Table of Contents

State/Territory Name: Alabama

State Plan Amendment (SPA) #: AL-24-0030-VCTE

This file contains the following documents in the order listed:

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

Children and Adults Health Programs Group

March 25, 2024

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

Dear Wanda Davis:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number AL-24-0030-VCTE, submitted on January 10, 2024, has been approved. Through this SPA, Alabama has demonstrated compliance with both the Inflation Reduction Act (IRA) Section 11405(b)(1) and the longstanding requirement in regulations at 42 CFR §§ 457.410(b)(2) and 457.520(b)(4) to cover age-appropriate vaccines. This SPA has an effective date of October 1, 2023.

Section 11405(b)(1) of the IRA requires states with separate CHIPs that include coverage for adults to provide coverage and payment for approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost sharing. Current regulations at 42 CFR §§ 457.410(b)(2) and 457.520(b)(4) require states to cover age-appropriate vaccines and their administration in accordance with the recommendations of the ACIP without cost sharing. The state provided the necessary assurances to demonstrate compliance with both requirements.

Also through this SPA, Alabama makes non-substantive technical updates to remove outdated references in order to more clearly reflect existing policies and to transfer existing information to the most current version of the CHIP SPA template.

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

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

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

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

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

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

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))
Scott Harris, State Health Officer, Alabama Department of Public Health, January 5, 2024
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: Cathy Donald Position/Title: Acting CHIP Director_
Name: Shaundra B. Morris_ Position/Title: Director, ADPH Financial Services
Name: _____ Position/Title: _____

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

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

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

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

Subpart A.

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

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark

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

7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or

through a combination of these programs. These options are described further below:

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

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
    - 1 (General Description)
    - 2 (General Background)

  They will also be required to complete the appropriate program sections, including:
    - 4 (Eligibility Standards and Methodology)
    - 5 (Outreach)
    - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
    - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
    - 3 (Methods of Delivery and Utilization Controls)
    - 4 (Eligibility Standards and Methodology)
    - 6 (Coverage Requirements for Children's Health Insurance)
    - 7 (Quality and Appropriateness of Care)
    - 8 (Cost Sharing and Payment)
    - 11 (Program Integrity)
    - 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions

outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

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

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

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

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

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

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

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

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

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

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

From inception 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 Alabama's CHIP was subsumed, on October 1, 2002, by the Alabama Medicaid SOBRA Program for Pregnant Women and Children and Alabama's CHIP became a separate child health program. On January 1, 2014, Alabama's CHIP returned to a combination program due to provisions of the ACA increasing the minimum Medicaid income level to 138 percent of FPL for children under age 19.

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

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

Alabama has not and will not claim expenditures for child health assistance

prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. I

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

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

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

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

Original Plan
Effective Date: February 1, 1998
Implementation Date: February 1, 1998

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

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

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

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

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

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

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

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

Amendment 16 – AL-18-0016-PAR - Attestation and documentation of Mental Health Parity and Addiction Equity.
Submission Date: July 10, 2018
Effective Date: October 1, 2017*
Implementation Date: October 1, 2017*
***Note: Benefits were adjusted in October 2010 to be compliant with mental health parity; this amendment did not require any benefit changes**

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

Effective Date: July 1, 2019
Implementation Date: July 1, 2019

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

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

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

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

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

Amendment 23 – AL-22-0023-OBJ
Edits to align Strategic Objectives and Performance Goals with CARTS
Submission Date: March 30, 2022
Effective Date: October 1, 2021
Implementation Date: October 1, 2021

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

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

Implementation Date: October 1, 2022

Amendment 26 - AL-23-0026-RIM2
CS9 Eligibility - ~~Statewide~~ Expanding Coverage from Conception to Birth
Submission Date: January 9, 2023
Effective Date: May 1, 2023
Implementation Date: May 1, 2023

Amendment 27 - AL-23-0027-CC
Amending AL-19-0017-RIM to discontinue HSI
Submission Date: January 9, 2023
Effective Date: October 1, 2023
Implementation Date: September 30, 2023

Amendment 28 - AL-23-0028-ROR
Reach Out and Read HSI
Submission Date: February 1, 2023
Effective Date: June 1, 2023
Implementation Date: June 1, 2023

Amendment 29 - AL-23-0029-MH
Project clean up ECHO Model for IECMH
Submission Date: February 1, 2023
Effective Date: June 1, 2023
Implementation Date: June 1, 2023

SPA #30 AL-24-0030-VCTE
Purpose of SPA: Transition the current approved State Plan into the new Title XXI Template; Assure Compliance with SHO #23-003 re: Mandatory Coverage of Adult Vaccinations; updating and relocating the Grievance Policy description from Attachment A to Section 12; and other minor technical edits
Proposed effective date: October 1, 2023
Submission Date: January 5, 2024
Proposed implementation date: October 1, 2023

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
AL-14-0016 (Original: AL-14-0016 Effective/Implementation Date: January 1, 2014)	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections Geographic

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
AL-20-0019-CEN (affects only CS15) Effective Implementation Date: July 1, 2020		**CS10** **CS15**	**Children With Access to Public Employee Coverage** **MAGI-Based Income Methodologies**	**Area 4.1.1; Age 4.1.2; and Income 4.1.3 Section 4.4.1: Supersedes only the information on dependents of public employees in this section; supporting documentation should be incorporated as an appendix to the current state plan** **Incorporate within a separate subsection under section 4.3**
AL-23-0026-RIM2 Original: AL-19-0018-RIM Effective/Approval Date: July 1, 2019)		**CS9**	**Coverage from Conception to Birth**	
(Original: AL-14-0014 Effective/Implementation Date: January 1, 2014) **AL-16-0015-MEXP** **Effective/Implementation Date: October 1,**	**XXI Medicaid Expansion**	**CS3**	**Eligibility for Medicaid Expansion Program** **CHIP Medicaid expansion to cover Medicaid enrollees ages 14 years to**	**Supersedes the current Medicaid expansion section 4.0**

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
2015			19 years with incomes above 18% FPL through 141% FPL	
AL-14-0015 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
AL-14-0018 Effective/Implementation Date: January 1, 2014	Eligibility Process	CS24	Single, Streamlined Application Screen and Enroll Process Renewals	Supersedes the current sections 4.3 and 4.4
AL-14-0017 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20 CS21 CS27	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial – Social Security Number Substitution of Coverage Non-Payment of Premiums Continuous Eligibility	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1 Supersedes the current section 4.4.4 Supersedes the current section 8.7 Supersedes the

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
				current section 4.1.8

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

In accordance with approved policies, on November 7, 2023, a certified letter explaining the changes proposed in AL-24-0030-VCTE was mailed to the Tribal Chairman of the one federally recognized Native American tribe in Alabama, the Poarch Band of Creek Indians. The letter included the purpose for the proposed changes and a description of the changes. In the letter, the Tribal Chairman was reminded of the opportunity to respond within 30 days and was provided contact information for submitting a response. The certified letter was signed by the CHIP Deputy Director.

TN No: Approval Date Effective Date December 7, 2023

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

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

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

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

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health

insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Prior to CHIP, the only two programs offering health insurance to low-income children were Medicaid and the Alabama Child Caring Foundation (ACCF). Medicaid served children at the minimum income levels required by federal law. This meant that Medicaid coverage was available to children at three different levels of income and age:

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

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

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

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

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

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

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

ALL Kids PLUS, added as a third amendment to the CHIP State Plan (October, 1999), serves

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

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

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

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

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

Cost: The cost of the HSI is budgeted to be $360,000 for FY2023. This figure is based on anticipated enrollment (870 enrollees) in 36 counties with an average enrollment of 2.5 months.

HSI II – Reach Out and Read (ROR) Initiative: As permitted under section 2105(a)(1)(D)(ii) of the Social Security Act and federal regulations at 42 CFR 457.10, the State of Alabama is implementing a health services initiative (HSI) that will use CHIP funds, within the federal administrative expenditures cap allowed for states, to continue to deliver Reach Out and Read, an AAP-endorsed, evidence-based model to promote early literacy, early learning and school readiness as part of routine pediatric primary care visits for children, birth to age 5 in five Alabama counties (Jefferson, Macon, Marshall, Monroe, and Randolph). Funding for this initiative is to bolster ROR efforts in the five counties for the existing ROR program in order to increase grade level reading. This HSI will assist in transforming the standard of pediatric care for young children in Alabama to sharpen the focus on activities that support social and emotional development. The criteria used to determine eligibility for the services is the age of the child and the type of visit. The child must be seen for a well-child visit in order to receive the service.

Funds under this HSI will not supplant or match CHIP Federal Funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds. Metrics used to measure the impact of the state's HSI program on the health of low-income children will be included in the state's CHIP Annual Report.

Cost: The cost of the HSI is budgeted to be $500,000 and limited to two years ($250,000 for FY 2023 and $250,000 for FY2024). The budget timeline for the ROR HSI begins June 1, 2023 and will end May 31, 2025.

