Section 1

General Description and Purpose of the State Child Health Insurance Plan

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

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

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

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

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

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 X 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 Effective date: February 1, 2004 (premiums >150% FPL)
July 1, 2004 (premiums 100%-150% FPL)
May 1, 2009 (premiums >150% FPL)
January 1, 2010 (enrollment cap)
October 10, 2013 (remove wait list)
July 26, 2016 (remove enrollment cap)
August 6, 2016 (premium lock out period)
October 1, 2017 (mental health parity)
July 1, 2018 (Managed Care Regulations)

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

The State of Arizona seeks advice on a regular, ongoing basis from all of the federally-recognized tribes, Indian Health Service (IHS) Area Offices, tribal health programs operated under P.L. 93- 638, and urban Indian health programs in Arizona regarding Medicaid and CHIP matters. These matters include but are not limited to State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals, and proposals for demonstration projects. The AHCCCS Tribal Consultation Policy serves as a guidance document that includes the process by which reasonable notice and opportunity for consultation should occur and scenarios in which AHCCCS shall engage in the consultative process.

The frequency of consultation is dependent on the frequency in which policy changes are proposed. When a proposed policy change requires consultation, the State will to its best ability provide notice of the tribal consultation meeting date as well as a description of the proposed policy change to be discussed. Ideally, a consultation meeting, which provides an opportunity for discussion and verbal comments to be made regarding a proposed change, will occur either in-person or by conference call 45 days prior to the submission of the policy change to CMS. The State will also provide an opportunity for written comments. Ideally, during the 45-day period, tribes and I/T/U will be provided at least 30 days to submit written comments regarding the policy change for consideration. Verbal comments presented at the meeting as well as written comments will be included in an attachment to accompany the submission of a State Plan Amendment, waiver proposal, waiver renewal, or proposal for a demonstration project.

In situations that require immediate submission of a policy change to CMS, an expedited process may be implemented that will have the effect of lessening the time between the consultation meeting and submission of the policy change to CMS. This process may require for consultation to occur one day prior to the submission of the policy change to CMS. In order to expedite the process, written comments may be solicited in the meeting notification with a description of the policy change and the date when the change will be submitted to CMS. At least 14 days will be provided for the submission of written comments to be considered. This process would be completed prior to submission to CMS.

A series of meetings with tribes as well as the IHS, tribal health programs operated under P.L. 93-638, and urban Indian health programs (collectively referred to as " I/T/U ") have occurred and will continue to occur in order to make appropriate revisions to the AHCCCS Tribal Consultation Policy, which serves as a document that guides how the State will consult with tribes and I/T/U.

More specifically, the consultation process for the development and submission of this State Plan Amendment occurred on May 18, 2016. The attachment submitted to CMS describes in more detail which parties were notified of the consultation meeting and opportunity for comment, the meeting agenda, individuals that participated in the meeting, relevant materials that were discussed, and verbal comments received. It is important to note that this process was intended to be as inclusive as possible. The following entities in Arizona were notified of the consultation process regarding this State Plan Amendment.

- Tribal Leaders
- Tribal Health Directors
- Directors of Indian Health Service Area Offices
- Directors of Tribal Health Programs Operated under PL. 93-638
- Directors of Urban Indian Health Programs
- Director of InterTribal Council of Arizona, Inc.
- Director of the Advisory Council on Indian Health Care

Section 2

General Background and Description of State Approach to Child Health

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.

MEDICAID HEALTH INSURANCE

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 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 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

Section 3. Methods of Delivery and Utilization Controls

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

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

3.1.1 Choice of Delivery System

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

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

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

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

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

All CHIP eligible children – other than American Indians – are required to receive services through a managed care delivery system; American Indian children can elect to receive services through managed care or on a a FFS basis which is referred to as the American Indian Health Plan (AIHP). Additionally, American Indian children can receive services from I.H.S. and 638 facilities regardless of managed care enrollment.

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

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

AHCCCS enables KidsCare eligible members to access services covered under one of the available Health Plans. Previously enrolled members who have been disenrolled for less than 90 days will be automatically enrolled with the same Contractor, if still available, pursuant to the terms of the Arizona Medicaid Section 1115 Demonstration Waiver Special Terms and Conditions [42 CFR 438.56(g)].

AHCCCS members eligible under a contracted Health Plan who become eligible for another AHCCCS Program will be enrolled as follows:

1. Members determined to have a Serious Mental Illness will be enrolled with a RBHA, including members with a CRS designation and KidsCare members; with the exception of members determined to have an SMI who opt to transfer from a RBHA to an AHCCCS Complete Care Contractor for the provision of physical health services only as outlined in AHCCCS ACOM Policy 442.
2. Children in State custody will be enrolled in DCS/CMDP to receive physical health services including CRS services and will be assigned to a RBHA for provision of behavioral health services.
3. Members eligible for Arizona Long Term Care System will be enrolled with DES/DDD or an ALTCS E/PD Contractor, as applicable.

Members who do not choose a Contractor prior to AHCCCS being notified of their eligibility are automatically assigned to a Contractor based on re-enrollment rules, family continuity, or the auto-assignment algorithm. If a member is auto-assigned, AHCCCS sends a Choice Notice to the member and allows the member 90 days to choose a different Contractor. See Section D, Paragraph 6, Auto-Assignment Algorithm, for further explanation.

<u>American Indians:</u>

The American Indian Health Program (AIHP) is responsible for integrated care for American Indian adult and child members who select AIHP and who have not determined to have Seriously Mentally Ill. Integrated care services include both physical and behavioral health services, including services related to a CRS condition. American Indians not determined to be SMI can choose to enroll as follows:

1. In an AHCCCS Complete Care Contractor to receive both physical health services and behavioral services (adults 18 and over only),
2. In AIHP for physical and behavioral health services, and
3. In AIHP for physical health services and receive behavioral health services from a TRBHA.

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.

