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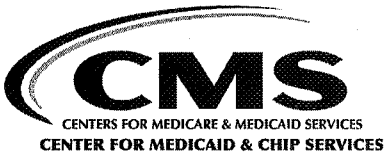
State/Territory Name: Alabama

State Plan Amendments (SPA) #: AL-CHIPSPA#14

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 S2-26-12
Baltimore, Maryland 21244-1850



DEC 2 2 2014

Cathy Caldwell
Director, Bureau of Children's Health Insurance
201 Monroe Street
Montgomery, AL 36104

Dear Ms. Caldwell:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number 14, submitted on September 29, 2014, has been approved. This amendment has a retroactive effective date of January 1, 2014.

Through this SPA, the state updates the federal poverty levels (FPLs) for its premium and cost sharing fee categories in Alabama's CHIP program, ALL Kids, to be consistent with Modified Adjusted Gross Income (MAGI) eligibility levels. The state also makes necessary editorial changes to accommodate previously approved Affordable Care Act SPAs.

Your title XXI project officer is Ms. Cassandra Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
Facsimile: (410) 786-5943
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and Ms. Jackie Glaze, Associate Regional Administrator (ARA) in our Atlanta Regional Office. Ms. Glaze's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have any additional questions, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services at (410)786-5647. We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Cindy Mann
Director

cc: Jackie Glaze, ARA, CMS Region IV

OMB #: 0938-0707
Exp. Date:

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

Preamble

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

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

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

Form CMS-R-211

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

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

State/Territory: 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))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: Donald E. Williamson, M.D. Position/Title: State Health Officer
Name: Reuben E. Davidson Position/Title: Public Health Administrative Officer
Name: Cathy Caldwell Position/Title: CHIP Director

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

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

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

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

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

1.1.3. ☐ A combination of both of the above.

*** 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.**

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

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

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

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date:

Original State Plan – February 1, 1998
Amendment 1 – Establishment of ALL Kids: October 1, 1998
Amendment 2 – Establishment of ALL Kids PLUS: October 1, 1999
Amendment 3 – Disregards: June 1, 2001
Amendment 4 - Compliance: August 24, 2001
Amendment 5 – Waiting List, Cost Sharing, Benefit Changes: October 1, 2003
Amendment 6 – Discontinuance of the Waiting List and other Clean-Up changes November 23, 2004
Amendment 7 – Raise the upper income eligibility limit to 300% of FPL and other minor changes: October 1, 2009
Amendment 8 – Include a private foundation grant as an additional source of state funding: October 27, 2009
Amendment 9 – Establishment of a Prospective Payment System for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): October 1, 2009;
Addendum on Dental Benefits Under Title XXI: October 1, 1998
Amendment 10 – Eligibility for children of employees of a public agency (state employees and public education employees): 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. Implementation Date: April 15, 2011
Amendment 12 – Increase premiums, increase co-pays and revise the methodology for determining annual aggregate cost-sharing: May 1, 2012
Amendment 13 – Establishment of copayments for therapy services (physical, occupational, and speech), vision services and chiropractic services; and cleanup changes: 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 January 1, 2014

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
AL-14-0016 **Effective/Implementation Date: January 1, 2014**	**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-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-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	**Non-Financial**	**CS17**	**Non-Financial Eligibility – Residency**	**Supersedes the current section 4.1.5**

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Effective/Implementation Date: January 1, 2014	**Eligibility**	**CS18**	**Non-Financial – Citizenship**	**Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR**
		CS19	**Non-Financial – Social Security Number**	**Supersedes the current section 4.1.9.1**
		CS20	**Substitution of Coverage**	**Supersedes the current section 4.4.4**
		CS21	**Non-Payment of Premiums**	**Supersedes the current section 8.7**
		CS27	**Continuous Eligibility**	**Supersedes the current section 4.1.8**

Implementation date:
Original State Plan – February 1, 1998

Amendment 1 – Establishment of ALL Kids: October 1, 1998
Amendment 2 – Establishment of ALL Kids PLUS: October 1, 1999
Amendment 3 – Disregards: June 1, 2001
Amendment 4 - Compliance: August 24, 2001
Amendment 5 – Waiting List, Cost Sharing, Benefit Changes: October 1, 2003
Amendment 6 – Discontinuance of the Waiting List and other Clean-Up changes November 23, 2004
Amendment 7 – Raise the upper income eligibility limit to 300% of FPL and other minor changes: October 1, 2009
Amendment 8 – Include a private foundation grant as an additional source of state funding: October 27, 2009

Amendment 9 – Establishment of a Prospective Payment System for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): August 25, 2010;
Addendum on Dental Benefits Under Title XXI: October 1, 1998
Amendment 10 – Eligibility for children of employees of a public agency (state employees and public education employees): January 20, 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: April 15, 2011
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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-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	**Non-**	**CS17**	**Non-Financial Eligibility –**	**Supersedes the current section 4.1.5**

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Effective/Implementation Date: January 1, 2014	**Financial Eligibility**		**Residency**	
		CS18	**Non-Financial – Citizenship**	**Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR**
		CS19	**Non-Financial – Social Security Number**	**Supersedes the current section 4.1.9.1**
		CS20	**Substitution of Coverage**	**Supersedes the current section 4.4.4**
		CS21	**Non-Payment of Premiums**	**Supersedes the current section 8.7**
		CS27	**Continuous Eligibility**	**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 the State Plan Amendment, when it occurred and who was involved.

In accordance with approved policies, on August 28, 2014, a certified letter explaining the changes proposed in SPA 14 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 reason for the proposed changes, the proposed effective date, and any anticipated impact on members of the Poarch Band of Creek Indians. In the letter, the Tribal Chairman was also reminded that he 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: **September 28, 2014**

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

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

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.

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.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

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

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.

<u>Alabama Department of Public Health</u>

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. A more detailed description of current outreach activities can be found in Section 5 of this document.

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 outstationed 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. See section 5 for additional outreach efforts.

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 eligibles. 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 outstationed 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 outstationed 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)**

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.