Find information on Reach Out and Reach and the evidence supporting its effectiveness at https://reachoutandread.org/why-we-matter/

HSI III – Infant and Early Childhood Mental Health Services: As permitted under section 2105(a)(1)(D)(ii) of the Social Security Act and federal regulations at 42 CFR 457.10, the State of Alabama is implementing a health services initiative (HSI) that will use CHIP funds, within the federal administrative expenditures cap allowed for states, to increase workforce capacity around Infant and Early Childhood Mental Health Services (IECMH). IECMH works to develop the capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships. The vision of the Alabama IECMH System of Care is that "*Every child has opportunities from the start to reach their full potential within healthy positive relationships.*" To achieve this vision, their mission is "*to create and sustain a culturally sensitive system that promotes positive early experiences through collaborative partnerships, empowering families, and building capacity across communities.*"

Alabama Department of Mental Health will establish the evidence based Project ECHO Model® learning framework to train a variety of professionals (childcare workers, head start staff, mental health clinicians, etc.) statewide working directly with children birth to five and their families on topics such as Understanding Trauma in Young Children, What is IECMH and IECMH Consultation and Why It is Important, Self-Care, Addressing Behavioral

Challenges in Young Children, Attachment, and Early Brain Development. The Project ECHO Model® is a telementoring program designed to create communities of learners by bringing together healthcare or other service providers and experts in topical areas using didactic and case-based presentations, fostering an "all learn, all teach approach." The only eligibility to participate in the IECMH ECHO training/telementoring program is to be a professional serving young children and families who want to build their capacity to address the social/emotional, and behavioral needs of the population they care for. The participating professionals will be surveyed in those foundational topics to determine additional topics they desire to learn about that will be applicable and beneficial to their practice. Advertisement of the availably of the training will be coordinated through our partner state agencies and local agencies who serve low-income children/families. Child welfare and childcare licensing staff will be asked to share information with local childcare and county staff, through the training calendar on the website for the Alabama Association for Infant and Early Childhood Mental Health (First 5 Alabama) which is sent out to all First 5 Alabama members (many of whom serve low-income children), to Early Head Start and Head Start state and local administrators, etc. Metrics used to measure the impact of the state's HSI program on the health of low-income children will be included in the state's CHIP Annual Report.

Funds under this HSI will not supplant or match CHIP Federal Funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

Cost: The cost of the HSI is budgeted to be $20,000 for FY 2023 and funding will end September 30, 2023.

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

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

ALL Kids provides a certified letter to the federally recognized tribe in the

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

Section 3. Methods of Delivery and Utilization Controls

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

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☒ No, the State does not use a managed care delivery system for any CHIP populations.

☐ Yes, the State uses a managed care delivery system for all CHIP populations.

☐ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the

State in its managed care delivery system below in Section 3.1.2.

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

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- 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); 42 CFR 457.490(a)) The utilization control 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); 42 CFR 457.490(b))

Alabama CHIP Methods for Assuring Delivery

Phase I - Medicaid Expansion

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

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

ALL Kids:

Program Operation–Administration

From inception of the program in 1998 through May, 2001, ALL Kids contracted with the State Employee's Insurance Board (SEIB) to serve as its enrollment and premium billing/receiving office. As enrollment grew, ALL Kids staff increased, and the need for data management grew, the ADPH CHIP unit and SEIB jointly decided to move the enrollment and premium billing/receiving functions

to the CHIP unit. The Alabama Department of Public Health (Department) now manages all enrollment aspects of the ALL Kids program and utilizes other contractors to administer certain aspects of the ALL Kids program including, but not limited to, the following:

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

Program Operation-Benefits and Services

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

1. Furnishing coverage information and ID cards;
2. Member service responses to claims inquiries;
3. Claims certification, investigation, adjudication, and internal appeals process;
4. Processing and distribution of benefit payments to providers;
5. Appropriate and accurate fee administration;
6. Strict financial accounting and reconciliation;
7. Effective management of networks (if applicable);
8. Demonstrated capability to serve Alabama membership;
9. Effective medical, pharmacy and dental management including medical review of claims decisions;
10. Production of claims, contract, and other legal forms as required;
11. Establishment and maintenance of appropriate banking arrangements;
12. Continuous and accurate electronic transmission of all data;
13. Production of reports that capture claim and utilization experience and trends;
14. Other special services as may be requested from time to time
15. Have a network of physicians, dentists, pharmacies, and other providers capable of meeting the demands of the ALL Kids Program.
16. Facilitation of a medical home for each enrollee.

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

be implemented August 25, 2010 for all qualifying services rendered on or after October 1, 2009.

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

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

ALL Kids PLUS

Program Operation-Administration

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

Several state agencies, other provider entities, and advocates within the state have met to develop the concept and plan of operation for ALL Kids PLUS.

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

Authorizing agencies bill the insurance vendor(s) for any authorized PLUS services that the agencies have provided directly or indirectly. The Alabama Department of Public Health reimburses the insurance vendor(s) in the same manner that reimbursement for the basic ALL Kids program is handled. At this time, the participating PLUS agencies do not utilize a central integrated data system.

However, their day-to-day practice involves coordination through the case manager with other agencies to avoid duplication. Each agency submits all claims/data to the insurance vendor (BCBS) for adjudication and reimbursement. While a child may have claims submitted by more than one agency, only one agency may be reimbursed for case management services.

Alabama CHIP's Utilization Control Systems

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

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

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

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

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State's responses to the following questions will only apply to those populations.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

☐ No
☐ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an

enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☐ Managed care organization (MCO) (42 CFR 457.10)
- ☐ Capitation payment
  Describe population served:

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
- ☐ Capitation payment
- ☐ Other (please explain)
  Describe population served:

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

☐ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
- ☐ Capitation payment
- ☐ Other (please explain)
  Describe population served:

☐ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Other (please explain)

☐ Primary care case management entity (PCCM Entity) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
- ☐ Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

☐ Provision of intensive telephonic case management

- ☐ Provision of face-to-face case management
- ☐ Operation of a nurse triage advice line
- ☐ Development of enrollee care plans
- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State
- ☐ Provision of enrollee outreach and education activities
- ☐ Operation of a customer service call center
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers
- ☐ Coordination with behavioral health systems/providers
- ☐ Other (please describe)

3.1.2.2 ☐ The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

Guidance: Only complete Section 3.1.3 if the State uses a PAHP to exclusively provide non-emergency medical transportation (a NEMT PAHP). If a NEMT PAHP is the only managed care entity for CHIP in the State, please continue to Section 4 after checking the assurance below. If the State uses a PAHP that does not exclusively provide NEMT and/or uses other managed care entities beyond a NEMT PAHP, the State will need to complete the remaining sections within Section 3.

☐ The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about

disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).

- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

3.2.1 ☐ The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 ☐ The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 ☐ The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

3.2.4 ☐ The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

- ☐ Based on public or private payment rates for comparable services for comparable populations; and
- ☐ Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

Guidance: States that checked both boxes under 3.3.1 above do not need to make the next assurance. If the state is unable to check both boxes under 3.1.1 above, the state must check the next assurance.

- ☐ If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))

3.3.2 ☐ The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))

3.3.3 ☐ The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))

3.3.4 ☐ The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))

3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))

- ☐ No, the State does not require any MCO, PIHP, or PAHP to pay remittances.
- ☐ Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.
- ☐ Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

If the State requests some, but not all, MCOs, PIHPs, and PAHPs to pay remittances through the contract for not meeting the minimum MLR required by the State, please describe which types of managed care entities are and are not required to pay remittances. For example, if a state requires a medical MCO to pay a remittances but not a dental PAHP, please include this information.

If the answer to the assurance above is yes for any or all managed care entities, please answer the next assurance:

☐ The State assures that it if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

- Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the Federal matching rate; and
- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

3.3.6 ☐ The State assures that each MCO, PIHP, and PAHP calculates and reports the medical loss ratio in accordance with 42 CFR 438.8. (42 CFR 457.1203(f))

3.4 Enrollment

☐ The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

- Accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(1));
- Will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(3)); and
- Will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. (42 CFR 457.1201(d), cross-referencing to 438.3(d)(4))

3.4.1 Enrollment Process

3.4.1.1 ☐ The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

3.4.1.2 ☐ The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to

continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))

☐ Yes
☐ No

If the State uses a default enrollment process, please make the following assurances:

☐ The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))

☐ The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

3.4.2.1 ☐ The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))

3.4.2.2 ☐ The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))

3.4.2.3 ☐ If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

3.4.2.4 MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.

☐ The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State. Reasons for disenrollment may not include an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, PCCM or PCCM entity seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b)(2))

3.4.2.5 Enrollee Requests for Disenrollment.

Guidance: The State may also choose to limit disenrollment from the MCO, PIHP, PAHP, PCCM, or PCCM entity, except for either: 1) for cause, at any time; or 2) without cause during the latter of the 90 days after the beneficiary's initial enrollment or the State sends the beneficiary notice of that enrollment, at least once every 12 months, upon reenrollment if the temporary loss of CHIP eligibility caused the beneficiary to miss the annual disenrollment opportunity, or when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

Does the State limit disenrollment from an MCO, PIHP, PAHP, PCCM and PCCM entity by an enrollee? (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

☐ Yes
☐ No

If the State limits disenrollment by the enrollee from an MCO, PIHP, PAHP, PCCM and PCCM entity, please make the following assurances (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)):

☐ The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))
☐ The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))

☐ The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

3.4.2.6 ☐ The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 ☐ The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 ☐ The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 ☐ The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 ☐ The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
- Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5 ☐ If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to

confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6 ☐ The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
    - That oral interpretation is available for any language and written translation is available in prevalent languages;
    - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
    - How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☐ The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required to enroll in a mandatory managed care program and within a timeframe that enables the

potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;
- Covered benefits including:
  - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
  - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service;
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

3.5.8 ☐ The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9 ☐ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:

- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must

make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

3.5.10 ☐ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
  - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
  - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
  - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes an emergency medical condition and emergency services;
  - The fact that prior authorization is not required for emergency services; and
  - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;

- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
  - The right to file grievances and appeals;
  - The requirements and timeframes for filing a grievance or appeal;
  - The availability of assistance in the filing process; and
  - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

3.5.11 ☐ The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

3.5.12 ☐ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

3.5.13 ☐ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))

3.5.14 ☐ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:

- Which medications are covered (both generic and name brand); and
- What tier each medication is on.

3.5.15 ☐ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).

