded, discounted fee-for-service*, PPO, delivery system. In order to assure delivery of the insurance product(s), the Department utilizes a private health care delivery organization(s) to provide benefits and services. Both indemnity plan(s) and or managed care plans(s) are acceptable and have been used. The selected vendor(s) is required to perform, including but not limited to, the following:

1. Furnishing coverage information and ID cards;
2. Member service responses to claims inquiries;
3. Claims certification, investigation, adjudication, and internal appeals process;
4. Processing and distribution of benefit payments to providers;
5. Appropriate and accurate fee administration;
6. Strict financial accounting and reconciliation;
7. Effective management of networks (if applicable);
8. Demonstrated capability to serve Alabama membership;

9. Effective medical, pharmacy and dental management including medical review of claims decisions;
10. Production of claims, contract, and other legal forms as required;
11. Establishment and maintenance of appropriate banking arrangements;
12. Continuous and accurate electronic transmission of all data;
13. Production of reports that capture claim and utilization experience and trends;
14. Other special services as may be requested from time to time
15. Have a network of physicians, dentists, pharmacies, and other providers capable of meeting the demands of the ALL Kids Program.
16. Facilitation of a medical home for each enrollee.

*The exception to the fee-for-service payment system is the method of reimbursement to federally qualified health centers (FQHCs) and rural health clinics (RHCs) based on a prospective payment system (PPS). This is in compliance with section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In accordance with this provision of CHIPRA, ALL Kids has elected to adopt the Medicaid PPS Rates effective October 1, 2009. This method of payment will be implemented August 25, 2010 for all qualifying services rendered on or after October 1, 2009.

In the past, ALL Kids has used three (3) insurance venders, Blue Cross Blue Shield of Alabama (statewide), Prime Health (in 10 southwestern counties from 10/98-9/00) and United Healthcare (14 counties from 10/01-7/02) for the above services. However, due to low enrollment in Prime Health and United Healthcare (which was due to patient choice), each of those programs elected, with the mutual consent of the ALL Kids program, to discontinue serving as an ALL Kids vendor. Currently, the only ALL Kids vendor for the above services is Blue Cross Blue Shield of Alabama. This vendor provides services statewide.

CHIP makes health care coverage available to all individuals eligible for ALL Kids on a "guaranteed issue" basis with no exclusions of coverage for pre-existing conditions, and on a "guaranteed renewable" basis for those eligible.

ALL Kids PLUS

Program Operation-Administration

For this addition to the program, the Alabama Department of Public Health has partnered (and seeks to partner) with other governmental agencies (which serve special needs children) to provide the state match, provide or provide for covered ALL Kids PLUS services, to authorize case by case reimbursement for ALL Kids PLUS services, to notify ALL Kids PLUS families of their approval for services, and select one case manager per child so as to minimize duplication and gaps in services. PLUS services became available through CRS as of October 1, 2000. An ALL Kids PLUS contract was signed with the Department of Mental Health and Mental Retardation effective October 1, 2002.

Several state agencies, other provider entities, and advocates within the state have met to develop the

concept and plan of operation for ALL Kids PLUS.

At the present time, the list of ALL Kids PLUS authorizing agencies is restricted to those governmental agencies supplying the state match money. If other state or appropriated matching funds become available, this restriction may be modified or eliminated. A child must be enrolled in ALL Kids to qualify for PLUS services. When a child is identified with a special condition or need that a participating agency serves, he/she is referred to that agency based on that special condition/need. This agency will, based on the availability of funds, assign a case manager to the child, authorize needed services within the agency, and make referrals to other authorizing agencies for additional services if needed. All agencies authorizing PLUS services for a child notify the child's case manager and referral site (if different) for approval of services. Each child will only have one ALL Kids PLUS case manager. The decision as to which agency will provide the case management will be determined by the agencies involved in the child's care and will be based on what makes the best practice sense and is in the best interest of the child.

Authorizing agencies bill the insurance vendor(s) for any authorized PLUS services that the agencies have provided directly or indirectly. The Alabama Department of Public Health reimburses the insurance vendor(s) in the same manner that reimbursement for the basic ALL Kids program is handled. At this time, the participating PLUS agencies do not utilize a central integrated data system. However, their day-to-day practice involves coordination through the case manager with other agencies to avoid duplication. Each agency submits all claims/data to the insurance vendor (BCBS) for adjudication and reimbursement. While a child may have claims submitted by more than one agency, only one agency may be reimbursed for case management services.

☐ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS Regional Office for review and approval. (Section 2103(f)(3))

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review,

coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR 457.490(b))

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

Utilization control mechanisms are in place for the ALL Kids program to ensure that children use only health care that is appropriate, medically necessary, and/or approved by the State or the participating health plan. In addition, policies are in place to assure that necessary care is delivered in a cost-effective and efficient manner according to the vendors' medical necessity definition. The current Blue Cross Blue Shield policies are available upon request.

Before being approved for participation in the ALL Kids program, health plan vendors must develop and have in place utilization review policies and procedures, demand management, and disease state management mechanisms. Provider networks approved for the ALL Kids program are accepted based on evidence of the vendors' provider credentialing policies, provider accessibility, cost-effectiveness, and efficiency.

Each ALL Kids PLUS authorizing state agency has a utilization review mechanism particular to that agency. Services approved for ALL Kids PLUS are those which are developmentally necessary and/or physically necessary. Reviewing the appropriate use of services is part of the case manager's duties.

The Alabama Medicaid Agency applies the same utilization controls to the CHIP Medicaid expansion enrollees as it does to the entire Medicaid child book of business.

