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

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

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

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

_____
(Signature of Agency Head)

Date: ***March 31, 2000***

Reporting Period: ***February 2, 1998 to September 30, 1999***

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Alabama's responses to template questions are bolded and italicized.

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

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

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

- ***The estimated baseline number of uninsured children in Alabama is 168,600. Of these, 64,000 were ≤ 100% Federal Poverty Level (FPL), 48,900 were between 101- and 200% FPL and 55,600 were >200% FPL. This is the same estimate reported in the 1998 Annual Report.***

Confidence intervals by income:

Income	*Est. # Uninsured Children*	*90% Confidence*	*Interval*
≤100% FPL	*64,000*	*36,998*	*92,339*
101-200% FPL	*48,900*	*26,405*	*70,511*
>200% FPL	*55,600*	*27,481*	*83,536*
Totals	*168,500*	*90,884*	*246,386*

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

- ***This estimate is based on data from the Southern Institute on Children and Families publication entitled "Uninsured Children in the South, Second Report, November 1996", which is based on the 1994 Census Bureau's Current Population Survey (CPS), reflecting 1993 data. This is the same report we used in our original plan and in our 1998 Annual Report***

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

- ***While acknowledging the many problems with the CPS as a survey for health insurance coverage and the age of the data, it is nevertheless, the best data available and a reasonable estimate for planning purposes.***

- ***See section 1.1 for confidence intervals.***

- ***The Behavioral Risk Factor Surveillance System (BRFSS) is a data source, which will be evaluated for use as an additional tool for estimating the number of uninsured children in Alabama. BRFSS is a telephone survey, which collects information from adults, aged 18 and over on preventive practices related to health indicators. The BRFSS is conducted in all 50 states, the District of Columbia, and three territories, through funds disbursed by CDC. This survey tool can be used to address issues specific to a state through state-added questions. In Alabama, about 180 surveys are completed each month for an annual total of 2200 completed surveys. The survey is conducted through a private contractor at the Survey Research Unit at the University of Alabama at Birmingham. The surveys are collected by a computer-assisted telephone interviewing (CATI) system. The sampling method for the survey is disproportionate stratified random sampling. In this method, telephone numbers are categorized as having a low or high probability of being a residential number. Numbers in the stratum with a high probability are sampled more than the numbers in the low stratum. Several questions pertaining to health insurance coverage for children living in the household have been added to Alabama's BRFSS. The first survey containing these questions was conducted between January 1999 and December 1999. The data obtained from these questions will be analyzed and their usefulness as a tool for estimating the number of uninsured Alabama children will be evaluated.***

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

- ***The CHIP Phase I Medicaid Expansion began February 2, 1998. As of September 30, 1999, an estimated 16,696 children had been enrolled in CHIP Phase I.***
- ***CHIP Phase II, ALL Kids, began October 1, 1998. As of September 30, 1999, 26,213 children had been enrolled in ALL Kids.***
- ***Due to the "woodwork effect" from the Chip outreach it is estimated that an additional 30,000 children have been added to the SOBRA Medicaid program.***
- ***This reflects an estimated additional 72,909 children who have been insured since the initiation of CHIP.***

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

- ***The total number of children enrolled in CHIP Phase I and the number of additional children enrolled in SOBRA Medicaid are obtained from monthly enrollment reports and estimates provided by the AMA. These estimates are based on current and historic Medicaid enrollment.***
- ***The total number of children enrolled in ALL Kids is obtained from the weekly and monthly enrollment reports provided to the CHIP staff by The State Employees Insurance Board (SEIB). SEIB is the entity that is under contract with ADPH to manage the ALL Kids enrollment. Monthly enrollment reports are also provided by Blue Cross Blue Shield (BCBS), the major insurance vendor, and are used to periodically validate enrollment counts.***

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

- ***Since Phase I enrollment data are based on both actual monthly enrollment counts and on estimates, there is a small amount of unreliability in the exactness of these numbers but they reflect a very reasonable estimate.***
- ***Since the ALL Kids data stated above are based on actual enrollment numbers they are very reliable. The major sources of enrollment data have been compared and the numbers are extremely compatible.***

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

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title

XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

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

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

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

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

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Objective 1 ***Low-income children who were previously without health insurance coverage will have health insurance coverage through Alabama's Title XXI Program.***	***By October 1, 1999, 17,000 previously uninsured low-income children will have or have had health insurance coverage through Phase I CHIP – Medicaid Expansion.***	Data Sources: ***AMA enrollment data*** Methodology: • ***Medicaid enrollment records were examined to provide an estimate of the unduplicated number of children ever enrolled in Phase I since the beginning of the CHIP program. This number was compared to the target enrollment stated in the performance goal.*** Numerator: • ***The estimated unduplicated number of Phase I enrollees is 16,696.*** Denominator: • ***The target number of Phase I enrollees is 17,000, as stated in the performance goal. This projection, provided by AMA was based on previous Medicaid enrollment.*** Progress Summary: • ***As of September 30, 1999 Medicaid estimates there have been 16,696 children enrolled in CHIP phase I.*** • ***This number indicates 98 % of Goal achieved.***

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(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO CHIP ENROLLMENT		
Objective 2 ***Previously uninsured children who may potentially be eligible for Alabama's Title XXI Program will be identified through ongoing outreach activities***	***By February 1, 1999, mechanisms to conduct ongoing outreach will have been developed and implemented in the three broad areas (1) an increase in the number of eligibility workers so that at least 14,000 previously uninsured children will be identified as potential Title XXI eligibles in Phase I. (2) update/expansion of existing outreach activities;(3) activities to identify, enroll, and serve Alabama's growing qualified Hispanic population***	***Performance Goal 1:*** Data Sources: ***AMA personnel/employment records, AMA enrollment records*** Methodology: • ***Assessment will be made of the number of Medicaid eligibility workers employed prior to Phase I implementation and after Phase I implementation. Phase I enrollment data will be reviewed to determine the adequacy of staffing.*** Numerator ***1:*** • ***Number of Medicaid eligibility workers added for implementation of Phase I*** Denominator***:*** • ***Estimated number of Medicaid eligibly workers required to meet enrollment goal of 14,000*** Progress Summary: • ***Prior to the implementation of CHIP Phase I, Medicaid expansion, Medicaid SOBRA had nine existing vacancies of SOBRA outstationed eligibility workers. With the anticipated implementation of Phase I, the AMA requested approval to replace the nine vacancies and to hire an additional 23 workers. The AMA was granted approval to hire 23 total workers. Nine of***

		those were placed in the already vacant positions. The remaining 14 were new positions. This brought the total Medicaid eligibility workers to 119. These workers were hired and trained between January 1998 and March 1998. Location of the new workers was based on a chart of anticipated Medicaid eligibles. The AMA coordinated with ADPH on the placement of these outstationed workers. Space to house the workers was donated by county ADPH offices and computers were purchased and installed in the new sites by ADPH. • ***In attachment 1, we have provided dates of training for the AMA employees and agency policies that have been put into place in the AMA for CHIP Phase I.*** ***Performance Goal 2:*** Data Sources: • ***AMA files and ADPH files which reflect CHIP outreach activities*** Methodology***:*** • ***AMA and ADPH files will be reviewed to evaluate the increase in outreach activities.*** Numerator***: NA*** Denominator: NA Progress Summary: • ***To publicize Phase I of the CHIP Program, The AMA organized news releases, sent out provider and recipient letters, provided provider training, included information in employee newsletters and distributed pamphlets and posters.*** • ***Attachment 1contains provider letters, employee newsletters,***

		recipient letters, pamphlets, posters, and news releases that the AMA sent out to publicize Phase I of CHIP. Specific mail outs were targeted to Medicaid-eligibles, including a brochure that accompanies the annual notice sent to families coming up for recertification. The Posters, brochures, and other materials were widely distributed to schools, other health and human service agencies, medical providers and their respective association and community-based advocacy organizations. A specific simplified SOBRA application was developed to enable families already in the AMA data system to add a CHIP-eligible teen without having to submit a new application. A toll-free hotline to answer calls and direct potential eligibles to outstationed eligibility workers was well publicized. Staff was added to man the toll-free telephone hotline. The AMA closely coordinated with provider organizations including the Alabama Hospital Association and the Alabama Chapter of the American Academy of Pediatrics, to offer brochures and other information when potential eligibles came for care. • ***To announce the start of enrollment for the ALL Kids Program, Phase II of Alabama's Children's Health Insurance Program, approximately 300 persons attended a kickoff rally news conference held in August 1998 in Montgomery on the state capital steps. The news conference was timed to coincide with the start of the school year. A special feature of the news conference was its live satellite uplinking to sites in six Alabama cities. State Health Officer Dr. Donald Williamson, Alabama's governor, lieutenant governor, legislative leaders and CHIP Commission members, summarizing the value of this achievement, made addresses. Then after 15 minutes the satellite broadcast was terminated. The program then cut to six Alabama cities where local leaders spoke about the meaning of the program in their own communities. This provided an opportunity for them to***

		answer questions from the news media and discuss the potential impact to their community, where application were available locally. Media in the State Capitol also had an opportunity to pose questions to the state's top leaders. News coverage of this event was especially widespread, in part because of the simultaneous news conferences. A taped satellite feed was also made available to all of the state's television stations (see attachment 2). • ***Regular press releases and updates on enrollment in the program received widespread distribution throughout the state. These resulted in large amounts of radio and television news coverage of the program. In addition, there were numerous radio and television interviews, including four on National Public Radio.*** • *CHIP information was added to both ADPH and AMA's web sites (see attachment 2).* • ***Staff from ADPH has made numerous presentations to interested parties throughout the state.*** • ***ADPH provided presentation materials to numerous others to make CHIP presentations.*** • ***A mail out consisting of 850,000 applications and brochures was sent to all Alabama public school systems. The school systems were asked to send these home with the students. Attachment 2 includes copies of letters sent to school superintendents, principals and counselors from the Department of Education's State Superintendent's office.*** • ***The ADPH and the AMA agreed on procedural operations, which enhanced outreach and enrollment. These operations included having a joint application (see attachment 2), which serves as the***

		enrollment application for SOBRA Medicaid and ALL Kids. Procedures for processing mail-in applications for both programs were established. Routine referral mechanisms for transferring applications between the two agencies were also established. The eligibility unit within the AMA also trained ALL Kids enrollment workers in how to screen for Medicaid eligibility and assisted in processing complex applications. • ***Additionally, the ADPH designed, printed, and distributed All Kids application packets, brochures (distributed with brochure holders), and posters (see attachment 2). These publications were revised at least twice to make them more user friendly. The ADPH produced several Power Point presentations that were shared with other state agencies and local ADPH staff. Below is a list of outreach activities, which were conducted by ADPH staff.*** • ***ADPH distributed ALL Kids application packets through all public school systems in Alabama (approximately 850,000 packets were distributed) at the beginning of the 1998-99 school year.*** • ***Statewide outreach was conducted through many partners such as The Department of Education, Department of Human Resources, Alabama Hospital Association, Medical Association of the State of Alabama, Alabama Pharmacy Association, Alabama Chapter of the American Academy of Pediatrics, Alabama Family Practice Physicians Association, Alabama Primary Care Association, Alabama Arise, Family Voices and Voices of Alabama Children.*** • ***Numerous articles were published in newspapers and professional publications (see attachment 2).*** • ***Numerous presentations were made to the target population and to health and social service organizations, which have contact***

		with the target population. • ***Outreach was conducted to lawyers through an article in the monthly Alabama Bar Association newsletter (see attachment 2).*** • ***Weekly statistics were maintained for Phase I and ALL Kids to monitor progress.*** • ***Procedures to monitor enrollment, complaint resolution, provider accessibility and telephone hot-line accessibility have been developed.*** • ***An orientation packet was developed for new CHIP Commission members.*** • ***ADPH submitted and received approval of 2 HCFA special outreach projects (HCFA Television Public Service Announcement Pilots and Fall Outreach Campaign).*** • ***AMA and ADPH assisted in the development and implementation of the RWJF Covering Kids grant program.*** • ***In August 1998 ADPH held 2 live satellite conferences, which were widely publicized statewide, to introduce phase I and ALL Kids, explain application procedures and answer questions.*** • ***In August 1999 ADPH held 2 live satellite conferences, titled "Children's Health Insurance Program, One Year Later" to update on CHIP activities, explain revised application and ALL Kids reenrollment procedures and answer questions (see attachment 2).*** • ***20 minute instructional videos were produced by ADPH for***

		pediatricians, family practice physicians, emergency room physicians, dentists and pharmacists. Each discipline's tape had an introduction by a leader within that discipline explaining the importance of CHIP and ALL Kids. The videos were distributed through professional association's annual meetings, mail-outs, etc. • ***ALL Kids staff participated in regional provider meetings with Medicaid to update them about ALL Kids services and date.*** • ***ADPH staff attended various professional association annual meetings to explain the ALL Kids program.*** • ***ADPH staff attended regional Hospital Association meetings and gave ALL Kids presentations. Hospital Administrators attended these meetings from each of these regions.*** ***Performance Goal 3:*** Data Sources: • ***AMA files and ADPH files which reflect CHIP outreach activities to Alabama's Hispanic population*** Methodology: • ***AMA and ADPH files will be reviewed to evaluate the increase in outreach activities for Alabama's Hispanic Population.*** ***Numerator Performance Goal 3: NA*** ***Denominator Performance Goal 3: NA*** Progress Summary***:*** • ***The joint application form and ALL Kids brochure were translated into Spanish (see attachment 2). Additionally, a***