Guidance: Requirements for marketing activities include, but are not limited to, that the MCO, PIHP, PAHP, PCCM, or PCCM entity does not distribute any marketing materials without first obtaining State approval; distributes the materials to its entire service areas as indicated in the contract; does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. (42 CFR 104(b))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.5 (3.5.16 through 3.5.18).

3.5.16 ☐ The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.

3.5.17 ☐ The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

Guidance: States should also complete Section 3.9, which includes additional provisions about the notice procedures for grievances and appeals.

3.5.18 ☐ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

Guidance: The State should also complete Section 3.10 (Program Integrity).

3.6.1 ☐ The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)

3.6.2 ☐ The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.3 ☐ The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete the remaining assurances in Section 3.6 (3.6.4 through 3.6.20.

3.6.4 ☐ The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.5 ☐ The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:

- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
- Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
- Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)

3.6.6 ☐ The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))

3.6.7 ☐ The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

3.6.8 ☐ The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network

providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

3.6.9 ☐ The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 ☐ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:
- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☐ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:
- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

3.6.12 ☐ Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:

- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

3.6.13 ☐ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

3.6.14 ☐ The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

3.6.15 ☐ The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)

3.6.16 ☐ The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's

coordination of services;

- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

Guidance: For assurances 3.6.17 through 3.6.20, applicability to PIHPs and PAHPs is based a determination by the State in relation to the scope of the entity's services and on the way the State has organized its delivery of managed care services, whether a particular PIHP or PAHP is required to implement the mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(a)(2))

3.6.17 ☐ The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.

3.6.18 ☐ The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))

3.6.19 ☐ The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:

- Is in accordance with applicable State quality assurance and utilization review standards;
- Reviewed and revised upon reassessment of functional need, at least

every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

3.6.20 ☐ The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

3.7.1 ☐ The State assures that it has established a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorders providers and requires each MCO, PIHP and PAHP to follow those policies. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(b)(1))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.7 (3.7.2 through 3.7.9).

3.7.2 The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:

- ☐ Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
- ☐ MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));
- ☐ MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));
- ☐ If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and
- ☐ MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3 The State assures that each contracted MCO, PIHP, and PAHP complies with the subcontractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

- ☐ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- ☐ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;
- ☐ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions; and
- ☐ The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 ☐ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

3.7.5 ☐ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))

3.7.6 ☐ The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.7 ☐ The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.8 ☐ The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)

3.7.9 ☐ The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

3.8 Beneficiary Protections

3.8.1 ☐ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

3.8.2 ☐ The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

3.8.3 ☐ The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
- Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete Section 3.9. States with PCCMs and/or PCCM entities should be adhering to the State's review process for benefits.

3.9.1 ☐ The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 ☐ The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 ☐ The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?

☐ Yes
☐ No

Guidance: Only states that answered yes to assurance 3.9.4 need to complete the next assurance (3.9.5).

3.9.5 ☐ The State assures that the external medical review is:

- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
- Independent of both the State and MCO, PIHP, or PAHP;
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

3.9.6 ☐ The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))

3.9.7 ☐ The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

3.9.8 ☐ The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))

3.9.9 ☐ The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.

3.9.10 ☐ The State assures that the notice of an adverse benefit determination explains:

- The adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

3.9.11 ☐ The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))

3.9.12 ☐ The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

3.9.13 The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

☐ Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

☐ Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

☐ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

- ☐ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- ☐ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
- ☐ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 ☐ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15 ☐ The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

3.9.16 ☐ The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

3.9.17 ☐ The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 ☐ The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 ☐ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 ☐ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☐ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
  - The right to request a State review, and how to do so.
  - The right to request and receive benefits while the hearing is pending, and how to make the request.
  - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

3.9.22 ☐ For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))

3.9.23 ☐ The State assures that if it offers an external medical review:

- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
- The review is independent of both the State and MCO, PIHP, or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260,

cross-referencing to 42 CFR 438.408(f))

3.9.24 ☐ The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))

3.9.25 ☐ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

3.9.26 ☐ The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)

3.9.27 ☐ The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

Guidance: The State should complete Section 11 (Program Integrity) in addition to Section 3.10.

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the first seven assurances (3.10.1 through 3.10.7).

3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:

- ☐ Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;
- ☐ Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and
- ☐ Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)

3.10.2 ☐ The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 ☐ The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 ☐ The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including

the termination of the provider agreement with the MCO, PIHP or PAHP;

- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

3.10.5 ☐ The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))

3.10.6 ☐ The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))

3.10.7 ☐ The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))

3.10.8 ☐ The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))

3.10.9 ☐ The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent

or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

3.10.10 ☐ The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

3.10.11 ☐ The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)

3.10.12 The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:

- ☐ Encounter data in the form and manner described in 42 CFR 438.818.
- ☐ Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.
- ☐ Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.
- ☐ Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.
- ☐ Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.
- ☐ The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

- ☐ It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial

Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))

☐ It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and

☐ It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14 ☐ The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))

3.10.15 ☐ The State assures that services are provided in an effective and efficient manner. (Section 2101(a))

3.10.16 ☐ The State assures that it operates a Web site that provides:

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;
- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

Guidance: Only States with MCOs need to answer the next three assurances (3.11.1 through 3.11.3).

Intermediate sanctions are defined at 42 CFR 438.702(a)(4) as: (1) Civil money penalties; (2) Appointment of temporary management (for an MCO); (3) Granting enrollees the right to terminate enrollment without cause; (4) Suspension of all new enrollment; and (5) Suspension of payment for beneficiaries.

3.11.1 ☐ The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2 ☐ The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3 ☐ The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

Guidance: Only states with PCCMs, or PCCM entities need to answer the next assurance (3.11.4).

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?

☐ Yes
☐ No

Guidance: Only states with MCOs and states that answered yes to assurance 3.11.4 need to complete the next three assurances (3.11.5 through 3.11.7).

3.11.5 ☐ The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))

3.11.6 ☐ The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))

3.11.7 ☐ The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

Guidance: The State should complete Sections 7 (Quality and Appropriateness of Care) and 9 (Strategic Objectives and Performance Goals and Plan Administration) in addition to Section 3.12.

Guidance: States with MCO(s), PIHP(s), PAHP(s), or certain PCCM entity/ies (PCCM entities whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes - see 42 CFR 457.1240(f)) - should

complete the applicable sub-sections for each entity type in this section, regarding 42 CFR 457.1240 and 1250.

3.12.1 Quality Strategy

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities need to complete section 3.12.1.

3.12.1.1 ☐ The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360

(relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

3.12.1.2 ☐ The State assures that the goals and objectives for continuous quality improvement in the quality strategy are measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(2))

3.12.1.3 ☐ The State assures that for purposes of the quality strategy, the State provides the demographic information for each CHIP enrollee to the MCO, PIHP or PAHP at the time of enrollment. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(6))

3.12.1.4 ☐ The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))

3.12.1.5 ☐ The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).

3.12.1.6 ☐ The State assures that it will submit to CMS:
- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
- A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 ☐ Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:
- Make the strategy available for public comment; and
- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

3.12.1.8 ☐ The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next two assurances (3.12.2.1.1 and 3.12.2.1.2).

3.12.2.1.1 ☐ The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:

- Standard performance measures specified by the State;
- Any measures and programs required by CMS (42 CFR 438.330(a)(2);
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
- Mechanisms to detect both underutilization and overutilization of services; and
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

Guidance: A State may request an exemption from including the performance measures or performance improvement programs established by CMS under 42 CFR 438.330(a)(2), by submitting a written request to CMS explaining the basis for such request.

3.12.2.1.2 ☐ The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve

significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
- Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

Guidance: Only states with a PCCM entity whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes need to, complete the next assurance (3.12.2.1.3).

3.12.2.1.3 ☐ The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:

- Standard performance measures specified by the State;
- Mechanisms to detect both underutilization and overutilization of services; and
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.2.2.

3.12.2.2.1 ☐ The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 ☐ The State assures that it annually requires each MCO, PIHP, and PAHP to:
1) Measure and report to the State on its performance using the standard measures required by the State;
2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

3.12.2.2.3 ☐ The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:

- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.3.

3.12.3.1 ☐ The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or PAHP has received accreditation by a private independent accrediting agency, that the MCO, PIHP, and PAHP authorizes the private independent accrediting entity to provide the State a copy of its recent accreditation review that includes the MCO, PIHP, and PAHP's accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(a) and (b)).

3.12.3.2 ☐ The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.4.

☐ The State assures that it will implement and operate a quality rating system that issues an annual quality rating for each MCO, PIHP, and PAHP, which the State will prominently display on the Web site required under 42 CFR 438.10(c)(3), in accordance with the requirements set forth in 42 CFR 438.334. (42 CFR 457.1240(d))

Guidance: States will be required to comply with this assurance within 3 years after CMS, in consultation with States and other Stakeholders and after providing public notice and opportunity for comment, has identified performance measures and a methodology for a Medicaid and CHIP managed care quality rating system in the Federal Register.

3.12.5 Quality Review

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5 and 3.12.5.1.

☐ The State assures that each contract with a MCO, PIHP, PAHP, or PCCM entity requires that a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP or PCCM entity, except as provided in 42 CFR 438.362. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(a))

3.12.5.1 External Quality Review Organization

3.12.5.1.1 ☐ The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

3.12.5.1.2 ☐ The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next three assurances (3.12.5.2.1 through 3.12.5.2.3). Under 42 CFR 457.1250(a), the State, or its agent or EQRO, must conduct the EQR-related activity under 42 CFR 438.358(b)(1)(iv) regarding validation of the MCO, PIHP, or PAHP's network adequacy during the preceding 12

months; however, the State may permit its contracted MCO, PIHP, and PAHPs to use information from a private accreditation review in lieu of any or all the EQR-related activities under 42 CFR 438.358(b)(1)(i) through (iii) (relating to the validation of performance improvement projects, validation of performance measures, and compliance review).