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0.☐ Medicaid Expansion

4.0.1. Ages of each eligibility group and the income standard for that group:

4.1.☐ **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0☐ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

4.1.1 ☐ Geographic area served by the Plan if less than Statewide:

4.1.2 ☐ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

4.1.2.1-PC☐ Age: through birth (SHO #02-004, issued November 12, 2002)

4.1.3 ☐ Income of each separate eligibility group (if applicable):

4.1.3.1-PC☐ 0% of the FPL (and not eligible for Medicaid) through % of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4☐ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5☐ Residency (so long as residency requirement is not based on length of time in state):

4.1.6☒ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

Children will be eligible for ALL Kids regardless of disability. ALL Kids PLUS is available to children with special conditions/needs who are enrolled in ALL Kids. ALL Kids PLUS enrollment is restricted to services authorized and financed by PLUS participating agencies. However, if access to additional matching funds becomes available and/or the health needs of CSHCC/N change, authorized services will be revised to reflect these changes.

4.1.7☒ Access to or coverage under other health coverage:

A child is not eligible for ALL Kids if s/he has any other health insurance coverage or is eligible for Medicaid.

4.1.8 ☐ Duration of eligibility, not to exceed 12 months:

4.1.9 ☒ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 42 CFR 457.310 and 457.320 that are not addressed above. For instance:

Comprehensive health coverage will be provided from conception to birth for those with family incomes up to and including 312% FPL, whose mothers do not have comprehensive coverage, and reside in select counties in Alabama (initially Montgomery, Macon and Russell). A phased in approach (see CS9 for list of initial phase counties) will be utilized until coverage is offered statewide. The time frame for the phase in period will be 3-5 years. Comprehensive coverage will be provided to this population from the date of enrollment and will continue until the last day of the month in which the 60 day postpartum period has elapsed after the end of a pregnancy. The date of enrollment may be as early as the first day of maternity-related service provision even if the application is completed a few days after the service is received. In other cases coverage will begin on the date the application is received by the CHIP office. Prenatal care, labor and delivery and limited postpartum care are paid using a bundled payment. In addition to the bundled payment, the state will provide comprehensive coverage during the postpartum period through ALL Babies HSI Initiative. For example, if a woman gives birth on June 26, benefits covered in the bundled package or postpartum HSI would end on August 31. Obstetric coverage for current ALL Kids members includes all prenatal care through 90 days postpartum and is billed as a bundled payment. Social Security numbers for the babies will not be required unless and until the child is born and applies for renewal.

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☐ States should specify whether Social Security Numbers (SSN) are required.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☒ Continuous eligibility

Section 2107(e)(1)(J) applies section 1902(e)(16) equally to CHIP and allows individuals who were eligible for and enrolled in CHIP while pregnant to remain eligible regardless of changes in circumstance except for the following:

screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2)Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2.(Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

5.1.1. (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

In Alabama, thanks to outreach efforts of a variety of public and private agencies and organizations, there is a high awareness level of children's health insurance programs and their eligibility requirements. Over one-fourth of children under the age of 19 in Alabama are covered by Medicaid or ALL Kids. The programs are reaching children who might not otherwise have access to the health care they need.

Prior to CHIP, the Medicaid Program was the only public health insurance program for children in Alabama. Health services are provided in Alabama to uninsured and Medicaid enrolled children by private physicians, the 67 Alabama Department of Public Health (ADPH) county health departments, 16 primary care centers (including Federally Qualified Health Centers), two children's hospitals (The Children's Hospital of Alabama and Women's and Children's Hospital at the University of South Alabama) school health nurses, and one Indian Health Service Clinic. In addition to the two children's hospitals, Alabama Department of Rehabilitation Services, Children's Rehabilitation Services (CRS) provides specialty care to uninsured and Medicaid enrolled children with special health care needs. As lead agency for Alabama's Early Intervention System, this agency coordinates services for infants and toddlers eligible for IDEA (Individuals with Disabilities Education Act), part C. This section describes the current efforts made by the ADPH to provide health care services, and to identify and enroll uncovered children in the Medicaid and ALL Kids programs. This section also describes the efforts made by CRS, the Alabama Medicaid Agency, the Alabama Department of Human Resources, and the Alabama Department of Mental Health and Mental Retardation to identify and enroll all uncovered children who are eligible to participate in the Medicaid and ALL Kids programs.

Alabama Department of Public Health
As the CHIP lead agency, the ADPH is actively involved in all aspects of identification and enrollment of children who are eligible to participate in public health insurance programs and

health insurance programs that involve public-private partnerships. Activities include the creation, publication, and distribution of marketing materials, management of the ALL Kids enrollment process, and targeted outreach activities for specific populations such as faith-based organizations, etc.

The Alabama Department of Public Health provides some direct as well as support patient care for uninsured and Medicaid enrolled children and adolescents. Direct services for this population include: preventive child health services (well-child check-ups), prenatal services, Women Infants and Children Supplemental Nutrition [WIC] program services, preventive health education, immunizations, and Family Planning program services. Support services include case management services, the provision of information and referral via toll-free telephone lines, and laboratory services. These services are funded through federal Title V Maternal and Child Health Block Grant funds, federal Title X Family Planning program funds, federal WIC Program funds, Medicaid program reimbursements, federal immunization funds, state legislative appropriations, some local government appropriations, and a small amount of patient fee revenue. A variety of the above direct and support services are provided within ADPH county health departments. In fiscal year 2001, 34,664 children (birth through age 18 years) received health services in local county health departments. (This number excludes single service patients [STD-only, Immunization-only, WIC-only].) The Alabama Department of Public Health is the state's Title V agency. Additionally, there are approximately 512 school health nurses, R.N.s and L.P.N.s, (working under the auspices of the ADPH, private hospitals, the Alabama State Department of Education, and/or local education agencies) in the state who provide a variety of health screening services, primary care and emergency services, Medicaid/ALL Kids enrollment facilitation, etc.

Income assessments are performed on all patients enrolled in ADPH clinics. The income assessments are reviewed for possible Medicaid eligibility. Beginning in FY 1991, Medicaid eligibility workers were out-stationed in health departments and other health care facilities to accept applications and complete Medicaid eligibility determinations at the time of health visits. A streamlined, four-page expanded Medicaid eligibility form, which was implemented in FY 1991, has been revised into a joint application with CHIP and the Alabama Child Caring Foundation (ACCF) and is available at county health departments. Out-stationed Medicaid eligibility personnel currently assist patients in completing the forms and data is put into an automated Medicaid system on-site. Final determination for Medicaid can then be made immediately. If the children appear to be ALL Kids or ACCF eligible the application is forwarded to the appropriate program.