		Spanish-speaking enrollment worker was employed in the ALL Kids enrollment office.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Objective 3 ***Children enrolled in Alabama's Title XXI Program will have a usual source of health care.***	***By February 1, 1999, 100% of those children enrolled in Alabama's Title XXI Program (except those exempted from participation in managed care such as children in foster care) will have a medical home as evidenced by documented assignment of a provider for Phase I enrollees or a usual source of care for each child enrolled in ALL Kids.***	***Phase I –Medicaid Expansion*** Data Sources: • ***AMA enrollment records*** Methodology: • ***AMA enrollment records will be examined to determine CHIP Phase I enrollment and also to determine which of these children are currently exempted.*** Numerator: • ***Number of Phase I currently with a medical home*** Denominator: • ***Number of Phase I children minus those currently exempted*** Progress Summary: • ***Since Phase I is a Medicaid expansion those children are enrolled in Medicaid's managed care program, Patient 1st, a primary care case management (PCCM) system and are assigned to a gatekeeper physician. Medicaid enrollment records indicate that all children, except those appropriately exempted have been assigned to a gatekeeper physician.*** ***Phase II – ALL Kids***

		Date Sources***:*** • ***Enrollment records obtained from SEIB's ALL Kids enrollment office, BCBS claims data, Prime Health enrollment files Intracorp data systems, University of Alabama at Birmingham, School of Public Health (UAB) Access to Care Survey*** Methodology: • ***ALL Kids enrollment reports will be used to determine ALL Kids enrollment.*** • ***BCBS claims data will be examined to determine the number of children who have had both a well doctor visit and a preventive dental visit, thus establishing a medical home.*** • ***Intracorp's data systems will be examined to determine how many children had check up visits scheduled following outbound calls.*** • ***UAB's access to care survey contains questions concerning usual source of care, both before and after ALL Kids. This information will be used to assess usual sources of care for ALL Kids enrollees.*** Numerator: • ***Number of ALL Kids enrollees who have a usual source of care*** Denominator: • ***Number of ALL Kids enrollees*** Progress Summary:

		• ***ALL Kids enrollees enrolled with Prime Health (less than 1% of the ALL Kids population) are assigned to a gatekeeper physician.*** • ***ALL Kids enrollees enrolled with BCBS are not assigned to a gatekeeper physician. ALL Kids strongly recommends that every enrolled child receives a well doctor check up and a preventive dental check up as soon as possible after enrollment. All children enrolled in ALL Kids are mailed a post card reminding their parent of the importance of these preventive visits along with encouragement to schedule the appropriate appointments. If the child has not had both visits within the first 120 days of enrollment their name and identifying information is forwarded to Intracorp for follow up. Intracorp is a medical management company which has been contracted by Blue Cross Blue Shield to place out bound calls as a means of follow up for children who have not received both a well doctor and a preventive dental visit. Since ALL Kids began October 1, 1999 and no children had been enrolled 120 days until February 1, 2000, we only had seven months of outbound calls during this reporting period. We are in the process of analyzing the effectiveness of this system. Intracorp estimates that 25% of the parents who receive these follow-up calls schedule the needed check-up visits. We are currently working with Intracorp on a system to prioritize names for follow-up phone calls.*** • ***BCBS estimates that 20% of ALL Kids enrollees had a well doctor visit within the first 90 days of enrollment, 13% had a preventive dental visit and 6% had both.*** • ***The UAB Access to Care Survey was a retrospective survey of first year ALL Kid enrollees (see attachment 3). This survey***

		was mailed to a random sample (6,200) of the households of the 25,748 children that enrolled in ALL Kids from October 1, 1998 to September 30, 1999. The primary purpose of this first year survey was to determine the difference in access to care before the child was enrolled in ALL Kids and after the child enrolled in ALL Kids. Of the 6,200 surveys mailed, 85 were returned with undeliverable addresses. At this time, approximately 3,538 (58%) have returned the survey. • ***The UAB Access to Care Survey results indicates that the number of children who have a usual source of care increased after enrollment in ALL Kids. Before ALL Kids, 32% of children did not have a personal doctor or group of doctors they saw when sick. After enrolling in ALL Kids, only 9% did not have a personal doctor. When asked if the children had a usual source of care for vaccinations or routine care, 32% did not have a usual source for routine care before ALL Kids as opposed to 8% after enrolling in ALL Kids. Nineteen percent of respondents said it was a big problem to get a personal doctor before enrolling in ALL Kids. After enrolling in ALL Kids only .7% said it was a big problem. Sixteen percent said they did not get a personal doctor for their child before ALL Kids; only 5% did not get a personal doctor or nurse after they enrolled in ALL Kids.***

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(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Objective 4 ***Alabama's title XXI Program will improve the health status of children enrolled in the program as well as improve the overall health care system accessed through the program.***	***By February 1, 1999, the following health status and health care system measures for Alabama's Title XXI Program will show acceptable incremental improvements for at least the following data elements: immunization status, adolescent well visits, satisfaction with care***	***Immunization status:*** Data Sources: • ***Pediatric Health History (completed at time of application), ALL Kids enrollment data base, The ADPH Immunization Registry, Immunization data provided by the Department of Public Health Immunization Unit, data provided by Intracorp (a company under contract to provide follow-up on ALL Kids' enrollees who have not received both a well doctor and a preventive dental visit within the first 120 days of enrollment). Claims data to be provided by Health Care Integrated Analysis (HCIA), which is to include BCBS, Prime Health and Medicaid, claims data.*** Methodology: • ***Two random samples, one of 13 month old and one of 24-month-old children will be drawn from the ALL Kids enrollment database. These samples will be matched against the Immunization registry (maintained by The Department of Public Health) to determine immunization status of these children. These data will be used to establish a baseline for comparison of future year's data on this population (see attachment 4).*** • ***Intracorp places outbound calls to care givers of children who have not had a well doctor and a preventive dental visit within the first 120 days of enrollment (see attachment 5). When the parent is reached, a series of questions is asked,***

		including immunization status of the child. These data will be used as immunization status comparisons to the general population and to the ALL Kids population. • ***Data are now being collected as part of the Pediatric Health History. For future reporting periods, these data will be available for comparison.*** Numerator***:*** • ***Number of 13 and 24 month old ALL Kids enrollees who are "up-to-date" on immunizations*** ***Denominator:*** • ***Number of 13 and 24 month old All Kids enrollees*** Progress Summary: • ***ALL Kids CHIP children born in 1998 that are at least 13 months old had an up to date (UTD) percentage of 39%. Of the 50 children randomly selected of the 137 provided, 19 were UTD, 30 were not UTD, and one child was not found in any of our three immunization databases (SIIS, PHALCON, or ALACLAS). This compares to a maximum UTD percentage for Alabama of 45% (the MMR percentage) per the most recent National Immunization Survey (NIS) (Enclosure 2). The MMR vaccine normally given after one year of age appears to be the biggest problem with the low numbers.*** • ***ALL Kids CHIP children born in 1997 that are at least 24 months old had a completion rate of 71%. Of the 50 children randomly selected from the 221 provided, 34 were complete, 14 were not complete, and two were not found. This compares with a completion rate of 76% for Alabama from***

		the same NIS. • ***These results are not completely comparable because the ALL Kids data is current as of last month but the NIS was done between July 1998 and June 1999. Nevertheless, this data will assist us in establishing a baseline for future comparisons.*** • ***The complete and up to date percentages appear low. There are at least two reasons for this. Whereas we were able to find almost all of the children, we have no assurance that we have all of the shots for each child. For example, since our systems do not yet include Medicaid billing data, we know we are missing some shots that we will get from that source when we get that data. Secondly, the first MMR shot is given by the county health departments at 12 months of age but most private physicians wait until the child is 15 months old. The younger group especially was missing a lot of the MMRs.*** • ***The over arching goal of the Childhood Immunization Initiative is to have all children up to date on immunizations by two years of age. For future studies we may choose to drop the 13-month-old group.*** ***Adolescent well visits:*** Data Sources: • ***Claims data obtained from (HCIA), Three surveys, designed, distributed and analyzed by The University of Alabama at Birmingham, School of Public Health (UAB)*** Methodology: • ***Claims data obtained from HCIA will be used to establish a***

		baseline number of adolescent well visits. Additional years data will be compared to this baseline. • ***UAB's Access to Care Survey contains questions concerning well doctor visits, both before and after ALL Kids. This information will be used to assess the rate of adolescent well visits before and after ALL Kids coverage (see attachment 3)*** ***Numerator Adolescent well visits:*** • ***Number of ALL Kids enrollees from 13 to 18 years of age who have had a well doctor visit in the past 12 months*** ***Denominator Adolescent well visits:*** • ***Number of ALL Kids enrollees from 13 to 18 years of age*** Progress Summary: • ***HCIA data was not available during this reporting period. When this data becomes available it will be analyzed and used to establish a baseline for adolescent well visits. This baseline will be used as a comparison for future data.*** • ***UAB's retrospective random sample survey indicates that the adolescents (13-18 years of age) that were enrolled in ALL Kids between October 1, 1998 and September 30, 1999 received more adequate well visit care after enrolling in ALL Kids. Before enrolling in ALL Kids, only 30% of adolescents received routine preventive care as soon as the parent wanted. However, that number increased to 82% after enrolling in ALL Kids. Before enrolling in ALL Kids, 40% of adolescents did not have a primary health care provider. After enrolling in ALL Kids, only 18% of adolescents did not have a primary health care provider.***

		Satisfaction with Care: Data Sources: • ***UAB surveys*** Methodology: • ***Data obtained through the UAB Access to Care Survey will be used to evaluate the ALL Kids enrollee's satisfaction with care since enrolling in the ALL Kids program.*** Numerator***: NA*** Denominator***: NA*** ***Progress Summary:*** • ***To date, 58% of the UAB Access to care Surveys have been returned. This is a higher percentage than would be expected with this type survey. This large return rate indicates satisfaction with the ALL Kids program (see attachment 3)***. • ***As part of UAB's Access to Care Survey, respondents were given the opportunity to voice their concerns or express their thoughts on the ALL Kids program. Forty-five percent of those returning surveys made a comment. Of those that responded, almost 16% expressed a sense of relief or security since their child has been enrolled in ALL Kids. Almost 40% expressed praise or thanks for the program. Eleven percent thought their child received better care since being enrolled in ALL Kids. Six percent had questions about ALL Kids coverage. Few expressed complaints about the coverage or***

		the program in general. Overall, ALL Kids received overwhelming positive responses from those surveyed.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Objective 5 ***The infrastructure of the Alabama Department of Public Health (ADPH) and the Alabama Medicaid Agency will be able to accommodate all critical facets of Phase I of Alabama's Title XXI Program. (Phase I is defined as expanding Medicaid Program eligibility to uninsured children who are less than 19 years of age, born on or before September 30, 1983, and who have incomes equal to or less than 100% of the FPL.)***	***By February 1, 1998, the capacity within the Alabama Medicaid Agency, in the following critical areas, will be appropriately expanded to meet the target of enrolling approximately 12,000 children in Year I of Alabama's title XXI Program: (1) data systems with regard to eligibility determination, enrollment, participant information, health service utilization, billing, health status, provider information, etc.: (2) personnel (eligibility workers, administrative staff, and support staff), (3) staff training, (4) publications/documents including program manuals, literature for program personnel, consumers and providers, etc.***	***Performance goal 1:*** Data Sources: • ***Data systems of the AMA*** Methodology: • ***Data systems records of the AMA will be examined to assess completion of appropriate system changes to accommodate the data needs of the Phase I CHIP program*** Numerator: ***NA*** Denominator: ***NA*** Progress Summary: • ***AMA has worked with its fiscal agent and made appropriate system changes through a contract amendment. Additionally, AMA's information system personnel have modified data systems in place in relation to enrollment and participant information.***

