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State/Territory Name: Alabama

State Plan Amendment (SPA) #: AL-22-0025-CE

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

December 23, 2022

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-22-0025-CE submitted on August 25, 2022, with additional information received on December 16, 2022, has been approved. Through this SPA, Alabama provides 12 months of continuous postpartum coverage to individuals enrolled in its separate CHIP, pursuant to section 9822 of the American Rescue Plan Act of 2021 (ARP). This SPA has an effective date of October 1, 2022 and extends through March 31, 2027, and is a companion to the Medicaid continuous postpartum coverage SPA, AL-22-0007.

Section 9822 of the ARP added section 2107(e)(1)(J) to the Social Security Act, which requires states to provide continuous eligibility throughout an individual's pregnancy and 12-month postpartum period in CHIP if the state has elected this option in Medicaid. In Alabama, this provision applies to targeted low-income children who are pregnant.

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: Teela Sanders	Position/Title: 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

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
AL-14-0016 (Original: AL-14-0016 Effective/Implementation Date: January 1, 2014)	**MAGI Eligibility & Methods**	**CS7**	**Eligibility – Targeted Low Income Children**	**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**
		CS10	**Children With Access to Public Employee Coverage**	
AL-20-0019-CEN (affects only CS15) Effective Implementation Date: July 1, 2020		**CS15**	**MAGI-Based Income Methodologies**	**Incorporate within a separate subsection under section 4.3**
AL-19-0018-RIM Effective Date: July 1, 2019 Implementation Date: July 1, 2019		**CS9**	**Coverage from Conception to Birth**	
(Original: AL-14-0014 Effective/Implementation Date: January 1, 2014)	**XXI Medicaid Expansion**	**CS3**	**Eligibility for Medicaid Expansion Program**	**Supersedes the current Medicaid expansion section 4.0**
AL-16-0015-MEXP Effective/Implementation			**CHIP Medicaid expansion to cover Medicaid enrollees ages**	

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Date: October 1, 2015			**14 years to 19 years with incomes above 18% FPL through 141% FPL**	
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** **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 April 26, 2022, a certified letter explaining the changes proposed in AL-22-0025 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 Director.

TN No: Approval Date Effective Date: May 26, 2022

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))

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). 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:

- The individual requests a voluntary disenrollment;
- The individual is no longer a resident of the state;
- The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual; or
- The individual dies.

4.1-PW☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1)"lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☐ **Lawfully Residing Option**(Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the

following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐Elected for pregnant women.
☐Elected for children under age

4.1.1-LR☐ The State provides assurance that for an individual whom it enrolls in

Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS☐ **Supplemental Dental**(Section 2103(c)(5)-A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. **Assurances-** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan:(Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1.☒These standards do not discriminate on the basis of diagnosis.

4.2.2.☒Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. ☒These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-

income children.

4.2-DS Supplemental Dental -Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS☐ These standards do not discriminate on the basis of diagnosis.

4.2.2-DS☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3-DS☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR 457.350)
Superseded by ACA SPA

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR 457.305(b))

There are no public notice state laws regarding enrollment caps and waiting lists in CHIP. Due to insufficient state funds, ALL Kids initiated a waiting list beginning with all new enrollees who would have had an effective date October 1, 2003. Public and enrollee notices about the waiting list 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 during the year funds are not available at sufficient levels for coverage of children and funding is projected to be depleted before the end of the fiscal year, it is the State's intent to place eligible children on a waiting list until adequate funding becomes available to resume enrollment. Alabama will provide public notice through press releases, written communication with stakeholders and stakeholder groups, presentations, and written communication from the program to all applicant families

whose child(ren) is/are placed on the waiting list.

When a waiting list is implemented, the program has and will continue to receive new applications. These applications will be screened for Medicaid eligibility and then reviewed for ALL Kids eligibility. If a child is eligible for Medicaid, the child will be enrolled in Medicaid. Each family whose child is placed on the ALL Kids waiting list will be notified, by letter, of this placement. The notification letter will also contain information stating that the parent may wish to contact Medicaid if his situation changes and he believes that his child may be eligible for Medicaid. If the child remains on the waiting list for longer than three (3) months, the family will be periodically notified via letter that the child's name is still on the waiting list.

If the State is using a waiting list, children will be enrolled on ALL Kids from the waiting list on a first on–first off basis as funding permits. When attrition has lowered program enrollment to a level at which there are sufficient state funds to re-open enrollment, children will be removed from the waiting list (on a first on first off basis) and enrolled in ALL Kids. Children who are removed from the waiting list whose application information is greater than 90 days old will be asked to complete a form updating changes in information on their family size, income, and other points of eligibility. Upon receipt of the form, ALL Kids enrollment staff will evaluate the child's eligibility for ALL Kids. Then, if eligible, either the child will be enrolled in ALL Kids or Medicaid and the family will be notified.

Children who have current enrollment in ALL Kids will be allowed to continue to renew their enrollment as long as they continue to meet all points of eligibility and have their renewal forms submitted and premium balances paid in full within 90 days after the date of termination.