New applications, as well as annual reviews of established patients, are assessed by ADPH intake staff and/or care coordinators for possible referral for medical assistance through Medicaid, ACCF, or SSI. When appropriate, staff assist families in completing the application forms, making appointments, and gathering medical information. Out-stationed Medicaid eligibility workers are based in many ADPH clinics, hospitals, and primary care centers across the state. Additionally, two Medicaid out stationed workers and a clerk are now located in the CHIP office who process many ALL Kids referrals. A third worker will be added in FY 2003.

Cross training sessions with staff at many levels has improved interagency communication at the community level.

In order to provide additional outreach, the ADPH operates two toll-free telephone lines for use by the general public. The toll-free telephone lines (established prior to the implementation of CHIP and continued to the present) are known as Healthy Beginnings and Info Connection. Two integral parts of the information provided to callers, via these telephone lines, are information on Medicaid, ALL Kids, and ACCF eligibility and referrals to health providers who accept Medicaid-eligible children and Medicaid-eligible pregnant women. Referral services provided by the Healthy Beginnings and Info Connection staff members are expanded through consultation supplied by a host of additional professionals located within the ADPH. The toll-free number for Healthy Beginnings is 1-800-654-1385. The Info Connection number is 1-800-545-1098. Both lines are operational 24 hours a day, seven (7) days a week; office hours are from 8:30 A.M. to 4:30 P.M. each week day. The Healthy Beginnings and Info Connection lines are publicized statewide through newspapers, television, posters, and pamphlets. Presentations regarding the lines are conducted statewide to various organizations and agencies. The numbers are also published in Alabama South Central Bell telephone books. Additionally, with the implementation of CHIP, the CHIP unit maintains two toll-free telephone lines (888-373-5437 for enrollment and eligibility issues and 877-774-9521 for administrative issues). Finally, in addition to the above efforts, ALL Kids, Medicaid, and the Alabama Child Caring Foundation have developed a joint application and renewal form for use by all three programs. This enables families to be screened for eligibility for all three programs and facilitates referrals and timely enrollment in the appropriate program.

Alabama Department of Economic and Community Affairs (ADECA)

ADECA notifies the ALL Kids regional staff when a plant or large business plans to close in the near future. ALL Kids regional staff present ALL Kids information and materials at employee meetings prior to the plant/business closing. In order to prevent gaps in health insurance coverage for the children of the employees of the plant/business, an ALL Kids policy was developed which provides for beginning ALL Kids coverage (for eligible children) the day after employer sponsored coverage ends if an application is received by the ALL Kids enrollment unit within 30 days after the plant/business closing.

Alabama Department of Rehabilitation Services

Children's Rehabilitation Service

Children's Rehabilitation Service (CRS) also has coordination agreements with the Alabama Medicaid Agency. (These contracts existed prior to CHIP and have continued to be in effect.) The Alabama Medicaid Agency contracted with CRS for the provision of specialty medical services, specialized therapy (such as physical, occupational, speech, etc.) services, and case management services to children with special health care needs. With the implementation of ALL Kids, CRS clinics were added as preferred providers under the ALL Kids basic benefits

package and the ALL Kids PLUS package.

New applications, as well as annual reviews of established patients, are assessed by CRS intake staff and/or care coordinators for possible referral for medical assistance through Medicaid, ALL Kids, ACCF, or SSI. When appropriate, staff assist families in completing the application forms, making appointments, and gathering medical information. Joint Medicaid/ALL Kids/ACCF eligibility forms are available in all CRS offices and clinics. As in the ADPH, cross training sessions with staff at many levels has improved interagency communication at the community level. Medicaid and ALL Kids information and outreach brochures and posters are available in every CRS office throughout the state.

Additionally, like the ADPH, CRS operates toll-free telephone lines for use by the general public. One line is operated at the state level in Montgomery and additional lines are located in each CRS district office. An integral part of the information provided to callers, via these telephone lines, is Medicaid, ALL Kids, and ACCF eligibility and referral information. CRS and Early Intervention (EI) have both completed database matches with ALL Kids files to identify children known to both programs. CHIP staff have participated in many staff trainings throughout the state to assist CRS and EI staff in outreach for ALL Kids, Medicaid, and ACCF.

Division of Early Intervention
As the lead agency for Alabama's early intervention system for infants and toddlers with developmental disabilities and their families, this unit provides a toll free Child Find telephone number for use by the general public and primary referral sources. Additional efforts for coordination are described in the PLUS sections of this document.

Medicaid Agency
The Alabama Medicaid Agency has 135 eligibility workers in over 170 locations to enroll children eligible for SOBRA Medicaid whose the family's income is at or below 100 percent of FPL (for children born after September 30, 1983) or 133 percent of the FPL (for children through age five). With the implementation of CHIP, 23 workers were added throughout the state. In March, 2002, two eligibility workers and a clerk were housed in the ALL Kids central office to review applications referred from the ALL Kids eligibility workers. In addition to the CHIP office, these workers are located in places children are likely to go to receive health care -- county health departments, Federally Qualified Health Centers and hospitals. Because workers are in the community, they can and do establish working relationships with public and private providers, social service agencies and others. For example, supervisors provide in-service training and education on Medicaid, ALL Kids, and ACCF eligibility to physicians, Head Start workers, day care centers, Human Resources staff and others. The Alabama Medicaid Agency also has 10 district offices located throughout the state that process applications for the elderly and the disabled population. The 80 eligibility workers and 20 supervisors advise applicants about other programs and refer the applicants to the proper

office when they do not qualify for a disabled program. They also advise about programs for which other family members may be eligible. These district offices work closely with providers to keep them informed of all programs available through the Medicaid Agency.