		Performance goal 2: Data Sources: • ***Personnel/employment records of the AMA*** Methodology: • ***Personnel/employment records of the AMA will be examined to evaluate the adequacy of staffing to accommodate the target Phase I enrollment*** Numerator: ***NA*** Denominator: ***NA*** Progress Summary: • ***Staff has been added to The AMA (see attachment 1). Prior to the implementation of CHIP Phase I, Medicaid expansion, Medicaid SOBRA had nine existing vacancies of SOBRA outstationed eligibility workers. With the anticipated implementation of Phase I, the AMA requested approval to replace the nine vacancies and to hire an additional 23 workers. The AMA was granted approval to hire 23 total workers. Nine of those were placed in the already vacant positions. The remaining 14 were new positions. These workers were hired and trained between January 1998 and March 1998. Location of the new workers was based on a chart of anticipated Medicaid eligibles. The AMA coordinated with ADPH on the placement of these outstationed workers. Space to house the workers was donated by county ADPH offices and computers were purchased and installed in the new sites by ADPH.***

		Performance goal 3: Data Sources: • ***Staff training records of the AMA*** Methodology: • ***Examine staff training records of the AMA to assess the adequacy of staff training to accommodate the target Phase I enrollment*** Numerator: ***NA*** Denominator: ***NA*** Progress Summary: • ***Training was provided for AMA outstationed eligibility workers. Agency policies have been put into place in AMA for CHIP Phase I (see attachment 1).*** ***Performance goal 4:*** Data Sources: • ***Alabama Medicaid printed materials*** Methodology: • ***The printed materials produced by AMA will be examined to assess that literature in relation to CHIP Phase I has been produced.*** Numerator: ***NA*** Denominator: ***NA***

		Progress Summary: ***To publicize Phase I of the CHIP Program, The AMA organized news releases, sent out provider and recipient letters, provided provider training, included information in employee newsletters and distributed pamphlets and posters(see attachment 1).***

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OTHER OBJECTIVES		
Objective 6 ***Health care coverage will be expanded as quickly as possible to children between 100% and 200% of the federal poverty level.***	***1. By May 1998, a plan to expand health care coverage to children between 100 and 200% of the federal poverty level will have been submitted to HCFA.*** ***2. By August 1, 1998, health care coverage will be expanded to offer coverage for children between 100 and 200% of the federal poverty level in at least 1/3 of the counties in the state.*** ***3. By April 1, 1999, a plan to insure access to specific services for children with special health care needs will have been developed. One reason the HMO with the largest commercial enrollment in the state was selected as the benchmark coverage is the numerous aspects within the package which will be advantageous to children with special health care needs such as rehabilitation services, home health services, durable medical***	***Performance Goal 1:*** Data Sources: • ***Alabama's CHIP Plan amendment submit to HCFA May 21, 1998, approved August 18, 1998*** Numerator: ***NA*** Denominator: ***NA*** Methodology: • ***Alabama's CHIP Plan Amendment will be examined to verify that coverage has been expanded to children between 100 and 200% FPL.*** Progress Summary: • ***This goal has been achieved. A plan to expand coverage to children between 100 and 200% FPL was submitted to HCFA on May 21, 1998 and approved August 18, 1998.***

	health services, durable medical equipment, skilled nursing care services and others. The Department has already begun working with other State agencies and members of the CHIP Advisory Council to identify funds and services that could be included in a wrap around (plus) package for children with special health care needs. The Department anticipates a future plan amendment to add this feature. ***(4) By October 1, 1999, 20,000 previously uninsured low-income children will have or have had health insurance coverage through ALL Kids.***	***Performance Goal 2:*** Data Sources: • ***Alabama's CHIP Plan amendment submitted to HCFA May 21, 1998, approved August 18, 1998*** Numerator: ***NA*** Denominator: ***NA*** Methodology: • ***Alabama's CHIP Plan Amendment will be examined to verify that coverage has been expanded to children between 100 and 200% FPL in at least 1/3 of Alabama counties.*** Progress Summary: • ***This goal was achieved August 18, 1998 upon approval by HCFA of the plan amendment. Outreach and enrollment processes were in place beginning in August 1998. This coverage began and is ongoing in 100% of counties in Alabama.*** ***Performance Goal 3:*** Data Sources: • ***CHIP Plan Amendment II, submitted to HCFA July 1, 1999, approved September 24, 1999*** Numerator: ***NA*** Denominator: ***NA***

		Methodology: • ***Alabama's CHIP Plan Amendment II will be examined to verify that a plan to insure access to specific services for children with special health care needs has been developed.*** Progress Summary: • ***This goal was achieved when CHIP Plan Amendment II was submitted to HCFA on July 1, 1999. This last amendment was approved by HCFA September 24, 1999. All Kids Plus expenses will be paid as of October 1, 1999.*** ***Performance Goal 4:*** Data Sources: • ***Enrollment records obtained from SEIB's ALL Kids enrollment office*** Numerator***:*** • ***ALL Kids target enrollment by October 1, 1999 (20,000)*** Denominator***:*** • ***Number of children ever enrolled in ALL Kids during FY99 (26,213)*** Methodology: • ***Enrollment reports provided by SEIBs ALL Kids enrollment office will be examined to determine the unduplicated number of children ever enrolled in ALL Kids.*** Progress Summary: • ***This goal was achieved. There were 26,213 children enrolled in the ALL Kids program during FY99.***

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OTHER OBJECTIVES		
Objective 7 ***ALL Kids enrollees who have special conditions/needs will have sources for coordinated services to meet those conditions/needs.***	***1. By September 30, 2000, 100% of children currently receiving ALL Kids Plus services will have one designated case manager.*** ***2. During FY 2000, fifty percent of children identified with special health care conditions/need will receive ALL Kids Plus services to meet those needs.***	• ***Activities related to this objective did not take place during this reporting period. Progress made toward these performance goals will be reported in future evaluations.***

SECTION 2. BACKGROUND

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

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

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

✓ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: ***CHIP Phase I – Medicaid Expansion***

Date enrollment began (i.e., when children first became eligible to receive services***):*** ***February 2, 1998***

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

Name of program: ***CHIP Phase II - ALL Kids***

Date enrollment began (i.e., when children first became eligible to receive services): ***October 1, 1998***

____ Other - Family Coverage

Name of program: _____

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

____ Other - Employer-sponsored Insurance Coverage

Name of program: _____

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

____ Other - Wraparound Benefit Package

Name of program: _____

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

____ Other (specify) _____

Name of program: _____

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

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

N/A

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

N/A

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

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

- ***There were two pre-existing programs which influenced the development of Alabama's CHIP, AMA and the Blue Cross Blue Shield Alabama Child Caring Foundation (ACCF). These two programs are still in existence and work cooperatively with CHIP so that both programs complement each other. The paragraphs below briefly explain the influence that AMA and ACCF had on the development of CHIP.***

Influence on Phase I

- ***The AMA's program that primarily influenced CHIP was the SOBRA Medicaid Program. This program covered children birth to age 6 years with incomes ≤ 133% FPL and children ages 6 -14 years with incomes ≤ 100% FPL. At the time the CHIP legislation passed, there***

was no SOBRA coverage for children over 14 years of age (except for pregnant females). Because the federal legislation at that time mandated that a state have an approved CHIP plan by 9/30/98 or risk losing a significant part of its CHIP allocation, expediency was a major consideration. In designing CHIP, issues of benefits, outreach, enrollment, data, and financial operations were considered.

- ***CHIP Phase I was designed to extend Medicaid coverage for children ≤ 100% FPL up to 19 years of age. It was believed by Alabama's CHIP Commission members as well as staffs of the AMA, ADPH, and advocacy groups that this was the best way in which to begin offering a suitable benefit package to a large number of uninsured children with the least amount of "re-tooling" or "program construction." Another major consideration, which influenced the decision to use a Medicaid expansion to cover these children, was the fact that they will eventually be covered by Medicaid using Title XIX funds.***

Influence on Phase II

- ***The CHIP Commission considered a number of other issues regarding Medicaid in authorizing the development of CHIP Phase II. These issues included provider availability, ability to serve state employees, benefits (particularly for children with special health care needs), stigma of government programs, entitlement concerns, and financial considerations. While there were both positives and negatives to many of these points, the CHIP Commission made the decision to design CHIP Phase II as a private insurance program rather than an additional Medicaid expansion, particularly due to statewide adequacy of the provider network.***

- ***During the time period in which the two phases of CHIP were developed, there was ongoing communication between ADPH CHIP staff and the executive director of the Alabama Child Caring Foundation (ACCF). ACCF is a program developed by Blue Cross Blue Shield of Alabama 13 years ago to serve children birth through 18 years who were not eligible for coverage by Medicaid. ACCF provides ambulatory health insurance (no coverage for hospitals, pharmacies, or dentists) for children whose parents cannot afford health insurance for them, who are not eligible for Medicaid and who have no other health insurance. ACCF serves about 6,000 children per year and has provided insurance to approximately 30,000 children since the program began. ACCF had a long waiting list for enrollment. Prior to CHIP, ACCF and Medicaid were the only two health insurance programs for low-income children in Alabama. Building***

on the experiences of ACCF and Medicaid, the following decisions were made regarding CHIP Phase II (ALL Kids):

- ***Create a statewide program***
- ***Use recognized, private, insurance vendors***
- ***Use private insurance preferred provider rates***
- ***Provide 12 month continuous eligibility***
- ***Keep verification requirements to a minimum***

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

___✓___ No pre-existing programs were "State-only"

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

- ***While it is not a state governmental program, ACCF (described above) was and is a non-Medicaid health insurance program for children. ACCF had been serving the children who then became eligible for the ALL Kids Program. CHIP and ACCF have worked closely to ensure that children can make a seamless transition from one program to the other. As children enrolled in ACCF come up for their annual renewal, ACCF screens them for ALL Kids (and Medicaid) eligibility, if they appear to be eligible for either of the programs they are encouraged to apply. With the creation of ALL Kids, ACCF has adjusted its criteria to provide limited benefits to children who are not eligible for Medicaid and ALL Kids. ACCF continues to maintain an enrollment of about 6,000 per year.***

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

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

✓ Changes to the Medicaid program

- ***Prior to Title XXI implementation, the State of Alabama had already made many provisions, which affected the provision of accessible, affordable, quality health insurance and healthcare for children. AMA had already implemented a shortened application, mail in applications, elimination of a face to face interview, elimination of an assets test, Outstationed Medicaid eligibility workers with the capability to input on-line applications and complete eligibility determinations and certifications on-site, and a newborn screening form. Since Title XXI AMA has also adopted 12 months continuous eligibility for children under 21.***

____ Presumptive eligibility for children
____ Coverage of Supplemental Security Income (SSI) children
✓ Provision of continuous coverage (specify number of months ***12***)____
____ Elimination of assets tests
____ Elimination of face-to-face eligibility interviews
____ Easing of documentation requirements

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

- ***While welfare reform has caused a significant decrease in the TANF population in Alabama, the number of children on Medicaid has increased. Many families have opted to apply for Medicaid at Department of Human Resources offices through the use of our joint application for TANF and Medicaid. There are boxes on the application, which allow a family to apply for TANF alone, Medicaid alone, or both programs. They can also apply for food stamps with the same application. Other families prefer to apply through our Outstationed Medicaid eligibility workers based at Health departments, hospitals, FQHC's and clinics. The Medicaid and TANF programs have been totally de-linked, and families can apply for Medicaid through a shortened mail-in application, whereas if a family applies for TANF, they must comply with child support enforcement activities, job search activities, a face-to-face interview, and a lengthier application process in general. Many families in Alabama choose to use the shortened Medicaid application process.***

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

____ Health insurance premium rate increases
✓ Legal or regulatory changes related to insurance

- ***There were several federal legislative changes being considered and enacted during the planning stages of CHIP ("Mental Health Parity Act", "Newborn and Mothers Health Protection Act" and "Health Insurance Portability & Accountability Act"). While none of these regulations had a direct effect on the design of the CHIP plan, there were probably some indirect effects.***

_____ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)

_____ Changes in employee cost-sharing for insurance

_____ Availability of subsidies for adult coverage

_____ Other (specify) _____

✓ Changes in the delivery system

✓ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)

- ***Although there has been a very low HMO penetration in the state of Alabama, PPO systems are becoming the norm. Due to this fact, the ALL Kids program was designed using the BCBS and PH PPO networks.***

✓ Changes in hospital marketplace (e.g., closure, conversion, merger)