3.12.5.2.1 ☐ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))

3.12.5.2.2 ☐ The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State's quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)

3.12.5.2.3 ☐ The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

Guidance: Only states with PCCM entities need to complete the next assurance (3.12.5.2.4).

3.12.5.2.4 ☐ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross

referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5.3.

3.12.5.3.1 ☐ The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

3.12.5.3.2 ☐ The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).

3.12.5.3.3 ☐ The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:

- The EQRO has sufficient information to use in performing the review;
- The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
- For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
- The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))

3.12.5.3.4 ☐ The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn

as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));

- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
  - Objectives;
  - Technical methods of data collection and analysis;
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
  - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 ☐ The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 ☐ The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 ☐ The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42

CFR 438.10(c)(3) by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 ☐ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

3.12.5.3.9 ☐ The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))

3.12.5.3.10 ☐ The State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(d))

Section 4. Eligibility Standards and Methodology

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

4.0. ☐ **Medicaid Expansion**

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

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

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.
See CS18

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

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

See CS7 and CS9

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

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

See CS7 and CS9

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

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

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

See CS17

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

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

4.1.7 ☒ Access to or coverage under other health coverage:

A child is not eligible for ALL Kids if s/he has ~~any~~ other credible health insurance coverage or is eligible for Medicaid at the time of applicaton. See CS10.

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

See CS27

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

Comprehensive health coverage will be provided from conception to birth for those with family incomes up to and including 312% FPL, whose mothers do not have comprehensive coverage, and reside in select counties in Alabama (initially Montgomery, Macon and Russell). A phased in approach (see CS9

for list of initial phase counties) will be utilized until coverage is offered statewide. The time frame for the phase in period will be 3-5 years. Comprehensive coverage will be provided to this population from the date of enrollment and will continue until the last day of the month in which the 60-day postpartum period has elapsed after the end of a pregnancy. The date of enrollment may be as early as the first day of maternity-related service provision even if the application is completed a few days after the service is received. In other cases, coverage will begin on the date the application is received by the CHIP office. Prenatal care, labor and delivery and limited postpartum care are paid using a bundled payment. In addition to the bundled payment, the state will provide comprehensive coverage during the postpartum period through ALL Babies HSI Initiative. For example, if a woman gives birth on June 26, benefits covered in the bundled package or postpartum HSI would end on August 31. ~~**Obstetric coverage for current ALL Kids members includes all prenatal care through 90 days postpartum and is billed as a bundled payment.**~~

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

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

See CS19. Social Security numbers for newborn are not required unless and until the child is born and applies for renewal.

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

4.1.9.2 ☒ Continuous eligibility

See CS27**.** Section 2107(e)(l)(J) applies section 1902(e)(16) equally to CHIP and allows individuals who were eligible for and enrolled in CHIP while pregnant to remain eligible regardless of changes in circumstance except for the following:

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

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for

instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

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

4.1- LR ☐ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

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

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

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

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

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

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

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

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
(vi) Aliens currently in deferred action status; or
(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;
(6) An alien who has been granted withholding of removal under the Convention Against Torture;
(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

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

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

4.1-DS ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only

supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

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

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

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

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

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

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

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

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

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

Superseded by ACA SPA

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

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

There are no public notice state laws regarding enrollment caps and waiting lists in CHIP. Due to insufficient state funds, ALL Kids initiated a waiting list beginning with all new enrollees who would have had an effective date October 1, 2003. Public and enrollee notices about the waiting list were issued during the month of September 2003 prior to the impact of the waiting list. On August 23, 2004, ALL Kids reopened enrollment and discontinued use of the waiting list.

If during the year funds are not available at sufficient levels for coverage of children and funding is projected to be depleted before the end of the fiscal year, it is the State's intent to place eligible children on a waiting list until adequate funding becomes available to resume enrollment. Alabama will provide public notice through press releases, written communication with stakeholders and stakeholder groups, presentations, and written communication from the program to all applicant families whose child(ren) is/are placed on the waiting list.

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

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

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

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

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the

citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

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

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

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

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

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

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

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

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

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and

those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

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

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

The State of Alabama assures that through enrollment screening processes, children whose applications are considered to be eligible for medical assistance under the State Medicaid plan will be referred for assistance under the appropriate plan. Additionally, ALL Kids eligibility staff ~~query~~ use the joint All Kids and Medicaid eligibility system, CARES, 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" from BCBS which indicates children who have current BCBS health insurance ~~or have terminated a BCBS policy within the last three months~~. In addition, internal audit ~~quality assurance~~ reviews are conducted monthly on a sample of ALL Kids applications ~~enrollees~~. Redetermination is completed every 12 months.

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

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

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

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

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

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

4.4.5. ☒ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (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 periodically ~~and coordinate regularly~~ with the Alabama Commission on Indian Affairs to ensure that Native American Children are identified and enrolled in ALL Kids. Additionally, a Native American was hired under a one-year contract to consult with ALL Kids staff and develop a comprehensive strategy to outreach to Native American children.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

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

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

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

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

Section 5. Outreach and Coordination

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

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

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

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

Prior to CHIP, the Medicaid Program was the only public health insurance program for children in Alabama. Health services are provided in Alabama to uninsured and Medicaid

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

<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.

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

Income assessments are performed on all patients enrolled in ADPH clinics. The income assessments are reviewed for possible Medicaid eligibility. Beginning in FY 1991, Medicaid

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

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

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

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

<u>Alabama Department of Economic and Community Affairs (ADECA)</u>
ADECA notifies the ALL Kids regional staff when a plant or large business plans to close in the near future. ALL Kids regional staff present ALL Kids information and materials at employee

meetings prior to the plant/business closing. In order to prevent gaps in health insurance coverage for the children of the employees of the plant/business, an ALL Kids policy was developed which provides for beginning ALL Kids coverage (for eligible children) the day after employer sponsored coverage ends if an application is received by the ALL Kids enrollment unit within 30 days after the plant/business closing.

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

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

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

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

Medicaid Agency
The Alabama Medicaid Agency has 135 eligibility workers in over 170 locations to enroll children eligible for SOBRA Medicaid whose the family's income is at or below 100 percent of

FPL (for children born after September 30, 1983) or 133 percent of the FPL (for children through age five). With the implementation of CHIP, 23 workers were added throughout the state. In March, 2002, two eligibility workers and a clerk were housed in the ALL Kids central office to review applications referred from the ALL Kids eligibility workers. In addition to the CHIP office, these workers are located in places children are likely to go to receive health care -- county health departments, Federally Qualified Health Centers and hospitals. Because workers are in the community, they can and do establish working relationships with public and private providers, social service agencies and others. For example, supervisors provide in-service training and education on Medicaid, ALL Kids, and ACCF eligibility to physicians, Head Start workers, day care centers, Human Resources staff and others. The Alabama Medicaid Agency also has 10 district offices located throughout the state that process applications for the elderly and the disabled population. The 80 eligibility workers and 20 supervisors advise applicants about other programs and refer the applicants to the proper office when they do not qualify for a disabled program. They also advise about programs for which other family members may be eligible. These district offices work closely with providers to keep them informed of all programs available through the Medicaid Agency.

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

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

Outreach occurs after the birth of an infant to a Medicaid recipient. Following the birth of each newborn whose mother is a Medicaid recipient, the Alabama Medicaid Agency sends the infant's parent or guardian a pamphlet on the Early Periodic Screening, Diagnosis, and

Treatment (EPSDT) program as well as a pamphlet on immunizations. When children are enrolled in the SSI Program, they are automatically enrolled in the Medicaid Program. Additionally, a brochure is sent to parents/guardians of all new SSI eligible children encouraging them to participate in the EPSDT program. In addition to these efforts, social workers within the ADPH conduct patient recruitment as a part of their case management activities. These recruitment efforts are conducted through community presentations and professional relationships with other State and local agencies which serve mothers and children.

The Alabama Department of Human Resources and the Alabama Department of Mental Health and Mental Retardation also provide case management services for Medicaid children known to their agencies, in order to facilitate their enrollment in health services particularly mental health services through the Rehabilitation Option.

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

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

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

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

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

Television commercials

- **Radio spots**
- **Brochures have been distributed to date for out stationed Medicaid workers, public health workers, county human resources workers, Early Intervention Coordinating Councils, Mental Health Centers, family services centers, primary health care centers, hospitals, advocacy and professional organization, and in the school system, principles and guidance counselors. Brochures distributed at state meetings of Alabama Conference of Social**

Work, Medical Association, American Academy of Pediatrics-Alabama Chapter, Alabama Dental Association, Family Practice doctors, and others

Satellite conferences to provide information about the basic ALL Kids Program and instruction in completing the application.

Distribution of applications and brochures to all public school systems, local health departments, welfare offices, hospitals, community health centers, physician and dentist offices, pharmacies, WIC clinics, and family law attorneys, etc.

Public forums for parents and advocates of CSHCC/N (Children with Special Health Care Conditions/Needs)

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

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

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

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

In August of 1999, the ADPH broadcasted a nationwide satellite conference to educate the

provider community and other concerned individuals regarding ALL Kids PLUS. In addition, CHIP staff provided training on the PLUS program to CRS staff at regional meetings.

Alabama Department of Human Resources (DHR)
The DHR has continued to partner with the ADPH to communicate ALL Kids information to their county staffs. They have provided initial and continuing updates to county DHR staff as well as provided periodic shipments of applications, posters, etc. The DHR has also assisted with outreach efforts through its childcare management agencies and facilitated communication with licensed child day-care homes and centers.