Applications for Medicaid, ALL Kids, and ACCF are easily available to anyone who needs one. Applications are available not only from Medicaid workers but also at physicians' offices, county offices of the Department of Human Resources and hospitals. All sources of the joint application (i.e., ADPH, CRS, etc.) allow a "mail-in" application process thereby allowing Medicaid to complete a phone interview instead of a face-to-face interview. Medicaid has a toll-free number for anyone to call to ask questions about Medicaid eligibility and find out where and how to apply. The number is 1-800-362-1504. Medicaid's Web site contains information on Medicaid eligibility and is used by advocates to assist people who want to apply for Medicaid.

Through its Medical Care Advisory Committee and its Physicians Task Force, Medicaid receives guidance on ways to reach potential Medicaid eligible. Medicaid staff regularly brief these groups, who represent both providers and consumers, on all facets of the Medicaid program, including eligibility. Both groups are kept informed of upcoming changes in the Medicaid program and encouraged to provide comments and suggestions.
With welfare reform and the separation of Medicaid eligibility from eligibility for public assistance, the Alabama Medicaid Agency and the Department of Human Resources have developed new cooperative arrangements to assure that children in the state's lowest income families have access to Medicaid. Applications may be completed through the mail with a telephone interview, thus eliminating the need for a face-to-face contact. Currently DHR workers assess their clients to determine whether they might be eligible for any Medicaid, ALL Kids, or ACCF program. Workers help to complete forms, gather information and make appointments as necessary. However, the enrollment function for this Medicaid program will be transferred from DHR to the Medicaid Agency within the coming year.

Outreach occurs after the birth of an infant to a Medicaid recipient. Following the birth of each newborn whose mother is a Medicaid recipient, the Alabama Medicaid Agency sends the infant's parent or guardian a pamphlet on the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program as well as a pamphlet on immunizations. When children are enrolled in the SSI Program, they are automatically enrolled in the Medicaid Program. Additionally, a brochure is sent to parents/guardians of all new SSI eligible children encouraging them to participate in the EPSDT program. In addition to these efforts, social workers within the ADPH conduct patient recruitment as a part of their case management activities. These recruitment efforts are conducted through community presentations and professional relationships with other State and local agencies which serve mothers and children.

The Alabama Department of Human Resources and the Alabama Department of Mental Health and Mental Retardation also provide case management services for Medicaid children

known to their agencies, in order to facilitate their enrollment in health services particularly mental health services through the Rehabilitation Option.

Through CHIP Phase I, the Alabama Medicaid Agency, working with the Alabama Department of Public Health, took several major steps to identify and enroll all uncovered children who were eligible to participate in this public health insurance program.

New eligibility workers were hired and they, plus existing eligibility workers, were trained in CHIP eligibility criteria as well as other Medicaid eligibility criteria. These eligibility workers are out stationed in health departments, hospitals, community health centers, CHIP office, etc.

In order to streamline the CHIP/Medicaid enrollment process, the Alabama Medicaid Agency initiated continuous eligibility for all Medicaid children under the age of 19 years, on April 1, 1998. Continuous eligibility means that Medicaid enrolled children maintain their Medicaid coverage continuously for one year from enrollment or re-determination.

Additionally, numerous presentations, regarding CHIP, have been made by knowledgeable professionals who are members of the broad based CHIP Workgroup and CHIP staff. These presentations include addresses to education professionals, rural health groups, child care management agencies, parents of children with special health care needs, Indian Health Service staff, the general public, etc. Some specific activities include:

Notice to all Medicaid providers
News releases and camera-ready materials for newspapers
Articles published in newsletters of health care provider associations–Medical Association of the State of Alabama, Alabama Hospital Association, Alabama Dental Association, and others

Television commercials
Radio spots
Brochures have been distributed to date for out stationed Medicaid workers, public health workers, county human resources workers, Early Intervention Coordinating Councils, Mental Health Centers, family services centers, primary health care centers, hospitals, advocacy and professional organization, and in the school system, principles and guidance counselors. Brochures distributed at state meetings of Alabama Conference of Social Work, Medical Association, American Academy of Pediatrics-Alabama Chapter, Alabama Dental Association, Family Practice doctors, and others
Satellite conferences to provide information about the basic ALL Kids Program and instruction in completing the application.
Distribution of applications and brochures to all public school systems, local health departments, welfare offices, hospitals, community health centers, physician and dentist offices, pharmacies, WIC clinics, and family law attorneys, etc.
Public forums for parents and advocates of CSHCC/N (Children with Special Health Care Conditions/Needs)

With specific regard to the Conception to Birth expansion ~~and the RIM HSI~~, the ADPH will provide information to pertinent providers, hospitals and programs serving the target population residing in the counties in which the expansion is implemented.

In addition to the above, the state has engaged in the following particular activities to promote ALL Kids PLUS. Originally, it was anticipated that ALL Kids PLUS would involve four state programs, Children's Rehabilitation Service, Early Intervention, Mental Health/Mental Retardation, and Civitan International Research Center Sparks Clinics. After conducting database matches, reviews of Pediatric Health History information, claims data, through mutual agreement, Sparks determined that their services were being adequately reimbursed through the ALL Kids basic benefit package. Therefore, attention was focused on the remaining three agencies. Since that time, CHIP has entered into discussions with the Alabama Institute for the Deaf and Blind with regard to becoming an ALL Kids PLUS provider. CRS has had an active contract for the provision of PLUS services since October, 2000 and has served as a valuable partner in establishing protocols for the identification of ALL Kids enrollees in need of PLUS services and the identification of current clients in need of insurance coverage.