- ***In the decade prior to the CHIP legislation there had been major changes in the hospital marketplace. These changes had been brought about by changes in reimbursement practices of Medicare, Medicaid and the private insurance market. These changes brought about a large number of hospital closures in the late1980's and early 1990's. The rate of hospital closures had slowed during the years of CHIP program planning but many hospitals continued to collect insufficient revenues to cover operating expenses. This trend is continuing and may lead to additional hospital closings in the near future. While these factors had no direct effect on the design of the CHIP plan, there were probably some indirect effects.***

_____ Other (specify)

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

____ Changes in the demographic or socioeconomic context

_____ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _____

_____ Changes in economic circumstances, such as unemployment rate (specify) _____

_____ Other (specify) _____
_____ Other (specify) _____

SECTION 3. PROGRAM DESIGN

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

3.1 Who is eligible?

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

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program***
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	***Statewide***	***Statewide***	
Age	***Under 19 years of age, born on or before 9/30/83***	***Birth to 19 years of age***	
Income (define countable income) ***(See addendum below)***	***≤100% FPL***	***Birth to 6 years of age above 133 up to 200% FPL, 6 to 19 years of age above 100 up to 200% FPL***	
Resources (including any standards relating to spend downs and disposition of resources)	***N/A***	***N/A***	
Residency requirements	***Resident of Alabama***	***Resident of Alabama***	
Disability status	***N/A***	***N/A***	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	***Can have access to or coverage under other health insurance***	***Not eligible for ALL Kids if covered by other health insurance or eligible for Medicaid or state employee dependent coverage***	
Other standards (identify and describe)	***a. Must be a U.S. citizen or eligible***	***a. Must be a US citizen or an eligible immigrant*** ***b. Not be covered under***	

	immigrant, based on federal guidelines b. Not be institutionalized c. Must provide a social security number or proof that one has been applied for	***any health insurance c. Not be institutionalized d. Not be eligible for dependent coverage under state employees' insurance e. Not be covered or eligible for Medicaid***	

Addendum to Table 3.1.1

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

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

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

The Phase I - Medicaid Expansion portion was completed by Gretel Felton.

Phone: (334) 242-1720, Email: gfelton@medicaid.state.al.us

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

Title XIX Child Poverty-related Groups	_____	Gross	___✓___	Net	_____	Both
Title XXI Medicaid SCHIP Expansion	_____	Gross	___✓___	Net	_____	Both
Title XXI State-Designed SCHIP Program	___✓___	Gross	_____	Net	_____	Both
Other SCHIP program _____	_____	Gross	_____	Net	_____	Both

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

Title XIX Child Poverty-related Groups	***133***% of FPL for children underage ***6***
	100% of FPL for children aged 6-***19***
	born after 9/30/83
Title XXI Medicaid SCHIP Expansion	***100% of FPL for children aged under 19 born on or before 9/30/83***
Title XXI State-Designed SCHIP Program	***133***% of FPL for children aged ***0-6***
	100% of FPL for children aged ***6-19***
Other SCHIP program_____	____% of FPL for children aged

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

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

Table 3.1.1.3

Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Child, siblings, and legally responsible adults living in the household	***D***	***D***	***Y***	
All relatives living in the household	***N***	***N***	***N***	
All individuals living in the household	***N***	***N***	***N***	
Other (specify)	***Exclusion of individuals receiving SSI***	***Exclusion of individuals receiving SSI***	***Exclusion of individuals receiving SSI***	

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

Table 3.1.1.4				
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings Earnings of dependent children	***C ****	***C ****	***C ****	
Earnings of students	***C ****	***C ****	***C ****	
Earnings from job placement programs	***C *****	***C *****	***NR***	
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	***C***	***C***	***NR***	
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	***NC***	***NC***	***NR***	
Education Related Income Income from college work-study programs	***NC ******	***NC ******	***C***	
Assistance from programs administered by the Department of Education	***NC*** *****	***NC ******	***NR***	
Education loans and awards	***NC ******	***NC ******	***NC***	
Other Income Earned income tax credit (EITC)	***NC***	***NC***	***NR***	
Alimony payments received	***C***	***C***	***C***	
Child support payments received	***C***	***C***	***C***	
Roomer/boarder income	***C***	***C***	***C***	
Income from individual development accounts	***C***	***C***	***NR***	

development accounts				
Gifts	***C**** **	***C**** **	***C (cash gift)***	
In-kind income	***NC***	***NC***	***NC***	
Program Benefits Welfare cash benefits (TANF)	***NC***	***NC***	***NC***	
Supplemental Security Income (SSI) cash benefits	***NC***	***NC***	***NC***	
Social Security cash benefits	***C***	***C***	***C***	
Housing subsidies	***NC***	***NC***	***NR***	
Foster care cash benefits	***C***	***C***	***NC***	
Adoption assistance cash benefits	***NC***	***NC***	***NR***	
Veterans benefits	***C***	***C***	***C***	
Emergency or disaster relief benefits	***NC***	***NC***	***NR***	
Low income energy assistance payments	***NC***	***NC***	***NR***	
Native American tribal benefits	***NC***	***NC***	***NR***	
Other Types of Income (specify)				

* Earnings of a child are disregarded if the child is a full time student.

** JPTA income (earned) is excluded for up to 6 months per calendar year.

*** Title IV student income in not counted. Only income which exceeds education related costs are counted for other student grants.

**** $30 is disregarded per person per calendar year.

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

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

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

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

Table 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	***$90, 30 1/3 as applicable***	$***90, 30 1/3 as applicable***	$ ***NA***	$
Self-employment expenses	$ ***Reasonable operating expenses***	$ ***Reasonable operating expenses***	$ ***Reasonable operating expenses***	$
Alimony payments Received	$ ***NA***	$ ***NA***	$ ***NA***	$
Paid	$ ***NA***	$ ***NA***	$ ***NA***	$
Child support payments Received	$50	$50	$ ***NA***	$
Paid	$ ***NA***	$ ***NA***	$ ***NA***	$
Child care expenses	$175 ***per month for children 2 years and older, $200 per month for children under 2***	$175 ***per month for children 2 years and older, $200 per month for children under 2***	$ ***NA***	$
Medical care expenses	$ ***NA***	$ ***NA***	$ ***NA***	$
Gifts	$ ***30 per family member per calendar***	$ ***30 per family member per calendar***	$ ***NA***	$

	quarter	***quarter***		
Other types of disregards/deductions (specify)	$ ***Step parent and sibling income***	$ ***Step parent and sibling income***	$ ***Step parent income***	$

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

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

Title XIX Poverty-related Groups	✓	No	_____	Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program	✓	No	_____	Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program	✓	No	_____	Yes (complete column C in 3.1.1.7)
Other SCHIP program	_____	No	_____	Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

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

Table 3.1.1.7

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

for other assets? *(Enter I or A)*				

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

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999?

___ Yes ✓ No

3.1.2 How often is eligibility redetermined?

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

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

✓ Yes → Which program(s)? ***CHIP Phase I – Medicaid Expansion and CHIP Phase II – ALL Kids***

For how long? ***12 Months***

_____ No

3.1.4 Does the CHIP program provide retroactive eligibility?

✓ Yes → Which program(s)? ***Only for CHIP Phase I – Medicaid Expansion***

For how long? ***Up to 3 Months***

_____ No

3.1.5 Does the CHIP program have presumptive eligibility?

_____ Yes → Which program(s)? _____

Which populations? _____

Who determines? _____

✓ No

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

✓ Yes → Is the joint application used to determine eligibility for other State programs? If yes, specify.
There is a joint application used for Medicaid and ALL Kids (see attachment 2). The decision was made during the ALL Kids planning phase that the Medicaid / ALL Kids application process needed to be as seamless as possible. It was decided that the existing Medicaid application, with the addition of ALL Kids information, would be used. In October 1999 The Alabama Caring Foundation was included on the joint application. This allows the family to complete one application and the children to be insured with the appropriate program, based on family income and size.

____ No

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

Phase I – Medicaid Expansion

Strengths

- ***Medicaid requires no assets tests.***
- ***There is no face-to-face interview required.***
- ***Retroactive coverage is available.***
- ***Outstationed Medicaid eligibility workers are available in numerous locations throughout the state.***
- ***Applications can be mailed, faxed or tuned in at any of the sixty-seven counties where outstationed staff are located, as well as the Medicaid Central Office in Montgomery.***
- ***CHIP eligibles that qualify through the Medicaid Expansion can have other insurance and still qualify for coverage.***
- ***Much verification is obtained via computer matches to eliminate unnecessary documentation requirements by the client.***
- ***AMA data systems allow for data to be entered locally and transmitted to the central office.***
- ***Because of the automated eligibility system and the centralized database, eligibility determination can be made from any point within the system.***

- ***Because of the joint application and ALL Kids outreach, when children turn out to be Medicaid eligible, rather than ALL Kids eligible, it gives the opportunity for education and encouragement to accept Medicaid.***

Weaknesses

- ***Medicaid requires that all points of eligibility be documented and verified.***
- ***Because of increased volume of ALL Kids applications the time period for processing an application may, at times, be lengthy.***

Phase II – ALL Kids

Strengths

- ***Applications are available in numerous sites, on the CHIP web site and by calling the ALL Kids toll free number.***
- ***The application is totally mail-in.***
- ***Only verification of age is required and a variety of sources for this verification are accepted.***
- ***Eligibility workers usually process applications in a timely manner.***
- ***Tracking of applications is automated so that any worker can review the system and give parents application status information over the phone.***
- ***Eligibility workers seek to obtain information over the phone when the information is missing from the application***
- ***Daily, enrollment data is transferred electronically to the main insurance vendor (Blue Cross Blue Shield of Alabama). Data is transferred by hard copy to Prime Health as needed.***
- ***Blue Cross Blue Shield of Alabama sends family's enrollment cards, provider directories, and benefit information in a very timely manner.***
- ***Both child health insurance programs use the same application and have excellent transmittal procedures so that enrollment in Alabama's low income insurance programs for children appears seamless when a single application may be evaluated by both of these agencies.***
- ***ALL Kids has 12 months of continuous coverage. There is a "good through" date printed on the ALL Kids insurance card. This allows the parent and provider to know that the child has coverage through this date. ALL Kids has an annual renewal process that will take place prior to the "good through" date.***

Weaknesses

- ***Because of sporadic increases in the volume of applications and re-enrollment forms to be processed, the time period for processing an application may, at times, be lengthy.***
- ***Because the different agencies have different enrollment requirements, revisions to the joint application form cannot always be accomplished as quickly as desired.***
- ***There are no local ALL Kids offices available for those individuals who may require assistance in completing the application.***

require assistance in completing the application.

- ***ALL Kids eligibility determination is a manual process and can only be done in the central office. There is no remote access to the ALL Kids eligibility system.***
- ***The ALL Kids database has been folded into the SEIB's database and at times it is necessary to make modifications to meet the needs of the ALL Kids program.***

Phase I – Medicaid Expansion has a localized eligibility system and Phase II – ALL Kids has a centralized eligibility system. This is viewed as a weakness as far as ease of application processing. If eligibility for both programs could be determined by either system, eligibility determination could be accomplished in a more timely manner. This difference can also be viewed as strength because certain eligibility determining processes can be piloted in the ALL Kids centralized system before implementation in the Medicaid localized system.

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

Phase I – Medicaid Expansion

Strengths:

- ***The Medicaid review process is automated each month. The computer generates review notices that are sent to each claimant with a review form. No action is required on the part of the eligibility worker or claimant at this point.***
- ***Claimants receive review forms and notices telling them what items may be needed to complete the review the month prior to the scheduled review.***
- ***Claimants have until the month following the review before a break in eligibility occurs if the review process is not completed.***
- ***If a break in eligibility does occur claimant can still be certified for coverage retroactively.***
- ***Most information is already in the client's case record. Only income and information that has changed must be verified at review.***
- ***One form is sent to each family and the family annual review is coordinated so all family members have one review regardless of when they come into the program.***

Weaknesses:

- ***Because ALL Kids and SOBRA Medicaid do not use the same redetermination form, referral between the agencies is not seamless.***

Phase II – ALL Kids

The ALL Kids program, which began October 1, 1998, provides 12 months of continuous coverage. Our first reenrollment took place October 1, 1999. There was no reenrollment during the reporting period covered by this evaluation. The following are strengths and weaknesses of the reenrollment system that began October 1, 1999.

