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

Preamble

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

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

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

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

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

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

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

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

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

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

Name: Position/Title:
Name: Position/Title:
Name: Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments

concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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

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

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

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

1.1.3. ☐ A combination of both of the above.

In May 1998, the Arizona legislature approved Senate Bill 1008 (Laws of 1998, Chapter 11) authorizing the implementation of a Title XXI Child Health Insurance Program. This program is referred to as KidsCare (see Attachment A). The passage of the legislation was the culmination of many meetings convened by Governor Jane Dee Hull and legislative hearings which provided a venue for the public to testify about the proposal. Additionally, staff from AHCCCS, Arizona's Medicaid program, have met continually with interested parties to discuss the implementation of the program.

Arizona submitted a Title XXI State Plan to extend health care coverage statewide for children up to the age of 19. The effective date for the State Plan was October 1, 1997 which enabled the state to prepare for the implementation of the program. Actual services were rendered beginning November 1, 1998. Income thresholds were set at 150% of federal poverty level (FPL) at the beginning of the program. Beginning October 1, 1999 income levels were raised to 200% of the FPL. Arizona does not impose a resource test for this population. AHCCCS performs all KidsCare eligibility determinations for new applicants and redeterminations of eligibility based on a simplified eligibility process. A process has been implemented to determine whether a child is eligible for Medicaid prior to a determination of eligibility for KidsCare.

Arizona provides KidsCare services through established AHCCCS health plans which are referred to as contractors throughout this document.

All children have a choice of available contractors and primary care providers in a geographic service area. Additionally, Native Americans can elect to receive services through the Indian Health Service (IHS), 638 tribal facilities or one of the contractors. The KidsCare service package is the same service package offered

to Medicaid recipients. AHCCCS coordinates educational activities with the assistance of safety net providers, other state agencies, tribal entities and organizations, advocacy groups and other appropriate entities.

Copayments are assessed for all members, except Native Americans. In addition, families with income above 100% of FPL are assessed premiums. The total cost for premiums and copayments will not exceed 5 percent of the family income.

The number of children who are eligible for the program may be capped based on the available state and federal funding.

AHCCCS coordinates with other private and public programs which provide health care services to children. Arizona does not want to encourage employers or parents to discontinue current insurance coverage for children. Therefore, as a protection against "crowd out", children must be without group health insurance for three months before eligibility will be granted for KidsCare.

The three month bar provision will be waived under the following circumstances:

1. Reached their lifetime insurance limit;
2. Are newborns;
3. Are transitioning Title XIX members;
4. Are applicants who are seriously or chronically ill;
5. Are Title XXI members who lose insurance coverage;
6. Are enrolled with Children's Rehabilitative Services; or
7. Are Native American members receiving services from IHS or a 638 Tribal Facility.

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

AHCCCS assures that the expenditures for child health assistance are not claimed prior to the time that the state has legislative authority to operate the State plan or plan amendment as approved by CMS.

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

AHCCCS ensures that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

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

Original Implementation date: November 1, 1998

Amendment #9 Effective date: February 1, 2004 (premiums >150% FPL)
July 1, 2004 (premiums 100%-150% FPL)

Amendment #12 Effective date: January 1, 2010 (KidsCare Enrollment Freeze)

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

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

When the KidsCare program was implemented, AHCCCS used the CPS methodology described in Attachment B. Since March 2000, AHCCCS has opted to use the CPS methodology to describe the manner and extent to which the children in the state targeted the low-income children and other classes of children, by income level and other relevant factors to make a distinction between creditable coverage under public health insurance programs and public private partnerships.

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

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

The state is taking a number of steps to identify and enroll children who are eligible for public health insurance programs. The following describes these programs.

<u>MEDICAID HEALTH INSURANCE</u>

Arizona has several on-going major public efforts aimed at identifying, referring, and enrolling children in public insurance programs. Arizona currently has a an amendment to our 1115 Waiver enabling the state to cover persons up to 100% of the FPL, a HIFA Waiver for parents, and numerous public health programs that provide health care services to children.

Formal referral processes are in place between governmental and community agencies which aid in the identification, referral and enrollment of uninsured children in the appropriate program. For example, by state law, children and pregnant women must be screened for Medicaid eligibility before applying for state-funded public programs or private programs. Coordination efforts have become even more critical since the implementation of KidsCare in November 1998.

As of May 1, 2002, AHCCCS health plans provided Medicaid services to 680,716 acute care Medicaid members and 34,334 long term care members enrolled in the Arizona Long Term Care System. Acute care members are individuals who enrolled with the AHCCCS health plans but not eligible for the Arizona Long Term Care System. Included in the acute care population are 73,713 Native Americans who elected to receive Medicaid services from the IHS. Arizona currently serves 371,267 children under the age of 19 through Medicaid. As of May 1, 2002, 48,212 children were enrolled in KidsCare.

The state has several agencies who perform eligibility functions. The Arizona Department of Economic Security (DES) processes applications and determines eligibility for Medicaid groups, except the SSI Cash, SSI-Medical Assistance Only (MAO) groups, the Medicare cost sharing programs, and ALTCS. For SSI-Cash, the Social Security Administration performs the eligibility determinations. AHCCCS performs eligibility for SSI-MAO, the Medicare cost sharing programs, and ALTCS. As mentioned in Section 1.1.3, AHCCCS determines KidsCare eligibility.

EFFORTS TO IDENTIFY AND ENROLL CHILDREN IN PUBLIC INSURANCE PROGRAMS

In addition to Medicaid, Arizona has five public initiatives which identify and help enroll children in programs that serve children. AHCCCS coordinates with these programs and initiatives to ensure that children who do not qualify for KidsCare are referred to other public and private programs.

Outstationed Eligibility Workers

Arizona has outstationed eligibility workers at some of the 14 Federally Qualified Health Centers (FQHCs), in hospitals which serve a disproportionate number of low income persons, and at five Arizona Department of Juvenile Corrections locations. At these outstationed sites, a person applying for Medicaid is assisted by an eligibility worker who submits a completed application to the appropriate eligibility office.

Community Health Centers

Arizona has 32 community health centers that offer a wide range of health care services based on a sliding fee scale. Community health centers provide primary care services, including care for acute and chronic illnesses, injuries, family planning and prenatal care, emergency care and diagnostic services.

Maternal and Child Health Block Grant

Maternal and Child Health Block Grant funds are administered by the Arizona Department of Health Services (ADHS). This department funds, monitors and evaluates a variety of statewide community-based programs, which provide education and assistance for enrollment in public health insurance programs. These programs include: Healthy Start, High Risk Perinatal Programs, Pregnancy and Breast Feeding Hotline, Children's' Information Center, Reproductive Health, County Block Grant and Children's' Rehabilitative Services.

Children's Rehabilitative Services

Funded by a Title V block grant, the ADHS/Children's Rehabilitative Services (CRS) provides health care services to children with special health needs. Additionally, Medicaid eligible children receive services through CRS and AHCCCS reimburses ADHS with Medicaid funds for covered services provided by the program. A DES Family Assistance eligibility worker is located at each CRS site and field clinic to process applications for public assistance programs.

Indian Health Services (IHS) and Tribal Entities

There are three IHS Area Offices in Arizona: Phoenix, Tucson and Navajo. Each area office has a designated service delivery area in which IHS Service Units and health centers provide health care services to Native Americans, including those who are AHCCCS members.

There are three urban Indian Health Centers in Arizona. Each has a unique relationship with the IHS and receives an allotment from the IHS federal appropriation to provide health care services to Native Americans residing in Phoenix, Tucson and Flagstaff.

Tribal governments have established healthcare programs for tribal members. In general, the majority of these services are behavioral health

services and/or alcohol and substance abuse programs.

The Gila River Indian Community has opted to contract for the delivery of health care from the Phoenix Area IHS through the P.L. 93-638 contracting process. The Gila River Health Care Corporation is the tribal governing body which oversees the operation of the HuHuKam Memorial Hospital which is located on the Gila River reservation. The hospital provides primary health care services to tribal members and also operates an outpatient clinic on weekdays with scheduled appointments.

In addition, the Gila River Indian Community Department of Health, operates a Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) program through an intergovernmental agreement with AHCCCS. This tribal program ensures that children receive the services required under the EPSDT program.

AHCCCS continues to look at ways of increasing enrollment of Native American families in both reservations and urban communities. The *KidsCare News* is a newsletter that provides information of special interest to the tribal communities. The AHCCCS Native American Coordinator is a key link between AHCCCS and the tribal community promoting communication and education to the members.