Initially it was anticipated that children would be identified for the PLUS program through an in-depth analysis of the Pediatric Health History and chart reviews. Practical experience has shown that this was not the most productive method of identification. Database matches were necessary as a first action to even identify ALL Kids enrollees who were being served by CRS. After this baseline was established, claims reviews were shown to be a more valuable mechanism in identifying children eligible for PLUS services than were chart reviews. This claims review revealed that a much smaller percentage of ALL Kids enrollees, than originally projected, were in need of services beyond those available in the basic benefits package. Program staff continually monitor feedback from providers and families regarding the need for additional services. This type of feedback and analysis has influenced the approaches that have been used with the other potential ALL Kids PLUS agencies. Through the activities of the regional ALL Kids staff, central office social work consultant, and customer service staff, ALL

Kids enrollees in need of these specialized services provided by ALL Kids PLUS agencies have been identified and referred as appropriate.

In August of 1999, the ADPH broadcasted a nationwide satellite conference to educate the provider community and other concerned individuals regarding ALL Kids PLUS. In addition, CHIP staff provided training on the PLUS program to CRS staff at regional meetings.

Alabama Department of Human Resources (DHR)
The DHR has continued to partner with the ADPH to communicate ALL Kids information to

their county staffs. They have provided initial and continuing updates to county DHR staff as well as provided periodic shipments of applications, posters, etc. The DHR has also assisted with outreach efforts through its childcare management agencies and facilitated communication with licensed child day-care homes and centers.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

There is only one health insurance program for children in Alabama that resembles a public-private partnership. This program is known as the Alabama Child Caring Foundation (ACCF) and is a part of Blue Cross Blue Shield. The Alabama Child Caring Foundation provides limited ambulatory health insurance to low income, non-Medicaid/non-ALL Kids, uninsured children under the age of 19 years who remain full-time students through grade 12. The program is funded through private donations and matching funds from Blue Cross Blue Shield. Outreach for this program is conducted through articles in Blue Cross Blue Shield publications and public service announcements in local newspapers, via television, and radio stations. The University of Alabama and Auburn University coaches' television shows expressly advertise the Foundation. Case finding is conducted by school administrators, school nurses, day care operators, and others. Additionally referrals to the Foundation are received from the ALL Kids program, local offices of the ADPH, the Alabama Medicaid Agency, the Alabama Department of Human Resources, the Alabama Department of Industrial Relations Dislocated Workers program, individual health care providers, civic organizations, churches, Sunday School classes, other religious organizations, and from Foundation participants.

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

5.2. (formerly 2.3)Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health

coverage.(Section 2102(a)(3),2102(b)(3)(E)and 2102(c)(2))(42CFR 457.80(c)).This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

The State of Alabama assures coordination with other public and private programs providing creditable coverage for low-income children. The SOBRA Medicaid program, ALL Kids, and the Alabama Child Caring Foundation have developed and use joint application and renewal forms.

All applications received by the ALL Kids enrollment unit are screened for Medicaid eligibility. When a child is identified by an ALL Kids enrollment worker as potentially eligible for Medicaid, the family's application is sent to a Medicaid enrollment worker. Medicaid then processes it. As stated previously, two Medicaid enrollment workers and one clerical worker are physically located within the ALL Kids enrollment unit. This process also works in the reverse (applications are sent from Medicaid to ALL Kids).

When a child is identified by an ALL Kids enrollment worker as not potentially eligible for the Medicaid or ALL Kids but potentially eligible for the Alabama Child Caring Foundation (ACCF), the family's application is sent to ACCF which then processes it and the opposite is also true.

Because it is recognized that the eligibility and enrollment systems of these three programs are not as seamless as needed, ALL Kids employs a full time MSW staff person. This staff person has responsibility to assist families in overcoming obstacles related to eligibility, enrollment, claims, and referral for specialty services as needed. Additional responsibilities include development and maintenance of the ALL Kids policy manual.

In addition, the State coordinates with the ALL Kids PLUS authorizing agencies. See the previous section for a broader description of the collaboration.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, out stationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and

assist them in enrolling in the appropriate program.

5.3. **Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

Phase I - Medicaid Expansion

This portion of the outreach section, as it pertains to Phase I of Alabama's Title XXI program, consists solely of efforts that were targeted toward Medicaid eligibles who were born after September 30, 1983 and who are under 19 years of age. There were four primary avenues through which outreach was conducted. These avenues were (1) the use of existing outreach approaches, (2) an initiative to improve communication with and services for the state's rapidly expanding Hispanic population, (3) an increase in the number of Medicaid eligibility workers, and (4) coordination with the State Medical Association and physicians to educate physicians and their potentially eligible patients. Detailed information regarding these efforts is available from CHIP upon request.

Phase II - ALL Kids

Outreach for ALL Kids is conducted through coordinated Statewide and regional efforts and in each county through partnerships, contracts, and regional CHIP coordinators. These efforts consist of a three-pronged approach: (1) Statewide media campaigns and initiatives; (2) outreach conducted by multi-county regional workers and consultants; and, (3) outreach conducted through existing programs and agencies. The purposes of all of these activities is to build networks and coalitions of persons who can inform individuals about the availability of ALL Kids and what it has to offer, and assist individuals in completing application forms. Outreach is conducted by a variety of individuals and in a variety of settings. Each feature of the three-pronged outreach approach is described below:

- **Statewide media campaigns and initiatives - The media campaigns focus on informing individuals about the availability of ALL Kids and what they have to offer as well as providing information regarding where applications or other information may be obtained. Additionally, ALL Kids staff attend a wide variety of association meetings and conferences to inform memberships of the availability of children's health insurance. The staff have developed specialized outreach materials (from videos to informational brochures and flyers to specific handouts) for specific groups to meet their needs.**

  Staff have exhibited at booths and presentations to the Medical Association of the State

of Alabama, Alabama Chapter of the American Academy of Pediatrics, Family Practice Physicians, Dentists, Social Workers, Department of Human Resources staff, Mental Health staff, Family Law Judges, Hospitals, Hospital auxiliaries, WIC staff, Public Health Staff, etc.