Strengths:

- ***ALL Kids has a totally mail-in reenrollment form (see attachment 2).***
- ***No verification is necessary on reenrollment.***
- ***Notice of reenrollment process is sent to families two months prior to coverage expiration and a reminder post card is sent to families six weeks prior to coverage expiration.***
- ***Because All Kids, SOBRA Medicaid, and the Blue Cross Blue Shield Child Caring program do not use the same reenrollment form, changes to the form can be made more quickly and tailored specifically to ALL Kids.***

Weaknesses:

- ***Since the enrollment office's contact with families is annually, during enrollment and reenrollment, some children cannot be located at the time of reenrollment.***
- ***Because All Kids, SOBRA Medicaid, and the Blue Cross Blue Shield Child Caring program do not use the same reenrollment form, referral among the agencies is not seamless***

The reenrollment process differs from the initial enrollment process in that a different, shorter form is used, no verification is required, and the ALL Kids enrollment office not the family initiates the process.

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

3.2.1 Benefits

Table 3.2.1 CHIP Program Type ***Phase I (Medicaid Expansion)***			
Benefit	Is Service Covered? (✓ = yes)	Cost-Sharing (Specify) ***There is no cost sharing for children less than 18 years of age.*** ***The copays listed below apply to 18 year olds. Treatment cannot be denied for nonpayment of copays.***	Benefit Limits (Specify) ***None apply if the condition for treatment was identified during an EPSTD screening. Some services do require prior authorization.***
Inpatient hospital services	✓	***$50 copay***	
Emergency hospital services	✓		
Outpatient hospital services	✓	***$3 copay***	
Physician services	✓	***$1 copay***	
Clinic services	✓		
Prescription drugs	✓	***$.50, $1, $3 copays, based on the price of the prescription***	
Over-the-counter medications	✓		
Outpatient laboratory and radiology services	✓		
Prenatal care	✓		
Family planning services	✓		
Inpatient mental health services	✓		
Outpatient mental health services	✓		
Inpatient substance abuse treatment services	✓		
Residential substance abuse treatment services	✓		
Outpatient substance abuse treatment services	✓		

Durable medical equipment	✓	***$3 copay***	
Disposable medical supplies	✓	***$1 copay***	
Preventive dental services	✓		
Restorative dental services	✓		
Hearing screening	✓		
Hearing aids	✓		
Vision screening	✓		
Corrective lenses (including eyeglasses)	✓		
Developmental assessment	✓		
Immunizations	✓		
Well-baby visits	✓		
Well-child visits	✓		
Physical therapy	✓		
Speech therapy	✓		
Occupational therapy	✓		
Physical rehabilitation services	✓		
Podiatric services	✓		
Chiropractic services	✓		
Medical transportation	✓		
Home health services	✓		
Nursing facility	✓		
ICF/MR	✓		
Hospice care	✓		
Private duty nursing	✓		
Personal care services	✓		
Habilitative services	✓		
Case management/Care coordination	✓		
Non-emergency transportation	✓		
Interpreter services			

Table 3.2.1 CHIP Program Type ***Phase II - ALL Kids***			
Benefit	Is Service Covered? (✓ = yes)	Cost-Sharing (Specify) ***For ALL Kids enrollees who are between 100-150% FPL. There is no cost sharing (this includes premiums, deductibles and copays)*** ***For ALL Kids enrollees who are between 151-200% FPL there is a $50 per year premium ($60 per year if not paid in one payment) with a maximum of $150 per year per family, no deductibles and $5 copays on some services, as noted below.***	Benefit Limits (Specify)
Inpatient hospital services	✓	***$ 5 copay***	***365 days of care during each hospital confinement; 100% coverage after copay***
Emergency hospital services	✓	***$ 5 per visit copay***	
Outpatient hospital services	✓	***Preferred Outpatient Facilities:*** ***Accidental Injury $5 copay*** ***Surgery no copay*** ***Medical Emergency $5 copay*** ***Hemodialysis no copay*** ***IV Therapy, Chemotherapy and Radiation Therapy no copay*** ***Diagnostic Lab and X-ray no copay***	
Physician services	✓	***$ 5 per visit copay***	
Clinic services	✓	***$ 5 per visit copay***	
Prescription drugs	✓	***Generic drugs are mandatory when equivalents are available.*** ***Generic Drugs: $1 copay*** ***Brand Name Drugs: $3 copay***	

Over-the-counter medications			
Outpatient laboratory and radiology services	✓		
Prenatal care	✓		
Family planning services	✓		
Inpatient mental health services	✓	***$5 copay per confinement*** ***Inpatient mental health Physician Services: no copay***	***Up to 30 days of inpatient care each calendar year***
Outpatient mental health services	✓		***100% for outpatient mental health and chemical dependency (alcohol and drug abuse) care or treatment limited to 20 visits each calendar year***
Inpatient substance abuse treatment services	✓	***$5 copay per confinement***	***Confinement limited to 72 hours each episode not to exceed 20 days each calendar year***
Residential substance abuse treatment services	✓	***$5 copay per confinement***	***Confinement limited to 72 hours each episode not to exceed 20 days each calendar year***
Outpatient substance abuse treatment services	✓		***Limited to 20 visits each calendar year***
Durable medical equipment	✓		
Disposable medical supplies			
Preventive dental services	✓		***2 cleaning and check-ups per year. Maximum dental benefits: $1000 per member each calendar year.***
Restorative dental services	✓	***$5 copay***	***Maximum dental benefits: $1000 per member each calendar year***
Hearing screening	✓		
Hearing aids	✓		***$750 per ear, no more than once every 24 months***
Vision screening	✓		***Limited to one exam each calendar year***
Corrective lenses (including eyeglasses)	✓		***Limited to one pair of eyeglasses each calendar year***

			No coverage for contact lenses
Developmental assessment	✓		
Immunizations	✓		
Well-baby visits	✓		***In accordance with American Academy of Pediatrics guidelines***
Well-child visits	✓		***Annually***
Physical therapy	✓		
Speech therapy	✓		
Occupational therapy	✓		
Physical rehabilitation services	✓		
Podiatric services	✓		***Only covered if problem resulting from disease***
Chiropractic services	✓		***Limited to 12 visits or $400 each calendar year***
Medical transportation			
Home health services	✓		***Limited to 60 days each calendar year***
Nursing facility	✓		***Limited to 100 days in a lifetime***
ICF/MR			
Hospice care	✓		
Private duty nursing			
Personal care services			
Habilitative services			
Case management/Care coordination	✓		***ALL Kids case management is an insurance based model and is focused on cost containment***
Non-emergency transportation			
Interpreter services			
Other (Specify) ***A 24 Hour nurse line is available to provide help***			

from a registered nurse who can answer questions about medical problems prescription drugs and more.			
Other (Specify) ***The Baby Yourself Program is a prenatal wellness program, designed for pregnant teens. Pregnant mothers of ALL Kids enrollees may also participate.***			
Other (Specify)			

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

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

- ***The AMA offers a comprehensive benefits package that provides a broad range of preventive, diagnostic and treatment services. There is no cost sharing for children under 18 years of age and some modest copays for 18 year olds (see table 3.2.1).*** ***There are no limitations on benefits if the condition being treated was identified through an EPSDT screening. This is extremely important for children with special health care needs. Medicaid provides vouchers for nonemergency transport to and from medical appointments. Interpretive services are provided trough AT&T language lines.***

- ***The ALL Kids program offers a comprehensive benefits package that provides a broad range of preventive, diagnostic and treatment services. Both preventive medical and preventive dental services are provided and encouraged. ALL Kids strongly recommends that every enrolled child receives a well doctor check up and a preventive dental check up as soon as possible after enrollment. All children enrolled in ALL Kids are mailed a post card reminding their parent of the importance of these preventive visits along with encouragement to schedule the appropriate appointments. If the child has not had both visits within the first 120 days of enrollment their name and identifying information is forwarded to Intracorp for follow up. Intracorp is a medical management company which has been contracted by Blue Cross Blue Shield to place out bound calls as a means of follow up for children who have not received both a well doctor and a preventive dental visit. Since ALL Kids began October 1, 1999 and no children had been enrolled 120 days until February 1, 2000 we had only seven months of outbound calls during this reporting period. We are in the process of analyzing the effectiveness of this system. Intracorp estimates that 25% of the parents who receive these follow-up calls schedule the needed check-up visits. We are currently working with Intracorp on a system to prioritize names for follow-up phone calls.***

- ***The joint application form and ALL Kids brochure were translated into Spanish. Additionally, a Spanish-speaking enrollment worker was employed in the ALL Kids enrollment office.***

3.2.3 Delivery System

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

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
A. Comprehensive risk managed care organizations (MCOs)	***In one Alabama county, there was one MCO. It terminated Oct. 1, 1999.***	***None***	
Statewide?	____ Yes ___✓ No	____ Yes ____ No	____ Yes ____ No
Mandatory enrollment?	___✓ Yes ____ No	____ Yes ____ No	____ Yes ____ No
Number of MCOs	1	***NA***	
B. Primary care case management (PCCM) program	***Yes, in all counties except Mobile***	***None***	
Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	***None***	***None***	
Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	***None***	***None***	
Other (specify): Services paid on capitaded basis	***In CHIP Phase I – Medicaid Expansion, all services except inpatient hospital services are paid on a fee for service basis. Inpatient hospital services are paid on a capitated***	***In CHIP Phase II – ALL Kids, all services except some mental health services are paid on a fee for service basis. These mental health services are paid on a capitated basis.***	

	basis.		
F. Other (specify) _____			
G. Other (specify) _____			

3.3 How much does CHIP cost families?

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

_____ No, skip to section 3.4

✓ Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program ***There is cost sharing for 18-year-old Phase I enrollees.***	State-designed CHIP Program ***There is cost sharing for ALL Kids enrollees above 150 up to 200%FPL.***	Other CHIP Program*
Premiums	***None***	***For ALL Kids enrollees above 150 up to 200% FPL there is a $50 per year premium ($60 per year if not paid in one payment) with a maximum of $150 per year per family***	
Enrollment fee	***None***	***None***	
Deductibles	***None***	***None***	
Coinsurance/copayments**	***For 18 year olds, there are copays on some services. See table 3.2.1***	***For ALL Kids enrollees above 150 up to 200%FPL there are copays on some services. (See table 3.3.1)***	
Other (specify)			

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

- ***There are no premiums for Phase I – Medicaid Expansion.***

- ***For the ALL Kids program, there are no premiums for enrollees whose family income is above 100 up to150% FPL. For enrollees whose income is above 150 up to 200% FPL there is a $50 per year premium, ($60 per year if not paid in one payment) with a maximum of $150 per family per year.***

- ***When a child is enrolled in ALL Kids as "limited fee" (above 150 up to200% FPL), a coupon book is mailed out, along with instructions, to the parent. This coupon book contains identifying information, so that when a payment is returned it may be properly credited. The parent is to return a coupon with the entire $50 premium payment or is to return one coupon per month with a $6 payment for 10 months.***

- ***If families fail to pay the premiums, no action is taken during the first 10 months of coverage, but reenrollment cannot be completed until premiums for the previous year are paid in full.***

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

____ Employer
✓ Family
____ Absent parent
____ Private donations/sponsorship
✓ Other (specify)
- ***If the family is unable to afford the ALL Kids premium we will work with other sources to aid the family in paying the premium.***

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

N/A

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

NA

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

- ***The literature provided to the parents of the Phase I includes information about the copays for 18 year olds.***

- ***The ALL Kids enrollment office sends out information informing the parent of the child's "limited fee" status (the child fits into the upper income level of the ALL Kids program and premiums and some copays will apply). Premium information, along with a coupon book to be used to pay premiums is also sent at enrollment.***

- ***The ALL Kids insurance card that is sent out by Blue Cross Blue Shield or Prime Health will be coded as "copay", alerting the parent and the provider that enrollee is in the limited fee category and that copays are charged for some services.***

- ***Information concerning the 5% cap is included in the guidebooks sent to enrollees from Blue Cross Blue Shield and Prime Health.***

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

✓ Shoebox method (families save records documenting cumulative level of cost sharing)

- ***This is the method used by the ALL Kids program. There is no system in place for monitoring the 5% cap for the children enrolled in CHIP Phase I. Since copays only apply to 18 year olds, this is not an issue for any other age group. It is very unlikely that expenditures would ever exceed the 5% limit. In addition to this, services cannot be denied for non-payment of copay.***

____ Health plan administration (health plans track cumulative level of cost sharing)

____ Audit and reconciliation (State performs audit of utilization and cost sharing)

____ Other (specify) _____

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

- ***No families have notified ALL Kids or the Medicaid Agency that the 5% cap has been reached.***

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

- ***There was not sufficient data available during this reporting period to conduct analyses to assess the effects of premiums on participation or the effects of cost sharing on utilization. This reporting period covers the first year of operation of the ALL Kids program. Reenrollment began October 1, 1999. There was no reenrollment during this reporting period. Therefore, these analyses could not be made for this evaluation. The ALL Kids program has contracted with HCIA to provide Blue Cross Blue Shield and Prime Health claims data. This data, along with reenrollment date will be used to analyze these issues for future evaluations.***