<u>Alabama Department of Human Resources (DHR)</u>
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.

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

There 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.

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

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.

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

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

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

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.

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.

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.

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

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

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

X Geographic area served by the Plan: **Statewide**

4.1.2. X ☐ Age: **A child is eligible for ALL Kids if the date of birth on the application indicates that the child is less than 19 years of age.**

4.1.3. X Income: **Income eligibility is defined as above 133% of the Federal Poverty Level (FPL) up to and including 300% FPL for children less than six years of age and above 100% of FPL for those aged 6-18. It is the State's intent to cover as many children as possible up to 300% of the FPL. If during the year State matching funds are not available at sufficient levels for coverage of all children to this income level and funding is 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 prior public notice and will notify CMS when placing applicants on a waiting list.**

The definition of household size is the same as that for children under the Medicaid poverty level definition, which includes the biological or adoptive parent(s) in the home, unborn children, and sibling children under 19. Income will be determined by totaling all earned and unearned income of family members included in the family size received on a monthly basis. Like Alabama Medicaid, certain income disregards will be considered under ALL Kids. Specific amounts will be deducted from gross monthly income when determining ALL Kids financial eligibility. The deductions used will be the standard Alabama Medicaid disregards which are: $90 for each wage earner, up to $50 child support received, up to $200 child care expenses for a child up to 24 months of age and up to $175 for child care expenses for a child 24 months of age and over (or incapacitated adult). If the income, after these standard disregards are made, is equal to or less than 300%FPL but over the Medicaid income eligibility limit and the applicant is otherwise eligible, the applicant will be enrolled in ALL Kids. The Department and Medicaid will collaborate closely to assure coverage through the appropriate program (i.e., Medicaid or CHIP) for those children whose incomes fall near the low-end threshold.

Income is based on self-declaration as recorded on the application.

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. X Residency (so long as residency requirement is not based on length of time in state) : **A child must be a resident of the State of Alabama to be eligible for ALL Kids. Residency will be based on self-declaration as recorded on the application.**

4.1.6. X 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. X 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. X Duration of eligibility: **Eligibility for ALL Kids will commence on the first day of the month following the month of receipt of the application. An exception to this is allowed for newborns for whom coverage begins at birth when applications are received within 60 days after the birth. Two other exceptions are when Medicaid coverage ends or private insurance is involuntarily terminated. In these cases, ALL Kids coverage begins when the other insurance(s) ends so that there is no lapse in coverage for the child. Coverage for all ALL Kids enrollees is continuous for one year unless the child moves out of state or reaches the age of 19 years. Consistent with industry standards, children who become 19 years of age prior to the end of the year's enrollment will have coverage through the end of the month of birth.**

Children must have their eligibility redetermined each year. If more than one insurance vendor is available to an applicant, an individual will be "locked in" to the plan s/he chooses for enrollment (after the first month of enrollment) for a period of one year. Exceptions will be made for those children whose parent(s)/guardians(s) move from one provider region to another or if provider networks change significantly.

If an individual is pregnant at the time of annual renewal, her eligibility extends to 60 days post-partum unless she is or will the renewal process is initiated and eligibility is re-determined.

4.1.9. X Other standards (identify and describe): **Social Security number is requested of all individuals listed on the application. Non-applicants are not required to supply social security numbers. Social Security numbers are required for all applicant children. If the parent/guardian refuses or is unable to supply a Social Security number for an applicant child and citizenship can be otherwise established, a pseudo-Social Security number is given to the child. Parents are offered assistance in obtaining Social Security numbers as necessary.**

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

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

4.2.2. X 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. X These standards do not deny eligibility based on a child having a pre-existing medical condition.

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

Applying the ALL Kids Eligibility Standards

The eligibility standards for initial enrollment are as follows:

Under 19 years of age

From above the upper Medicaid income eligibility level up to and including 312% FPL following MAGI-based methodologies (see CS15).

Not be enrolled in or eligible for Medicaid

Not covered by another group health insurance policy (If an existing policy is in effect but does not provide comprehensive coverage then it does not exclude the child from eligibility for CHIP.)

Not in an institution

Resident of Alabama

Citizen of the US or an eligible "immigrant" child (The definition of an eligible immigrant child is the definition described in the January 14, 1998 "Dear State Health Official" letter from HCFA and HRSA. This letter indicates that any child

born in the United States is a citizen and eligible to receive services funded by CHIP in addition to:

- **All legal immigrant children who were in the US before August 22, 1996,**
- **Refugees, asylees and certain Cuban, Haitian and Amerasian immigrants,**
- **Unmarried, dependent children of veterans and active duty service members of the Armed Forces, and**
- **Legal immigrants arriving on or after August 22, 1996, and in continuous residence for 5 years.**

Applying the ALL Kids PLUS Eligibility Standards

The eligibility standards for initial enrollment are as follows:

Be enrolled in the basic ALL Kids Program
Have a condition for which a PLUS service is available
Be in need of a PLUS agency authorized ALL Kids PLUS service for which the participating agency has funds available

Redetermination Process

Redetermination (renewal) is completed every 12 months. For renewal, all of the preceding standards apply. See CS21 and CS27 at the end of this State Plan.

At the State's discretion additional time may be allowed for enrollees to complete the renewal process as a result of a disaster event. Additionally, the State may also waive outstanding premium balances for enrollees/applicants living in and/or working in FEMA or Governor declared disaster areas at the time of a disaster event.

Process for Enrollment

ALL Kids utilizes a single, streamlined application form and eligibility and enrollment system using a rules-based engine in accordance with ACA rules. ALL Kids receives applications by numerous means (online, mail, fax, phone, in person). Applications are entered into the eligibility and enrollment system and enrolled according to eligibility criteria. If an incomplete application is received and not able to be determined from another appropriate source, the staff contacts the family (by telephone and/or letter) in an attempt to obtain the necessary information ALL Kids sends enrollment notification to the insurance plan which the family/child has chosen. Once the enrollment transaction has been completed, the vendor supplies the family with enrollment materials including an insurance card, explanation of benefits, and information on locating providers. Premium payment information is sent quarterly to families as appropriate. Current enrollees are not terminated for non-payment of premium during the 12-month coverage period. At one month, four months, seven months, and 10 months, families are notified of outstanding premium balances. They are notified upon enrollment and at renewal that premiums must be paid in full for ALL Kids coverage to be renewed. If a renewal application is received within 90 days past the coverage end date (and the premium is paid no later than 90 days past the coverage end date), enrollees may renew with no lapse in coverage.