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

STATE FUNDED PROGRAM

Unlike some states, Arizona does not have public-private partnerships with insurers which offer child health insurance products. In 2002, the legislature authorized 100%state-funding for the working poor, with income up to 200 percent of FPL. Persons who are chronically ill as defined in rule, may have household income up to 400 percent of the FPL.

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

Additional efforts by AHCCCS include the partnership with the Department of Education (DOE) to provide information to families

about KidsCare through the Child Nutrition Program (school lunch program). Due to the success of this partnership, AHCCCS plans to explore other methods to reach children through the schools.

AHCCCS has also partnered with small businesses and minority business companies in the community to disseminate information about the SCHIP Program.

AHCCCS has developed and implemented a universal application (*Application for AHCCCS Health Insurance*) to simplify the referral and eligibility processes for individuals and families when applying for SCHIP, Medicaid and state-funded programs. Users of this application include the general public, eligibility staff, hospitals, advocacy groups, community organizations and agencies. This application is also available on the Internet.

AHCCCS is partnering with a group of community health centers to demonstrate a web based eligibility application. Health-e-Arizona is a partnership between the Community Health Centers Collaborative Ventures, Inc. (CHCCV), AHCCCS and the Department of Economic Security (DES). Effective June 17, 2002, Health-e-Arizona is being piloted at El Rio Health Center. After a test period, Health-e-Arizona will be piloted at 7 CHCCV member organizations in 35 sites statewide. Deloitte Consulting, (who developed Health-e-App for the California HealthCare Foundation), worked with CHCCV, AHCCCS and DES to modify the application to meet Arizona's requirements. Health-e-Arizona enables clinic workers to screen for Title XIX and Title XXI eligibility. Clinic workers will send completed applications, documentation and signatures electronically to AHCCCS and DES. This project was funded by CHCCV without Title XIX, Title XXI or state funds.

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

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

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

AHCCCS administers the Title XXI KidsCare Program. The program uses Title XXI funding to provide targeted, low income children with a choice of one of the 10 prepaid, capitated AHCCCS health plans, the Indian Health Service and P.L. 638 tribal facilities.

AHCCCS HEALTH PLANS

In partnership with AHCCCS, the health plans have been delivering quality, managed care services for almost 20 years. Their commitment to quality management is evidenced by the fact that at least half of the contractors voluntarily have sought and received accreditation from the National Committee for Quality Assurance (NCQA). Please see Attachment E for a profile of the current health plans who participate in the KidsCare Program.

AHCCCS health plans have been very successful in assuring access to care. Over 89 percent of practicing physicians in the state participate in the program. Care is available in a wide range of settings, including FQHCs and many of the Rural Health Centers, who have elected to subcontract with the health plans.

AHCCCS health plans are held to the same standards for KidsCare that are required for the Medicaid program. In order to secure a contract to deliver Medicaid services, bidders must respond to a Request for Proposal (RFP) and submit a proposal with specific capitation rates for one or more of the nine geographic service areas in the state. A critical element in the bid evaluation performed by AHCCCS is an assessment of how each prospective contractor will meet all financial and operational requirements, ensure quality of care and provide a sufficient network to meet specified accessibility requirements. Following is a more detailed description of the elements which are scored during the RFP process:

Program

- Member Services
- Quality and Utilization Management

- Early Periodic Screening Diagnosis and Treatment
- Maternal Health/Women's Health
- Behavioral Health Services

Provider Network

- Development of Capacity
- Management and Oversight

Organization

- Organization and Staffing
- Fraud and Abuse
- Subcontracts
- Claims and Third Party Liability
- Liability Management
- Grievance and Appeals
- Financial Standards
- Encounters

Capitation Rates

- All offerors submit detailed capitation bids which are evaluated against actuarially sound rate ranges. For the KidsCare Program, AHCCCS sets the rates based on an actuarial analysis.

Ongoing Monitoring

AHCCCS monitors the solvency of the health plans and their delivery of health care services with the following activities:

Quarterly and annual financial reporting

- On-site annual operational and financial reviews
- Performance measures using administrative data and medical records
- Member surveys
- Network reporting
- Encounter validation studies to determine completeness, accuracy and timeliness
- Solvency standards
- Coordination of benefits
- Educational efforts
- Medical studies
- Frequent meetings with contractors' executive management

Other Intergovernmental Agreements

In addition to amending health plan contracts, AHCCCS has amended the current Intergovernmental Agreements with the ADHS for behavioral health services and children's rehabilitative services, and the DES for KidsCare services provided to foster care children. Amendments with ADHS are necessary to provide behavioral health services through the Regional Behavioral Health Authorities for the KidsCare population and to reimburse ADHS for services provided to KidsCare eligible special needs children who are also enrolled in the CRS program. The amendment with DES is necessary to direct foster children eligible for KidsCare to the Comprehensive Medical and Dental Program, which is the current health plan for foster care children.

Indian Health Services/638 Tribal Facilities

AHCCCS also enables KidsCare eligible Native American children to use the Indian Health Service or 638 facilities operated by tribal governments who want to participate in the program. Of course, a Native American child who is eligible for KidsCare may also elect to enroll with one of the available AHCCCS health plans or a participating state employee HMO.

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

AHCCCS has a managed care system that relies on multiple strategies to provide appropriate and medically necessary services. Children enrolled in the KidsCare Program have a choice to enroll with any of the available contractors in their geographic service area, including Indian Health Services, and have the right to choose a primary care provider (PCP) from the available practitioners. The PCP is contractually responsible for coordinating the care of members and approving referrals for medically necessary specialty services.

The AHCCCS Medical Policy Manual (AM/PM), which is available to all contractors and providers, specifies covered and excluded services under the KidsCare Program, as well as prior authorization (PA) requirements.

Each contractor is responsible for maintaining a utilization management program which includes: medical claims review, concurrent review, inpatient discharge planning, profiles of individual providers, drug utilization monitoring, analysis of durable medical equipment orders and non-emergency prior authorization.

Contractors must have a 24-hour telephone number staffed by health care professionals who advise members about the appropriate use of the emergency room and how to use urgent care centers. KidsCare members are subject to a $5.00 copayment when Emergency Departments are utilized for nonemergency services, in order to discourage inappropriate use of these facilities.

AHCCCS reviews and monitors contractors' utilization management through an analysis of their financial reporting, through on-site operational and financial reviews and reviews of the utilization reports and the annual utilization management plan submitted by the contractors. These tools are discussed further in Section 7.1.

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

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

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

4.1.1. ☒ Geographic area served by the Plan: Statewide.

4.1.2. ☒ Age: KidsCare is available to children under 19 years of age. A child is considered to be under age 19 through the day before the child's 19th birthday. Coverage will continue through the month in which the child turns age 19.

4.1.3. ☒ Income: The combined gross income of the family household members may not exceed 200% of the FPL. As required by CMS, certain payments and grants as specified in 20 CFR Part 416, the Appendix to Subpart K, are excluded when determining gross income. All wages paid by the Census Bureau for temporary employment related to census activities are excluded.

See Attachment G for a description of family household income and the methodology for evaluating family income.

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources): No Resource Test.

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): Arizona residency is required. An Arizona resident is a person who currently lives in Arizona and intends to remain in the state indefinitely. AHCCCS requires a signature on the application declaring that the child is an Arizona resident.

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

4.1.7. ☒ Access to or coverage under other health coverage: A child is not eligible for KidsCare if the child is:

- Eligible for Medicaid.
- Covered under an employer's group health insurance plan.
- Covered through family or individual health care coverage.

- Eligible for health benefits coverage under a state health benefits plan on the basis of a family member's employment with a public agency (see Attachment H).
- Covered under an employer's group health insurance plan or by private insurance within the last three months and the health insurance coverage was terminated for a reason other than involuntary loss of employment. This exclusion does not apply to persons with group health insurance who resigned from employment to avoid termination of employment. This exclusion also does not apply to children who:
    1. Reached their lifetime insurance limit;
    2. Are newborns;
    3. Are transitioning Title XIX members;
    4. Are applicants who are seriously or chronically ill:
    5. Are Title XXI members who lose insurance coverage;
    6. Are enrolled with Children's Rehabilitative Services; or
    7. Are Native American members receiving services from IHS or a 638 Tribal Facility.

4.1.8. ☒ Duration of eligibility:

- Fails to cooperate in meeting the requirements of the program;
- Cannot be located;
- Attains the age of 19.
- Is no longer a resident of the state;
- Is an inmate of a public institution;
- Is enrolled in Medicaid;
- Is determined to have been ineligible at the time of approval;
- Obtains private or group health insurance;
- Is adopted and no longer qualifies for KidsCare;
- Is a patient in an institution for mental diseases; or
- Voluntarily withdraws from the program.