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

☒ No
☐ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

CHIP (Kidscare) members who are American Indian and who are enrolled in managed care may also receive services at IHS/638 facilities at any time. The claim will be reimbursed by the member's enrolled health plan.

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

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

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

  All Title XXI eligible children receive services through an MCO, with the exception of American Indians who elect to receive services on a Fee-For-Service basis through AIHP.

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

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

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

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

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

☐ Provision of intensive telephonic case management
☐ Provision of face-to-face case management
☐ Operation of a nurse triage advice line
☐ Development of enrollee care plans
☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
☐ Oversight responsibilities for the activities of FFS providers in the FFS program
☐ Provision of payments to FFS providers on behalf of the State
☐ Provision of enrollee outreach and education activities
☐ Operation of a customer service call center

☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement
☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers
☐ Coordination with behavioral health systems/providers
☐ Other (please describe)

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

3.2. General Managed Care Contract Provisions

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

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

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

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

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:
☒ Based on public or private payment rates for comparable services for comparable populations; and

☒ Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

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

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

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

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

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

☒ No, the State does not require any MCO, PIHP, or PAHP to pay remittances.

☐ Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.

☐ Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

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

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

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

- Reimburses CMS for an amount equal to the Federal share of the

remittance, taking into account applicable differences in the Federal matching rate; and

- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

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

3.4 Enrollment

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

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

3.4.1 Enrollment Process

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

3.4.1.2 ☒ The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

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

☒ Yes
☐ No

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

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

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

3.4.2 Disenrollment

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

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

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

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

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

AHCCCS does not allow MCOs to dis-enroll members.

3.4.2.5 Enrollee Requests for Disenrollment.

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

☒ Yes
☐ No

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

☒ The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))

☒ The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))

AHCCCS and the KidsCare program are exempt from strict compliance with some aspects of these provisions as described in Paragraph 1 of the 1115 demonstration waiver list.

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

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

438.56(c)(2))

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

3.5 Information Requirements for Enrollees and Potential Enrollees

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

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

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

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

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

3.5.5 ☒ If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

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

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

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

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

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;
- Covered benefits including:
  - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
  - For a counseling or referral service that the MCO, PIHP, or PAHP

does not cover because of moral or religious objections, where and how to obtain the service;

- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

AHCCCS and the KidsCare program are exempt from strict compliance with some aspects of these provisions as described in Paragraph 1 of the 1115 demonstration waiver list.

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

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

- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

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

- Information that enables the enrollee to understand how to

effectively use the managed care program, which, at a minimum, must include:
  - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
  - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
  - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes an emergency medical condition and emergency services;
  - The fact that prior authorization is not required for emergency services; and
  - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
  - The right to file grievances and appeals;
  - The requirements and timeframes for filing a grievance or appeal;

    - The availability of assistance in the filing process; and
    - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
  - How to access auxiliary aids and services, including additional information in alternative formats or languages;
  - The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
  - Information on how to report suspected fraud or abuse.

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

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

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

3.5.14 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:
- Which medications are covered (both generic and name brand); and
- What tier each medication is on.

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

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

3.5.17 ☒ The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any

unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

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

3.6 Benefits and Services

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

CHIP (Kidscare) members are not a qualified population for enrollment in the American Indian Medical Home (PCCM) program. AHCCCS and the KidsCare program have authority to claim expenditures for capitation even though MCOs do not necessarily comply with 4398.14. See Paragraph 3 of the list of Expenditure Authorities approved as part of the 1115 demonstration.

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

3.6.3 ☒ The State assures that it:

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

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

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

- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or

mental disabilities;

- Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
- Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)

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

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

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

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

3.6.9 ☒ The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the

State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 ☒ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☒ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:

- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

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

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

3.6.13 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to

deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

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

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

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

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

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

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

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

- Is in accordance with applicable State quality assurance and utilization review standards;
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

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

3.7 Operations

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

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

☒ Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));

☒ MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly

treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));

☒ MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));

☒ If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and

☒ MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

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

☒ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions; and

☒ The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in

the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

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

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

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

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

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

3.8 Beneficiary Protections

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

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

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

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

3.9 Grievances and Appeals

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

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

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

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

☐ Yes
☒ No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☒ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

☒ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

☒ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

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

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

3.9.16 ☒ The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than

72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

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

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

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

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

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

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

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:

- The right to request a State review, and how to do so.
- The right to request and receive benefits while the hearing is pending, and how to make the request.
- That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

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

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

- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
- The review is independent of both the State and MCO, PIHP, or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))

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

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

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

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

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

3.10 Program Integrity

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

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

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

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

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

- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

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

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

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

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

3.10.9 ☒ The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

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

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

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

☒ Encounter data in the form and manner described in 42 CFR 438.818.

☒ Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.

☒ Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.

☒ Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.

☒ Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.

☒ The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

☒ It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))

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

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

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

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

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

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

3.11 Sanctions

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

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

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

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

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

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

3.12 Quality Measurement and Improvement; External Quality Review

3.12.1 Quality Strategy

3.12.1.1 ☒ The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and

services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a “significant change” for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii).

(42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

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

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

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

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

3.12.1.6 ☒ The State assures that it will submit to CMS:

A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and

- A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 ☒ Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:

Make the strategy available for public comment; and

- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

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

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

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

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

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

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

3.12.2.2.2 ☒ The State assures that it annually requires each MCO, PIHP, and PAHP to:
1) Measure and report to the State on its performance using the standard measures required by the State;
2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
3) Perform a combination of options (1) and (2) of this

assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

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

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

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

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

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

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

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

CFR 438.330(e)(1))

3.12.3 Accreditation

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

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

3.12.4 Quality Rating

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

3.12.5 Quality Review

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

3.12.5.1 External Quality Review Organization

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

3.12.5.1.2 ☒ The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence

and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

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

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

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

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

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

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

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

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

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

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

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
- For each EQR-related activity (mandatory or optional)

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

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

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

3.12.5.3.7 ☒ The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 ☒ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a)

for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

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

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

Section 4

Eligibility Standards and Methodology

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. X Geographic area served by the Plan: Statewide

4.1.2. X 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. X 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. X Residency:

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. X 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. X Duration of eligibility:

A child who is determined eligible for KidsCare is guaranteed an initial 12 months of continuous coverage unless the child (or parent or legal guardian if appropriate):

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

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

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

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

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. The newborn's KidsCare eligibility begins with the newborn's date of birth. 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.