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

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

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

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

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

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

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

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

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

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

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

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

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

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

Phase I - Medicaid Expansion

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

Phase II - ALL Kids

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

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

Staff have exhibited at booths and presentations to the Medical Association of the State of Alabama, Alabama Chapter of the American Academy of Pediatrics, Family Practice Physicians, Dentists, Social Workers, Department of Human Resources staff, Mental Health staff, Family Law Judges, Hospitals, Hospital auxiliaries, WIC staff, Public Health

Staff, etc.

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

Phase III - ALL Kids PLUS

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

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

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

Section 6. Coverage Requirements for Children's Health Insurance

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

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

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

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

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

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

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

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

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

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

description.)

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

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

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

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

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

- hearing services.

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

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

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

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

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

benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

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

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

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

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

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

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

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

6.1.4.4. ☒ Coverage that includes benchmark coverage plus additional coverage

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

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

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

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

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

6.1.4.7. ☒ Other (Describe)

Comprehensive health coverage will be provided from conception to birth for those with family incomes up to and including 312% FPL, whose mothers do not have comprehensive coverage, and reside in select counties in geographic areas in Alabama where CHIP unborn coverage is available. Alabama will utilize a phased in approach (see CS9 for list of initial phase counties) until coverage is provided statewide. Prenatal care, labor and delivery and limited postpartum care are paid using a bundled payment. In addition to the bundled payment, the state will provide comprehensive coverage during the postpartum period through ALL Babies HSI Initiative. Coverage begins upon enrollment and will continue until the last day of the month in which the 60 day postpartum period has elapsed after the end of a pregnancy. For example, if a woman gives birth on June 26, benefits covered in the bundled package or postpartum HSI would end on August 31. The first day without coverage would be September 1. The date of enrollment may be as early as the first day of maternity-related service provision even if the application is completed a few days after the service is received. In other cases coverage will begin on the date the application is received by the CHIP office. The definition of comprehensive coverage includes coverage for obstetrical benefits. If a pregnant woman has other coverage but the other coverage does <u>not</u>

include obstetrical benefits, then the other coverage would be considered non-comprehensive, regardless of any other benefits it insures. In this circumstance, the pregnant woman would meet the criterion for not having comprehensive coverage.

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

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

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

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

Health insurance benefits provided to conception to birth enrollees will be identical to the health insurance benefits provided to any pregnant ALL Kids enrollee. The date of enrollment may be as early as the first day of maternity-related service provision even if the application is completed a few days after the service is received. In other cases coverage will begin on the date the application is received by the CHIP office. Prenatal care, labor and delivery and limited postpartum care are paid using a bundled payment. In addition to the bundled payment, the state will provide comprehensive coverage during the postpartum period through ALL Babies HSI Initiative. In geographic areas in Alabama where CHIP unborn coverage is available, coverage for bundled obstetrical benefits begins upon enrollment and will continue until the last day of the month in which the 60 day postpartum period has elapsed after the end of a pregnancy. For example, if a woman gives birth on June 26, benefits covered in the bundled package or postpartum HSI would end on August 31. The first day without coverage would be September 1.

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

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

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

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

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

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

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

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

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

6.2.10. ☒ 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))

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

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

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

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

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

6.2.14. ☐ 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)

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

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

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

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

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

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

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

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

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

6.2.22.1 ☐ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

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

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

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

COVID-19 Vaccine:

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

COVID-19 Testing:

- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

COVID-19 Treatment:

- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
    - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
    - The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
    - The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

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

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

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

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

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

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

6.2.27. ☒ 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-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

☐ State-developed schedule
☒ American Academy of Pediatrics/ Bright Futures
☒ Other Nationally recognized periodicity schedule (please specify: Multiple periodicity schedules are leveraged for screenings and assessments including the United States Preventive Task Force (USPSTF), Bright Futures by the American Academy of Pediatrics, and *Recommendations for Well-Woman Care – A Well-Woman Chart* developed by the Women's Preventive Services Initiative – WPSI.)
)
☐ Other (please describe:)

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

6.3.1- BH ☐ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and

United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH ☐ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

New Directions Behavioral Health (NDBH) is the CHIP/ALL Kids mental health benefit vendor. Specifically, NDBH provides clinical review and network services designed to get members the right care at the right time with the right providers. Their focus extends to social determinants of health, connecting members with community services and support. NDBH does not directly provide mental health or substance abuse disorder treatment. Some of the network services provided include an online PCP Toolkit containing resources including validated screening instruments, Release of Information form, Member facing education materials, Clinical Practice Guidelines, NDBH support line and other resources.

NDBH provides a dedicated Physician Help Line for PCP's to access a Behavioral Health Clinician or Medical Director as needed to consult on appropriate screening or referral for their patients.

NDBH participates in BCBSAL's Circle of Care Summit to provide education on behavioral health topics and resources available. The Summit is a unique opportunity for primary care physicians (including Pediatricians) from across Alabama to learn about new initiatives that focus on innovation and best practices, opioid management strategy, expanding access to rural healthcare, and improved patient outcomes for Alabamians.

NDBH toolkits are updated at least annually or whenever new clinical content is available. BCBSAL leverages its network services infrastructure including 10+ provider service representatives, webinars, townhall meetings, newsletters, and email capabilities to ensure providers are kept up to speed on all behavioral health screening tools.

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are provided for individual, group, and family therapy.
Precertification is not required.

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

Tobacco cessation benefits are available for all FDA approved nicotine withdrawal drugs prescribed by a physician and dispensed by a licensed pharmacist from an in-network pharmacy.
8 counseling sessions are provided each year with 2 quit attempts.
Additional counseling and/or quit attempts are available if necessary and NDBH can provide community resources if needed. (Example: 1800QuitNow.)

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

Prior Authorization is required through pharmacy.
Medications covered for the treatment of OUD include all FDA approved drugs including naltrexone, buprenorphine alone and in combination with naloxone, and methadone. All these medications are available for ALL Kids members at the lowest tier 1 generic share.

Prior authorization is required for certain OUD medications. Buprenorphine in combination with naloxone remains the main stay and most popular MAT and does not require prior authorization. An authorization is required if a member receives a dose above the FDA recommended target dose to mitigate potential diversion. Single agent buprenorphine requires an authorization before use. Oral naltrexone is available without restriction while the extended release injectable form requires an authorization. Methadone through the appropriate channels does not contain utilization management when used for OUD. If needed DBH Case Management assists members navigate accessing these

benefits. Opiate agonist treatment (methadone or buprenorphine) is the standard of care for pregnant women with OUD.

The prior authorization requirement does not preclude DEA-waivered providers, office-based opioid treatment (OBOTs,) or opioid treatment programs (OTPs) from providing MAT services.

As noted above and in recognition of the critical access need, there is no prior authorization required for buprenorphine products in combination with naloxone. Patients have access irrespective of their participation in counseling and even those who have an authorization approved for a dose above the FDA recommended target.

Being mindful of the unique diversion potential for buprenorphine products when used without naloxone and the FDA label which indicates they ”should be used as part of a complete treatment plan that includes counseling and psychosocial support”, the clinical criteria evaluates for counseling. The criteria evaluate to enrollment or agreement to enroll. For members who have completed 6 or more months or counseling, the provider can attest that the patient no longer needs counseling. Extended release naltrexone also requires the “Patient is in a comprehensive rehabilitation program”. These criteria may be overruled in unique circumstances and are reviewed by a clinical pharmacists or physicians for patient-specific circumstances before being denied. All members (children and mothers of unborn children) are subject to the same policies.

Participation in therapy is only required in select circumstances as noted above and is consistent across different settings.

6.3.2.3.2- BH ☐ Alcohol Use Disorder

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

NDBH provides referrals to community resources to meet adolescent/child peer support needs such as guidance in dealing with grief associated with loss, help individuals with disabilities and/or health impairments achieve maximum

independence, and other support groups that allow for sharing methods for coping and encouraging one another.

6.3.2.5- BH ☒ Caregiver Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Family Therapy, Individual, and Group Family Support services are covered. Additional caregiver support is provided by Case Management Services and Referrals. Support services include collaboration with another parent with experience in the challenges of coping with children/adolescents with substance abuse issues and/or mental health disorders. Services include instructional sills, emotional support and advocacy support. The services are intended to deliver coping and capacity skills to resolve or improve the parent/caregiver's to improve or resolve the child's life.

6.3.2.6- BH ☒ Respite Care
Provided for: ☒ Mental Health ☐ Substance Use Disorder

NDBH provides referrals to community resources for both short (respite care) and long term (caregiver support). The types of community resources are focused on assisting children to live in their homes by providing a break for the primary caregivers. The goal is to provide safe and supportive environments on a short-term basis for children with mental health conditions when their families need relief. Respite services are provided either in the home or in approved out-of-home settings.

6.3.2.7- BH ☒ Intensive in-home services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are available primarily through Community Mental Health Centers, Noah's Ark, the Child Resource Center, etc. with no limitations. Services covered include individual, family and group counseling; adventure-based counseling; psychiatric evaluation; crisis intervention (including emergency / mobile intervention); child case management; juvenile court and school evaluations; hospital referrals; and behavioral aide services to children and adolescents age 3 to 18 years as deemed necessary by the treating clinician. Precertification is not required.

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are available. Amount and duration are dependent on NDBH clinical review and medical necessity criteria. Services covered include but are not limited to symptom education and management, mindfulness, emotion regulation skills, medication education, relapse prevention, healthy relationships, communication skills, distress tolerance, pain management, critical thinking, and goal setting. Precertification is required

6.3.2.9- BH ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are available for individual, family, and group psychotherapy. Basic Living Skills are provided in an individual and group setting through Community Mental Health Center providers with no limitations. Precertification is required for Intensive Outpatient, Partial Hospitalization, Residential, and Inpatient Treatment Programs which may include psychosocial rehabilitation components.