KidsCare members are notified on the approval notice of the requirement to report changes that affect eligibility. Ineligibility due to excess income does not affect the initial 12 months of continuous coverage.

4.1.9. ☒ Other standards (identify and describe):

Citizenship or Qualified Alien Status. A child must be a United States citizen or a qualified alien. Unless one of the exceptions listed in P.L. 104-193 is applicable, a child who is a qualified alien who entered the United States on or after August 22, 1996 is not eligible for KidsCare until five years after the child became a qualified alien.

Assignment of Rights. Under Arizona law, assignment of payments for medical care from any first or third party occurs when the application is signed. Assignment is explained on the application form.

Social Security Number. The application for KidsCare is a joint application for Medicaid and KidsCare. AHCCCS requests a Social Security Number on the KidsCare application but does not deny eligibility for KidsCare due solely to the failure to provide a Social Security Number or refusal to apply for a Social Security Number. However, if the financial screening determines that the child would be eligible for Medicaid if an application were processed and the child, or responsible party, refuses to apply for a Social Security Number necessary to complete the Medicaid application, AHCCCS denies the KidsCare eligibility. Please see the requirement in Section 4.4.2.

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

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

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

The following describes the methods of establishing and continuing eligibility and enrollment.
The child, a family member or legal guardian, fills out a simple application form, which is submitted, to AHCCCS. If assistance with the application is needed, appropriate personnel assist the applicant. The form also serves as an application for Medicaid.

AHCCCS has published the application form and instructions for completing the form in English and Spanish. Based on the demographics in Arizona of other ethnic groups, AHCCCS does not believe that developing the application in other languages is necessary since no other ethnic group exceeds 3% of the population. However, an interpreter is provided, if needed.

AHCCCS completes an eligibility determination for KidsCare applications within

30 days from the date of receipt of a signed, completed application in an AHCCCS eligibility office except in unusual circumstances. One example would be when the agency can not reach a decision because the applicant failed to provide required information or take required action.

When information needed to make an eligibility determination is not submitted with the application, AHCCCS sends a notice to the applicant or the representative outlining the information required and the time frame for providing the information. AHCCCS gives applicants ten calendar days to provide any information necessary to enable AHCCCS to determine the applicant's eligibility.

Applicants must choose a health plan or the IHS before enrollment into the KidsCare Program.

Written materials about the various health plans and their toll-free telephone numbers are available with the application form. In addition, the covered services are outlined in the written materials. If a Native American selects the Indian Health Service or a tribal facility, AHCCCS provides any KidsCare services not provided by these entities on a fee-for-service basis off-reservation.

The KidsCare providers are:

- AHCCCS health plans, which includes Comprehensive Medical and Dental Program (CMDP) for foster care children.
- For Native Americans, any of the above or the Indian Health Service or a 638 tribal facility.

For eligibility determinations completed by the 25th day of the month, KidsCare eligibility begins with the first day of the month following the month in which the child is determined to meet the eligibility criteria for the program. Children who are determined eligible for the program after the 25th day of the month are eligible for the program the first day of the second month following the determination of eligibility.

Once the application is approved, the applicant is enrolled with their chosen provider and AHCCCS sends a notice confirming the choice and a member identification card to the member. Following enrollment, the contractor provides a member handbook to the member, which contains important information about how to access health care for KidsCare eligible children.

AHCCCS approves a newborn of a mother who is eligible for KidsCare on the date the child is born and enrolled in the KidsCare Program. The newborn's KidsCare eligibility begins with the newborn's date of birth. Prior to approval, the agency contacts the mother by telephone to reverify household composition and

monthly income. Once approved for KidsCare, AHCCCS enrolls the newborn with the mother's health plan. AHCCCS notifies the mother by mail of the newborn's enrollment into KidsCare and is given an opportunity to change health plans at that time.

If a member of a family is enrolled in KidsCare and another child is born to the family, AHCCCS enrolls the newborn in KidsCare if the family income meets the KidsCare criteria. Eligibility is prospective. The same process applies to a child who may be reunited with a family.

A member is allowed to change contractors on an annual basis and when an individual moves into a new geographic area not served by the current contractor. A member can change PCPs at any time. The option to change contractors is based on the member's anniversary date, which is the first day of the month that the member is enrolled into KidsCare. Ten months following the anniversary date, the member will be sent an annual enrollment notice advising that a different contractor may be selected. A list of contractors, with toll-free numbers and the available services, is included. The member, or parent of the child, has three weeks to change contractors. If a change is requested, the effective date is a year from the anniversary date. Enrollees must notify AHCCCS of a change in address or other circumstances that could affect continued eligibility or enrollment.

Children who elect to enroll with IHS or a 638 tribal facility are allowed to disenroll at any time upon request and choose a contractor for all KidsCare services. Similarly, Native American children enrolled with a contractor or other provider, are allowed to disenroll at any time upon request and enroll with the IHS.

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

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

Due to insufficient state funds, an enrollment freeze has been placed on the KidsCare program effective January 1, 2010. The program will place individuals on a waiting list and no new applications will be processed until such time that the AHCCCS Administration is able to verify that funding is sufficient, and the Governor agrees that the AHCCCS Administration may begin processing new applications.

Despite the KidsCare enrollment freeze, applications will continue to be evaluated and processed for potential Medicaid eligibility. If a child does not meet the Medicaid eligibility requirements, the authorized representative of

the child will be notified in writing of the denial of Medicaid and will also be notified of the denial of KidsCare due to the enrollment cap. The notice will also state that the child will be placed on a waiting list for KidsCare.

Children who have current enrollment in the KidsCare program will be allowed to continue to renew their enrollment so long as they continue to meet all the eligibility and renewal criteria including timely premium payments.

When sufficient funding becomes available and the Governor agrees that the AHCCCS Administration may begin processing new applications, the Administration shall contact an applicant on the waiting list and ask the applicant to submit a new application if the original application is more than 60 days old. The Administration shall fill spaces in the order that an application is received and approved. In the event the enrollment freeze is lifted, public notice will occur using the methods described above for the implementation of the freeze. CMS will also be notified in writing.

4.4. Describe the procedures that assure that:

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

AHCCCS ensures that a child who is not eligible for Medicaid, but who meets KidsCare eligibility criteria, is enrolled in KidsCare. AHCCCS administers both the Medicaid and KidsCare Program. Medicaid screening is part of the KidsCare eligibility determination process. Records of KidsCare eligibility are maintained in a database that is also used for Medicaid eligibility. The database is checked for current Medicaid eligibility before determining KidsCare eligibility. Medicaid eligibility always overrides KidsCare eligibility.

AHCCCS accepts a declaration on the application confirming that there is no other creditable insurance including the state health benefits plan. A family member, legal representative or the child is required to report changes in employer insurance coverage or eligibility for group health insurance or other creditable insurance.

When conducting a renewal (periodic redetermination) of KidsCare

eligibility, AHCCCS screens for potential Medicaid eligibility, group health plan, health insurance coverage, or other state health benefits. If a child appears to meet the Medicaid eligibility criteria, AHCCCS forwards a copy of the renewal application and all obtained verification to the Department of Economic Security staff for an eligibility determination. For review of potential group health plan coverage see section 4.4.4.1.

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

As stated in subsection 4.4.1, AHCCCS administers both Medicaid and the KidsCare Program and ensures that any child eligible for Medicaid is enrolled in Medicaid. The application form used for KidsCare initiates an application for Medicaid, which is determined simultaneously. Medicaid eligibility always overrides KidsCare eligibility.

If a child appears to meet Medicaid eligibility criteria, AHCCCS forwards a copy of the application and all obtained verification to the Department of Economic Security staff for an eligibility determination. Prior to a full Medicaid determination, AHCCCS enrolls the child into KidsCare. If the child is approved for Medicaid, AHCCCS claims Medicaid funding, rather than KidsCare funding, back to the date of Medicaid eligibility which generally is prior to the KidsCare eligibility effective date.

If the KidsCare staff screen a child both Medicaid and KidsCare ineligible, they forward the application to the AHCCCS Central Screening Unit (CSU). The CSU reviews the application and makes a full Medicaid eligibility determination. If the child is ineligible for Medicaid due to income, the CSU sends notification of the decision to the family.