3.4 How do you reach and inform potential enrollees?

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

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	✓=Yes	Rating (1-5)	✓=Yes	Rating (1-5)	✓=Yes	Rating (1-5)
Billboards						
Brochures/flyers	✓	***4***	✓	***5***		
Direct mail by State/enrollment broker/administrative contractor	✓ ***Annual renewal notices***	***5***	✓	***5***		
Education sessions			✓	***5***		
Home visits by State/enrollment broker/administrative contractor						
Hotline	✓	***5***	✓	***5***		
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake			✓	***3***		
Prime-time TV advertisements			✓	***4***		
Public access cable TV			✓	***4***		
Public transportation ads						
Radio/newspaper/TV advertisement and PSAs			✓	***3***		
Signs/posters			✓	***3***		
State/broker initiated phone calls						
Other (specify) ***Joint Application***	✓	***5***	✓	***5***		
Other (specify)						

3.4.2 Where does your CHIP program conduct client education and outreach?

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	✓=Yes	Rating (1-5)	✓=Yes	Rating (1-5)	✓=Yes	Rating (1-5)
Battered women shelters			✓	***2***		
Community sponsored events	✓	***3***	✓	***3***		
Beneficiary's home						
Day care centers			✓	***2***		
Faith communities			✓	***2***		
Fast food restaurants						
Grocery stores						
Homeless shelters			✓	***1***		
Job training centers						
Laundromats						
Libraries						
Local/community health centers	✓	***3***	✓	***4***		
Point of service/provider locations	✓	***3***	✓	***5***		
Public meetings/health fairs	✓	***3***	✓	***2***		
Public housing			✓	***1***		
Refugee resettlement programs						
Schools/adult education sites	✓	***4***	✓	***5***		
Senior centers			✓	***1***		
Social service agency	✓	***4***	✓	***5***		
Workplace ***Employment Offices***	✓	***3***	✓	***2***		
Other (specify)						
Other (specify)						

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

- ***The effectiveness of the outreach for the ALL Kids Program is monitored is several ways. First, in all outreach activities where applications and brochures have been distributed in quantity, not one agency has sought to return any material to us. Second, daily, the CHIP administrative office receives requests from agencies and providers for additional application packages , posters and brochures. The pediatric health history includes questions regarding how an applicant became aware of ALL Kids and where the application package was obtained. From this information it is known that the most popular sources of ALL Kids information and applications are schools, followed by physician's offices. A periodic summary of toll free telephone lines is also generated which indicates how effective outreach regarding the telephone number has been. Additionally, CHIP is contracting with the University of Alabama at Birmingham, School of Public Health to survey new enrollees to ascertain the effectiveness of ALL Kids outreach. Finally, ADPH can analyze the number of "hits" on the CHIP web site as well as the number of e-mails to CHIP staff generated by the public using this site.***

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

- ***The joint application form and ALL Kids brochure were translated into Spanish (see attachment 2). Additionally, a Spanish-speaking enrollment worker was employed in the ALL Kids enrollment office.***

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

- ***UAB conducted a retrospective survey of first year ALL Kids enrollees (se attachment 3). This survey was mailed to a random sample (6,200) of the households of the 25,748 children that enrolled in ALL Kids from October 1, 1998 to September 30, 1999. The primary purpose of this first year survey was to determine the difference in access to care before the child was enrolled in ALL Kids and after the child enrolled in ALL Kids. Of the 6,200 surveys mailed, 85 were returned with undeliverable addresses. At this time, approximately 3,538 (58%) have returned the survey.***

- ***The survey also provides information regarding outreach activities. The respondents were asked where they first learned about the ALL Kids program. Schools, Health Department, and friends and relatives were the most common responses. When asked where respondents got their survey the overwhelming response said they obtained their ALL Kids applications from schools (41%). Twenty-eight percent (28%) of the respondents got their applications from the health department.***

- ***The target population was school age children. Since 41% of the respondents obtained their applications at school, and almost 50% of the respondents are in the six to twelve year old age group, distributing the applications in schools is considered to be very successful for the target population.***

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

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

Table 3.5

Type of coordination	Medicaid*	Maternal and child health	Other (specify) ***WIC***	Other (specify) ***Numerous advocacy groups, social service agencies and professional organizations ** see list below***
Administration	✓			
Outreach	✓	✓	✓	✓
Eligibility determination	✓			
Service delivery	✓	✓		
Procurement				
Contracting				
Data collection	✓	✓		
Quality assurance	✓			
Other (specify)				
Other (specify)				

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

** ***The Department of Education, Department of Human Resources, Alabama Hospital Association, Medical Association of the State of Alabama, Alabama Pharmacy Association, Alabama Chapter of the American Academy of Pediatrics, Alabama Family Practice Physicians Association, Alabama Primary Care Association, Federally Qualified Health Centers and Hospitals***

- ***Federally Qualified Health Centers and Hospitals also coordinated with the CHIP program in service delivery.***

- ***Coordination with Medicaid: Phase I of Alabama's CHIP is a Medicaid expansion. Coordination in each of these areas (excluding procurement) is handled either in face to face meetings, periodic***

written reports, through written contracts, or sharing space on outreach documents and conducting co-presentations. The application for CHIP eligibles can also be used for children eligible under SOBRA Medicaid. Additionally, the ALL Kids application packet contains basic eligibility information on SOBRA so families can be educated on the availability of insurance for low-income children.

- ***Coordination with Maternal and Child Health (MCH): Coordination with MCH includes collaboration with the traditional MCH program within the ADPH as well as the Children's Rehabilitation Services, the program for children with special health care needs. The MCH programs assist in outreach by serving as a distribution point for applications and brochures as well as information about the program. Because of the number of nurse practitioners in MCH service delivery systems, the ALL Kids Program broadened its provider network to include physician alternatives. Finally data from CHIP enrollment reports are used as part of the MCH Block Grant annual report.***

- ***Coordination with WIC: Coordination with WIC has been focused on outreach. The WIC Program has twice printed ALL Kids information on its food instruments. CHIP staff has furnished the topic of the message while WIC staff have written the actual content and conducted the work to have the message printed on the food voucher.***

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

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

Eligibility determination process:

- ***There is no crowd out provisions in place for Phase I – Medicaid Expansion.***
- ***The following provisions apply to Phase II – ALL Kids***

✓ Waiting period without health insurance (specify)
For the ALL Kids program, if insurance has been voluntarily terminated there is a 3 month waiting period before children can be covered

✓ Information on current or previous health insurance gathered on application (specify)

- ***On the joint application, information is requested concerning other insurance coverage. If the child/ren is/are covered under other health insurance, including Medicaid they are not eligible for ALL Kids. If the child/ren is/are covered under other health insurance and are Medicaid eligible they may be covered under Phase I, Medicaid expansion.***

____ Information verified with employer (specify) _____

✓ Records match (specify)

- ***SEIB's enrollment*** workers ***check both the AMA and BCBS systems for coverage prior to enrollment (82% of insured Alabamians have BCBS insurance).***

____ Other (specify) _____

____ Other (specify) _____

✓ Benefit package design:

____ Benefit limits (specify)

✓ Cost-sharing (specify)

- ***For ALL Kids enrollees above 150 up to 200% FPL, there are premiums of $50 per year ($60 if not paid in one payment) and copays on some services.***

____ Other (specify) _____

____ Other (specify) _____

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

____ Other (specify) _____

____ Other (specify) _____

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

- ***ALL Kids enrollment workers have access to the Alabama Healthcare Information Network, which currently contains BCBS enrollment data. Enrollment data for other private insurance companies will be added in the future. This database is checked prior to ALL Kids enrollment. This database contains not only current enrollment, but it will also show if insurance has been canceled in the last 12 months. If insurance has been voluntarily canceled in the past 90 days then the child cannot be enrolled in ALL Kids until after this 90 day period has passed. Approximately 82% of insured Alabamian have BCBS insurance, so this enables us to have a very high level of assurance in monitoring and avoiding crowd out.***

- ***UAB conducted a retrospective survey of first year enrollees in CHIP Phase II - ALL Kids (see attachment3). Questions were asked concerning prior insurance coverage. Twenty-nine percent never had insurance before ALL Kids. Almost 37% have been on Medicaid in the past. The main reason stated for not having insurance is that it cost too much. 75% reported being without health insurance for longer than six months.***

- ***Since most insured Alabamians are covered under BCBS and since ALL Kids has access to BCBS enrollment records and children must go through a 90 day waiting period before enrolling in ALL Kids after insurance has been voluntarily terminated, we feel that crowd-out is not a significant problem with the ALL Kids program. Data from the UAB Access to Care Survey also supports this conclusion.***

PROGRAM ASSESSMENT

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

4.1 Who enrolled in your CHIP program?

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

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

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

Alabama

M-SCHIP Enrollment Statistics FFY 1998 and FFY 1999

Phase I – Medicaid Expansion

The Alabama Medicaid Agency has only provided an estimated unduplicated number of Phase I – Medicaid Expansion enrollees ever enrolled in FY 1999. No additional data is available at this time. When this data is provided to the ADPH by the AMA the reporting will be updated.

Table 4.1.1 in NASHP Framework for State Evaluations							
Characteristics		Number of children ever enrolled		Average number of months of enrollment		Year end enrollees as percentage of unduplicated enrollees per year	
		FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children		0	13,242	-	NA	-	NA
Age							
	Under 1	0	NA	-	NA	-	NA
	1-5	0	NA	-	NA	-	NA
	6-12	0	NA	-	NA	-	NA
	13-18	0	NA	-	NA	-	NA
Countable Income Level							
	At or below 150% FPL	0	NA	-	NA	-	NA
	Above 150% FPL	0	NA	-	NA	-	NA
Age and Income							
Under 1							

	At or below 150% FPL	0	NA	-	NA	-	NA
	Above 150% FPL	0	NA	-	NA	-	NA
1-5							
	At or below 150% FPL	0	NA	-	NA	-	NA
	Above 150% FPL	0	NA	-	NA	-	NA
6 - 12							
	At or below 150% FPL	0	NA	-	NA	-	NA
	Above 150% FPL	0	NA	-	NA	-	NA
13-18							
	At or below 150% FPL	0	NA	-	NA	-	NA
	Above 150% FPL	0	NA	-	NA	-	NA
Type of plan							
Fee-for-service		0	13,242	-	NA	-	NA
Managed care		0	NA	-	NA	-	NA
PCCM		0	NA	-	NA	-	NA

NA = Alabama's M-SCHIP program was scheduled to begin Q2/98. For that program, Alabama only reported the FFY 1999 unduplicated number of children enrolled during the year.

Alabama

S-SCHIP Enrollment Statistics FFY 1998 and FFY 1999[a]

Phase II – ALL Kids

Table 4.1.1 in NASHP Framework for State Evaluations							
Characteristics		Number of children ever enrolled		Average number of months of enrollment		Year end enrollees as percentage of unduplicated enrollees per year	
		FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children		-	26,213	-	0.0	-	98.2%
Age							
	Under 1	-	257	-	0.0	-	98.4%
	1-5	-	4,429	-	0.0	-	98.1%
	6-12	-	13,214	-	0.0	-	99.0%
	13-18	-	8,313	-	0.0	-	96.8%
Countable Income Level							
	At or below 150% FPL	-	17,684	-	0.0	-	98.3%
	Above 150% FPL	-	8,529	-	0.0	-	98.0%
Age and Income							
Under 1							

	At or below 150% FPL	-	107	-	0.0	-	100.0%
	Above 150% FPL	-	150	-	0.0	-	97.3%
1-5							
	At or below 150% FPL	-	2,091	-	0.0	-	98.2%
	Above 150% FPL	-	2,338	-	0.0	-	98.1%
6 - 12							
	At or below 150% FPL	-	9,434	-	0.0	-	99.2%
	Above 150% FPL	-	3,780	-	0.0	-	98.7%
13-18							
	At or below 150% FPL	-	6,052	-	0.0	-	96.8%
	Above 150% FPL	-	2,261	-	0.0	-	96.9%
Type of plan							
Fee-for-service		-	26,213	-	0.0	-	98.2%
Managed care		-	0	-	-	-	-
PCCM		-	0	-	-	-	-

a. Alabama began reporting data for the S-SCHIP program in Q1/99. The state was not able to report member months until FFY 2000.

Alabama

SCHIP Data System: Summary of State-Reported Enrollment Information

The Alabama Medicaid Agency has only provided an estimated unduplicated number of Phase I – Medicaid Expansion enrollees ever enrolled in FY 1999. No additional data is available at this time. When this data is provided to the ADPH by the AMA the reporting will be updated.