☐ Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan.(42 CFR 457.355)

4.3.2. ☐ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility Check here if the state elects the option to rely on a

finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR

457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan.(Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

The State of Alabama assures that through enrollment screening processes, children whose applications are considered to be eligible for medical assistance under the State Medicaid plan will be referred for assistance under the appropriate plan. Additionally, ALL Kids eligibility staff query the Medicaid eligibility system to ensure applicants are not currently on any Medicaid program. All applications request the parent/guardian to provide the names and addresses of their employers. Eligibility staff screen all applications to ensure applicant children are not currently covered under group health insurance and have not voluntarily terminated group coverage within the last three months. In an effort to further minimize crowd-out, ALL Kids receives a daily "error report" which indicates children who have current BCBS health insurance or have terminated a BCBS policy within the last three months. In addition, quality assurance reviews are conducted on a sample of ALL Kids enrollees. Redetermination is completed every 12 months.

4.4.2. ☒ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR 457.350(a)(2)).

When a child's application is reviewed by ALL Kids and determined to be eligible for Medicaid, ALL Kids enrolls the child in Medicaid. Because a joint application is used, no additional form is required to be completed. Parents are notified by ALL regarding this determination

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP.(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

ALL Kids and Medicaid have a joint eligibility and enrollment system. When a Medicaid enrollment worker determines that a child is ineligible for Medicaid and eligible for ALL Kids, the worker enrolls the child in ALL Kids. Coverage is based on the application receipt date at the Medicaid office or the child's last date of Medicaid or ALL Kids coverage. ALL Kids staff work very closely with the Medicaid central office and Medicaid enrollment workers to ensure that the policies and procedures of both agencies reflect the agencies' desires for seamless transitions between the two agencies.

4.4.4. ☐ the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)
This section is superseded by ACA SPA

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

4.4.5. ☒ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section2102(b)(3)(D)) (42CFR 457.125(a))

The State of Alabama assures the provision of child health assistance to targeted low-income children in the State who are American Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)). As Stated in section 4.1, the ALL Kids program will provide Statewide coverage. No ALL Kids enrollee identified as being an American Indian will be charged a premium or co-pay. This policy extends to all children who identify themselves as an American Indian children whether they are a member of a federally recognized tribe or one of the eight state-only recognized tribes. Representatives from the Poarch Band of Creek Indians (the only federally recognized Tribe in Alabama) have assisted in the development of ALL Kids PLUS. Tribal children will have access to PLUS services.

CHIP staff meet and coordinate regularly with the Alabama Commission on Indian Affairs to ensure that Native American Children are identified and enrolled in ALL Kids. Additionally, a Native American was hired under a one-year contract to consult with ALL Kids staff and develop a comprehensive strategy to outreach to Native American children.
Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the

Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage poir to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening thresho for all children, based on the highest Medicaid income threshold, or it m set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of hov this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on th income finding from the Express Lane agency, pending the completion the screen and enroll process.

CHIP Eligibility

State Name: Alabama

OMB Control Number: 0938-1148

Transmittal Number: ___ - ___ - ___

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility **CS27**

2105(a)(4)(A) of the SSA and 42 CFR 457.342 and 435.926; 2107(e)(1)(J) and 1902(e)(16) of the SSA

Mandatory 12-Month Postpartum Continuous Eligibility in CHIP for States Electing This Option in Medicaid

At state option in Medicaid, states may elect to provide continuous eligibility for an individual's 12-month postpartum period consistent with section 1902(e)(16) of the SSA. If elected under Medicaid, states are required to provide the same continuous eligibility and extended postpartum period for pregnant individuals in its separate CHIP. A separate CHIP cannot implement this option if not also elected under the Medicaid state plan.

State elected the Medicaid option to provide continuous eligibility through the 12- month postpartum period: Yes

The 12-month postpartum continuous eligibility applies for the period beginning on the effective date of this SPA (no earlier than April 1, 2022) and is available through March 31, 2027.

☒ The state assures the extended postpartum period available to pregnant targeted low-income children or targeted low-income pregnant women under section 2107(e)(1)(J) of the SSA is provided consistent with the following provisions:

☒ Individuals who, while pregnant, were eligible and received services under the state child health plan or waiver shall remain eligible throughout the duration of the pregnancy (including any period of retroactive eligibility) and the 12-month postpartum period, beginning on the day the pregnancy ends and ending on the last day of the 12th month consistent with paragraphs (5) and (16) of section 1902(e) of the SSA

☒ Continuous eligibility is provided to targeted low income children who are pregnant or targeted low-income pregnant women (if applicable) who are eligible for and enrolled under the state child health plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

■ The individual or representative requests voluntary disenrollment.

■ The individual is no longer a resident of the state.

■ The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to the individual.

■ The individual dies.

Unlike continuous eligibility for children, states providing the 12-month postpartum period may not end an individual's continuous eligibility due to non-payment of premiums or becoming eligible for Medicaid.

☒ Consistent with section 2107(e)(1)(J) of the SSA, the state assures that continuous eligibility is provided through an individual's pregnancy and 12-month postpartum period regardless of non-payment of premiums, or an individual becoming eligible for Medicaid.