If the child is eligible for Medicaid, the child is enrolled in Medicaid. The family is notified of any enrollment decision (approval or disapproval for CHIP and Medicaid) by the agency which initially processes the application.

ALL Kids PLUS enrollment procedures are conducted by each participating PLUS agency which serves or potentially serves the child. Enrollment procedures will consist of two elements - financial and health-need-based. When a child is referred to an authorizing agency, that agency determines whether or not funds are available to serve the child's need. If funds are available and the child's need(s) can be met by that agency, the child may be enrolled in ALL Kids PLUS through that agency and a case manager is assigned to the child. If the child needs services provided by another authorizing agency, the case manager makes a referral for enrollment with the second agency. The case manager may change depending upon the child's needs.

ALL Kids and Medicaid use the same approved, single, streamlined application form developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act. Medicaid eligibility workers can also make ALL Kids eligibility determinations. Alabama is a determination state accepting eligibility determinations the Federally Facilitated Marketplace.

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

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

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.

4.3.2. MAGI-Based Income Methodologies The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described in CS15 at the end of this State Plan, and consistent with 42 CFR 457.315 and 435.603(b) through (i). ***UNABLE TO ADD TO 508 COMPLIANT TEMPLATE***

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

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.

Effective January 1, 2011, ALL Kids eligibility rules will allow the enrollment of children of employees of a public agency who meet all eligibility requirements. This change is made in compliance with section 10203 (d) (2) (D) of the Patient Protection and Affordable Care Act which allows exceptions to the exclusion of children of employees of a public agency from enrolling in CHIP. Health insurance plans for state employees and public education employees in Alabama are administered by two separate state agencies, the State Employees Insurance Board (SEIB) and the Retirement Systems of Alabama (RSA), respectively. With respect to the provisions in the law, SEIB and RSA satisfy subparagraph (B) "*Maintenance of Effort with Respect to Per Person Agency Contribution for Family Coverage.*" The Maintenance of Effort for each agency is calculated by comparing the annual agency expenditure for Fiscal Year 2009 to the annual agency expenditure for Fiscal Year 1997 (increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers). The annual agency expenditure in Fiscal Year 2009 was not less than the annual agency expenditure in Fiscal Year 1997 (increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers). The State of Alabama will continue to calculate Maintenance of Effort on an annual basis to assure compliance with the provisions of the law.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

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. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

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. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)(c))**

4.4.4.1. ☐ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. **X** Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

The State of Alabama assures that insurance provided under ALL Kids will not substitute for coverage under group health plans. Alabama implements several measures to minimize the effects of crowd-out in the CHIP program.

The joint application requires that the applicant state whether or not s/he has current health insurance and whether s/he has terminated that insurance within the past three months and the reason for this termination.

The ALL Kids program has a waiting period policy to deter crowd-out. Children, whose private coverage is voluntarily dropped, have a three-month waiting period before they can enroll in ALL Kids. ALL Kids monitors the percentage of applicants who are denied for not meeting the three-month waiting period due to voluntary termination of other coverage. There are four exceptions to the waiting period policy which pertain to minimizing crowd-out: (1) children whose previous private coverage is through an individual policy; (2) children whose previous private coverage is through COBRA; (3) children whose previous private coverage is through the Alabama Child Caring Foundation; (4) children whose previous private coverage lifetime benefits limits have been met (ACA removes lifetime limits effective September 23, 2010).

The ALL Kids program also requires a premium contribution for all children with the exception of Native Americans. This family contribution is a disincentive for families to drop group employer coverage for the ALL Kids program. Additionally, since the ALL Kids package was designed to be similar to the standard benefit levels offered through most employers, there is no incentive to drop employer-based dependent coverage in favor of ALL Kids based on benefit levels alone.

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. Since Blue Cross Blue Shield currently provides 85% of the private health insurance coverage in the State, ALL Kids should have a high success rate in identifying children with private health care coverage. In FY 2009, approximately 3% of applicants (4,392) were denied ALL Kids coverage due to having other health insurance currently or in the past three months.

Because enrollment in ALL Kids PLUS is limited to enrollment in the basic ALL Kids Program, all statements above which apply to the basic program also apply to ALL Kids PLUS.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5. Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

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.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

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

Phase I - Medicaid Expansion (no longer in existence)

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.**

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 (Section 2103)

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

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

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

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

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

6.1.1.3. **X** 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.

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

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If ☐ existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for ☐ existing comprehensive state-based coverage.

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

6.1.4.1. ☐ Coverage the same as Medicaid State plan

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

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. **X** 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 D 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 ☐

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

6.1.4.7. ☐ Other (Describe)

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

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.

6.2.1. **X** Inpatient services **(Section 2110(a)(1))**

6.2.2. **X** Outpatient services **(Section 2110(a)(2))**

6.2.3. **X** Physician services **(Section 2110(a)(3))**

6.2.4. **X** Surgical services **(Section 2110(a)(4))**

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

6.2.6. **X** Prescription drugs **(Section 2110(a)(6))**

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

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

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

6.2.10.**X** 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. **X** 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. **X** 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. **X** Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. **X** Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15. **X** Nursing care services (See instructions) **(Section 2110(a)(15))**

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

6.2.17. **X** Dental services **(Section 2110(a)(17))**

6.2.18. **X** Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. **X** Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. **X** Case management services **(Section 2110(a)(20))**

6.2.21. **X** Care coordination services **(Section 2110(a)(21))**

6.2.22 **X** Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. **X** Hospice care **(Section 2110(a)(23))**

6.2.24. **X** Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

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

6.2.26. **X** Medical transportation **(Section 2110(a)(26))**

6.2.27. **X** Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. **X** 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.-D The State will provide dental coverage to children through one of the following. 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.-D X State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:

1. **Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)**
2. **Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)**
3. **Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)**
4. **Endodontic (i.e., root canals) (CDT codes: D3000-D3999)**
5. **Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)**
6. **Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)**
7. **Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)**
8. **Orthodontics (i.e., braces) (CDT codes: D8000-D8999)**
9. **Emergency Dental Services**

ALL Kids utilizes the BCBS of Alabama preferred Dental Network. Reimbursement for services delivered to ALL Kids' enrollees is paid based on the preferred dental network fee schedule. All network dentists agree to accept this as payment in full, with the exception of enrollee co-pays (no copayments on preventive or diagnostic services).