- **Outreach conducted by multi-county regional workers and consultants – since the Spring of 2002, ALL Kids consultants have been and/are employed throughout the state, to disseminate information about the program to develop coalitions and networks of local residents to assist individuals in completing and submitting applications. These regional coordinators, their supervisory directors, and consultants are many times based in the county health departments but also utilize numerous off-site locales and alternative working hours.**
- **Outreach conducted through existing programs and agencies - Information about CHIP, applications, and application assistance are available through existing child-related programs such as the Child Care Management Agencies and their targeted child day care centers, Food Stamps, Maternal and Child Health Block Grant Program clinics, WIC clinics, community health centers, Indian Health Services, school nurse programs, school counselor programs, Early Intervention programs, other social service agencies, etc. These programs and agencies have successful histories of serving the target population and the CHIP program utilizes their contact with this population to broaden outreach efforts. Dissemination of CHIP information to these entities has been facilitated since representatives of these agencies and programs served on the CHIP Advisory Council and continue to be in contact with CHIP as stakeholders.**
- **With specific regard to the Conception to Birth expansion ~~and the RIM HSI~~, the ADPH will provide information to pertinent providers, hospitals and programs serving the target population residing in the counties in which the expansion is implemented.**

Phase III - ALL Kids PLUS

Outreach for this special population is conducted primarily by the ALL Kids PLUS authorizing agencies. Outreach includes educating primary and specialty care physicians regarding ALL Kids PLUS, identifying and contacting children who may need PLUS services through reviews of agency rolls and possible reviews of the pediatric health histories (part of the application process), contact with community health centers, etc. Information about ALL Kids PLUS is incorporated into all publications and presentations.

In an effort to continually improve the ALL Kids PLUS, CHIP staff continue to meet with the ALL Kids PLUS participating agencies to identify and resolve any problematic areas and to recruit additional participating agencies. PLUS agencies assist the CHIP staff in developing contracts, performance standards, and procedures for ongoing monitoring and oversight of the ALL Kids PLUS program.

NOTE: The application form and other materials have been translated into Spanish. Additionally, the ALL Kids enrollment unit employs a Spanish-speaking staff member and a Hispanic consultant has been hired to develop a Hispanic outreach plan.

Section 6. Coverage Requirements for Children's Health Insurance

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☒ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Checkbox below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☒ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

The benefit package offered by the health maintenance organization with the largest insured commercial, non-Medicaid enrollment of covered lives was selected after several well attended public meetings where the benefits of the three benchmark plans were compared with the assistance of the insurers/administrators for the three plans. The benefit plan was altered slightly to make it more appropriate for children's needs.

In addition to the ALL Kids basic benefits package, additional benefits may be available for enrollees who have special needs. These additional benefits are known as ALL Kids PLUS benefits and are only available as prescribed by ALL Kids PLUS authorizing agencies. These decisions regarding what benefits are provided, the requirements for their receipt, and the provision of the benefits is under the auspices of the PLUS authorizing state agencies. These state agencies are those with which CHIP has a contract for the provision of ALL Kids PLUS services, those agencies that ordinarily serve children with special health care conditions and needs, and which provide the matching funds for federal CHIP funding

The ALL Kids benefits plan is described in the ALL Kids Summary Plan Description (SPD), which is available upon request. The benefit package for enrollees in the CHIP Medicaid expansion will be identical to other children enrolled in comprehensive Medicaid categories.

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as

described in 42 CFR 457.430:

- coverage of prescription drugs,
- mental health services,
- vision services and
- hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☐ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. ☐ Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT).

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver.

6.1.4.3. ☐ Coverage that the State has extended to the entire Medicaid population.

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in §457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☒ Coverage that includes benchmark coverage plus additional coverage.

In the second amendment to the Alabama CHIP State Plan, ALL Kids PLUS was established which provided additional benefits for children with special health care conditions/needs. Attachment A contains a detailed description of the ALL Kids PLUS component of CHIP.

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than coverage under one of the benchmark plans specified in 457.420, through the use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done).

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☒ Other. (Describe)

Comprehensive health coverage will be provided from conception to birth for those with family incomes up to and including 312% FPL, whose mothers do not have comprehensive coverage, and reside in select counties in geographic areas in Alabama where CHIP unborn coverage is available. Alabama will utilize a phased in approach (see CS9 for list of initial phase counties) until coverage is provided statewide. Prenatal care, labor and delivery and limited postpartum care are paid using a bundled payment. In addition to the bundled payment, the state will provide comprehensive

coverage during the postpartum period through ALL Babies HSI Initiative. Coverage begins upon enrollment and will continue until the last day of the month in which the 60 day postpartum period has elapsed after the end of a pregnancy. For example, if a woman gives birth on June 26, benefits covered in the bundled package or postpartum HSI would end on August 31. The first day without coverage would be September 1. The date of enrollment may be as early as the first day of maternity-related service provision even if the application is completed a few days after the service is received. In other cases coverage will begin on the date the application is received by the CHIP office. The definition of comprehensive coverage includes coverage for obstetrical benefits. If a pregnant woman has other coverage but the other coverage does not include obstetrical benefits, then the other coverage would be considered non-comprehensive, regardless of any other benefits it insures. In this circumstance, the pregnant woman would meet the criterion for not having comprehensive coverage.

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

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

A description of the scope, amount and duration of services covered under ALL Kids and ALL Kids PLUS, as well as any exclusions and limitations can be found in the ALL Kids Summary Plan Description (SPD) which is available upon request.

Health insurance benefits provided to conception to birth enrollees will be identical to the health insurance benefits provided to any pregnant ALL Kids enrollee. The date of enrollment may be as early as the first day of maternity-related service provision even if the application is completed a few days after the service is received. In other cases coverage will begin on the date the application is received by the CHIP office. Prenatal care, labor and delivery and limited postpartum care are paid using a bundled payment. In addition to the bundled payment, the state will provide comprehensive coverage during the postpartum period through ALL Babies HSI Initiative. In geographic areas in Alabama where CHIP unborn coverage is available, coverage for bundled obstetrical benefits begins upon enrollment and will continue until the last day of the month in which the 60 day postpartum period has elapsed after the end

of a pregnancy. For example, if a woman gives birth on June 26, benefits covered in the bundled package or postpartum HSI would end on August 31. The first day without coverage would be September 1.