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are available through Community Mental Health Centers and the Blue Cross and Blue Shield of Alabama provider network. Precertification is required. Day treatment is billed in hourly increments up to 4 hours a day and is available to people who have been recently discharged from hospital or have transitioned back into their community but require ongoing support to prevent relapse of symptoms. All professionals who furnish services are legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of their State licenses, certifications, or registrations. Day Treatment benefits provide a more intensive therapeutic experience than meeting with an outpatient therapist once a week and can include individual and group therapy. Structured, scheduled activities promoting socialization, recovery, self-advocacy, development of natural supports and maintenance of community living skills are also provided.

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are available.
Precertification is required.
Upon receiving a service request, NDBH makes benefit determinations based on the clinical information provided by the treating provider or facility. The amount and duration of services is dependent on NDBH medical necessity criteria and an overview of typical services is below.
Partial Hospitalization provides 6 hours of therapeutic intervention 5 days a week. Treatment is provided by licensed clinical staff with physician oversight. Partial programs are either used as a step down from 24-hour care in a psychiatric hospital setting (inpatient treatment) or can also be used to prevent the need for an inpatient hospital stay. Covered benefits include individual and group therapy, psychoeducation, skill-building practice, and periodic evaluations. If medication is needed, medication management is also covered.

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are available for 24-hour therapeutically planned structured services for substance abuse, severe emotional disturbance or other mental health needs. Care is provided either in a freestanding psychiatric / substance abuse facility or within a unit of a general hospital or medical center. Licensed professionals including physicians and counseling staff provide the services. Programming varies based on needs of the child.
Inpatient care is leveraged for crisis stabilization and residential treatment is leveraged as a step down and/or direct admission for short term, intense, focused treatment to promote a successful return home.
Whether inpatient or residential treatment, the facilities providing services work closely with the child, family and other community resources to promote a successful return to the home.
Precertification is required. Upon receiving a service request, NDBH makes benefit determinations based on the clinical information provided by the treating provider or facility. The need for inpatient vs. residential treatment services and the amount or duration of services is driven by NDBH clinical review and medical necessity criteria.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☒ Residential Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are available.
Precertification is required and covered benefits include a combination of individual and group therapy sessions, family therapy sessions and other ongoing care to facilitate the healing process.
Upon receiving a service request, NDBH makes benefit determinations based on the clinical information provided by the treating provider or facility. The amount and duration of services is dependent on NDBH medical necessity criteria.

6.3.4.2- BH ☒ Detoxification
Provided for: ☒ Substance Use Disorder

Benefits are available.
Precertification is required and covered benefits include evaluation, stabilization and fostering entry into substance abuse treatment.
Upon receiving a service request, NDBH makes benefit determinations based on the clinical information provided by the treating provider or facility. The amount and duration of services is dependent on NDBH medical necessity criteria.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are available via mental health providers. Emergent Outpatient Services for assessment and evaluation are covered under outpatient benefits. Precertification is not required. Benefits are also provided for pre-hospital screening by a Community Mental Health Center.

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Crisis Intervention and Stabilization can involve telephonic, online and / or in-person treatment activities provided to a patient who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration and serve as an alternative to 24-hour inpatient care. The services include a focus patient assessment and rapid intervention for youth experiencing a

behavioral health crisis, allowing for immediate de-escalation of the situation in the least restrictive setting possible; prevention of the condition from worsening; and the timely stabilization of the crisis. The services are designed to provide time-limited, on-demand crisis intervention services in any setting in which a behavioral health crisis is occurring, including homes, schools and EDs. Depending on the needs of the child, the stabilization component may include a temporary, out-of-home crisis resolution in a safe environment. The primary method of mobile crisis service delivery is via Alabama Community Mental Health Centers (CMHC). The services may also include a co-response with law enforcement and emergency medical personnel, crisis peer support, crisis case management, regional call centers, and respite options. New Directions Behavioral Health Care Managers refer members to CMHC sites for medically necessary Crisis Intervention and Stabilization services.

6.3.6- BH ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are available and include either home- or community-based interventions with a licensed clinician. Typically, this level of service does not require authorization. ND stays involved by providing referrals and coordinating with Continuing Care Service providers. Goals and activities are discussed during therapy sessions to identify issues, evaluate / motivate and offer skills to address problems. All services support the child and his/her family

6.3.7- BH ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefits are available. NDBH supports Mental Health Services Administration (MHSA) providers with care coordination, including a dedicated care coordinator, and expect that the treating facility, attending physician, and/or professional provider make every reasonable effort to coordinate care with the member's current treating providers (therapist, psychiatrist, primary care physician, etc.) and the patient's previous treating providers, when available and appropriate, or upon readmission. This is pursued whenever there is a substantial change in the member's condition, or approximately every two months, whichever occurs first. Consultation Services are covered on an inpatient and outpatient bases.

6.3.7.1- BH ☒ Intensive wraparound
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Intensive wraparound services are provided via Community Mental Health Centers (e.g. Project Family Integrity Network Demonstration (FIND) and includes basic living skills, individual therapy, medication monitoring, family therapy, family support, in home therapy, day treatment, group therapy, and case management.) The intensive wraparound services are included as part of other covered services that a child may be receiving through a Community Mental Health Center.

6.3.7.2- BH ☒ Care transition services
Provided for: ☒ Mental Health ☒ Substance Use Disorder
NDBH supports ALL Kids members and their providers with care transition and discharge planning. The treating facility and attending physician or professional provider should begin discharge planning at admission and continue throughout the treatment period. The discharge plan is developed in conjunction with the member and the member's family and support systems. The treating facility and attending physician or professional provider will address the member's continuing care needs (ambulatory appointments, medications, etc.) and any economic and transportation issues, referring to community-based resources or services, as needed.

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

NDBH supports ALL Kids members with a dedicated case manager and individualized case management plans including objective, measurable, and short-term treatment goals that address current needs and relevant psychosocial factors. The case management plan is developed in conjunction with the member and follows an assessment of psychological, psychosocial, medical and substance use needs. The plan includes an assessment of the home environment and family/support system. Available community resources should be included in the initial evaluation.

6.3.9- BH ☐ Other
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☐ ASAM Criteria (American Society Addiction Medicine)
☐ Mental Health ☐ Substance Use Disorders

☐ InterQual
☐ Mental Health ☐ Substance Use Disorders

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☐ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☐ Mental Health ☐ Substance Use Disorders

☐ CASII (Child and Adolescent Service Intensity Instrument)
☐ Mental Health ☐ Substance Use Disorders

☐ CANS (Child and Adolescent Needs and Strengths)
☐ Mental Health ☐ Substance Use Disorders

☐ State-specific criteria (e.g. state law or policies) (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

☒ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

ALL Kids, Blue Cross and Blue Shield of Alabama and NDBH do not require use of specific Assessment Tools. Providers, based on clinical training and licensure, select and implement tools based on preference and needs. Other mental health providers / entities require specific Assessment Tools depending on accreditation requirements. Example - Community Mental Health Centers require use of a CANS assessment as part of their Department of Mental Health accreditation.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

Case Management:

New Directions Behavioral Health (NDBH) is the CHIP/ALL Kids mental health benefit vendor. Specifically, NDBH provides assessment tools, clinical review and network services designed to get members the right care at the right time with the right providers.

The focus extends to social determinants of health, connecting members with community services and support. NDBH does not directly provide mental health or substance abuse disorder treatment. Some of the network services provided include an online PCP Toolkit containing resources including validated screening instruments, validated assessment tools, Release of Information forms, Member facing education materials, Clinical Practice Guidelines, NDBH support line and other resources. All materials are updated at least annually or when clinical guidelines change, whichever is sooner. Updates are provided via newsletter, website updates, conference settings like the Circle of Care Summit (Summit) and via NDBH staff described below.

The Summit, offered by BCBSAL, provides education on behavioral health topics and resources available, including assessment tools. The Summit is a unique, at least annual, opportunity for primary care physicians (including Pediatricians) from across Alabama to learn about new initiatives that focus on innovation and best practices, assessment tools, opioid management strategies, expanding access to rural healthcare, and improved patient outcomes for Alabamians.

NDBH also provides a dedicated Physician Help Line for PCP's to access a Behavioral Health Clinician or Medical Director as needed to consult for their patients.

In addition, a NDBH dedicated case manager provides a comprehensive assessment that assesses functioning in the following categories:

- Safety/Risk
- Psychosocial
- Activities of Daily Living
- Member Strengths
- Behavioral health/substance abuse/ and physical health diagnoses
- Medications
- Medical & Behavioral Health Providers
- Cultural Linguistic and Health Literacy Needs

A PSC 17 on all children and adolescents is provided which looks at the member's functioning and whether they could benefit from psychiatric evaluation and services. There are also some behavioral activation scales that look at the member's activation and avoidance behavior in dealing with depression. NDBH does not typically apply the PHQ9 to children and adolescents since it is designed for adults.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

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

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) 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.

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

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

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

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ 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, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC ☐ 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, also attach a description of the services and applicable CDT codes)

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children

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(Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice (§457.496(f)(1)(i)).

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for the different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

☐ International Classification of Disease (ICD)

☒ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines

☐ Other (Describe:)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

☒ Yes

☐ No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((§457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Act provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☐ Yes

☒ No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of §457.496(b) related to deemed compliance.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan

☐ A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under

the State child health plan, §457.496(b)(3) limits deemed compliance to those children only and you must complete Section 6.2.3- MHPAEA to complete the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (§457.496(b)(2)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

☐ All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions (Section 1905(r)).

☐ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan (Section 1905(r)).

☐ All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (Section 1905(r)(5)).