When costs are expected to exceed $1500 for a calendar year, ALL Kids utilizes a prior authorization process to ensure medically necessary services are provided. Costs associated with diagnostic and preventive services are excluded from this $1500 threshold. The amount is calculated by totaling the amount paid in dental claims minus the amount paid for preventive and diagnostic dental services.

If an enrollee is in need of dental services beyond $1500 in a calendar year, providers are instructed to submit a predetermination request to BCBS. BCBS reviews all provider requests to determine dental necessity of services and ALL Kids provides final approval to pay for services exceeding $1500. Providers are familiar with this process and dentally necessary services are provided in a timely manner regardless of the time of year. There is no unnecessary carry-over of services that need immediate attention.

If a family would like to appeal the BCBS/ALL Kids decision regarding the application of "medically necessary," there is an appeals process which is consistent with the requirements of 42 CFR 457.1160 (b) and in compliance with state laws, the Security Act of 1974 (ERISA) and all other applicable regulations of the Department of Labor Procedures.

6.2.1.2-D Periodicity Schedule. The State has adopted the following periodicity schedule:

- ☐ State-developed Medicaid-specific
- **X American Academy of Pediatric Dentistry**
- ☐ Other Nationally recognized periodicity schedule
- ☐ **Other (description attached)**

6.2.2-D Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1.-D ☐ **FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)**

6.2.2.2-D ☐ **State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)**

6.2.2.3.-D ☐ **HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)**

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

6.3.1. **X** The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

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

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

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

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** **(Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (**2102(a)(7)(A)) (42CFR 457.495(a))**

The State utilizes the expertise within the University of Alabama at Birmingham (UAB) School of Public Health in the implementation of the assessment of the ALL Kids program. Quality and appropriateness of care is assessed through the use of surveys such as a new enrollee survey, a continuous enrollee survey, and a disenrollee survey. Both process measures as well as outcome measures are considered when assessing the quality and appropriateness of care. CHIP also reviews claims data for quality assessment. Among the items used in tracking are the use of several claims data indicators such as whether or not children truly have a "medical home"; how well they are adhering to the recommended scheduled well-child exams; whether or not they are appropriately immunized; whether or not non-trauma based emergency room use is going down; how referrals are being made and if specialty care and related services are being received; and, patterns of prescription drug use. The State is also considering using other databases that can provide general indicators of child health and well-being such as the State's immunization registry, adolescent pregnancy rates and health care utilization patterns identifiable off birth certificates, and the results of child death review efforts. Alabama monitors customer/patient/provider satisfaction through the use of surveys and informal communications with families, advocacy groups, and providers.

In addition to these monitoring strategies, the State assures access to care through monitoring of the provider network and benefit package design. Program staff are actively involved in identifying new providers for the ALL Kids network and have been particularly involved in the addition of pediatric dentists, primary care nurse practitioners, community mental health centers and emergency transportation providers. Geographic distribution of providers is monitored and is crucial when decisions regarding vendor choice are made.

The ALL Kids benefits package requires preauthorization only for hospitalization services. Therefore, access to all primary care providers and specialists is open to all enrollees without referral. Claims data are monitored by program staff to ensure quality and appropriateness of care. In addition, the State employs a masters level social worker to assist families who are experiencing difficulties accessing necessary services due to benefit structure or provider geographic availability. This staff member works closely with case managers at the vendor to identify areas in need of attention and provides the State with recommendations for benefit plan adjustment and/or provider network issues.

The ALL Kids PLUS program coordinates the evaluation of quality and appropriateness of

care with the ALL Kids PLUS authorizing agencies and CSHCC/N advocacy groups through collaboration with stakeholders. It is also anticipated that an evaluation of ALL Kids PLUS may become part of the UAB evaluation in the future.

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

7.1.1. ☐ Quality standards

7.1.2. **X**☐ Performance measurement

The State ensures quality through contracted performance measures. These measures have been adapted in conjunction with the standards recommended by the AAP.

7.1.3. **X** Information strategies

Vendors are required to provide key health indicators information.

7.1.4. **X** Quality improvement strategies

The performance guarantees and provider recoupment policy were included in the RFP and are included in the contract with the health plan.

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

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

Access is monitored through a number of methods including the following:

Periodic review of the number and types of providers by county
Quarterly review of claims data
Quarterly review of new enrollee, continuous enrollee, and disenrollee survey data
Feedback from families via telephone, e-mail, and postal service mail
Feedback from providers

Further, the state uses claims data to monitor well-baby care as is described in 7.1.

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

Access is monitored through a number of methods including the following:

Quarterly review of claims data
Quarterly review of new enrollee, continuous enrollee, and disenrollee survey data
Feedback from families via telephone, e-mail, and postal service mail
Feedback from providers
Feedback from the CHIP Social Work Consultant

Further, the state uses claims data to monitor emergency room use as is described in 7.1.

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

Access is monitored through a number of methods including the following:

Periodic review of the number and types of providers by county
Quarterly review of claims data
Quarterly review of new enrollee, continuous enrollee, and disenrollee survey data
Feedback from families via telephone, e-mail, and post service mail
Feedback from providers
Feedback from CSHCC/N advocates and ALL Kids PLUS providers

The ALL Kids PLUS network includes State agencies that serve children with special health care needs/conditions and that contract with CHIP to provide state matching funds for ALL Kids enrollees who use PLUS services. Currently, Children Rehabilitation Services is the only active PLUS program. The PLUS agency provides ALL Kids children with an individual case manager who will monitor access to specialists and treatment.