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

6.2.3. ☒ Physician services (Section 2110(a)(3))

6.2.4. ☒ Surgical services (Section 2110(a)(4))

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to

the home.

6.2.14. ☒ Home and community-based health care services (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15. ☒ Nursing care services (Section 2110(a)(15))

6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.17. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

6.2.18. ☒ Vision screenings and services (Section 2110(a)(24))

6.2.19. ☒ Hearing screenings and services (Section 2110(a)(24))

6.2.20. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

6.2.21. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))

6.2.22. ☒ Case management services (Section 2110(a)(20))

6.2.23. ☒ Care coordination services (Section 2110(a)(21))

6.2.24. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

6.2.25. ☒ Hospice care (Section 2110(a)(23))

Guidance: See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

6.2.26. ☐ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial,

therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.27.☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration, in accordance with the requirements of section 2103(c)(11)(A) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.
- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

COVID-19 Treatment:

- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
    - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
    - The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and

- The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

6.2.28. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.29. ☒ Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.30. ☒ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.31. ☒ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

Transplantation Services
Emergency and Urgent Care Services
Skilled Nursing Services
Vision Services

6.2-DC **Dental Coverage**(CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[6]) codes are included in the dental benefits:

Alabama has no state law applicable to public notice of either cost sharing changes or waiting list implementations in CHIP.

Public Notice of Cost Sharing Changes:

Specific public notice was given via a meeting of CHIP stakeholders in August 2003 and letters to enrollees' families informing them of the changes in cost sharing. This meeting and the mailings followed much publicity in the state regarding the state's financial situation and the possible impact on CHIP if a statewide referendum to raise taxes on (September 9, 2003) did not pass.

Public Notice of the Waiting List:

ALL Kids initiated a waiting list beginning with all new enrollees who would have had an effective date October 1, 2003. Once the decision had been made to establish a waiting list, a press statement was released and letters were sent to stakeholders and other interested parties informing them of the institution of a waiting list and stressing the importance of returning renewal forms on time. Additionally, a letter to this effect was sent to every enrollee family along with a new insurance card(s). All of these notices were issued during the month of September 2003 prior to the impact of the waiting list.

On August 23, 2004, ALL Kids reopened enrollment and discontinued use of the waiting list.

If the State determines that it is again necessary to implement a waiting list, it will provide prior, appropriate public notice.

There are no public notice state laws regarding enrollment caps and waiting lists in SCHIP.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

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

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not

limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
- All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

CHIP Budget

STATE: AL	**FFY Budget**
Federal Fiscal Year	**2023**
State's enhanced FMAP rate	**80.70%**
Benefit Costs	
Insurance payments	**----**
Managed care	**----**
per member/per month rate	
Fee for Service	**$ 298,566,016**
Total Benefit Costs	**$ 298,566,016**
(Offsetting beneficiary cost sharing payments)	**$ 6,600,000**
Cost of Proposed SPA Changes – Benefit	**$ 10,000,000**
Net Benefit Costs	**$ 301,966,016**
Administration Costs	
Personnel	**$ 6,384,170**
General administration	**$ 3,875,354**
Contractors/Brokers	

STATE: AL	FFY Budget
Claims Processing	
Outreach/marketing costs	$ 794,500
Health Services Initiatives	$ 610,000
Other	$ 1,229,312
Total Administration Costs	$ 12,893,336
10% Administrative Cap	$ 30,196,602
Cost of Proposed SPA Changes	$ 10,360,000
Federal Share	$ 254,091,497
State Share	$ 60,767,855
Total Costs of Approved CHIP Plan	$ 314,859,352

NOTE: Cost of Proposed SPA Changes consist of benefit and postpartum HSI coverage for 36 counties (See CS9).

The Source of State Share Funds: State General Fund

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

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

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

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

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

10.3-DC☒ The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

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

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

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

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

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

Section 12. Applicant and Enrollee Protections(Sections 2101(a))

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

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes

and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

Alabama's appeals process meets the requirements of the Program Specific Review as outlined in CFR.457.1120 – 457.1180. The ALL Kids appeals and grievance process can be found in Attachment A. The individuals involved in the Information review (first level) are not involved in the Administrative Review (second level) thus impartiality in the appeals process is provided. The individuals who conduct the Administrative Review are not involved in the Information Review process not in the original determination process. The review process for children enrolled in a CHIP Medicaid expansion is the same as the review process for children enrolled in other Medicaid full service children's programs

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

The State assures that the State laws or regulations are consistent with the intent of 42 CFR 457,1130(b). This grievance process for health service matters is provided by the insurance vendor and is in compliance with state laws, the Employee Retirement Income Security Act of 1974 (ERISA), and all other applicable regulations of the Department of Labor Procedures. A copy of the Blue Cross Blue Shield of Alabama appeals process can be found in the ALL Kids Summary Plan Description (SPD) which is available upon request. The grievance process for children enrolled in a CHIP Medicaid expansion is the same as the review process for children enrolled in other Medicaid full service children's programs.

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

ATTACHMENT A

GRIEVANCE POLICY

General Information

Applicants and enrollees of the ALL Kids Children's Health Insurance Program (CHIP) have a right to discuss and question how eligibility for enrollment was determined. In particular they have the right to request review of program decisions concerning:

- Denial of eligibility
- Failure to make a timely determination of eligibility
- Suspension or termination of enrollment, including disenrollment for failure to pay premiums.

The ALL Kids Review Process has three levels of review--Information Review, Administrative Review and Formal Review. Requests for an Administrative Review and Formal Appeal must be submitted in writing. All correspondence with the
applicant /enrollee concerning Administrative Review or Formal Review will be in writing.