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 60 days to change contractors. If a change is requested, the effective date is a year from the anniversary date or the month after the change is requested, whichever is later. Enrollees must notify AHCCCS of a change in address or other circumstances that could affect continued eligibility or enrollment.

American Indian children who elect to enroll with the American Indian Health Program are allowed to disenroll at any time upon request and choose a contractor for all KidsCare services. Similarly, American Indian children enrolled with a contractor or other providers are allowed to disenroll at any time upon request and enroll with the American Indian Health Program.

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

Arizona does not currently have an enrollment cap or wait list in place. AHCCCS will submit a state plan amendment if the state decides to implement an enrollment cap or waiting list.

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 access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))

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. 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 is the same application for Medicaid, which is determined simultaneously. Medicaid eligibility always overrides KidsCare eligibility.

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. X 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 and Coordination

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 are 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 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.)**

6.1.1 ☐ **Benchmark coverage;** (Section 2103(a)(1))

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)) **Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.**

6.1.3. ☐ **Existing Comprehensive State-Based Coverage;** (Section 2103(a)(3)) **[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))

Arizona will use the same benefits as are provided under the Medicaid State plan. Any limitations on the covered services are discussed in this section and will be 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 or the state employee HMO, if the HMO

elects to participate in the program, will receive the following KidsCare services, subject to the limitations described below:

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

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

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

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 applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

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

6.1.4.7. ☐ Other. (Describe)

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))**

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.
c. Medically necessary transplant services, which are not experimental, if provided to correct or ameliorate disabilities,

physical illnesses or conditions. Transplantation services will be 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. Certified behavioral health professionals include certified independent social workers, certified marriage/family therapists, and certified professional counselors.

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 Medicare certified 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. X 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. X 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. X 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. X 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. X Vision screenings and services (Section 2110(a)(24))

6.2.19. X **Hearing screenings and services (Section 2110(a)(24))**

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

Inpatient substance abuse treatment is limited to acute detoxification.

6.2.21. X **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.

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

Case management for persons with developmental disabilities.

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

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

6.2.24. X **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.

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

Hospice services for a terminally ill member.

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

6.2.27. X **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.

6.2.28 **Premiums for private health care insurance coverage (Section 2110(a)(25))**

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

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

6.2.30. X **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.

6.2.31.X **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.

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

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

☒ International Classification of Disease (ICD)

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ Other (Describe:)

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

☒ Yes

☐ No

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

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

☒ Yes

☐ No

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☒ All children covered under the State child health plan.

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

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

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain

comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

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

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

Section 7

Quality and Appropriateness of Care

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. X 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. X 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 15 Months	The percent of children age 15 months who 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. X 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. X 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 8. Cost Sharing and Payment (Section 2103(e))

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

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

8.1.1. **X** YES
8.1.2. NO, skip to question 8.8.

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

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.

Effective May 1, 2009, the premium amounts for children when parents are not enrolled are as follows:

PREMIUM AMOUNTS

Federal Poverty Levels (FPL)	1st Child	More than 1 Child
100% to 150%	$10.00	$15.00
151% - 175%	$40.00	$60.00 Total
176% - 200%	$50.00	$70.00 Total

8.2.2. Deductibles: Not Applicable

8.2.3. Coinsurance or copayments: No copayments are charged.

8.2.4. Other: N/A

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:

- Member notices will be sent prior to implementation
- 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.
- Posted on the AHCCCS public website
- Presented to the State Medicaid Advisory Committee

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

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

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

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

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:

X 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.

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

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 childs 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.

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

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

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

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

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

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

Section 9

Strategic Objectives and Performance Goals & Plan Administration

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

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

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

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

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

9.3.8. Performance measures for special targeted populations.

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

9.5. X **The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)**
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. X **The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)**

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

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

9.8.1. X **Section 1902(a)(4)(C) (relating to conflict of interest standards)**
9.8.2. X **Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)**
9.8.3. X **Section 1903(w) (relating to limitations on provider donations and taxes)**
9.8.4. X **Section 1132 (relating to periods within which claims must be filed)**

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

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,

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 enrollment cap

Prior public notice of the enrollment cap, effective January 1, 2010, 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.

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 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?	The implications for the pharmacy are the same as if any other person with another type of insurance would not have the 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.

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 for the KidsCare Budget. The state share of the program is funded with monies from the Tobacco Tax Fund. The removal of the enrollment cap has no state budget impact because no state match is required. However, the overall CHIP allotment shortfall has a negative state budget impact because CHIP funding for the M-CHIP child expansion population is contingent on availability of funds. Since the CHIP allotment is insufficient, there is a state general fund cost to cover this population at the regular FMAP when CHIP is not available.

Section 10

Annual Reports and Evaluations

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

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

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

Section 11

Program Integrity

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

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

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

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. X 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. X Section 1124 (relating to disclosure of ownership and related information)

11.2.3. X Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. X Section 1128A (relating to civil monetary penalties)

11.2.5. X Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. X Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12

Applicant and Enrollee Protections

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

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

Eligibility and Enrollment Matters

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

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.

Health Services Matters

12.2 Please describe the review process for health services matters that complies 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

Premium Assistance Programs

12.3 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.