In general, the Medicaid standards will be used to establish qualifications for ALL Kids PLUS case management staff. All case management staff will meet specific qualifications, including education, training and appropriate credentialing which will be established by the participating agencies.

In most circumstances, the agencies' delivery systems are discrete and clear which program provides services for specific conditions. However, where there is potential for overlap in responsibilities, the determination of which agency will provide case management will be done based on the needs of the child with input from the family and by determining what is in the best interest of the child. The agencies using the case management process, will coordinate with each other, the child, the family, and the care providers in determining if a change in case management is needed.

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

The health plan vendor has policies in place to assure that prior authorization of health services are completed in accordance with state law or regulations promulgated by the Department of Labor. CHIP staff receive feedback from providers and enrollee families if time periods are exceeded. All prior authorization of health services is in accordance with state laws.

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

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

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

8.1.1. **X** YES

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

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

There will not be any cost sharing of any type for families who are Native Americans or Alaskan Natives. For all other families cost sharing will be as follows in 8.2.1. and 8.2.3.:

8.2.1. Premiums:

There are three (3) categories of enrollees: No Fee (Native Americans and Alaskan Natives). Low-Fee (children with family incomes from the base (above 141% FPL) up to and including 156% FPL), and Fee (children with family incomes greater than 156% FPL up to and including 312% FPL). There is no cost sharing for children in the No Fee group. There is a $52 premium per child, per year for children in the Low-Fee group. There is a $104 premium per child, per year for children in the Fee group. Premiums can be paid in one payment or in periodic payments (weekly, monthly, quarterly…) throughout the year. A family's total premium payments are limited to three times the individual premium rate (i.e. $156 or $312 depending upon the income level of the family). Enrollment data systems do not allow for a family to be billed in excess of these amounts. Outstanding premium balances may be waived at the State's discretion for applicants/enrollees living or working in FEMA or Governor declared disaster areas.

8.2.2. Deductibles: **None**

8.2.3. Coinsurance or copayments:

There are no copayments for preventive services. The only permitted copayments are:

Service	Low Fee Group Copayments (for Children with Incomes up to and including 156% FPL)	Fee Group Copayments (for Children with Incomes >156% FPL up to and including 312%)
Dental	$5/visit	$20.00/visit
Doctor's office visits	$3/visit	$13.00/visit
Behavioral Health office visits	$3/visit	$13.00/visit
ER Services	$6/facility charge	$60.00/facility charge
Inpatient Services (Hospital)	$200/confinement	$200/confinement
Non-Emergency ER Services	$6/visit	$60.00/visit
Allergy Testing	$6/lab visit	$17.00/lab visit
Allergy Treatment	$3/visit	$12/visit
Ambulance	$6/occurrence	$100/occurrence
Mental and Nervous (Inpatient)	$200/confinement	$200/confinement
Outpatient Surgical Facility	$6/visit	$100/visit
Substance Abuse (Inpatient)	$200/confinement	$200/confinement
X-ray (Outpatient Facility)	$6/total x-rays in 1 visit	$65/total x-rays in 1 visit
Therapies (Physical, Occupational, Speech)	**$3/visit**	**$13/visit**
Routine Eye Exam	**$3/visit**	**$13/visit**
Eye Glasses	**$3/frames and/or lenses**	**$13/ frames and/or lenses**

Chiropractic visits	**$2/visit**	**$5/visit**

In addition, a Generic Plus pharmacy benefit became effective October 1, 2012 for children in both the low fee and fee groups. Prescription drugs are divided into two groups: generic and preferred brands. The designation "preferred" is assigned by the third party administrator. The copayment schedule is as follows:

	Low Fee Group Copayments (for Children with Incomes up to and including 156% FPL)	**Fee Group Copayments (for Children with Incomes >156% FPL up to and including 312%)**
Generic	**$1.00**	**$5.00**
Preferred Brands	**$5.00**	**$25.00**

8.2.4. Other:

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

All enrollees are provided with coverage and cost-sharing information at initial enrollment through mailed documents. Additionally, this information is available online. All enrollees are notified of cost-sharing changes through letters mailed directly to the residence addresses on file with CHIP. In addition all stakeholders, including provider organizations/associations and state agencies, are notified by letter or other appropriate means of communication (i.e. email, fax notifications, and/or meetings) when changes are made to cost-sharing requirements. CHIP staff and customer service representatives are trained to discuss cost-sharing requirements with families, including premiums, copayments, and the annual out of pocket expenses limit.

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

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

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

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

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

Alabama ensures that the annual aggregate cost-sharing for a family does not exceed five percent (5%) of a family's income as is required by Section 2103(3)(B) of Title XXI. In addition, cost sharing, both premiums and copayments are in compliance with CHIP regulations.

There is minimal cost sharing for families, other than Native Americans and Alaskan Natives who have no cost sharing. No family is charged for more than three (3) premiums even if the family has more than three children.

To protect families against excessive medical expenses and comply with the statutory limit of no more than five percent of family income being expended on cost sharing expenses, families will be notified in writing, at initial enrollment and renewal, of the annual out of pocket maximum. Families are informed of this policy through educational literature. Also, CHIP staff and partners are trained to educate families about the limit on out of pocket expenses. Families are encouraged to keep receipts for all copayments and premiums so that once the out of pocket maximum is reached they will have the necessary documentation to stop cost-sharing. If a family reaches this limit and notifies the ALL Kids program, ALL Kids will review the case and if the limit has been reached new insurance cards will be issued stating that the child(ren) are not subject to further co-pays for the coverage period.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

If a child is identified on an application as an American Indian, the enrollment worker automatically places the child in the no-fee category if the child becomes enrolled. Therefore the insurance vendor sends an insurance card, to the family, which indicates that the child is not subject to any co-pays.