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

In addition to the process described in subsection 4.4.1., the Department of Economic Security sends information daily to AHCCCS on children who lose their Medicaid coverage due to increased income. If eligible, AHCCCS approves the children for KidsCare.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the

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

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

The application requests information about group health plan coverage within the past three months. If a child is covered by group health insurance or was covered and the coverage was voluntarily discontinued, the child is not eligible for KidsCare for a period of three months unless the child has exceeded the lifetime limit to his or her insurance policy. AHCCCS grants exceptions to the three month period of ineligibility as discussed in 4.1.7.

AHCCCS monitors substitution under its Quality Control and Quality Assurance process to analyze the extent to which an applicant drops other health plan coverage. Records are reviewed to ensure that the three month period of ineligibility policy is applied appropriately. Action is taken as needed. Trends are monitored to ensure that the policy is consistantly applied throughout the program.

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

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

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

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

The minimum employer contribution.

The cost-effectiveness determination.

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

Meetings to discuss the KidsCare Program and education strategies have been and continue to be held with representatives from the three area IHS agencies, the Arizona Inter-tribal Council, which represents 20 of Arizona's 21 Indian Tribes, the Navajo Nation, Urban Indian Centers and the Indian Health Advisory Committee. In addition, the Governor's Office convened a meeting to discuss the KidsCare Program and invited representatives from the 21 tribes See Attachment I for a listing of the tribal entities who have participated in the discussions.

As discussed in Section 3, IHS and participating 638 tribal facilities may provide KidsCare services. In addition, Native American children may choose to enroll with a contractor in their geographic area.

Applications and enrollment information are available at IHS and appropriate tribal locations. AHCCCS also uses Native American events, newspapers, and radio stations as a forum for outreach. If IHS or tribal staff are willing to assist applicants in completing the application for AHCCCS health insurance, AHCCCS provides training.

AHCCCS has a Native American Coordinator who is available to the tribes for consultation, information and presentations.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

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

Arizona has designed a very effective educational program with the community to inform families about the availability of KidsCare and assist children with enrollment in the KidsCare Program. To accomplish these two goals, Arizona has established numerous coordination procedures as required by Title XXI.

Prior to implementation of KidsCare in 1998, the Governor's Outreach Work Group, with representatives from the following agencies/organizations, met several times to develop a comprehensive education plan:

AHCCCS
Arizona Association of Community Health Centers
Arizona Chapter of Academy of Pediatrics
Arizona Children's Action Alliance
Arizona Children's Association
ADHS/Community and Family Health Services
AHCCCS Contractors
Arizona Prenatal Care Coalition
Inter-tribal Council
Phoenix Children's Hospital
Participating Indian Tribes

The Governor's Office and AHCCCS worked collaboratively with tribal entities to inform Native American families about the availability of KidsCare and to assist in enrolling children in KidsCare. Please refer to Section 4.4.5 for a description of the Native American activities.

These efforts by AHCCCS have modeled successful methods used by other child-related programs (Maternal Child Health Block Grants and Women, Infants and Children Program [WIC]). The distribution of applications is targeted to those agencies, organizations and other entities who currently serve low income children. These efforts include providers for children with special health care needs and traditional safety net providers such as:

Arizona Chapter of Academy of Pediatrics, including the Medical Home

Project

ADHS which administers:

- Children's Rehabilitative Services
- Family Planning
- Healthy Start
- Immunization Sites
- Maternal Child Health
- WIC

Arizona Interagency Farmworkers Coalition

Big Brothers/Big Sisters

Community Family Services Agencies

Community Based Clinics (27, of which 14 are FQHCs)

Community Legal Services

County Health Departments

DES which administers:

- TANF
- Food Stamps
- Community Services Assistance
- Unemployment Insurance
- Job Services
- Child Support Enforcement
- Services for persons with developmental disabilities
- Children Youth and Families Services

Family Crisis Centers

Food Banks

Federation of Teachers

Headstart Programs, including Migrant Headstart program

Homeless Shelters

Hospitals

Indian Health Service

Inter-tribal Council

Other advocate groups

Preschool/Special Education

Professional associations (e.g., local medical and dental)

Schools

Social Security Administration

Arizona Department of Juvenile Corrections

State Education Association

Subsidized Housing Agencies

Tribal health care and social service programs

YMCA/YWCA.

AHCCCS, and other interested parties, have developed strategies that are culturally sensitive to Arizona's diverse population, including the translation of materials in English and Spanish. These strategies include, but are not limited to the following:

- Mass media
- Radio
- Television advertisement
- Brochures
- Posters
- Flyers
- Video

A referral hotline and information number (1 877-764-KIDS (5437)

Training community advocacy groups regarding assistance to families in the completion of the universal application (*Application for AHCCCS Health Insurance)*

Statewide community information forums

Information sharing with foundations (The Flinn Foundation and St. Luke's Charitable Trust)

Collaboration with minority health groups

Partnerships with various agencies, municipalities, community organizations and ecumenical groups

In addition to the strategies identified above, informational materials are distributed through:

AHCCCS participating doctors (approximately 89 percent of all physicians in Arizona)

- Faith organizations
- Community centers
- Day care centers
- Grocery stores
- Other medical providers, such as hospitals and pharmacies
- Public health offices
- Schools
- HUD
- Other appropriate locations

Education regarding the KidsCare Program conducted through collaborative arrangements with other state, county and city agencies as well as programs that conduct education in rural and inner-city areas.

Efforts are designed to inform families about the availability of the KidsCare program, provide basic information about eligibility and instruct families about how and where to apply for the program. Information about Medicaid and the state-funded programs is included as part of the overall strategy for enrollment.

Organizations distributing the applications and information about KidsCare are provided training as needed to assist with completing the application form and collecting information as necessary.

An applicant may also receive assistance to complete the application form by calling the KidsCare Office at their statewide toll free number, 1-877-764- KIDS (5437). The applicant is assisted by an AHCCCS staff person who:

- Explain the application process, including those items, which will require verification.
- Explain enrollment and choice.
- Obtain the necessary information to fill out the application.
- Mail the application and enrollment packet to the applicant for review, signature and supply any required verification.

Applications may be mailed to the AHCCCS KidsCare Office for an eligibility determination. Applications are tracked by source and disposition code, and efforts are modified based on this data.

To specifically target low income children of migrant workers, the Arizona Interagency Farmworkers Coalition has agreed to include information about KidsCare in their newsletters. The Coalition has relationships with a number of the prominent growers in the state who employ farmworkers. Through the Coalition, AHCCCS is given the opportunity to distribute KidsCare and Medicaid outreach materials with paychecks issued to the farmworkers.

The farmworkers typically rely on the WIC program, Headstart programs, FQHCs and other community-based clinics. Each of these will be actively involved in the KidsCare education campaign.

In addition, any individual interested in learning about KidsCare may call the main AHCCCS toll-free hotline number 24 hours a day, 7 days a week or the KidsCare hotline number to learn more about the program and how to apply for services

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

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

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

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

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

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

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

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

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

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

6.1.4.1. ☒ Coverage the same as Medicaid State plan

Arizona uses the same benefits as are provided under the Medicaid State plan. Any limitations on the covered services are discussed in this section

and are delineated in the AHCCCS Medical Policy Manual. The cost sharing requirements are specified in Section 8 of the State Plan.
Members who enroll in the KidsCare Program who select an AHCCCS health plan will receive the

KidsCare services, subject to the limitations described in subsection 6.2.

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage
6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
6.1.4.7. ☐ Other (Describe)

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

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

a. Inpatient hospital services, including medically necessary ancillary services, and emergency hospital services, if furnished by a licensed hospital and provided by or under the direction of a PCP or primary care practitioner according to federal and state law, rules, and AHCCCS Policies and Procedures. Inpatient hospital services include services provided in an institution specializing in the care and treatment of members with mental diseases.
b. Services in an Institution for Mental Diseases (IMD) when the member requires services in an inpatient psychiatric hospital. IMD are available to members who are determined to require these services after enrollment in KidsCare. However, applicants

in an IMD at the time of application are excluded from enrollment in KidsCare.

Medically necessary transplant services, which are not experimental, if provided to correct or ameliorate disabilities, physical illnesses or conditions. Transplantation services are authorized in accordance with AHCCCS transplantation policies.

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

Outpatient hospital services ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient hospital services include services provided by or under the direction of a PCP or primary care practitioner or licensed or certified behavioral health professional according to federal and state law.

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

Physician services if provided by or under the direction of a PCP, psychiatrist, or under the direction of a primary care practitioner according to federal and state law. Services are covered whether furnished in the office, the member's home, a hospital, a nursing home or other setting.

Only psychiatrists, psychologists, certified psychiatric nurse practitioners, physician assistants, certified independent social workers, certified marriage/family therapists, and certified professional counselors may bill independently for behavioral health services. Other behavioral health professionals, behavioral health technicians and behavioral health paraprofessionals shall be affiliated with, an AHCCCS registered behavioral health agency and services shall be billed through that agency.