Attachment A

Legislation

Senate Engrossed

State of Arizona
Senate
Forty-third Legislature
Fourth Special Session
1998

FILED

Betsey Bayless
Secretary of State

CHAPTER 4

SENATE BILL 1008

AN ACT

AMENDING SECTIONS 36-2907.06, 36-2907.08, 36-2921 AND 36-2923, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 4; AMENDING LAWS 1997, CHAPTER 186, SECTION 6; AMENDING LAWS 1997, CHAPTER 186, SECTION 8; MAKING APPROPRIATIONS; RELATING TO THE CHILDREN'S HEALTH INSURANCE PROGRAM; PROVIDING FOR CONDITIONAL ENACTMENT.

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-2907.06, Arizona Revised Statutes, is amended to read:

36-2907.06. Qualifying community health centers; contracts; requirements; definition

A. Subject to the availability of monies as prescribed in section 36-2921, the administration shall enter into an intergovernmental agreement pursuant to title 11, chapter 7, article 3 with the department of health services to contract with qualifying community health centers to provide primary health care services to indigent or uninsured Arizonans. The department of health services shall enter into one year contracts with qualifying community health centers for the centers to provide the following primary health care services:

1. Medical care provided through licensed primary care physicians and licensed mid-level providers as defined in section 36-2171.

2. Prenatal care services.

3. Diagnostic laboratory and imaging services that are necessary to complete a diagnosis and treatment, including referral services.

4. Pharmacy services that are necessary to complete treatment, including referral services.

5. Preventive health services.

6. Preventive dental services.

7. Emergency services performed at the qualifying community health center.

8. Transportation for patients to and from the qualifying community health center if these patients would not receive care without this assistance.

B. Each contract shall require that the qualifying community health center provide the services prescribed in subsection A of this section to persons who the center determines:

1. Are residents of this state.

2. Are without medical insurance policy coverage.

3. Do not have a family income of more than two hundred per cent of the federal poverty guidelines as established annually by the United States department of health and human services.

4. Have provided verification that the person is not eligible for enrollment in the Arizona health care cost containment system pursuant to this chapter.

5. Have provided verification that the person is not eligible for medicare.

C. The department of health services shall directly administer the program and issue requests for proposals for the contracts prescribed in this section. Contracts established pursuant to subsection A OR G of this section shall be signed by the department and the contractor prior to the transmission of any tobacco tax and health care fund monies to the contractor.

D. Persons who meet the eligibility criteria established in subsection B OR G of this section shall be charged for services based upon a sliding fee schedule approved by the department of health services.

E. In awarding contracts the department of health services may give preference to qualifying community health centers that have a sliding fee schedule. Monies shall be used for the number of patients that exceeds the number of uninsured sliding fee schedule patients that the qualifying community health center served during fiscal year 1994. Each qualifying community health center shall make its sliding fee schedule available to the public on request. The contract shall require the qualifying community health center to apply a sliding fee schedule to all of its uninsured patients.

F. The department of health services may examine the records of each qualifying community health center and conduct audits necessary to determine that the eligibility determinations were performed accurately and to verify the number of uninsured patients served by the qualifying community health center as a result of receiving tobacco tax and health care fund monies by the contract established pursuant to subsection A of this section.

G. AFTER THE HEALTH CARE FINANCING ADMINISTRATION APPROVES THE CHILDREN'S HEALTH INSURANCE PROGRAM ESTABLISHED PURSUANT TO ARTICLE 4 OF THIS CHAPTER, THE DEPARTMENT OF HEALTH SERVICES SHALL CONTRACT WITH QUALIFYING HEALTH CENTERS TO ALLOW THE QUALIFYING HEALTH CENTERS TO DELIVER OR ARRANGE TO PROVIDE THE HEALTH BENEFITS PURSUANT TO THIS SECTION TO CHILDREN WHO ARE DETERMINED ELIGIBLE PURSUANT TO SECTION 36-2983 AND WHO ELECT TO RECEIVE DIRECT, SLIDING FEE SCALE MEDICAL AND HEALTH CARE SERVICES FROM QUALIFYING HEALTH CENTERS PURSUANT TO THIS SECTION AND WITH HOSPITALS PURSUANT TO SECTION 36-2907.08. THE QUALIFYING HEALTH CENTERS SHALL PROVIDE DATA THE ADMINISTRATION DETERMINES IS SUFFICIENT TO ALLOW THE STATE TO APPLY FOR FEDERAL FUNDING UNDER THE PROGRAM ESTABLISHED PURSUANT TO ARTICLE 4 OF THIS CHAPTER. FOR THE PURPOSES OF THIS SUBSECTION, "QUALIFYING HEALTH CENTER" MEANS A COMMUNITY BASED FACILITY THAT ARRANGES TO PROVIDE OR DELIVER MEDICAL CARE ON A SLIDING FEE SCALE THROUGH THE EMPLOYMENT OF PHYSICIANS, PROFESSIONAL NURSES, PHYSICIANS ASSISTANTS OR OTHER HEALTH CARE TECHNICAL AND PARAPROFESSIONAL PERSONNEL.

~~G.~~ H. Contracts established pursuant to subsection A OR G of this section shall require qualifying community health center contractors AND QUALIFYING HEALTH CENTERS AS DEFINED IN SUBSECTION G OF THIS SECTION to submit information as required pursuant to section 36-2907.07 for program evaluations.

~~H.~~ I. For the purposes of this section "qualifying community health center" means a community based primary care facility that provides medical care in medically underserved areas as ~~defined pursuant to~~ PROVIDED IN section 36-2352, or in medically underserved areas or medically underserved populations as designated by the United States department of health and human services, through the employment of physicians, professional nurses, physician assistants or other health care technical and paraprofessional personnel.

Sec. 2. Section 36-2907.08, Arizona Revised Statutes, is amended to read:

36-2907.08. Basic children's medical services program; definition

A. ~~Beginning on October 1, 1996,~~ The basic children's medical services program is established to provide grants to hospitals that exclusively serve the medical needs of children or that operate programs designed primarily for children. The director of the department of health services, pursuant to an intergovernmental agreement with the director of the Arizona health care cost containment system ADMINISTRATION and subject to the availability of monies, shall implement and operate this program only to the extent that funding is available and has been specifically dedicated for the program.