☐ Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness (Section 1905(r)(5)).

☐ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness (Section 1905(r)(5)).

☐ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis (Section 1905(r)(5)).

☐ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary (Section 1902(a)(43)).

☐ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them (Section 1902(a)(43)(A)).

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements §457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs (§§457.496(d)(2)(ii); 457.496(d)(3)(ii)(B)).

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

Benefit Classification	Standards Used
Inpatient	Inpatient benefits are applied per the benefit plan to a registered inpatient bed patient in a hospital.
Outpatient	Outpatient benefits are applied per the benefit plan to a patient who is not a registered inpatient bed patient of a hospital.
Pharmacy	Pharmacy benefits are applied per the benefit plan and evidence based clinical criteria for use of medication, regardless of behavioral health or medical diagnosis.

Emergency	Services covered in connection with a medical condition that occur suddenly and without warning with symptoms which are so acute and severe as to require immediate medical attention.

6.2.3.1.1 MHPAEA The state assures that:

☒ The State has classified all benefits covered under the State plan into one of the four classifications.

☒ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the state use sub-classifications to distinguish between office visits and other outpatient services?

☐ Yes

☒ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to "classification(s)" includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

☒ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits. However if a state does provide any mental health or substance use disorders, those mental health or substance use disorder

benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan.

Annual and Aggregate Lifetime Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan (§457.496(c)).

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☒ No dollar limit is applied

Guidance: If there are no aggregate lifetime or annual dollar limit on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:)

☐ No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits (§457.496(c)(1)).

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (457.496(c)).
The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits (457.496(c)(3)).

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable, as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (§457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or

annual dollar limit to at least1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (§§457.496(c)(4)(i)(B); 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with §§457.496(c)(4)(i)(B) and 457.496(c)(4)(ii). Please include the state's methodology as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (§457.496(c)(2)(i); (§457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☒ No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply financial requirements to any

mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

☐ Yes

☐ No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (§457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (§457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (§457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of QTL to substantially all

medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification. (§457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in §§457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in §457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (§457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§457.496(d)(3)(i)(B)(2)).

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements (§§457.496(d)(4); 457.496(d)(5)).

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State

does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☒ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits, provider reimbursement rates and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in §457.496(d)(4)(ii).

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the state or MCE contracting with the State provide coverage of services provided by out of network providers?

☐ Yes

☒ No

6.2.6.2.2- MHPAEA If yes, please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

☒ State

Blue Cross Blue Shield of Alabama; Lucet (Behavioral Health Benefits Manager for BCBS); Prime Therapeutics (Pharmacy Benefits Manager for BCBS).

☐ Managed Care entities

☐ Both

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

☒ State

Blue Cross Blue Shield of Alabama; Lucet (Behavioral Health Benefits Manager for BCBS); Prime Therapeutics (Pharmacy Benefits Manager for BCBS).

☐ Managed Care entities

☐ Both

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

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

6.3.2. ☐ The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

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 percent 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))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is 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 Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

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))

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

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. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

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))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☐ No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan**.**

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA **Purchasing Pool**- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

☐ Yes
☐ No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA **Notice of Availability of Premium Assistance**- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

6.5-Vaccine coverages

Guidance: States are required to provide coverage for age-appropriate vaccines and their administration, without cost sharing. States that elect to cover children under the State plan (indicated in Section 4.1) should check box 6.5.1 States that elect to cover pregnant individuals under the State plan should also check box 6.5.2. States that elect to cover the from-conception-to-end-of-pregnancy population (previously referred to as the "unborn") option under the State plan should also check box 6.5.3.

6.5.1- Vaccine coverage for targeted-low-income children. ☒ The State provides coverage for age-appropriate vaccines and their administration in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), without cost sharing. (Section 2103(c)(1)(D)) (42CFR 457.410(b)(2) and 457.520(b)(4)).

6.5.2- Vaccine coverage for targeted-low-income pregnant individuals. ☐ The State provides coverage for approved adult vaccines recommended by the ACIP, and their administration, without cost sharing. (SHO # 23-003, issued June 27, 2023); (Section 2103(c)(12))

6.5.3-Vaccine coverage for from-conception-to-end-of-pregnancy population option. ☒ The state provides coverage for age appropriate (child or adult) vaccines and their administration in accordance with the recommendations of the ACIP, without cost- sharing, to benefit the unborn child.

Section 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality**- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☐ 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.

Guidance: The State must specify the qualifications of entities that will provide coverage and the

conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

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. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

~~**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.~~

7.1.1. ☒ Quality standards
NCQA acceditation standards and Health Plan Employer Data and Information Set (HEDIS)

7.1.2. ☒ Performance measurement

7.1.2 (a) ☒ CHIPRA Quality Core Set
ALL Kids reports data on all quality core set measures.

7.1.2 (b) ☒ ~~Other~~
~~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. ☒ Information strategies
A contracted v~~V~~endor~~s are required to~~ provide~~s~~ key health indicators information from the Consumer Assessment of Health Plan Survey (CAHPS) data. The contracted claims administrator provides explanation of benefits for all services rendered to enrolled individuals which includes the individual's rights/responsibilities, and the vendor also conducts customer satisfaction surveys.

7.1.4. ☒ Quality improvement strategies
~~The p~~Performance guarantees, network requirements, and provider recoupment policie~~sy were~~ are included in the ~~RFP and are included in the~~ contract with the health plan.

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 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:
Annual review of CAHPS data
Annual review of applicable CHIPRA quality core set measures
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

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
Annual review of applicable CHIPRA quality core set measures
Annual review of CAHPS 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:
Annual review of applicable CHIPRA quality core set measures
Annual review of CAHPS data
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)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

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.~~ This includes a monthly review of the timeliness of prior authorizations and mock audits to ensure compliance with NCQA guidelines. The health plan vendor provides to the State a monthly report of these reviews. When timeliness criteria are not met these issues are addressed with the vendor. Children enrolled in a Medicaid expansion are subject to the same prior authorization policies to which children enrolled in Medicaid's other full service children's programs are subject.

Section 8. Cost-Sharing and Payment

☐ 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) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

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 by age and income (if applicable) 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) and (c), 457.515(a) and (c))

At State discretion, cost sharing (including premiums and/or copayments) may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area.

There will not be any cost sharing of any type for families who are Native Americans or Alaskan Natives. There will also not be any cost sharing of any type for families whose children are enrolled in a CHIP Medicaid expansion. 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.

Premiums will not be charged to those enrolled in the From Conception to ~~Birth~~ End of Pregnancy expansion.

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**

For those enrolled in the Conception to Birth expansion, copayments will be assessed for the services and pharmacy as indicated in the above tables. Copayment amounts will be based on family income as noted below:

0% FPL up to and including 146% FPL - No copayment requirements
From >147% FPL up to and including 156% FPL - assigned to the Low Fee copayment structure
From >156% FPL up to and including 312% FPL – assigned to the Fee Group copayment structure

At State discretion, cost sharing (including premiums and/or copayments) may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area.

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

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration without cost sharing, in accordance with the requirements of section 2103(c)(11)(A) and 2013(e)(2) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

COVID-19 Treatment:

- The state provides coverage of COVID-19-related treatments without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

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

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without cost sharing, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. This coverage includes items and services, including drugs, that were covered by the state as of March 11, 2021.

8.2.4. ☐ Other:

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ 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)(A)) (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.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

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

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

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

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

8.4.1- MHPAEA ☒ There is no separate accumulation of cumulative financial requirements, as defined in §457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits (§457.496(d)(3)(iii)).

8.4.2- MHPAEA ☒ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits (§457.496(d)(3)(ii)(A)).

8.4.3- MHPAEA ☒ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required §457.560 (§457.496(d)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the

State applies financial requirements on any mental health or substance use disorder benefits.

☒ Yes (Specify: **inpatient, outpatient, prescription drugs, emergency room) Inpatient, outpatient, prescription drugs and emergency room**

)

☐ No

Guidance: If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☒ Yes

☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation.

☒ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits (§457.496(d)(3)(i)(E)).

Guidance: Please include the state's methodology as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (§457.496(d)(3)(i)(A))

☒ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (§457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in §457.496(d)(3)(i)(B)(1)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☒ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (§457.496(d)(3)(i)(E))

☒ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§457.496(d)(3)(i)(B)(2)).

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

Superseded by ACA SPA

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide 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 that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☒ 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.

8.7.1.2. ☒ 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).

8.7.1.3. ☒ 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.

8.7.1.4 ☒ 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 Section 12 (Applicant and Enrollee Protections) ~~Attachment A~~.

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

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

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

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section

2105(c)(6)(A)) (42CFR 457.626(a)(1))

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

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

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

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

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. **Reduce the number of uninsured children**
2. **Increase access to care**
3. **Increase the use of preventative care**

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

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:**

1.1: The percentage of low-income uninsured children will be maintained at less than, or equal to 4% of all children in AL

1.2: The percentage of low-income uninsured children in Medicaid's income eligibility range will be maintained at less than or equal to 6%

1.3: CHIP Population Uninsured – the percentage of uninsured children in the ALL Kids income eligibility range will be maintained at less than, or equal to 6%

2. **Performance Goals for Objective 2**

2.1: Access to Physicians – two or more physicians within 20 miles of the place of residence for at least 95% of ALL Kids enrollees

2.2: Urban Access to Dental Care – for at least 95% of those residing in an urban area to have access to two or more dentists within ten miles of their residence

2.3: Suburban Access to Dental Care – for at least 95% of those residing in a suburban area to have access to two or more dentists within 15 miles of their residence

2.4: Rural Access to Dental Care – for at least 95% of those residing in a rural area to have access to at least one dentist within 25 miles of their residence
2.5: Children Access to Primary Care Physicians – at least 90% of children and adolescents who have had no more than one gap in enrollment will have at least one primary care physician visit annually

3. **Performance Goal for Objective 3:**
3.1: Doctor Communication on Prevention – at least 95% of total CAHPS survey respondents reported that their primary care physician usually, or always, explained their health in a way that was easy to understand
3.2: Getting Needed Care – at least 95% of total CAHPS survey respondents reported that it was usually, or always, easy to get access to care, test, or treatments within the last six months
3.3: Annual Dental Visits – at least 75% of enrollees, between the ages of two and 19 had at least one dental visit during the year

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

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

The State assures to use reliable, independent data sources to assist in conducting

an objective evaluation of all performance measures. At a minimum, evaluation will be conducted annually to determine progress in meeting objectives.