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

Medically necessary surgical services under inpatient and outpatient services (Sections 6.2.1 and 6.2.2).

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

a. Outpatient services (Section 6.2.2).

b. Ambulatory services offered by a health center receiving funds under section 330 of the Public Health Services Act.
c. Rural health clinic services and federally qualified health center services and other ambulatory services.

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

a. Pharmaceutical services provided to a member if prescribed by the attending physician, practitioner, or dentist.
b. Prescription drugs for covered transplantation services provided according to AHCCCS transplantation policies.
c. Generally, medications dispensed by a physician or dentist are not covered.

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

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

Laboratory, radiological and medical imaging services.

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))

a. The following family planning services:
   - Contraceptive counseling, medication, supplies and associated medical and laboratory exams
   - Natural family planning education or referral
b. Infertility services and reversal of surgically induced infertility are not covered services.
c. Family planning services do not include abortion or abortion counseling.

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

a. Inpatient behavioral health services, other than inpatient and residential substance abuse treatment services, but including services furnished in a state operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
b. Services in a state operated mental hospital (e.g., Institution for Mental Diseases). IMD services are only available to members who are determined to require these services after enrollment.

Applicants who are receiving IMD services at the time of application are excluded from enrollment in KidsCare.

c. Partial care services are included as part of the inpatient benefit.

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

a. Outpatient behavioral health services, other than substance abuse treatment services, including services furnished in a state operated mental hospital (e.g., IMD) and community-based services.
b. Outpatient behavioral health services includes individual and/or group counseling/therapy, rehabilitation services, including basic and intensive partial care, emergency/crisis services, behavior management, psychosocial rehabilitation, evaluation and behavioral health related services.

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

See Section 6.2.17--Dental services for coverage of dental devices. Vision services include prescriptive lenses.

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

Medical supplies include consumable items that are disposable and are essential for the member's health.

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

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

a. Private duty nursing care, respiratory care services, and services provided by certified nurse practitioners in a home or other setting.
b. Certified nurse midwife services when they are rendered in collaboration with a licensed physician or PCP or primary care practitioner in accordance with AHCCCS Policies and Procedures.

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

A physician shall provide written certification of necessity of abortion.

6.2.17. ☒ Dental services (Section 2110(a)(17))

a. Dental services, including routine, preventive, therapeutic and emergency services.
b. Dentures and dental devices are covered if authorized in consultation with a dentist.

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

Inpatient substance abuse treatment is limited to acute detoxification.

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

a. Refer to coverage under 6.2.11 - Outpatient mental health services, subject to the limitations prescribed in that section.
b. Rehabilitation services provided by a substance abuse rehabilitation agency that do not exceed 30 outpatient visits for each 12-month period of eligibility.

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

Case management for persons with developmental disabilities.

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

Care coordination are available through contractors, primary care providers and behavioral health providers.

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

Therapy services are covered when necessary to prevent or ameliorate a condition, illness or injury, to prevent or correct

abnormalities detected by screening or diagnostic procedures or to maintain a level of ability.

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

Hospice services for a terminally ill member.

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

a. Services provided in a facility, home, or other setting if recognized by state law.
b. Respiratory therapy.
c. Eye examinations for prescriptive lenses.
d. Immunizations, preventive health services, patient education, age and gender appropriate clinical screening test and periodic health exams.

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

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

Emergency ambulance and non-emergency transportation are covered services when the transportation is medically necessary.

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

All printed materials are in English and Spanish. Outreach services will be available through AHCCCS, and others as specified in Section 4.4.5 and Section 5.

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

1. Nursing facility services in a nursing facility or in an alternative residential setting for a maximum of 90 days when the medical condition of the person indicates that–these services are necessary to prevent hospitalization.
2. Total parenteral nutrition services.
3. Podiatry services and optometrist services if furnished by a licensed podiatrist or optometrist, respectively.

4. Other practitioner's services are covered and include services provided by:
   a. Respiratory Therapists
   b. Certified Nurse Practitioners
   c. Certified Nurse Anesthetists
   d. Physician Assistants
   e. Nonphysician behavioral health professionals if the services are provided by social workers, physician assistants, psychologists, counselors, registered nurses, certified nurse practitioners, behavioral health technicians and other approved therapists who meet all applicable state standards. Except for behavioral health services provided by psychologists, psychiatric nurse practitioners, physician assistants, certified independent social workers, certified marriage/family therapists, and certified professional counselors, all nonphysician behavioral health professional services shall be provided by professionals affiliated with an approved behavioral health setting in accordance with rules and AHCCCS policies and procedures.
5. Home health services
   a. Home health services when necessary to prevent re-hospitalization or institutionalization, and may include home health nursing services, therapies, personal care, medical supplies, equipment and appliances and home health aide services.
   b. Nursing service and home health aide if provided on an intermittent or part time basis by a home health agency. When no home health agency exists, nursing services may be provided by a registered nurse.
   c. Therapy services.

Covered services are required to be authorized by the appropriate entity, unless otherwise indicated. Authorization by an appropriate entity shall be performed by at least one of the following: a PCP, primary care practitioner, or behavioral health professional as required by rule and AHCCCS policies and procedures. The appropriate entity shall authorize medically necessary services in compliance with applicable federal and state laws and regulations, AHCCCS policies and procedures and other applicable guidelines.

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

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section

2102(b)(1)(B)(ii)); OR

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

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

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

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

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

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F)

or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

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

The KidsCare Program uses performance measures, quality standards, information strategies and quality improvement studies to assure high quality care for members. The tools include:

- Quality standards defined in policy and contract
- Annual on-site operational and financial reviews
- Performance indicator and utilization measurement studies
- Compliance with national quality measures

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

7.1.1. ☒ Quality standards

Each contractor adheres to specific quality/utilization standards established by AHCCCS for the KidsCare Program. A comprehensive plan prepared by the contractor includes the following components:

- Program monitoring
- Program evaluation
- Member education
- Provider education
- Compliance with mandatory components of preventive care visits.

Contractors participate in an annual review of the KidsCare program which includes on-site visits by AHCCCS staff to contractors and medical record audits.

AHCCCS monitors compliance with quality assurance standards through an established process of operational and financial reviews for the Medicaid program. The reviews are conducted by a review team comprised of AHCCCS staff. The reviews are performed on-site through interviews with appropriate personnel and through

review of documentation in the following areas:

- Administration and Management
- Provider Services/Network Management
- Grievance and Appeals
- Medical Management
- Quality/Utilization Management
- Dental Services
- Maternal Health/Family Planning
- Behavioral Health
- Delivery System and Access to Care Standards
- Member Services
- Financial

The review tool contains standards from the review areas identified above and provides the basis for assessing contractor performance, as well as identifying areas where improvements can be made or where there are areas of noteworthy performance and accomplishment.

7.1.2. ☒ Performance measurement

AHCCCS requires contractors to meet the AHCCCS performance measures which are defined using HEDIS methodology as a guide. In particular, performance measurement will focus on the following areas:

- Age appropriate childhood immunizations
- Dental visits
- Well child visits in the first 15 months of life
- Well child visits in the third, fourth, fifth, and sixth year of life
- Access to a regular source of primary care

Indicator	**Summary Description**
1. Childhood Immunization Rate	The percent of members age two who were continuously enrolled for 12 months and received recommended immunizations.
2. Annual Dental Visit	The percent of members age 3-19 with at least one dental visit in the reporting year.
3. Well Child Visits Under	The percent of children age 15 months who

15 Months	received all recommended well child visits during the reporting year.
4. Well Child Visits for 3, 4, 5 and 6 Year Olds	The percent of children 3-6 who received a well child visit during the last year.

7.1.3. ☒ Information strategies

All contractors must inform new members about services within ten days of enrollment. Information includes:

- Benefits of preventive care
- A complete description of services available
- How to obtain these services and assistance with scheduling of appointments
- A statement regarding copayments which may be required

In addition, both eligibility workers and contractors are required to educate KidsCare Program enrollees about their benefits, rights and responsibilities. This education focuses on the importance of preventive services, such as immunizations and dental visits, health promotion activities and the importance of regular visits to their primary care provider instead of using the emergency room for primary care.

7.1.4. ☒ Quality improvement strategies

AHCCCS began a Quality Improvement Initiative in 1995 designed to use encounter data to monitor quality and to test new concepts of quality of care based on many of the recommendations for measurement from the Quality Assurance Reform Initiative (QARI) and the National Committee for Quality Assurance. The major components of the Initiative include:

Performance Measures as listed in subsection 7.1.2.