B. To receive a grant under this section, a hospital shall submit an application as prescribed by the director of the department of health

services in a request for proposal that indicates to the director's satisfaction that the applicant agrees to:

1. Use grant program monies to enhance the applicant's provision of additional medical services to children and to improve the applicant's ability to deliver inpatient, outpatient and specialized clinical services to indigent, uninsured or underinsured children who are not eligible ~~to receive services under this article~~ PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISIONS (a), (b), (c), (h) OR (j) OR SECTION 36-2931, PARAGRAPH 5.

2. Establish and enforce a sliding fee scale for children who are provided services with grant monies.

3. Account for monies collected pursuant to paragraph 2 of this subsection separately from all other income it receives and to report this income on a quarterly basis to the administration.

4. Use the grant to supplement monies already available to the applicant.

5. Match the grant as prescribed by the director by rule with private monies the applicant has pledged from private sources. The director shall waive this requirement if the applicant is seeking the grant to qualify for a private or public grant for the delivery of inpatient, outpatient or specialized clinical ~~care of~~ SERVICES TO indigent, uninsured or underinsured children who are not eligible ~~to receive services under this article~~ PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISIONS (a), (b), (c), (h) OR (j) OR SECTION 36-2931, PARAGRAPH 5.

6. Provide a mechanism to ensure that grant program monies are not used for children who are OTHERWISE eligible ~~for services under this article~~ PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISIONS (a), (b), (c), (h) OR (j) OR SECTION 36-2931, PARAGRAPH 5.

7. Not use grant monies to fund the provision of emergency room services.

C. By contract, the director of the department of health services shall require a grantee to:

1. Annually account for all expenditures it makes with grant program monies during the previous year.

2. Agree to cooperate with any audits or reviews conducted by this state.

3. Agree to the requirements of this section and other conditions the director determines to be necessary for the effective use of grant program monies.

D. The director of the department of health services may limit either or both the grant amount per contract or the number of contracts awarded. In awarding contracts to qualified applicants the director shall consider:

1. The amount of monies available for the grant program.

2. The need for grant monies in the area served by the applicant as stated by the applicant in the response to the request for proposals and as researched by the administration.

3. The number of children estimated to be served by the applicant with grant program monies.

4. The services that will be provided or made available with grant program monies.

5. The percentages of grant monies that the applicant indicates will be reserved for administrative expenditures, direct service expenditures and medical care personnel costs.

6. The financial and programmatic ability of the applicant to meet the contract's requirements.

E. If the department of health services determines that a hospital has used grant monies in violation of this section it shall prohibit that hospital from receiving additional grant program monies until the hospital reimburses the department. The department shall impose an interest penalty as prescribed by the director of the department of health services by rule. The director shall transmit penalties collected under this section to the state treasurer for deposit in the medically needy account of the tobacco tax and health care fund.

~~F. The director of the department of health services may expend monies from the medically needy account of the tobacco tax and health care fund transferred pursuant to section 36-2921, subsection A, paragraph 7 for the purpose of funding evaluations of the grant program established by this section. The director shall ensure that any evaluation is structured to meet at least the base requirements prescribed in section 36-2907.07.~~

~~G. The director of the department of health services may expend monies from the medically needy account of the tobacco tax and health care fund transferred pursuant to section 36-2921, subsection A, paragraph 7 for administrative costs associated with the establishment or the operation of the grant program. The amount withdrawn annually for grant program administrative costs shall not exceed two per cent of the sum of any transfers of monies made pursuant to section 36-2921 and any appropriation of monies for the specified purpose of supporting the nonentitlement basic children's medical services program established in this section.~~

~~H.~~ F. The department of health services shall directly administer the grant program and all contracts established pursuant to this section. The director of the department of health services shall publish rules pursuant to title 41, chapter 6 for the grant program before the issuance of the initial grant program request for proposals. The director of the department of health services and the contractor shall sign a contract before the transmission of any tobacco tax and health care fund monies to the contractor.

~~I.~~ G. In administering the basic children's medical services program and awarding contracts established pursuant to this section, the director of the department of health services shall seek to efficiently and effectively coordinate the delivery of services provided through the program with services provided through other programs including those established pursuant to chapter 2, article 3 of this title and sections 36-2907.05 and 36-2907.06. The director shall seek to ensure that this coordination results in providing for either or both the coverage of additional children or the provision of additional medically necessary services to children instead of supplanting existing service opportunities or duplicating existing programs with no attendant increase in coverage.

H. AFTER THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION APPROVES THE CHILDREN'S HEALTH INSURANCE PROGRAM ESTABLISHED PURSUANT TO ARTICLE 4 OF THIS CHAPTER, THE DEPARTMENT OF HEALTH SERVICES SHALL CONTRACT WITH HOSPITALS TO ENABLE THE HOSPITALS TO DELIVER OR ARRANGE TO PROVIDE COVERAGE SPECIFIED IN THIS SECTION TO CHILDREN WHO ARE DETERMINED ELIGIBLE PURSUANT TO SECTION 36-2983 AND WHO ELECT TO RECEIVE DIRECT, SLIDING FEE SCALE MEDICAL AND HEALTH CARE SERVICES FROM QUALIFYING HEALTH CENTERS PURSUANT TO SECTION 36-2907.06, SUBSECTION G AND FROM HOSPITALS PURSUANT TO THIS SECTION. THE CONTRACTING HOSPITALS SHALL PROVIDE DATA THE ADMINISTRATION DETERMINES IS SUFFICIENT TO ALLOW THE STATE TO APPLY FOR FEDERAL FUNDING UNDER THE PROGRAM ESTABLISHED PURSUANT TO ARTICLE 4 OF THIS CHAPTER.

~~J.~~ I. For the purposes of this section, "grant program" refers to the basic children's medical services program.