☒ Benefits provided during the 12-month postpartum period must be the same scope of comprehensive services consistent with the benefit package elected by the state under section 2103(a) of the SSA that is available to targeted low income children and/or targeted low-income pregnant women and may include additional benefits as described in Section 6 of the CHIP state plan.

CHIP Eligibility

Optional Continuous Eligibility for Children

The CHIP Agency may provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, during a continuous eligibility period up to 12 months, or until the time the child reaches an age specified by the state (not to exceed age 19), whichever is earlier.

The CHIP Agency elects to provide continuous eligibility to children under this provision. No

PRA Disclosure Statement

CHIP Budget

STATE: AL	FFY Budget
Federal Fiscal Year	**2023**
State's enhanced FMAP rate	**80.66%**
Benefit Costs	
Insurance payments	**----**
Managed care	**----**
per member/per month rate	**$273**
Fee for Service	**$ 493,400,853**
Total Benefit Costs	**$ 493,400,853**
(Offsetting beneficiary cost sharing payments)	**$ 6,600,000**
Cost of Proposed SPA Changes – Benefit	**$ 400,000**
Net Benefit Costs	**$ 487,200,853**
Administration Costs	
Personnel	**$ 6,636,292**
General administration	**$ 5,000,000**
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	**$ 500,000**
Health Services Initiatives	**$ 400,000**
Other	**$ 1,250,837**
Total Administration Costs	**$ 13,787,129**
10% Administrative Cap	**$ 49,340,085**
Cost of Proposed SPA Changes	**$ 400,000**
Federal Share	**$ 404,096,906**
State Share	**$ 96,891,076**
Total Costs of Approved CHIP Plan	**$ 500,987,982**

NOTE: Includes the costs associated with the current SPA.

The Source of State Share Funds: State General Fund

CHIP Eligibility

State Name: Alabama

OMB Control Number: 0938-1148

Transmittal Number: ____ - __ - ____

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility **CS27**

2105(a)(4)(A) of the SSA and 42 CFR 457.342 and 435.926; 2107(e)(1)(J) and 1902(e)(16) of the SSA

Mandatory 12-Month Postpartum Continuous Eligibility in CHIP for States Electing This Option in Medicaid

At state option in Medicaid, states may elect to provide continuous eligibility for an individual's 12-month postpartum period consistent with section 1902(e)(16) of the SSA. If elected under Medicaid, states are required to provide the same continuous eligibility and extended postpartum period for pregnant individuals in its separate CHIP. A separate CHIP cannot implement this option if not also elected under the Medicaid state plan.

State elected the Medicaid option to provide continuous eligibility through the 12- month postpartum period Yes

The 12-month postpartum continuous eligibility applies for the period beginning on the effective date of this SPA (no earlier than April 1, 2022) and is available through March 31, 2027.

☒ The state assures the extended postpartum period available to pregnant targeted low-income children or targeted low-income pregnant women under section 2107(e)(1)(J) of the SSA is provided consistent with the following provisions:

☒ Individuals who, while pregnant, were eligible and received services under the state child health plan or waiver shall remain eligible throughout the duration of the pregnancy (including any period of retroactive eligibility) and the 12-month postpartum period, beginning on the day the pregnancy ends and ending on the last day of the 12th month consistent with paragraphs (5) and (16) of section 1902(e) of the SSA

☒ Continuous eligibility is provided to targeted low income children who are pregnant or targeted low-income pregnant women (if applicable) who are eligible for and enrolled under the state child health plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

■ The individual or representative requests voluntary disenrollment.

■ The individual is no longer a resident of the state.

■ The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to the individual.

■ The individual dies.

Unlike continuous eligibility for children, states providing the 12-month postpartum period may not end an individual's continuous eligibility due to non-payment of premiums or becoming eligible for Medicaid.

☒ Consistent with section 2107(e)(1)(J) of the SSA, the state assures that continuous eligibility is provided through an individual's pregnancy and 12-month postpartum period regardless of non-payment of premiums, or an individual becoming eligible for Medicaid.

☒ Benefits provided during the 12-month postpartum period must be the same scope of comprehensive services consistent with the benefit package elected by the state under section 2103(a) of the SSA that is available to targeted low income children and/or targeted low-income pregnant women and may include additional benefits as described in Section 6 of the CHIP state plan.

CHIP Eligibility

Optional Continuous Eligibility for Children

The CHIP Agency may provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, during a continuous eligibility period up to 12 months, or until the time the child reaches an age specified by the state (not to exceed age 19), whichever is earlier.

The CHIP Agency elects to provide continuous eligibility to children under this provision. Yes

- (●) For children up to age 19
- ( ) For children up to age

The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends:

- [■] At the end of the 12 months continuous eligibility period.

The state assures that a child's eligibility is not terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

- [■] The child attains the age specified by the state Agency or age 19.
- [■] The child or child's representative requests voluntary disenrollment.
- [■] The child is no longer a resident of the state.
- [■] The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.
- [■] The child dies.
- [■] The child becomes eligible for Medicaid
- [■] There is a failure to pay required premiums or enrollment fees on behalf of a child, as provided for in the state plan.

PRA Disclosure Statement

V.20220204