Financial Measures of health plan fiscal viability, management of care, timely payment of claims and documentation of medical expenses.

Member Satisfaction Surveys conducted to provide information on access to care, communication between members and providers, and quality of care.

Provider Satisfaction Surveys designed to assess primary care practitioners' satisfaction with the KidsCare Program.

In the future, the Consumer Assessment of Health Plans Survey (CAHPS) data may be incorporated into AHCCCS' Quality Improvement Initiative, as well as any new reporting requirements which may be developed.

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

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

Effective October 1, 2001 Kidscare members are eligible for the same services covered for members under the Title XIX program, as specified in the acute-care renewal contract.

The AHCCCS Medical Policy Manual further specifies that KidsCare services must be provided according to community standards and standards under Title XIX for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) enrolled members. This ensures access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations.

The AHCCCS Medical Policy Manual also states that, "Contractors must comply with all Quality Management and Quality Improvement requirements." Acute-care contractors are encouraged to include in their EPSDT annual plans and quarterly progress reports activities that will ensure access to services by KidsCare members and/or acknowledge that EPSDT activities apply to both Title XIX and Title XXI members. These reports include monitoring and evaluation of utilization of services.

Members enrolled under the KidsCare Program are included in analysis of the AHCCCS acute-care Performance Indicators for well-child and dental visits. Title XXI members are reported separately for immunizations and children's access to PCPs. The KidsCare population also is included in medical audits, as appropriate.

Additional monitoring is accomplished through the OFR process.

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

AHCCCS requires all contractors to have sufficient provider capacity to absorb the additional KidsCare enrollment. Currently, all AHCCCS members have a choice of at least two contractors.

Contractors are required to meet the AHCCCS contractual standards for network capacity for primary care providers (PCPs). These standards include appointment availability, geographic accessibility, quality and utilization. AHCCCSA informs all health plans when a PCP, contracted with more than one contractor, exceeds 1800 AHCCCS members in their panel. This allows the health plans to more closely monitor these PCPs' adherence to the standards. All Contractors have a system in place to monitor and ensure that each member is assigned to an individual PCP and that PCP assignment data is current. Members are allowed to choose their initial PCP from the health plan network and change the assignment should they wish to do so.

In addition, KidsCare enrollees are assured access through existing AHCCCS standards for appointment standards for emergency, urgent and routine care, specialty providers, and dentists.

Contractors provide emergency services facilities adequately staffed by qualified medical professionals to provide emergency care on a 24-hour per day, 7-day per week basis for treatment of medically emergent conditions. Contractors must educate members about the appropriate utilization of emergency room services and monitor utilization by both members and providers.

AHCCCS, through its operational and financial reviews, monitors contractor compliance with these standards. The health plans are also required to submit a description of their networks to the Agency on a quarterly basis.

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

Contractors must follow care coordination policies set forth in of the AHCCCS Medical Policy Manual. These requirements include policies and procedures for identifying members with complex, serious and/or at-risk medical conditions, assessing those conditions, identifying medical

procedures to address and/or monitor the conditions, ensuring adequate care coordination among providers, and developing a plan of care appropriate to those conditions. The care plan must eliminate barriers to direct access to specialists, provide adequate access to support services, be time-specific, and be updated periodically.

Children with certain chronic, complex, or serious medical conditions receive services related to those conditions through the Children's Rehabilitative Services (CRS) program administered by the Arizona Department of Health Services. Contractors refer members who are potentially eligible for CRS services to the program for evaluation and enrollment if eligible. Contractors are required to monitor referrals to CRS and ensure that CRS-covered services are provided in a timely manner to eligible children. PCPs are required to coordinate care with CRS and to include those services in the member's medical record.

PCPs are accountable for maintaining a medical record which incorporates documentation of all health care services provided to assigned members, including PCP services, specialty medical and/or behavioral health services, all medications prescribed by the PCP and/or other providers, authorized durable medical equipment, dental services, emergency care, and hospitalizations, as required in the AHCCCS Medical Policy Manual. Contractors monitor PCP compliance with medical record keeping requirements through regular chart audits.

Contractors must ensure that appointments standards are met for specialty referrals within the following timeframes: emergency, within 24 hours of referral; urgent, within three days of referral; and routine, within 45 days of referral. Contractors monitor provider compliance with appointment standards through "secret shopper phone calls or regular/periodic on-site visits."

Indian Health Services and 638 Tribal Facilities are responsible for maintaining continuity of care and maintaining a complete medical record for each assigned member, as well as providing necessary referrals for specialty care.

AHCCCS monitors and assesses contractors' care coordination and case management processes, including referral to Children's Rehabilitative Services (CRS) and behavioral health services, through the Operational Financial Reviews (OFRs). Contractor compliance with appointment availability standards and QM/QI requirements also are evaluated in the OFRs.

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

The state complies with this requirement of decisions related to the prior authorization of health services. The timeframe for prior authorization of decisions is the same in SCHIP as in the Medicaid program.

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

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

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

8.1.1. ☒ YES
8.1.2. ☐ NO, skip to question 8.8.

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

8.2.1. Premiums:

On October 1, 1999, AHCCCS began imposing monthly premiums on families whose income exceeded 150 percent of the FPL.

AHCCCS worked collaboratively with KidsCare stakeholders to develop the premium billing proposal based on these goals:

- Insure more children.
- Promote accountability and responsibility.
- Notify KidsCare members of their premium rights and responsibilities.
- Reduce administrative costs and implement a simplified system.
- Have a process that is clear and understandable to the members.

The following is the premium billing and collection process:

- Payments are accepted on a monthly basis.
- The cost sharing methodology does not favor children from families with higher incomes over families with lower incomes.
- AHCCCS ensures that premiums are not assessed on Native American or Alaska Native populations.
- AHCCCS monitors the number of persons who are disenrolled due to nonpayment of premiums and notifies KidsCare members about their premium rights and responsibilities.
- The first monthly premium is not required prior to initial enrollment in the program.
- All premium payments are due by the 15th day of each month of enrollment.

- If the payment is not made by the due date, a past due notice will be sent with a request for payment no later than the last day of the month.

The premium amounts are:

PREMIUM AMOUNTS

Effective 2/1/04

Federal Poverty Levels (FPL)	1st Child	More than 1 Child
Above 100% to 150%		
Above 150% - 175%	$20.00	$30.00 Total
Above 175% - 200%	$25.00	$35.00 Total

Effective 7/1/04

Federal Poverty Levels (FPL)	1st Child	More than 1 Child
Above 100% to 150%	$10.00	$15.00 Total
Above 150% - 175%	$20.00	$30.00 Total
Above 175% - 200%	$25.00	$35.00 Total

8.2.2. Deductibles:
8.2.3. Coinsurance or copayments: No copayments are charged.
8.2.4. Other:

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

Information about cost sharing is included in the following:
- Education and application materials.
- Member handbooks provided by KidsCare contractors.
- *Arizona Administrative Register* and other rulemaking activities conducted by the AHCCCS Administration.
- Native American newsletters and meetings make it clear that the Native American and Alaska Native populations are exempt from paying any cost sharing.

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

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

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

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

The state assures enrollees will not be held liable for cost-sharing amounts for emergency services that are provided at a facility that does not participate in the enrollee's managed care network.

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

Premiums will not exceed the five percent cumulative maximum. Families are advised on the notice of approval that the total cost sharing under KidsCare can not exceed five percent of the families' income. Families are advised to contact AHCCCS if the total cost sharing exceeds the five percent limit. Upon notification, AHCCCS makes changes to the system to stop the imposition of monthly premiums.

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

The Application for AHCCCS Health Insurance requests information about the child's race. If the child is American Indian or Alaska Native, AHCCCS does not assess a premium or copayment.

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

A. The consequences for non payment of premium are as follows:
   1. If the payment is not made by the due date, AHCCCS sends a past due notice with a request for payment no later than the last day of the month.

2. If the payment is not received by the 15th day of the second month, AHCCCS mails a ten-day discontinuance letter. Services are terminated if the delinquent payment is not received the end of the second month. If AHCCCS receives the delinquent payment prior to the end of the second month, there is no break in coverage.
3. Persons may be re-enrolled if all outstanding balances are paid and an updated application is submitted.

B. The following is the hardship exemption to the disenrollment process:
1. The following definitions apply to this Section:
   a. "Major expense" means the expense is more than 10 percent of the household's countable income
   b. "Medically necessary" means as defined in 9 A.A.C. R9-22-101.
2. Whenever a monthly statement includes a past due amount and the benefits are at risk of being terminated, AHCCCS sends a separate notice with information about and instructions for requesting a hardship exemption.