Program	Federal Fiscal Year/ Quarter	Age indicator	Ever Enrolled	New Enrollees	Disenrollees	Member Months	Average Months of Enrollment	Unduplicated Ever Enrolled per year
			Line 1	Line 2	Line 3	Line 4	Line 5	Line 6
S-SCHIP								
	1998/Q1		0	0	0	0	-	0
	1998/Q2		0	0	0	0	-	0
	1998/Q3		0	0	0	0	-	0
	1998/Q4		0	0	0	0	-	0
	1999/Q1	all ages	12,988	12,988	0	0	0.00	0
	1999/Q2	all ages	17,532	4,544	0	0	0.00	0
	1999/Q3	all ages	21,229	3,697	0	0	0.00	0
	1999/Q4	all ages	26,213	4,509	475	0	0.00	26,213
M-SCHIP								
	1998/Q1		0	0	0	0	-	0
	1998/Q2		0	0	0	0	-	0
	1998/Q3		0	0	0	0	-	0
	1998/Q4		0	0	0	0	-	0
	1999/Q1		0	0	0	0	-	0
	1999/Q2		0	0	0	0	-	0

	1999/Q3		0	0	0	0	-	0
	1999/Q4		0	0	0	0	-	13,242

Alabama

SCHIP Data System: Summary of Statistics Derived from State-Reported Enrollment Information

The Alabama Medicaid Agency has only provided an estimated unduplicated number of Phase I – Medicaid Expansion enrollees ever enrolled in FY 1999. No additional data is available at this time. When this data is provided to the ADPH by the AMA the reporting will be updated.

Program	Federal Fiscal Year/ Quarter	Age indicator	Ever Enrolled	Growth in Ever Enrolled over Previous Quarter[a]	New Enrollees	Disenrollees	Enrolled @ start of Qrtr[b]	Enrolled @ end of Qrtr[c]	Quarterly Growth rate[d]	Member Months	Average Months of Enrollment	Average Monthly Enrollment[e]	Quarterly Disenrollment Rate[f]	Unduplicated Ever Enrolled per year	Year-end Enrollees as a percent of Unduplicated Enrollees per Year[g]
C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11	C12	C13	C14	C15	C16
				(C4Q2 - C4Q1)/C4Q1			C4 - C6	C4 - C7	(C9 - C8)/ C8			C11/3	C7/C13		(C4 - C7)/C15
S-SCHIP															
	1998/Q1		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1998/Q2		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1998/Q3		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1998/Q4		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1999/Q1	all ages	12,988	-	12,988	0	0	12,988	-	0	0.0	0.0	-	0	-
	1999/Q2	all ages	17,532	35.0%	4,544	0	12,988	17,532	35.0%	0	0.0	0.0	-	0	-
	1999/Q3	all ages	21,229	21.1%	3,697	0	17,532	21,229	21.1%	0	0.0	0.0	-	0	-
	1999/Q4	all ages	26,213	23.5%	4,509	475	21,704	25,738	18.6%	0	0.0	0.0	-	26,213	98.2%
M-SCHIP															
	1998/Q1		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1998/Q2		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1998/Q3		0	-	0	0	0	0	-	0	-	0.0	-	0	-

	1998/Q4		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1999/Q1		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1999/Q2		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1999/Q3		0	-	0	0	0	0	-	0	-	0.0	-	0	-
	1999/Q4		0	-	0	0	0	0	-	0	-	0.0	-	13,242	-

a. Percent change in enrollment over prior quarter

b. Ever Enrolled minus New Enrollees

c. Ever Enrolled minus Disenrollees

d. Percent change in enrollment between start and end of quarter

e. Member months divided by 3

f. Disenrollees as percent of Average Monthly Enrollment

g. Year end enrollees are calculated by subtracting Q4 Disenrollees from Q4 Ever Enrolled.

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

Phase II – ALL Kids Characteristics

Income	
Above 100 up to 150% FPL (***No Fee)***	74%
Above 150 up to 200% FPL (Limited Fee)	26%
Gender	
Male	50.56%
Female	49.44%
Race	
White	64%
Black	33%
Hispanic	1%
Native American	.6%
Asian	.4%
Other	1%

Source: ALL Kids Pediatric Health History Database

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

- ***This data is currently unavailable for CHIP Phase I – Medicaid Expansion.***

- ***UAB conducted a retrospective survey of first year enrollees in CHIP Phase II - ALL Kids (see attachment 3). This survey was mailed to a random sample (6,200) of the households of the 25,748 children that enrolled in ALL Kids from October 1, 1998 to September 30, 1999. The primary purpose of this first year survey was to determine the difference in access to care before the child was enrolled in ALL Kids and after the child was enrolled in ALL Kids. Of the 6,200 surveys mailed, 85 were returned with undeliverable addresses. At this time, approximately 3,538 (58%) have returned the survey.***

- ***Among the survey respondents, 29% never had health insurance before ALL Kids. Almost 37% have been on Medicaid in the past. Eleven percent has been without insurance for five years or more. The main reason stated for not having insurance is that it cost too much. Less than 6% have always had health insurance.***

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

- ***Due to the "woodwork effect" from the Chip outreach it is estimated that an additional 30,000 children have been added to the SOBRA Medicaid program.***

- ***ACCF was and is a non-Medicaid health insurance program for children. ACCF had been serving the children who then became eligible for the ALL Kids Program. CHIP and ACCF have worked closely to ensure that children can make a seamless transition from one program to the other. As children enrolled in ACCF come up for their annual renewal, ACCF screens them for ALL Kids (and Medicaid) eligibility, if they appear to be eligible for either of the programs they are encouraged to apply. With the creation of ALL Kids, ACCF has adjusted its criteria to provide limited benefits to children who are not eligible for Medicaid and ALL Kids. ACCF continues to maintain an enrollment of about 6,000 per year.***

4.2 Who disenrolled from your CHIP program and why?

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

- ***Phase I disenrollee data are not available at this time.***

- ***The ALL Kids program, which began October 1, 1998, provides 12 months of continuous coverage. Our first reenrollment took place October 1, 1999. Because of the 12 months continuous coverage, there were a minimal number of children who disenrolled during FY 1999. The only reasons a child would have been disenrolled during FY 1999 are: the child turned 19 years of age, the child was found to be enrolled in Medicaid or there was a request made by the parent to disenroll the child.***

- ***Based on disenrollment data provided by Blue Cross and Blue Shield there were 475 children disenrolled during FY99. 209 children aged out and 266 children disenrolled for the other reasons listed above.***

- ***Due to the fact that reenrollment did not begin until October 1999 we do not have data to determine accurate disenrollment rates or to provide comparisons to previous Medicaid disenrollment rates. We will have this data available for our 2000 Annual Report.***

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

- ***Phase I disenrollee data are not available at this time.***

- ***The ALL Kids program, which began October 1, 1998, provides 12 months of continuous eligibility. Our first reenrollment took place October 1, 1999. Therefore, we do not have reenrollment data for this evaluation. It will be part of our FY 2000 Annual Report.***

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

Phase I:

- ***Phase I disenrollee data are not available at this time.***

The ALL Kids program:

- ***The ALL Kids program, which began October 1, 1998, provides 12 months of continuous coverage. Our first reenrollment took place October 1, 1999. Because of the 12 months continuous coverage, there were a minimal number of children who disenrolled during FY 1999. The only reasons a child would have been disenrolled during FY 1999 are the child turned 19 years of age, the child was found to be enrolled in Medicaid or there was a request made by the parent to disenroll the child.***

- ***Data Source: BCBS FY99 Enrollment Report***

- ***Reporting Period: October 1, 1998 – September 30, 1999***

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total			***475***			
Access to commercial insurance						
Eligible for Medicaid						
Income too high						
Aged out of program			***209***			
Moved/died						
Nonpayment of premium						
Incomplete documentation						
Did not						

reply/unable to contact						
Other (specify)			***266 Requested, or currently enrolled in Medicaid***			
Other (specify)						
Don't know						

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

Phase I:

- ***Disenrollee data are not available at this time.***

ALL Kids Program:

- ***Names of children who did not have reenollment forms returned will be forwarded to local workers for follow up. The Robert Wood Johnson Foundation's Covering Alabama Kids Project, Family Healthcare of Alabama and the Hospital Association will provide follow up in numerous Alabama counties. These groups will attempt to make contact with the parent of the disenrolled child to determine if the child is currently insured. It not, assistance will be available to aid in completion of a new application.***

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999? ***These amounts represent benefits paid, no administration costs are included.***

FFY 1998 ***Phase I – Medicaid Expansion 2,788,912***

FFY 1999 ***Phase I – Medicaid Expansion 11,021,174***
Phase II – ALL Kids 15,690,500
Total 26,711,674

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

Table 4.3.1 CHIP Program Type ***Phase I- Medicaid Expansion***				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	***2,788,912***	***11,021,174***	***2,189,853***	***8,650,523***
Premiums for private health insurance (net of cost-sharing offsets)*	***249,219***	***958,118***	***195,686***	***752,027***
Fee-for-service expenditures (subtotal)				
Inpatient hospital services	***768,811***	***2,183,315***	***603,670***	***1,713,685***
Inpatient mental health facility services	***81,444***	***355,955***	***63,950***	***279,389***
Nursing care services				
Physician and surgical services	***326,350***	***1,188,463***	***256,250***	***932,825***
Outpatient hospital services	***187,754***	***644,603***	***147,425***	***505,947***
Outpatient mental health facility services				
Prescribed drugs	***342,147***	***1,334,914***	***268,654***	***1,047,774***
Dental services	***215,208***	***800,063***	***168,981***	***627,969***
Vision services	***76,064***	***186,442***	***59,726***	***146,339***
Other practitioners' services	***11,262***	***551,429***	***8,844***	***432,820***
Clinic services	***140,820***	***614,746***	***110,572***	***482,514***
Therapy and rehabilitation services		***5,454***		***4,281***
Laboratory and radiological services	***107,072***	***433,011***	***84,074***	***339,871***
Durable and disposable medical equipment	***8,702***	***41,440***	***6,831***	***32,526***
Family planning				
Abortions				
Screening services	***63,787***	***181,337***	***50,085***	***142,331***
Home health	***3,135***	***3,331***	***2,462***	***2,615***
Home and community-based services				
Hospice				
Medical transportation	***16,105***	***69,914***	***12,645***	***54,876***
Case management	***141,534***	***1,191,848***	***111,132***	***935,479***
Other Services	***49,498***	***276,791***	***38,866***	***217,253***

Table 4.3.1 CHIP Program Type ***Phase II - ALL Kids***				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures ***(Benefits less collections)***		***15,690,500***		***12,315,473***
Premiums for private health insurance (net of cost-sharing offsets)*				
Fee-for-service expenditures (subtotal)				
Inpatient hospital services		***1,442,043***		***1,131,859***
Inpatient mental health facility services		***87,884***		***68,979***
Nursing care services				
Physician and surgical services		***5,148,397***		***4,040,977***
Outpatient hospital services		***1,323,855***		***1,039,094***
Outpatient mental health facility services		94,199		79,937
Prescribed drugs		***1,755,863***		***1,378,177***
Dental services		***2,885,825***		***2,265,084***
Vision services		***403***		***317***
Other practitioners' services		***57,077***		***44,800***
Clinic services				
Therapy and rehabilitation services		***93,993***		***73,774***
Laboratory and radiological services		***1,214,363***		***953,153***
Durable and disposable medical equipment		***274,710***		***215,620***
Family planning				
Abortions				
Screening services				
Home health		***10***		***8***
Home and community-based services		***1,211***		***951***
Hospice				
Medical transportation		***37,267***		***29,250***
Case management				
Other Services		***1,457,818***		***1,144,242***

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

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

- ***Funds related to the 10% cap were used to fund CHIP administrative staff, expenses and equipment to support staff, outreach and enrollment. Contracts with consultants to assist with administrative functions related to getting the CHIP program operational were also funded with this money.***

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

- ***For the first year's outreach, the Alabama CHIP program partnered with multiple agencies and professional organizations. Rather than incur the outreach costs directly the program relied on "shot gun" outreach to reach as many people as quickly as possible through The Department of Education, Department of Human Resources, Alabama Hospital Association, Medical Association of the State of Alabama, Alabama Pharmacy Association, Alabama Chapter of the American Academy of Pediatrics, Alabama Family Practice Physicians Association and Alabama Primary Care Association, that CHIP had as partners. The10% administration funds were used to design and implement the application process, while the distribution of brochures and local outreach was actually conducted thru the partnerships.***

Table 4.3.2

Type of expenditure	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total computable share	***305,350***		4,529	1,956,335		
Outreach	6,259			361,738		
Administration	299,091	499,088	4,529	1,594,597		
Other_____						
Federal share	239,761		3,556	1,535,527		
Outreach	4,915			283,928		
Administration	234,846	391,734	3,556	1,251,599		
Other_____						

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

✓ State appropriations
____ County/local funds
____ Employer contributions
____ Foundation grants
Private donations (such as United Way, sponsorship)

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

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

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits	✓		
PCP/enrollee ratios	✓		
Time/distance standards	✓		
Urgent/routine care access standards	✓		
Network capacity reviews (rural providers, safety net providers, specialty mix)	✓		
Complaint/grievance/ disenrollment reviews	✓	✓	
Case file reviews	✓		
Beneficiary surveys	✓	✓	
Utilization analysis (emergency room use, preventive care use)	✓	✓	
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

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

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program ***NA***	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	____ Yes ✓ No	____ Yes ____ No	____ Yes ____ No
Requiring submission of aggregate HEDIS data by health plans	____ Yes ✓ No	____ Yes ____ No	____ Yes ____ No
Other (specify) _____	____ Yes ____ No	____ Yes ____ No	____ Yes ____ No

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

For Phase I

- ***Medicaid access to care measures apply to all Medicaid enrollees, the Phase I CHIP children are not separated out***.