Data Sources for Performance Goals	
Performance Goals	**Data Sources**
1.1: The percentage of low-income uninsured children will be maintained at less than, or equal to 4% of all children in AL	Survey data, American Community Survey, 1-yr, estimates
1.2: The percentage of low-income uninsured children in Medicaid's income eligibility range will be maintained at less than or equal to 6%	Survey data, American Community Survey, 1-yr, estimates
1.3: CHIP Population Uninsured – the percentage of uninsured children in the ALL Kids income eligibility range will be maintained at less than, or equal to 6%	Survey data, American Community Survey, 1-yr, estimates
2.1: Access to Physicians – two or more physicians within 20 miles of the place of residence for at least 95% of ALL Kids enrollees	BCBS provider network geo-Access data
2.2: Urban Access to Dental Care – for at least 95% of those residing in an urban area to have access to two or more dentists withing ten miles of their residence	BCBS provider network geo-Access data
2.3: Suburban Access to Dental Care – for at least 95% of those residing in a suburban area to have access to two or more dentists within 15 miles of their residence	BCBS provider network geo-Access data
2.4: Rural Access to Dental Care – for at least 95% of those residing in a rural area to have access to at least one dentist within 25 miles of their residence	BCBS provider network geo-Access data
2.5: Children Access to Primary Care Physicians – at least 90% of children and adolescents who have had no more than one gap in enrollment will have at least one primary care physician visit annually	CHIP claims data from BCBS system
3.1: Doctor Communication on Prevention – at least 95% of total CAHPS survey respondents reported that their primary care physician usually, or always, explained their health in a way that was easy to understand	CAHPS survey data
3.2: Getting Needed Care – at least 95% of total CAHPS survey respondents reported that	CAHPS survey data

it was usually, or always, easy to get access to care, test, or treatments within the last six months	
3.3: Annual Dental Visits – at least 75% of enrollees, between the ages of two and 19 had at least one dental visit during the year	HEDIS quality measure calculated by BCBS

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

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

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

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

9.3.8. ☐ Performance measures for special targeted populations.

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

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

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

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

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

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

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

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

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 ensuring 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. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (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), describe how and when prior public notice was provided as required in 42 CFR 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.

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

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

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

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

CHIP Budget

STATE: AL	**FFY Budget**
Federal Fiscal Year	**2024**
State's enhanced FMAP rate	**81.18%**

STATE: AL	FFY Budget
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate	
Fee for Service	571,466,037
Total Benefit Costs	**571,466,037**
(Offsetting beneficiary cost sharing payments)	6,600,000
Net Benefit Costs	**564,866,037**
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	6,247,909
General administration	7,008,751
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	900,000
Health Services Initiatives	700,000
Other	1,107,492
Total Administration Costs	**15,964,152**
10% Administrative Cap	57,146,604
Cost of Proposed SPA Changes	
Federal Share	471,517,947
State Share	109,312,242
Total Costs of Approved CHIP Plan	**580,830,189**

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State General Fund
Tobacco Settlement

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information

will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

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

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

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

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

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

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

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

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

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

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted

individuals)

11.2.4. ☒ Section 1128A (relating to civil monetary penalties)

11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

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

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

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

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

Applicants and enrollees of Alabama's CHIP, ALL Kids, have a right to discuss and question how eligibility for enrollment is determined. 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—Informal Review, Administrative Review and Formal Review. Requests for an Administrative Review and Formal Review must be submitted in writing. All correspondence with the applicant /enrollee concerning Administrative Review or Formal Review will be in writing.

Informal Review

In many cases, problems can be handled informally without the need for an Administrative or Formal Review. The applicant can initiate an Informal Review by contacting the ALL Kids office by telephone, e-mail, or letter. This request must be made to ALL Kids within 60 days of the date of the decision with which the applicant is dissatisfied. Once the request 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 applicant will be given the opportunity to provide clarification or submit additional information. Summation of the inquiry, review, and resolution will be maintained on file and noted with the appropriate applicant information. An informal review must be conducted before a request can be made for an administrative review.

If the problem remains unresolved to the satisfaction of the applicant, he/she will be provided detailed information regarding his/her right to an Administrative Review and his/her right to continued enrollment during the review process if appropriate. Appropriate notation will be kept in the applicant's electronic file noting the initial request, any information gathered during the Informal Review, the decision reached through the Informal Review, the date of such decision, and the applicants' intent to go forward with the Administrative Review Process.

Administrative Review

A written request for Administrative Review must be received within ten days of the final decision from the Informal Review. An ALL Kids designee will assist in gathering information that may clarify the request. All information on file from the Informal Review and any information gathered by the ALL Kids designee will be circulated to a three (3) person Administrative Review Committee. This committee will be three ALL Kids staff members who were not involved in the Informal Review and/or the original determination process.

The Committee's decision and the Program Director's review of the decision must be completed within 30 days of receiving the Administrative Review Request. The 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's rights to continued review and the policy regarding a request for Formal Review by the State Health Officer or designee. If the grievance remains unresolved to the satisfaction of the applicant, then he/she may file a request for a Formal Review by the State Health Officer or designee.

Formal Review

To be considered by the State Health Officer or designee, a written request for a Formal Review must be submitted to the ALL Kids office within ten days of the final decision of the Administrative Review Committee.

The applicant will be notified in advance of the date and time that the State Health Officer or designee will be hearing information regarding their case. The applicant may appear in person or have a representative present information to the State Health Officer or designee. He/she may also submit additional information.

A decision will be issued within 30 days following the receipt of the request for Formal Review. The applicant will be notified of the decision made by the State Health Officer or designee within three working days of the decision. The decision made by the State Health Officer or designee is the final

step in the administrative proceedings and will exhaust all administrative remedies.

Expedited Review
If a delay in the review of the enrollment or eligibility matter would result in worsening health conditions of the applicant, an expedited ALL Kids review may be provided. An Expedited Review will be made within 72 hours.

Right for Continued Benefits During the Review Process
When the eligibility decision under review is regarding renewal or re-determination of coverage, and the enrollee files a request for Administrative Review, CHIP staff may continue coverage for that enrollee if requested until the review process is complete. The enrollee may be responsible for any health services costs incurred if the resulting review decision supports termination of coverage.

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 ALL Kid's as described in the ALL Kids Review Process.

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

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

The State assures that the State laws or regulations are consistent with the intent of 42 CFR 457,1130(b). This grievance process for health service matters is provided by the insurance vendor and is in compliance with state laws, the Employee Retirement Income Security Act of 1974 (ERISA), and all other applicable regulations of the Department of Labor Procedures. A copy of the Blue Cross Blue Shield of Alabama (BCBS) appeals process can be found in the ALL Kids Summary Plan Description (SPD) which is provided to all enrollees upon enrollment or available upon request. Additionally, the SPD is also on the ALL Kids website. BCBS contracts with Independent Review Organizations (IRO) to conduct external reviews. When an external review is needed BCBS gathers all information related to previous appeals and denials, including correspondence and medical records that were used to make the decision to provide to the IRO. The IRO has 45 days to make a determination and once the determination is received (via email) the decision is binding and the member is notified. If denial is upheld by the IRO, BCBS notifies the member in writing and if it is overturned BCBS notifies the member in writing and processes the claims per contract benefits. The grievance process for children enrolled in a CHIP Medicaid expansion is the same as the review process for children enrolled in other Medicaid full service children's programs.

12.3. **Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure

that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices				
CMS Regional Offices	**States**		**Associate Regional Administrator**	**Regional Office Address**
Region 1-Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2-New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3-Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4-Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5-Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6-Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7-Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8-Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9-San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103

Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
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.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
    a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
    b. performed under the general supervision or at the direction of a physician, or
    c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. IN GENERAL- Subject to paragraph (2), the term ‘targeted low-income child’ means a child--
    a. who has been determined eligible by the State for child health assistance under the State plan;
    b. (i) who is a low-income child, or
    (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
    c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. CHILDREN EXCLUDED- Such term does not include--
    a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
    b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. MEDICAID APPLICABLE INCOME LEVEL- The term ‘Medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical

assistance under Section 1902(l)(2) for the age of such child.

5. TARGETED LOW-INCOME PREGNANT WOMAN.—The term ‘targeted low-income pregnant woman’ means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. CHILD- The term ‘child’ means an individual under 19 years of age.
2. CREDITABLE HEALTH COVERAGE- The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. LOW-INCOME CHILD - The term ‘low-income child’ means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. POVERTY LINE DEFINED- The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. PREEXISTING CONDITION EXCLUSION- The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under Section 2106.
8. UNINSURED CHILD- The term ‘uninsured child’ means a child that does not have creditable health coverage.

ATTACHMENT A

GRIEVANCE POLICY

General Information

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

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

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

ALL Kids Plus Services

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

Information Review

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

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

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

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

Administrative Review

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

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

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

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

Formal Review

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

request must be submitted on the Formal Review Request Form.

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

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

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

Expedited Review

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

Right for Continued Benefits During Appeals Process

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