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

At ten months into the enrollment period, the family is sent renewal materials which include a statement regarding any outstanding premium payment due along with the date current coverage terminates. Premium payments may be received at anytime throughout the enrollment period. However, if premiums are not paid in full by the end of the enrollment period, the child will not be eligible for renewal. An exception to this is made for families who have filed for bankruptcy during the enrollment year. At the time of renewal, if a family requests that its premium balance be forgiven, forgiveness will be granted if the family submits

proof of bankruptcy status. Premiums will be removed 24 months after an enrollee's coverage end date unless the child turned 19 while on the program in which case the premium is removed 12 months after the enrollee's coverage end date. The state does not participate in collection action or impose benefit limitations if enrollees do not pay copayments/coinsurance.

In the event of a disaster, the State may also waive outstanding premium balances upon request at renewal for families living or working in FEMA or Governor declared disaster areas at the time of a disaster event. If a family requests an outstanding premium balance to be waived, the balance will be waived if the family is determined to have been living or working in FEMA or Governor declared disaster areas based on self-declared application information or other documentation provided by the family.

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

X **(8.7.1.1 in the new SPA template)**State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

ALL Kids has an annual premium for those in cost sharing categories. Upon enrollment, families are notified, by letter, that premiums are due. Enrollees have the entire 12-month coverage period to pay premium balances and receipt of benefits is not contingent upon payment of premiums. Current enrollees are not terminated for non-payment of premium during the 12-month coverage period. At one month, four months, seven months, and 10 months, families are notified of outstanding premium balances. They are notified, every notice for past-due premiums and cost-sharing, that, in most circumstances, premiums must be paid in full for ALL Kids coverage to be renewed. If a renewal application is received within 90 days past the coverage end date (and the premium is paid no later than 90 days past the coverage end date), enrollees may renew with no lapse in coverage.

X The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**

The amount of family income written on the renewal form is reviewed by enrollment workers at the time of renewal. If it is known to ALL Kids that a family is experiencing financial difficulty, the ALL Kids Social Work Consultant and/or ALL Kids Regional staff may assist the family in locating assistance for premium payment. Non-payment of premiums is forgiven if the family provides proof of bankruptcy status during the enrollment period or if the family has been affected by disaster events (living or working in FEMA or Governor declared disaster areas at the time of a disaster event).

X In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

At the time of renewal, if the family's income has dropped but is still above the Medicaid eligibility level, if the decision is made to forgive the unpaid premium(s), the child is renewed and placed in the appropriate ALL Kids category. If a family's income has dropped below the ALL Kids eligibility, the child's application is reviewed for Medicaid eligibility and, if the child meets all eligibility requirements, s/he is enrolled in Medicaid.

X The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

This type of grievance is handled in the same impartial manner in which other grievances are handled as described in Attachment D.

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

8.8.1. **X** No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. **X** No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. **X** No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. **X** Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. **X** No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. **X** No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

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

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

1. **The number of low-income (≤200% FPL), uninsured children in AL will be reduced each year.**

2. **Given available funding, the number of low income (between the Medicaid eligibility upper income levels and 200% FPL), children enrolled in ALL Kids will be maintained at at least 50,000 (current enrollment) at any given time.**

3. **The number of low-income children (incomes in the Medicaid income eligibility ranges) enrolled in SOBRA Medicaid will be maintained at at least 300,000.**

4. **Enrollment in ALL Kids will result in more children having a medical home.**

5. **Enrollment in ALL Kids will result in a higher usage of preventive care.**

6. **Specialty services beyond the basic ALL Kids coverage package will be available for ALL Kids enrolled children with special health care needs.**

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

1. **Performance Goals for Objective 1:**
   a. **The number of low-income uninsured children in AL will be reduced by 1% each year until the number of low-income uninsured children is no larger than 10% of the children in the state.**
   b. **A tracking system will be established by April 2004, which will track applicants referred among ALL Kids, SOBRA Medicaid, and the Alabama Child Caring Foundation.**

2. **Performance Goals for Objective 2**
   a. **The percentage of families who do not renew their children's ALL Kids coverage due to a financial barrier (owing past premiums) will not be more than 3% annually.**
   b. **A higher percentage of families with ALL Kids enrolled child(ren), report that financial barriers to accessing care have been reduced since enrollment in ALL Kids in comparison to the time before enrollment in ALL Kids.**

c. **Plans which target outreach activities toward specific populations: (adolescents, Native Americans, and faith-based organizations) will be developed by October, 2002.**
d. **Plans which target outreach activities toward specific populations: (adolescents, Native Americans, and faith-based organizations) will be implemented each year beginning with FY 2003.**
e. **Plans which target outreach activities toward Hispanics, birth-to-five care providers, and Native Americans will be developed by January 1, 2004.**
f. **Plans which target outreach activities toward Hispanics, birth-to-five care providers, and Native Americans will be implemented each year beginning with FY 2005.**
g. **Plans which target outreach activities toward specific populations (other than adolescents, faith-based organizations, Hispanics, birth-to-five care providers, and Native Americans) will be developed and implemented as data or other information indicate.**
h. **Language and culture will not be barriers to enrollment or renewal as evidenced by the availability of telephone assistance in the customers' preferred languages, brochures and forms in both English and Spanish, and the availability of Spanish speaking, culturally competent customer service staff.**
i. **There will be an incremental reduction from year to year, in the percentage of children canceling ALL Kids coverage due to nonparticipation in the renewal process.**

3. **<u>Performance Goal for Objective 3:</u>**
There will be maintenance of effort or an increase, on the part of CHIP, to decrease the number of uninsured low-income (Medicaid eligible) children as evidenced by at least the following:
    i. **Continued use of a joint application form.**
    ii. **Continued use of a joint renewal form**
    iii. **Continued referral, without any barriers, of applications and renewals between ALL Kids and SOBRA Medicaid**
    iv. **Continued outreach efforts by CHIP staff for network building with community groups, professionals (individually and in groups), child care providers, schools, etc.**
    v. **Continued evaluation and monitoring of the application transfer/referral process between ALL Kids and Medicaid.**
    vi. **Continued computer enhancements to improve the communication with other agencies and current and potential ALL Kids enrollees.**