Sec. 3. Section 36-2921, Arizona Revised Statutes, is amended to read:

36-2921. Tobacco tax allocation

A. Subject to the availability of monies in the medically needy account established pursuant to section 42-1241, subsection C, paragraph 3 the administration shall use the monies in the account in the following order:

1. The administration shall withdraw the amount necessary to pay the state share of costs for providing health care services to any person who is eligible pursuant to section 36-2901, paragraph 4, subdivisions (a), (c) and (h) and who becomes eligible for a heart, lung, heart-lung, liver or autologous and allogeneic bone marrow transplant pursuant to section 36-2907, subsection A, paragraph 11, subdivision (d) as determined by the administrator and to any person who is eligible pursuant to section 36-2901, paragraph 4, subdivision (b) and who becomes eligible for a lung or heart-lung transplant pursuant to section 36-2907, subsection A, paragraph 11, subdivision (b), as determined by the administrator.

2. Beginning on August 1, 1995 and on the first day of each month ~~thereafter~~ UNTIL JULY 1, 1998, the sum of one million two hundred fifty thousand dollars shall be transferred from the medically needy account to the

medical services stabilization fund for uses as prescribed in section 36-2922.

3. THE ADMINISTRATION SHALL WITHDRAW THE SUM OF NINE MILLION TWO HUNDRED FIFTY-ONE THOUSAND ONE HUNDRED DOLLARS IN FISCAL YEAR 1998-1999 FOR DEPOSIT IN THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND ESTABLISHED BY SECTION 36-2995 TO PAY THE STATE SHARE OF THE CHILDREN'S HEALTH INSURANCE PROGRAM ESTABLISHED PURSUANT TO ARTICLE 4 OF THIS CHAPTER.

~~3.~~ 4. From and after August 1, 1995 and each year thereafter, the administration shall transfer the following monies to the department of health services to be allocated as follows if the department awards a contract:

(a) Five million dollars, for the mental health grant program established pursuant to section 36-3414.

(b) Six million dollars, for primary care services established pursuant to section 36-2907.05.

(c) Five million dollars, for grants to the QUALIFYING community health centers established pursuant to section 36-2907.06, SUBSECTION A.

~~4.~~ 5. ~~From and after August 1, 1995,~~ The administration shall transfer up to five hundred thousand dollars ~~annually~~ for fiscal ~~years~~ YEAR 1997-1998 for pilot programs providing detoxification services in counties having a population of five hundred thousand persons or less according to the most recent United States decennial census. The department OF HEALTH SERVICES shall report to the joint legislative oversight committee on the tobacco tax and health care fund no later than October 1, 1998 regarding the operation and effectiveness of the detoxification pilot programs funded pursuant to this ~~section~~ SUBSECTION. The report shall also include recommendations regarding the continued funding of these programs.

~~5.~~ 6. The administration shall transfer up to two hundred fifty thousand dollars annually for fiscal years 1995-1996, 1996-1997 and 1997-1998 for telemedicine pilot programs designed to facilitate the provision of medical services to persons living in medically underserved areas as provided in section 36-2352.

~~6.~~ 7. The administration shall transfer up to two hundred fifty thousand dollars annually beginning in fiscal year 1996-1997 for contracts by the department of health services with nonprofit organizations that primarily assist in the management of end stage renal disease and related problems. Contracts shall not include payments for transportation of patients for dialysis.

~~7.~~ 8. Contingent on the existence of a premium sharing demonstration project fund, beginning October 1, 1996 and until September 30, 1999, the administration shall withdraw the sum of twenty million dollars in each of fiscal years 1996-1997, 1997-1998 and 1998-1999 for deposit in the premium sharing demonstration project fund established by section 36-2923 to provide health care services to any person who is eligible for an Arizona health care

cost containment system premium sharing demonstration program enacted by the legislature. The Arizona health care cost containment system premium sharing demonstration program enacted by the legislature shall not be an entitlement program. BEGINNING ON OCTOBER 1, 1997, the administration shall annually withdraw monies from the medically needy account not to exceed two per cent of the sum of any monies transferred pursuant to this paragraph for administrative costs associated with the premium sharing demonstration project.

~~8.~~ 9. Subject to the availability of monies, the Arizona health care cost containment system administration shall transfer to the department of health services up to five million dollars ~~annually beginning~~ in fiscal ~~year~~ YEARS 1996-1997 AND 1997-1998 AND TWO MILLION FIVE HUNDRED THOUSAND DOLLARS IN FISCAL YEAR 1998-1999 for providing nonentitlement funding for a basic children's medical services program established by section 36-2907.08. The administration may also withdraw and transfer to the department amounts for program evaluation and for administrative costs as prescribed in section 36-2907.08.

~~9.~~ 10. Subject to the availability of monies, the sum of one million dollars shall be transferred to the health crisis fund for use as prescribed in section 36-797.

~~10.~~ 11. Subject to the availability of monies, the Arizona health care cost containment system shall transfer to the aging and adult administration in the department of economic security the sum of five hundred thousand dollars annually beginning in fiscal year 1997-1998 for services provided pursuant to section 46-192, subsection A, paragraph 4. Services shall be used for persons who meet the low income eligibility criteria developed by the aging and adult administration.

B. The department of health services shall establish an accounting procedure to ensure that all funds transferred pursuant to this section are maintained separately from any other funds.

C. The administration shall annually withdraw monies from the medically needy account in the amount necessary to reimburse the department of health services for administrative costs to implement each program established pursuant to subsection A of this section not to exceed four per cent of the amount transferred for each program.

D. The administration shall annually withdraw monies from the medically needy account in the amount necessary to reimburse the department of health services for the evaluations as prescribed by section 36-2907.07.

E. The administration shall annually report, no later than November 1 of each year, to the joint legislative oversight committee on the tobacco tax and health care fund the annual revenues deposited in the medically needy account and the estimated expenditures needed in the subsequent year to provide funding for services provided in subsection A, paragraph 1 of this section. The administration shall immediately report to the cochairs of the

oversight committee if at any time the administration estimates that the amount available in the medically needy account will not be sufficient to fund the maximum allocations established in this section.