C. The Administration grants a hardship exemption to the disenrollment requirements under A.R.S. § 36-2982 for a household who:
1. Is no longer able to pay the premium due to one of the hardship criteria listed below, and
2. Requests and provides all necessary written verification at the time of request.

D. The Administration considers the following hardship criteria:
1. Medically necessary expenses or health insurance premiums that:
   a. Are not covered under Medicaid or other insurance and
   b. Exceed 10 percent of the household's countable income;
2. Unanticipated major expense, related to the maintenance of shelter or transportation for work;
3. A combination of medically necessary and unanticipated major expenses in this section that exceed 10% of the household's countable income; or
4. Death of a household member.

E. The Administration must receive the written request and verification of exemption eligible criteria by the 10th day of the month in which the household receives the billing statement containing the current and past due premium notice.

F. The Administration notifies the head of household concerning the approval or denial of the request for exemption and discontinuance 10 days prior to the end of the month in which the request was received.

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

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to

disenrollment. (42CFR 457.570(a))

Medicaid rules regarding opportunities for impartial reviews prior to disenrollment apply to SCHIP. The premium payment is due by the 15th day of each month. If the payment is not made by the due date, AHCCCS sends a past due notice with a request for payment no later than the last day of the month. If the payment is not received by the 15th day of the second month, AHCCCS mails a ten-day discontinuance letter. Enrollees are ensured the opportunity to continue benefits pending the outcome of the hearing.

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

KidsCare members may report a change at any time. If a change in income is reported, AHCCCS reevaluates KidsCare and Medicaid eligibility and the premium amount.

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

If a change in income results in a lower premium amount, AHCCCS adjusts the premium amount the next prospective month after the change is reported. If the child appears to be Medicaid eligible, AHCCCS refers the application and documentation to the Department of Economic Security for a Medicaid determination.

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

AHCCCS sends a notice to the household at least 10 days before benefits are discontinued due to non-payment. The notice includes information about the right to request a hearing and how to request a hearing. If AHCCCS receives the hearing request prior to the discontinuance effective date, AHCCCS may continue benefits pending the outcome of the hearing. Prior to the hearing date, AHCCCS discusses all information with the household to determine if the premium was calculated correctly. If the premium amount is correct, AHCCCS informs the household that the

premium amount is correct and that the household has the right to request a hearing. If the premium amount is not correct, AHCCCS corrects the premium amount and the hearing is not necessary.

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

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

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

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

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

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

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

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

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

Arizona has established the following strategic objectives for the KidsCare Program:

- Decrease the percentage of children in Arizona who are uninsured or who do not have a regular source of health care.
- Improve the health status of children enrolled in KidsCare in Arizona through a focus on early preventive and primary care.
- Ensure that KidsCare eligible children in Arizona have access to a regular source of care and ensure utilization of health care by enrolled children.
- Avoid "crowd out" of employer coverage.
- Coordinate with other health care programs providing services to children to ensure a seamless system of coverage.

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

- Decrease the percentage of children in Arizona who are uninsured. (In the first year of the KidsCare Program, decrease the percentage of children with income under 150% of FPL who are uninsured and, in subsequent years, decrease the number of children with income under 200% of FPL who are uninsured.)
- Screen 100 percent of applications to determine if the child was covered by employer sponsored insurance within the last three months. If however, a child has exceeded the lifetime limit to his or her employer sponsored insurance policy; the child will not be required to go bare for three months.
- Improve the number of KidsCare eligible children who receive preventive and primary care by meeting goals according to Health People 2010:

1. 90 percent of children under two will receive age appropriate immunizations;
2. 90 percent of children under 15 months will receive the recommended number of well child visits;
3. 90 percent of three, four, five, and six year olds will have at least one well-child visit during the year;
4. 90 percent of children will have at least one dental visit during the year; and

- Ensure that KidsCare enrolled children receive access to a regular source of care:

1. 100 percent of enrolled children will be assigned a PCP; and
2. 90 percent of KidsCare children will see a PCP at least once during the first 12 months of enrollment.

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

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

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
  - 9.3.7.1. ☒ Immunizations
  - 9.3.7.2. ☒ Well childcare
  - 9.3.7.3. ☐ Adolescent well visits
  - 9.3.7.4. ☒ Satisfaction with care
  - 9.3.7.5. ☐ Mental health
  - 9.3.7.6. ☒ Dental care
  - 9.3.7.7. ☐ Other, please list:
9.3.8. ☐ Performance measures for special targeted populations.

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

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

AHCCCS will perform the annual assessments and evaluations required in Section 10. The annual report will include an assessment and update on the operation of the KidsCare Progam, including the increase in the percentage of Medicaid eligible children enrolled in Medicaid and the reduction in the percentage of uninsured children will be calculated from CPS data.

As addressed in Section 7, AHCCCS will measure the KidsCare Program's progress toward meeting its strategic objectives and performance goals through an evaluation of the contractors using encounter data and medical chart audits, with particular emphasis on preventive and primary care measures.

In addition, annual Operational and Financial Reviews of the KidsCare contractors and reviews of the Quality Management Plans addressing quality standards and how contractors propose to meet those standards will assist AHCCCS in ensuring the quality of health coverage.

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

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

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

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

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

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

Arizona has developed a collaborative process with many interested parties in the design, implementation and evaluation of the KidsCare State Plan. The state has a process for conducting a statewide collaborative effort to provide the community with awareness, education and an opportunity to shape the KidsCare Program (see Attachment N). The Children's Action Alliance also held public forums to discuss the parameters of the KidsCare Program.

In December 1997, the Governor convened a KidsCare Task Force consisting of state legislators, state agencies, representatives from the hospital and medical industry, advocacy organizations and tribal organization to develop recommendations about how targeted, low-income children could best be served by the funds available under Title XXI. The members of this task force are identified in Attachment O. The Governor's Office also convened a special meeting for the 21 Arizona tribes to discuss tribal issues.

The Governor worked with key legislators and other interested parties to introduce legislation on KidsCare. This legislation and the public hearings provided significant opportunities for state legislators and the public to comment and participate in the development of the KidsCare Program. In these legislative hearings, there has been overwhelming support from the community as evidenced by the testimony in support of the program. In addition to the legislative hearings, the community has endorsed this KidsCare Program as shown in Attachment P.

AHCCCS convened two public hearings to discuss the proposed State Plan. Over 275 persons were sent a copy of the State Plan and invited to the hearings. Over 70 persons attended the hearings which included an overview of the State Plan and an open forum for comments, questions and answers. The majority of the discussion involved questions about the operation of the program or the potential for state legislative changes which were answered at the hearing. The suggestions for changes to the State Plan and comments from AHCCCS are summarized in Attachment Q.

As part of Senate Bill 1008, the legislature requires annual reports beginning January 1, 2000, containing the following information:

1. The number of children served by the program.
2. The state and federal expenditures for the program for the previous fiscal year.
3. A comparison of the expenditures for the previous fiscal year with the expected federal funding for the next fiscal year.
4. Whether the federal funding for the next fiscal years will be sufficient to provide services at the current percentage of the FPL or whether an enrollment cap may be needed.
5. Any recommendations for changes to the program will be submitted to the Governor, the President of the Senate, Speaker of the House of Representatives, Secretary of State, the Director of the Department of Library, Archives and Public Records so they can monitor the implementation and evaluation of the program.

As part of the public process, AHCCCS held two public hearings on the proposed State Plan to provide the public with an opportunity to comment and will also hold public hearings on all proposed rules for this program.

AHCCCS has included KidsCare as a regular agenda item for discussion with the State Medicaid Advisory Committee and is working closely with health plans who will be responsible for the delivery of services through the following forums:

- AHCCCS Health Plan meetings
- Medical Directors' meetings
- Quality Management and Maternal Child Health meetings
- Other types of meetings (e.g., one-on-one meetings, rule meetings and State Plan meetings).

Please see sections 9.9.1 and 9.9.2 for a description of ongoing public involvement opportunities.

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

AHCCCS has an ongoing communication with the tribal communities. (See section 2.2.1. and 4.4.5. and 8.3.) An article was written in the KidsCare News to communicate to the communities that no cost sharing is required. The Application for AHCCCS Health Insurance requests information about the child's race. If the child is American Indian or Alaska Native, this information is input into the KEDS automated system which reads the race code and assigns a premium amount of zero.