4. **<u>Performance Goals for Objective 4:</u>**

a. **A higher percentage of families report that their ALL Kids enrolled child(ren) have a usual source of care since enrollment in ALL Kids than before enrollment in ALL Kids.**
b. **A lower percentage of families report that their ALL Kids enrolled child(ren) have used a hospital emergency room since enrollment in ALL Kids than before enrollment in ALL Kids.**

5. **Performance Goals for Objective 5**
   a. **A higher percentage of families report that their ALL Kids enrolled child(ren) have had a well child check-up in the past year since enrollment in ALL Kids than before enrollment in ALL Kids.**
   b. **A higher percentage of families report that their ALL Kids enrolled child(ren) have had a dental visit in the past year since enrollment in ALL Kids than before enrollment in ALL Kids.**
   c. **A higher percentage of families report that their ALL Kids enrolled child(ren) have had a vision screening in the past year since enrollment in ALL Kids than before enrollment in ALL Kids.**

6. **Performance Goal for Objective 6:**
   a. **Contracts with state agencies which serve children with special health care needs will be maintained for the purpose of providing specialty services beyond the basic ALL Kids coverage package for these children.**
   b. **Exploration of the feasibility of establishing contracts with other state agencies that serve children with special health care needs.**
   c. **Continued monitoring of access to specialty care for children with special health care needs.**

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Assurance of an Objective Means for Measuring Performance
To ensure an objective evaluation which can be independently verified, the evaluation will be based upon data bases which contain quantifiable information. These databases will, to the extent possible, contain numeric data. The ADPH will develop and/or direct the development of needed databases which do not currently exist. Since evaluation of some performance measures does not lend itself to numeric summation, measurement of these aspects of the plan will be based on review of a completed work plan which requires conclusive documentation. All data and documentation will be auditable.

At periodic intervals, a formal comparison of program performance to the goals

and measures set forth in this document or its subsequent amendments will be conducted. The CHIP staff directly responsible for the implementation of the program will conduct information comparisons of performance to these goals and measures on an ongoing basis. In this way, the program will be continuously monitored and activities may be adjusted so that the program may achieve its objectives.

Measure of Performance:	
MEASURE	**ROUGH DEFINITION OF MEASURE**
Reducing the Number of Uninsured	
Number of Uninsured	**CPS and/or NSAF and state data survey**
Tracking System	**Documentation that a tracking system exists and is used for 100% of the applications that are referred among ALL Kids, Medicaid, and Alabama Child Caring Foundation**
Related to SCHIP Enrollment	
Percentage of families not renewing due to owing past premiums	**Renewal database – comparison of number of non-renewals who owed premiums to the number who were due to renew.**
Percentage of families reporting a reduction in financial barriers to accessing health care	**New enrollee survey database – comparison of percentage of reports indicating a reduction in financial barriers to obtaining health care post-ALL Kids to pre-ALL Kids**
Development of plans to target outreach to adolescents, faith-based organizations	**Documentation of development of these plans on file**
Implementation of plans to target outreach to adolescents, faith-based organizations	**Documentation of implementation of these plans on file**
Development of plans to target outreach to Hispanics, Native Americans, and birth-to-five providers	**Documentation of development of these plans on file**

Implementation of plans to target outreach to Hispanics Native Americans, and birth-to-five providers	**Documentation of implementation of these plans on file**
Development and implementation of plans to target outreach to other groups	**Documentation of development and implementation of these plans on file**
Elimination of language and culture barriers	**Spanish and English brochures and applications forms on file** **Employment of bi-lingual customer service staff** **ALL Kids Customer service telephone operators are aware of and know how to use a telephone translating service.**
Reduction in percentage of children canceling ALL Kids due to nonparticipation in the renewal process	**Enrollment Data Management system – Comparison of number of enrollees who did not participate in the renewal process to those due to renew.**
Related to increasing Medicaid Enrollment	
Maintenance of effort with regard to:	
Use of a joint application form	**A joint SOBRA Medicaid and ALL Kids application form is in use**
Use of a joint renewal form	**A joint SOBRA Medicaid and ALL Kids renewal form is in use**

Seamless referral between ALL Kids and SOBRA Medicaid	**Seamless referral policy in place**
Continued outreach effort	**Outreach/Marketing files reflect outreach conducted by central office staff, regional staff, and federal program office.**
Evaluation of application transfer and referral process	**Evaluation on files of meeting minutes**
Continued computer enhancements	**Computer enhancements will be in place.**
Related to increasing access to care	
Reported usual source of care	**New Enrollees Survey**
Reported ER use	**New Enrollees Survey**
Related to use of preventive care	
Reported use of well-child check-up	**New Enrollees Survey**
Reported dental visit	**New Enrollees Survey**
Reported vision screening	**New Enrollees Survey**
Other	
Specialty service availability	**Contract(s) on file**
Exploration of feasibility for establishing contracts with other CSHCN state agencies	**Documentation on file (central office files and/or regional coordinator files)**
Monitoring access to care for CSHCN	**New Enrollees Survey**

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

9.3.1. **X** The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. **X** The reduction in the percentage of uninsured children.

9.3.3. **X** The increase in the percentage of children with a usual source of care.

9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☐ Immunizations
- 9.3.7.2. **X** Well child care
- 9.3.7.3. ☐ Adolescent well visits
- 9.3.7.4. **X** Satisfaction with care
- 9.3.7.5. ☐ Mental health
- 9.3.7.6. ☐ Dental care
- 9.3.7.7. ☐ Other, please list:

Please see 7.1 and 7.2

9.3.8. ☐ Performance measures for special targeted populations.

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

Alabama assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires.