Sec. 4. Section 36-2923, Arizona Revised Statutes, is amended to read:

36-2923. Premium sharing demonstration project fund; purpose; expenditures; nonlapsing; investment; definition

A. A premium sharing demonstration project fund is established for costs associated with an Arizona health care cost containment system premium sharing demonstration project that is to provide uninsured persons access to medical services provided by system providers. The fund consists of monies deposited from the medically needy account of the tobacco tax and health care fund pursuant to section 36-2921, subsection A, paragraph ~~7~~ 8 and premiums collected from demonstration project participants. The administration shall administer the fund as a continuing appropriation.

B. Beginning on October 1, 1997, if a premium sharing demonstration project is established, the administration shall spend monies in the fund through the first quarter of fiscal year ~~2000-2001~~ 2001-2002 to cover demonstration project expenditures. The administration may continue to make expenditures from the fund, subject to the availability of monies in the fund, for covering program costs incurred but not processed by the administration during the fiscal years in which the program officially operated.

C. The director may withdraw not more than seventy-five thousand dollars from the fund for the fifteen month period beginning July 1, 1996 and ending September 30, 1997 to cover administrative expenditures related to the development of a premium sharing demonstration project proposal or any premium sharing demonstration project analysis requested by a committee of the legislature.

D. Monies in the fund are CONTINUOUSLY APPROPRIATED THROUGH SEPTEMBER 30, 2001 AND ARE exempt from the provisions of section 35-190 relating to lapsing of appropriations, except that all unexpended and unencumbered monies remaining on October 1, ~~2001~~ 2002 revert to the medically needy account of the tobacco tax and health care fund.

E. The state treasurer shall invest the monies in the fund, and investment income shall be credited to the fund.

F. For purposes of this section, unless otherwise noted, "fund" means the premium sharing demonstration project fund.

Sec. 5. Title 36, chapter 29, Arizona Revised Statutes, is amended by adding article 4, to read:

ARTICLE 4. CHILDREN'S HEALTH INSURANCE PROGRAM

36-2981. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "ADMINISTRATION" MEANS THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION.

oversight committee if at any time the administration estimates that the amount available in the medically needy account will not be sufficient to fund the maximum allocations established in this section.

Sec. 4. Section 36-2923, Arizona Revised Statutes, is amended to read:

36-2923. Premium sharing demonstration project fund; purpose; expenditures; nonlapsing; investment; definition

A. A premium sharing demonstration project fund is established for costs associated with an Arizona health care cost containment system premium sharing demonstration project that is to provide uninsured persons access to medical services provided by system providers. The fund consists of monies deposited from the medically needy account of the tobacco tax and health care fund pursuant to section 36-2921, subsection A, paragraph ~~7~~ 8 and premiums collected from demonstration project participants. The administration shall administer the fund as a continuing appropriation.

B. Beginning on October 1, 1997, if a premium sharing demonstration project is established, the administration shall spend monies in the fund through the first quarter of fiscal year ~~2000-2001~~ 2001-2002 to cover demonstration project expenditures. The administration may continue to make expenditures from the fund, subject to the availability of monies in the fund, for covering program costs incurred but not processed by the administration during the fiscal years in which the program officially operated.

C. The director may withdraw not more than seventy-five thousand dollars from the fund for the fifteen month period beginning July 1, 1996 and ending September 30, 1997 to cover administrative expenditures related to the development of a premium sharing demonstration project proposal or any premium sharing demonstration project analysis requested by a committee of the legislature.

D. Monies in the fund are CONTINUOUSLY APPROPRIATED THROUGH SEPTEMBER 30, 2001 AND ARE exempt from the provisions of section 35-190 relating to lapsing of appropriations, except that all unexpended and unencumbered monies remaining on October 1, ~~2001~~ 2002 revert to the medically needy account of the tobacco tax and health care fund.

E. The state treasurer shall invest the monies in the fund, and investment income shall be credited to the fund.

F. For purposes of this section, unless otherwise noted, "fund" means the premium sharing demonstration project fund.

Sec. 5. Title 36, chapter 29, Arizona Revised Statutes, is amended by adding article 4, to read:

ARTICLE 4. CHILDREN'S HEALTH INSURANCE PROGRAM

36-2981. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "ADMINISTRATION" MEANS THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION.

2. "DIRECTOR" MEANS THE DIRECTOR OF THE ADMINISTRATION.

3. "CONTRACTOR" MEANS A HEALTH PLAN THAT CONTRACTS WITH THE ADMINISTRATION FOR THE PROVISION OF HOSPITALIZATION AND MEDICAL CARE TO MEMBERS ACCORDING TO THE PROVISIONS OF THIS ARTICLE OR A QUALIFYING PLAN.

4. "FEDERAL POVERTY LEVEL" MEANS THE FEDERAL POVERTY LEVEL GUIDELINES PUBLISHED ANNUALLY BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

5. "HEALTH PLAN" MEANS AN ENTITY THAT CONTRACTS WITH THE ADMINISTRATION FOR SERVICES PROVIDED PURSUANT TO ARTICLE 1 OF THIS CHAPTER.

6. "MEMBER" MEANS A PERSON WHO IS ELIGIBLE FOR AND ENROLLED IN THE PROGRAM, WHO IS UNDER NINETEEN YEARS OF AGE AND WHOSE GROSS HOUSEHOLD INCOME MEETS THE FOLLOWING REQUIREMENTS:

(a) FOR FISCAL YEAR 1998-1999, HAS INCOME AT OR BELOW ONE HUNDRED FIFTY PER CENT OF THE FEDERAL POVERTY LEVEL.

(b) FOR FISCAL YEAR 1999-2000, HAS INCOME AT OR BELOW ONE HUNDRED SEVENTY-FIVE PER CENT OF THE FEDERAL POVERTY LEVEL.