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

The public has the ability to be involved through the legislative and/or rulemaking process. During the Legislative session, there are many opportunities that the public can make comment to the House of Representatives or Senate. (See section 9.9)
AHCCCS ensures the public has the opportunity to be involved in the rulemaking process from the beginning to end. Initially, AHCCCS opens a docket and files a notice with the Secretary of State in the *Arizona Administrative Register*. Next, AHCCCS files proposed rules and notice with the Secretary of State in the *Arizona Administrative Register*. After that, AHCCCS receives written and oral comments from the public. The next step, involves a public hearing. The agency then reviews public comments and makes necessary changes to the proposed rules. In conclusion, the agency submits rules to the Governor's Regulatory Review Council for approval. The agency appears before the Council to answer questions regarding the rules. At this time, the public has one more opportunity to express their opinion (approval or disapproval) of the rule. After the Council approves the rules, the rule package is then filed with the Secretary of State.

Public notice for cost-sharing
AHCCCS provided many avenues for public involvement in the Cost Sharing implementation.

The Office of Community Relations provided Community and Provider Forums in which participants and AHCCCS staff discussed the cost-sharing changes, as well as additional information on other AHCCCS program changes and future updates. These forums were held in: Flagstaff, Tucson, Phoenix (2), and Yuma from August 26, 2003 to September 23, 2003. 404 providers, 356 community members, advocates, interested individuals, etc attended the forums. The Arizona Republic published a two-paragraph description of the Forums under the Health Briefs.

The Public Information Office had a brief description of the Forums in the Arizona Republic, which is Arizona's statewide newspaper.

The Office of Legal Assistance conducted Public Hearings in Phoenix, Tucson, and Flagstaff to reach individuals in the Northern, Central or Southern areas of Arizona. Information about date, time, and place of the

Public Hearings as well as the proposed rule language were posted September 4, 2003 on the AHCCCS website (www.ahcccs.state.az.us). AHCCCS accepted comments from the public on the rules from September 4, 2003 until close of business on September 24, 2003.

Seventeen individuals attended the public hearings held in Phoenix, Flagstaff, and Tucson. Prior to the hearings the agency received 7 written comments and, during the hearings, received public testimony from another 6 individuals. The majority of comments were from pharmacists or pharmaceutical companies concerned about the actual implementation of copays at the pharmacy counter. Comments were reviewed and merits discussed with executive management. On September 29, 2003 the final rules were filed with the Secretary of State's office and subsequently published in the Arizona Administrative Register on October 24, 2003. The following is a summary of the principle comments received at the public hearing and the agency's response.

PRINCIPLE COMMENTS	*AHCCCS RESPONSE*
Does pharmacy co-pays suggest that consumers will have a choice between a branded or generic product? Almost all of the health plans that serve TXIX population have a mandatory generic policy in place, therefore branded products that have generic equivalents will generally reject at the pharmacy level with a message to use the generic product. Can you please clarify the proposed changes for prescription copayments.	The health plan practice regarding pharmacy management has not changed. A member is not allowed to pay the higher amount to have brand name medication. However, most health plans have brand name medication available as off formulary which would require prior authorization.
R 9-22-711 E identifies the individuals who are subject to specific brand and generic co-payments and that the	The implications for the pharmacy are the same as if any other person with another type of insurance would not have the

provider may deny a service if the member does not pay the required co-payment. What are the implications to the pharmacy if they deny service?	money to pay the copay.
Federal Regulations prohibit pharmacies from collecting co-payments from Medicaid population when the individual refuses or is unable to pay the co-payment. Does A.R.S.36-2903.01 meet the federal standard? Has it been waived? If an individual refuses or is unable to pay the co-payment what actions may the pharmacy take regarding prescription services? Can they deny services	Federal law prohibits services to be denied for the categorical "entitled" groups. However, services can be denied if copayments are not made by the non-categorical groups.

A Public Hearing was held in Phoenix on January 12, 2004 regarding the February 1, 2004 premium increase. No testimony was received either verbally or in writing.

One of the areas targeted by the Arizona legislature in various legislative hearings was an increase in the monthly premiums that would be paid by families who had children or adults enrolled in a SCHIP program. The February 2004 increase is the result of the legislative mandate to enhance cost sharing. Interested parties had an opportunity to testify in the several public hearings and during the public hearings on the changes to AHCCCS' rules. In addition, the attached notice was sent to all who had children enrolled with KidsCare who would be affected by the increase in monthly premiums.

Public notice for the July 1, 2004 premium implementation for families with income between 100% and 150% of the FPL is scheduled for May 7, 2004. The Public Hearing will be held on June 9, 2004 to hear testimony on this premium change.

<u>Prior Public Notice for Enrollment Freeze</u>

Prior public notice of the enrollment cap will be communicated to the public by publication in the Arizona Administrative Register by the Secretary of State, posting on the AHCCCS Administration's internet website, written communication to the Legislature and Governor, the State Medicaid Advisory Committee, and other interested stakeholders. Notice to the public was also provided on October 9, 2009, when AHCCCS posted information about the potential impact of implementing a 15% reduction which identified elimination of the KidsCare program as a discretionary program that would not jeopardize federal stimulus dollars or voter protected programs. Finally, a public hearing with the opportunity to present public comments will be held on December 29, 2009 and tribal consultation will be held on December 28, 2009.

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

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

See Attachment S below for the KidsCare Budget. The state share of the program is funded with monies from the Tobacco Tax Fund.

Attachment S

Title XXI Budget

	FFY 2010
Enhanced FMAP rate	76.03%
BENEFIT COSTS	
Insurance payments	
Managed Care and FFS	$73,213,600
per member/per month rate X # of eligibles	$166.35
Total Benefit Costs	$73,213,600
(Offsetting beneficiary cost sharing payments)	($7,040,400)
Net Benefit Costs	$66,173,200
ADMINISTRATION COSTS	
Personnel	$6,003,300
General administration	$1,349,300
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	
Outreach/marketing costs	
Other	
Total Administration Costs	$7,352,600
10% Administrative Cost Ceiling	$7,352,600
Federal Share (multiplied by enhanced FMAP rate)	$55,901,700
State Share	$17,624,100
TOTAL PROGRAM COSTS	$73,525,800

Notes:

1) Enrollment actuals through January 1, 2010.

2) Expenditure actuals through November 30, 2009.

3) Administrative Cost estimates are as of November 2009.

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

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

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

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

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

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

The award of contracts to managed care organizations, for delivery of health care services to KidsCare members, is done through a competitive bidding process. During the last bidding process in 1997, there was competition for the awards in every geographic service area (GSA) the area which is covered by each contract). Currently, in each GSA, the member may choose between at least two MCOs.

All capitation rates, paid to the MCOs for KidsCare members, have been certified as actuarially sound by the Agency's consultant actuary firm.

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

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

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

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

12.1. Eligibility and Enrollment Matters

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

AHCCCS provides the opportunity for an external review (a hearing) with an Administrative Law Judge who works for the Office of Administrative Hearings. The Office of Administrative Hearings is a separate State agency. The right to a hearing is explained on the agency's decision notices which are sent to the primary informant when any action is taken to approve or deny eligibility, stop enrollment or increase the premium amount The notice provides an explanation of the hearing rights and gives the date by which a hearing must be requested, including the date to request a hearing if the person wants benefits to continue pending the hearing decision.

12.2. Health Services Matters

Please describe the review process for health services matters that comply with 42 CFR 457.1120.

The Administration provides both an informal and a formal review process to resolve health service matters presented by enrollees. The formal review process includes the opportunity for an expedited hearing which includes a formal evidentiary hearing. The hearing is conducted by an impartial third party, an Administrative Law Judge (ALJ), employed by an independent state agency, the Office of Administrative Hearings (OAH).

Enrollees are afforded due process. They may represent themselves or choose to be represented during the process. Additionally, they may fully participate in the process, having the opportunity to review all relevant information and to file supplemental information. If an expedited hearing is requested, it is held within 20-40 days of receipt of the request. State Law requires that the ALJ issue a recommended decision within 20 days from the date of the hearing, and that the Administration issue a decision adopting, modifying, or rejecting the ALJ recommended decision within 30 days. On average, this process is completed in less than 90 days.

If the dispute pertains to a reduction, suspension, or termination of services and

the enrollee files the request for expedited hearing within 15 business days of the postmark date of the notice, services will be continued until a final decision is rendered. State regulations and contract additionally authorize a hearing to be conducted on a more abbreviated timeframe if the enrollee establishes cause. Enrollees also have the option of challenging health services matters through an informal grievance process. Once a grievance determination is issued, the parties may request a formal evidentiary hearing which is conducted by OAH as generally outlined above

12.3. Premium Assistance Programs

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