ALL Kids Plus Services

Requests for review of decisions made regarding eligibility for the ALL Kids Plus services must first be made to the ALL Kids Plus participating agency's appropriate appeals process. This is necessary since eligibility for ALL Kids Plus is dependent on the participating agency's eligibility criteria for services. Once the appeals process through the ALL Kids Plus participating agency has been exhausted, an appeal request may be made to the Children's Health Insurance Program as described in ADPH ALL Kids Review Process.

Information Review

In many cases problems can be handled informally through the Information Review Process without the need for an Administrative or Formal Review. CHIP staff is committed to using the Information Review process to provide a speedy and fair resolution when possible and appropriate.

Parents/designated representatives can initiate an Information Review via contact (telephone, e-mail or letter) with the Enrollment Unit supervisory staff, CHIP administrative staff, the CHIP social work consultant, CHIP regional staff, or interested agencies. Once the problem has been received, the appropriate staff will review the situation and initiate immediate action to resolve the problem and

communicate the decision or resolution. If additional information is needed, the enrollee/applicant will be given the opportunity to provide clarification or submit additional information. Decisions made in the Information Review are usually provided within two working days. Notification to the applicant/enrollee will be communicated in the manner in which the request was made. Summation of the inquiry, review and resolution will be maintained on file and noted with the appropriate applicant/enrollee information.

If the problem remains unresolved in the eyes of the applicant/enrollee, they will be provided detailed information regarding their right to an Administrative Review, right to continued enrollment during the review process and provided copies of all forms and the procedures necessary to move forward through the review process. Appropriate notation will be kept in the applicant's/enrollee's electronic file noting the initial complaint, any information gathered during the Information Review, the decision reached through Information Review, the date of such decision and the applicant/enrollees intent to go forward with the Administrative Review Process.

Administrative Review

In order to be considered, an Administrative Review Request Form must be received within ten (10) days of the final decision from the Information Review. The CHIP social work consultant will assist in gathering information that may clarify the request. All information on file from the Information Review and any information gathered by the CHIP Social Work consultant will be circulated to a three person Administrative Review Committee whose members were not involved in the Information Review process nor in the original determination process.

The applicant/enrollee will be notified in advance of the date and time that the Administrative Review Committee will be hearing information regarding their situation. They have the right to speak in person or have a representative of their choosing present during the review. They may also submit additional information and review program records and guidelines pertaining to the matter under grievance.

The Committee's decision and the Program Director's review of the decision must be completed within thirty-days (30) of receiving the Administrative Review Request Form. Applicant/enrollees will be notified in writing of the Administrative Review Committee's decision within three working days of the decision. Additionally this notification will include the applicant/enrollee's rights to continued review and the policy regarding a request for Formal Review by the State Health Officer.

If the grievance remains unresolved in the applicant/enrollee's eyes, the applicant/enrollee may file a request for a Formal Review by the State Health Officer.

Formal Review

In order to be considered by the State Health Officer, a Request for Formal Review must be submitted to the CHIP office within ten (10) days of the final decision of the Administrative Review Committee. This request must be submitted on the Formal Review Request Form.

The applicant/enrollee will be notified in advance of the date and time that the State Health Officer will be hearing information regarding their case. Applicants/enrollees may appear in person or have a representative of their choosing to present information the State Health Officer. They may also submit additional information and review program records and guidelines pertaining to the matter under grievance.

Generally a decision will be issued within thirty-days (30) following receipt of the Request for Formal Review. Applicants/enrollees will be notified of the decision of the State Health Officer within three (3) working days of the decision.

The decision made by the State Health Officer is the final step in the administrative proceedings and will exhaust all administrative remedies.

Expedited Review

If the enrollment or eligibility matter under review would worsen health conditions of the applicant/enrollee or jeopardize lives, an expedited CHIP review may be provided. An Expedited Review will be made within seventy-two (72) hours by quickly obtaining and reviewing information so as not to cause unnecessary harm to the applicant/enrollee.

Right for Continued Benefits During Appeals Process

When the eligibility decision under review concerns renewal or re-determination of coverage, and the enrollee files a Request for Administrative Review, CHIP staff will ensure that coverage for that enrollee is continued until the review process is completed. The enrollee will be notified in writing of this continuation of coverage and their responsibility regarding any health services costs incurred if the resulting review decision supports termination of coverage. The enrollee will be issued a temporary health plan identification card with a coverage end date equal to the maximum length of time allowed for both the Administrative and Formal Review processes.

CHIP Eligibility

State Name: Alabama

OMB Control Number: 0938-1148

Transmittal Number: AL - 23 - 0026

Separate Child Health Insurance Program
Eligibility - Coverage From Conception to Birth **CS9**

42 CFR 457.10

■ **Coverage From Conception to Birth -** Coverage from conception to birth when the mother is not eligible for Medicaid.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Age Standard

From conception through birth.

Does the state have an additional age definition or other age-related conditions? No

Income Standards

Income standards are applied statewide. No

Select a method of geographic variation:

○ Standard varies by county or city.

◉ Standard varies in some other geographic way.

Enter each geographic area with a separate income standard, then enter the applicable income standard.

Add	Geographic Area	Description	Above (% FPL)	Up to & including (% FPL)	Remove
Add	Autauga, Barbour, Bibb, Bullock, Butler, Chambers,			312	Remove
Add	Chilton, Choctaw, Clarke, Coffee, Conecuh, Coosa			312	Remove
Add	Covington, Crenshaw, Dale, Dallas, Elmore, Escambia			312	Remove
Add	Geneva, Greene, Hale, Henry, Houston, Lee			312	Remove
Add	Lowndes, Macon, Marengo, Monroe, Montgomery, Perry			312	Remove
Add	Pike, Russell, Sumter, Tallapoosa, Washington, Wilcox			312	Remove

■ Exempted from requirement of providing or applying for a Social Security Number.

CHIP Eligibility

☒ Exempted from requirement of verifying citizenship status.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119