For ALL Kids

- ***UAB conducted a retrospective survey of first year enrollees in CHIP Phase II - ALL Kids (see attachment 3). This survey was mailed to a random sample (6,200) of the households of the 25,748 children that enrolled in ALL Kids from October 1, 1998 to September 30, 1999. The primary purpose of this first year survey was to determine the difference in access to care before the child was enrolled in ALL Kids and after the child enrolled in ALL Kids. Of the 6,200 surveys mailed, 85 were returned with undeliverable addresses. At this time, approximately 3,538 (58%) have returned the survey.***

- ***Among the survey respondents, half of the children are in the 6 – 12 age group, 34% are over thirteen years of age, and about 16% are five years of age or younger. Almost 75% of the respondents rated the child's health very good or excellent, 23% rated the child's health good, while less than 5% rated the child's health fair or poor. Twenty-nine percent never had insurance before ALL Kids. Almost 37% have been on Medicaid in the past. The main reason stated for not having insurance is that it cost too***

main reason stated for not having insurance is that it cost too much.

- ***Most reported that access to care for their child improved. For example, before enrolling in ALL Kids, about 67% of the respondents did have one particular doctor they saw when sick. After enrolling, 82% did have a primary health care provider. When asked if there was ever a time that the child needed medical care but could not get it for any reason, before enrolling in ALL Kids, 36% answered yes. After enrolling, 96% said could get medical care when the child needed it.***

- ***The respondents were asked how many times did the child go to a hospital emergency room. Before ALL Kids, almost 28% said they had been three or more times and 34% had been one or two times. After ALL Kids 8% made three or more trips to the emergency room while 20% went once or twice.***

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

- ***For Phase I, Medicaid access to care measures apply to all Medicaid enrollees, the Phase I children are not separated out. No changes are planed for the future.***

- ***For ALL Kids, the UAB Access to Care Survey will be an ongoing process.***

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

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

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

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

For Phase I

- ***Medicaid quality of care measures apply to all Medicaid enrollees, the Phase I children are not separated out.***

For ALL Kids

- ***Those responding to UAB's Access to Care Survey (see attachment 3) were given the opportunity to voice concerns or express thoughts on the ALL Kids program. Forty-five percent of those returning surveys made a comment. Of those that responded, almost 16% expressed a sense of relief or security since their child has been enrolled in ALL Kids. Almost 40% expressed praise or thanks for the program. Eleven percent thought their child received better care since being enrolled in ALL Kids. Six percent had questions about ALL Kids coverage. Few expressed complaints about the coverage or the program in general. Overall, ALL Kids received overwhelming positive responses from those surveyed.***

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

For Phase I

- ***Medicaid access to care measures apply to all Medicaid enrollees, the Phase I children are not separated out. No changes are planed for the future.***

For ALL Kids

- ***The UAB surveys will continue to be used as a tool for monitoring quality of care. As children disenroll from ALL Kids, parents will be asked questions pertaining to the care they received while enrolled in ALL Kids.***

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

- ***UAB Access to Care Survey (attachment 3)***

- ***BCBS "An Analysis of Health Care Cost and Utilization" report (attachment 6). In this report, the claims experience of the ALL Kids population is compared to the claims experience of BCBS's total population. There are some limitations to these comparisons. The ALL Kids population is made up entirely of children and the BCBS population contains all ages. Nevertheless, this provides a first assessment of usage. Plans are being made to compare the ALL Kids population to other private insurance groups.***

SECTION 5. REFLECTIONS

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

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

5.1.1 Eligibility Determination/Redetermination and Enrollment

- ***Because of the short time frame for getting Phase II, ALL Kids operational, the program partnered with a sister agency, State Employee's Insurance Board (SEIB), to operationalize our eligibility and enrollment for ALL Kids. Since they were in the business of compiling insurance information on state employees and transmitting such to insurance vendors, we were able to modify their existing system to accommodate ALL Kids enrollment. As a result, SEIB was able to hire staff, add equipment and have a system for enrollment in place in approximately 3 months. In order to become functional in such a short time, it was decided that the enrollment would be handled from a central location using a mail-in application. Another key decision was to use a joint application form with SOBRA Medicaid so applicant information could be shared between the two programs. All of the above decisions have both strengths and weaknesses.***

- ***After our kick off press conference and after sending 850,000 applications packets to all children in public schools in Alabama, our ALL Kids enrollment unit was flooded with applications. Again, it was decided that all attention of enrollment staff would be devoted to processing of applications and supporting the function of getting eligible children enrolled in ALL Kids. We had to add additional staff during the first year of operation to handle the volume of information coming in and even gave temporary assignments to several ADPH staff to work with the SEIB enrollment unit. The philosophy that guided the early decision making in starting ALL Kids was reflective of doing all that was necessary to get these children access to health care as quickly as possible. As a result, we exceeded by 31% our goal of enrolling 20,000 children in ALL Kids in the first year with obtaining an enrollment of 26,213. When that number is added to the 16,696 children who were enrolled in Phase I CHIP and the 30,000 additional children enrolled in SOBRA Medicaid, Alabama had at least 70,000 children who received health care because of the statewide initiative.***

- ***It was decided that ALL Kids enrollment should be kept as simple as possible and the system was established to accept application information by declaration except for proof of age. The decision to use a joint application form with SOBRA Medicaid was important since over half of the applications received for ALL Kids were Medicaid eligible. The difference in documentation and procedures for the ALL Kids and SOBRA Medicaid programs has resulted in comparisons, which in some cases have provided the opportunity to try procedures with ALL Kids and then later consider the applicability to Medicaid.***

5.1.2 Outreach

- ***The planning and implementation of CHIP was done in Alabama using a broad based work group to research issues and make recommendations on how we could best develop services for the uninsured in Alabama. The workgroup included other state agencies (Alabama Medicaid Agency, Department of Human Resources, Department of Mental Health and Mental Retardation, Department of Education and State Employee's Insurance Board), advocacy groups (Alabama Arise, Family Voices and Voices for Alabama Children), hospitals, community health centers, FQHC's and professional associations (Alabama Hospital Association, Medical Association of the State of Alabama, Alabama Pharmacy Association, Alabama Chapter of the American Academy of Pediatrics, Alabama Family Practice Physicians Association and Alabama Primary Care Association), When the implementation of Phase II began the state adopted the approach of "shot gun" outreach. Information was sent from a state level to local levels using the partners who worked with the CHIP planning. A detailed information brochure with application and stamped, self addressed envelope was used as the primary outreach tool. The agencies, advocacy groups and associations assisted by arranging forum meetings and mailings to send information to their local level constituencies. This shot gun approach (Just like a shot gun blast, we hit in some places and missed in others.) coupled with widespread public service announcements and press conferences resulted in ALL Kids receiving applications on approximately 90,000 children in the first year of the program.***

- ***By partnering with other entities and using public service announcements and press releases, and distributing information from a state wide level, outreach costs were kept to a minimum during the first year of operation. Most of the outreach funds during the first year were used to develop and print attractive, user friendly, mail in application packets that have been well received.***

5.1.3 Benefit Structure

- ***The benefits package developed for ALL Kids is comparable to private purchase insurance and to state employee's insurance. This has resulted in it being a very desirable insurance package. We continue to use our first year of operation to assess the areas for which additional coverage is needed, particularly for children with special needs, so that enhancements can be developed. The state is currently implementing additional benefits for special needs children under an ALL Kids Plus plan.***

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

- ***Alabama is pleased to note that 74% of the children that have been enrolled in ALL Kids are in the no-fee group with incomes less than 150 of FPL. Therefore only 26% of our ALL Kids enrollment are subject to modest annual premiums and cost sharing for some benefits. We are in the process of implementing a disenrollee survey to be sent to each family who has a child that moves off ALL Kids. One area that will be studies will be to see if there have been any negative effects on the enrollment with cost sharing.***

- ***Since a smaller portion of our enrollees have been in the fee group, we are phasing out using a third party contractor to collect premiums and that function has been moved to the enrollment administrator.***

5.1.5 Delivery System

- ***Over 98% of the children who are enrolled in ALL Kids are in the plan administered by Blue Cross Blue Shield (BCBS) of Alabama. Currently 82% of the people insured in this state are insured by BCBS. As a result, BCBS has an extensive network of providers that is now available to the ALL Kids population. Additionally, the reimbursement for ALL Kids services is based on the preferred provider rates developed by BCBS. All of this has resulted in very positive provider participation in ALL Kids.***

- ***Where there have been gaps identified in the BCBS provider networks, other providers have been added. For example, the state clinic system for children with special health care needs has been added to the BCBS network in addition to the community mental health centers. We have also allowed for nurse practitioners to be reimbursed (within certain standards) for providing ALL Kids services. This has helped the community health centers, particularly the satellite offices where a full complement of medical staff are not always available.***

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

- ***As mentioned in 5.1.2 above, Alabama has used a very broad based work group to assist with development and implementation of CHIP. This group was responsible for influencing the securing of legislative action and an appropriation of $5 million to implement CHIP within the state within one month of passage of the federal legislation. The efforts of this broad based work group also was a major factor in Alabama being the first state in the nation to have the CHIP plan approved. The workgroup was divided into four committees (benefits, financing, eligibility and outreach) that provided input into the major areas of program development. The***

implementation of ALL Kids was only effective because of the support from the agencies, associations and advocacy groups with their local constituencies.

- ***Our future outreach plans will involve coordination with agencies as we have done in the past but with emphasis on outreach strategies by regions of the state and certain targeted populations rather than state wide "shot gun" outreach strategies.***

5.1.7 Evaluation and Monitoring (including data reporting)

- ***We are now in the process of analyzing and assessing our current CHIP operations and developing strategies to strengthen our management and administrative capabilities. We have very promising data from the first surveys completed on a sample of the first year enrollees. We have a strong partnership with UAB to assist us in gathering further survey data and analysis of our claims and application information. We anticipate having excellent data available to make decisions on the future program initiatives.***

5.1.8 Other (specify) _____

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

- ***We now have a joint application that can be used for SOBRA Medicaid, ALL Kids and the BCBS Caring Program. This will enable the state to joint outreach and target application information to the appropriate program. This should greatly enhance the ability of families with uninsured children to access the care that is available. Since we have two systems for enrollment with one based on statewide mail in applications and the other with local out stationed eligibility workers, we are in the process of gathering evaluative data and using that information to compare each program's strengths. We will also look to ways to streamline the two systems and to make them as compatible as possible.***

- ***A strong partnership has developed with the grantee for the Robert Wood Johnson Covering Kids project in the state. The three pilot sites for that program will be used to test outreach, enrollment and re-enrollment strategies and decide applicability to state wide initiatives.***

- ***Future initiatives will include developing more "user friendly" literature while identifying more and different distribution sites for ALL kids information. We are partnering with the free and reduced price lunch program with schools systems and attending more district, regional and state meetings to educate those who have contacts with potential eligibles. We will divide the state into small geographic areas where concentrated outreach will be completed using Medicaid and media broadcast areas. Education and training in those areas will be provided throughout the community to increase the identification of those who are potentially eligible.***

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

- ***The restriction in the federal law which prohibits children of state employees from being considered for enrollment in a separate SCHIP program has caused barriers in Alabama. We have many state employees whose income is well within the ALL Kids guidelines and they are not able to afford the $164 month premiums for family coverage. We would like to see that prohibition removed.***