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

Alabama assures it will comply with the annual assessment and evaluation required under Section 10. On an annual basis, the Alabama will review its operations, progress made in reducing the number of uncovered low-income children, progress made in meeting the goals and objectives stated in 9.1 and 9.2 of this document, and its compliance with applicable Federal laws and regulations. Section 9.3 states how Alabama will measure the goals and

objectives in sections 9.1 and 9.2. Examples of data sources are: Census data, private foundation garnered data, data gathered via special surveys, utilization data from claims reports, enrollee family feedback from surveys, etc. The assessment will occur during the three months after the end of the fiscal year and a report of this assessment will be submitted to the Secretary by January 1 following the end of the fiscal year.

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

Alabama assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit.

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

Alabama assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

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

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

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

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

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

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

Efforts were made to make the process of developing the design and implementation of the Children's Health Insurance Program inclusive. News coverage about the advocacy of the Children's Health Insurance Program was provided regularly starting at the time that the issue came before the Alabama Legislature.

Formalized CHIP development groups were the CHIP Commission and the CHIP Task Force Work Groups. The CHIP Commission met three times, October 7, November 12 and December 17, 1998. The CHIP Task Force Work Groups met twelve times beginning August 6,

1998, and split into subcommittees to develop proposals in the following areas: (1) benefits, (2) eligibility, outreach and enrollment, and (3) funding. These subcommittee meetings were open to interested individuals and groups. At least three news conferences were held by the State Health Officer and/or the Medicaid Commissioner.

Public awareness was promoted through means such as television programs. Interested organizations such as Alabama ARISE, *the Alabama Developmental Disabilities Planning Council,* and Voices for Alabama's Children were provided information for their membership about CHIP. Media coverage was provided and CHIP information has been made available on the Internet at: http://www.adph.org/allkids (formerly: http://www.alapubhealth.org) since October 2, 1998. During the first six and one-half month period of October 4 through April 21, 1998, 1,247 hits were made on this site specifically requesting CHIP information. This website includes a description of the program, a calendar of scheduled events, and an opportunity for interested persons to express their opinions about the program's development. Order forms are available at every presentation. These forms enable participants to fax orders to the ALL Kids office and receive printed materials at no charge. The largest number of requests for information (312) came during the month of January. Newspaper editorials have praised the value of this program for our State's children.

The CHIP Task Force Work Groups were comprised of employees of the Alabama Medicaid Agency, Public Health Department employees, and other interested parties including representatives of the Alabama Primary Care Association, Alabama ARISE, *the Alabama Developmental Disabilities Planning Council,* Voices for Alabama's Children, the Alabama Child Caring Foundation, Alabama Dental Association, Alabama Hospital Association, Alabama Psychological Association, American Academy of Pediatrics-Alabama Chapter, Blue Cross Blue Shield, Children First, Children's Health System, Children's Hospital of Alabama, Family Voices, Health Maintenance Organization Association, Legislative Fiscal Office, Legislative Reference Service, Medical Association of the State of Alabama, University of Alabama at Birmingham, University of South Alabama, University of South Alabama Children's and Women's Hospital, United Health Care, as well as other State agencies including the Department of Education, the Department of Human Resources, the Department of Mental Health/Mental Retardation, State Employees' Insurance Board, State Insurance Department, and the Department of Rehabilitation Services. These entities are now referred to as stakeholders and they continue to be involved as program changes are developed.

The Alabama program will continue to inform the general public about CHIP through the news media, to announce planning meetings, and to invite additional groups with an interest in being involved or informed as they become identified.
There was extensive public involvement in the preparation of a comprehensive 133-page report which was released to the Alabama Legislature on January 12, 1998. In relation to the Governor's Task Force on Children's Health Insurance, periodic reports on the progress of recommendations contained the report are made.

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

A meeting was held with representatives of the 2,176 member Poarch Band of Creek Indians, the only federally recognized Native American group in Alabama. Six other tribes are recognized by the State. The CHIP Program was explained and discussion centered on ways to coordinate CHIP and Indian Health Service-funded care, the role of traditional Native American healing, outreach methods for children and some demographics of the Poarch Band. Several presentations have been made to the Alabama Commission on Indian Affairs and CHIP staff meet and coordinate regularly with staff of the Commission. Other forms of outreach have included numerous presentations to the tribes, presence at Native American festivals throughout the state and the employment of a Native American consultant whose specific task was to develop a regionally-based outreach plan to the Native American population in Alabama.

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

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.

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

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected 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 Plan FY2015

Enhanced FMAP rate 77.68	**Federal Fiscal Year Costs**	**Non-Federal plan expenditures**
Benefit Costs		
Insurance payments		
Managed care		
Fee for Service	**$144,218,381**	
Total Benefit Costs	**$144,218,381**	
(Offsetting beneficiary cost sharing payments)	**$(3,856,264)**	
Net Benefit Costs	**$140,362,117**	
Cost of Proposed SPA Changes - Benefit	**0**	
Administration Costs		
Personnel	**$4,242,244**	

General administration	**$2,400,823**	
Contractors/Brokers (e.g., enrollment contractors)	**--**	
Claims Processing	**--**	
Outreach/marketing costs	**$500,000**	
Other	**$856,933**	
Total Administration Costs	**$8,000,000**	
10% Administrative Cost Ceiling	**$15,595,791**	
Federal Share (multiplied by enh-FMAP rate)	**$116,152,701**	
State Share	**$32,209,416**	
TOTAL PROGRAM COSTS	**$148,362,117**	

Note: Include the costs associated with the current SPA.
The current SPA has no cost impact since it consists merely of language changes to maintain consistency with previously approved Affordable Care Act SPAs.

The Source of State Share Funds: State appropriations, Tobacco settlement

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

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

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

Section 10.3-D **X** Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website.

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

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

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

* While the effective date for sections 1-10 of this plan is October 1, 2002, the effective date for this section is August 24, 2001

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

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

Eligibility and Enrollment Matters

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

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 D. 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.

Health Services Matters

12.2 Please 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.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR ☐457.1, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

* While the effective date for sections 1-10 of this plan is October 1, 2002, the effective date for this section is August 24, 2001

ATTACHMENT D

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 a 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 a 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.