(c) FOR FISCAL YEAR 2000-2001 AND EACH FISCAL YEAR THEREAFTER, HAS INCOME AT OR BELOW TWO HUNDRED PER CENT OF THE FEDERAL POVERTY LEVEL.

7. "NONCONTRACTING PROVIDER" MEANS AN ENTITY THAT PROVIDES HOSPITAL OR MEDICAL CARE BUT DOES NOT HAVE A CONTRACT OR SUBCONTRACT WITH THE ADMINISTRATION.

8. "PHYSICIAN" MEANS A PERSON LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17.

9. "PREPAID CAPITATED" MEANS A METHOD OF PAYMENT BY WHICH A CONTRACTOR DELIVERS HEALTH CARE SERVICES FOR THE DURATION OF A CONTRACT TO A SPECIFIED NUMBER OF MEMBERS BASED ON A FIXED RATE PER MEMBER, PER MONTH WITHOUT REGARD TO THE NUMBER OF MEMBERS WHO RECEIVE CARE OR THE AMOUNT OF HEALTH CARE SERVICES PROVIDED TO A MEMBER.

10. "PROGRAM" MEANS THE CHILDREN'S HEALTH INSURANCE PROGRAM.

11. "PRIMARY CARE PHYSICIAN" MEANS A PHYSICIAN WHO IS A FAMILY PRACTITIONER, GENERAL PRACTITIONER, PEDIATRICIAN, GENERAL INTERNIST, OBSTETRICIAN OR GYNECOLOGIST.

12. "PRIMARY CARE PRACTITIONER" MEANS A NURSE PRACTITIONER WHO IS CERTIFIED PURSUANT TO TITLE 32, CHAPTER 15 OR A PHYSICIAN ASSISTANT WHO IS CERTIFIED PURSUANT TO TITLE 32, CHAPTER 25 AND WHO IS ACTING WITHIN THE RESPECTIVE SCOPE OF PRACTICE OF THOSE CHAPTERS.

13. "QUALIFYING PLAN" MEANS A CONTRACTOR THAT CONTRACTS WITH THE STATE PURSUANT TO SECTION 38-651 TO PROVIDE HEALTH AND ACCIDENT INSURANCE FOR STATE EMPLOYEES AND THAT PROVIDES SERVICES TO MEMBERS PURSUANT TO SECTION 36-2989, SUBSECTION A.

14. "TRIBAL FACILITY" MEANS A FACILITY THAT IS OPERATED BY AN INDIAN TRIBE AND THAT IS AUTHORIZED TO PROVIDE SERVICES PURSUANT TO PUBLIC LAW 93-638, AS AMENDED.

36-2982. Children's health insurance program; administration; nonentitlement; enrollment limitation; eligibility

A. THE CHILDREN'S HEALTH INSURANCE PROGRAM IS ESTABLISHED FOR CHILDREN WHO ARE ELIGIBLE PURSUANT TO SECTION 36-2981, PARAGRAPH 6. THE ADMINISTRATION SHALL ADMINISTER THE PROGRAM. ALL COVERED SERVICES SHALL BE PROVIDED BY HEALTH PLANS THAT HAVE CONTRACTS WITH THE ADMINISTRATION PURSUANT TO SECTION 36-2906, A QUALIFYING PLAN OR BY EITHER TRIBAL FACILITIES OR THE INDIAN HEALTH SERVICE FOR NATIVE AMERICANS WHO ARE ELIGIBLE FOR THE PROGRAM AND WHO ELECT TO RECEIVE SERVICES THROUGH THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY.

B. THIS ARTICLE DOES NOT CREATE A LEGAL ENTITLEMENT FOR ANY APPLICANT OR MEMBER WHO IS ELIGIBLE FOR THE PROGRAM. TOTAL ENROLLMENT IS LIMITED BASED ON THE ANNUAL APPROPRIATIONS MADE BY THE LEGISLATURE AND THE ENROLLMENT CAP PRESCRIBED IN SECTION 36-2985.

C. BEGINNING ON OCTOBER 1, 1997, THE DIRECTOR SHALL TAKE ALL STEPS NECESSARY TO IMPLEMENT THE ADMINISTRATIVE STRUCTURE FOR THE PROGRAM AND TO BEGIN DELIVERING SERVICES TO PERSONS WITHIN SIXTY DAYS AFTER APPROVAL OF THE STATE PLAN BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

D. THE ADMINISTRATION SHALL PERFORM ELIGIBILITY DETERMINATIONS AND REDETERMINATIONS FOR PERSONS APPLYING FOR ELIGIBILITY OR CONTINUED ELIGIBILITY PURSUANT TO THIS ARTICLE. IF AN ENTITY OTHER THAN THE ADMINISTRATION PERFORMS THE ELIGIBILITY DETERMINATIONS, THE ADMINISTRATION SHALL RECOUP ANY FEDERAL FISCAL SANCTIONS THAT RESULT FROM INACCURATE ELIGIBILITY DETERMINATIONS FOR THESE PERSONS.

E. THE ADMINISTRATION SHALL ADOPT RULES FOR THE COLLECTION OF COPAYMENTS FROM MEMBERS WHOSE INCOME DOES NOT EXCEED ONE HUNDRED FIFTY PER CENT OF THE FEDERAL POVERTY LEVEL AND FOR THE COLLECTION OF COPAYMENTS AND PREMIUMS FROM MEMBERS WHOSE INCOME EXCEEDS ONE HUNDRED FIFTY PER CENT OF THE FEDERAL POVERTY LEVEL. THE DIRECTOR SHALL ADOPT RULES FOR DISENROLLING A MEMBER IF THE MEMBER DOES NOT PAY THE PREMIUM REQUIRED PURSUANT TO THIS SECTION.

F. BEFORE ENROLLMENT, A MEMBER, OR IF THE MEMBER IS A MINOR, THAT MEMBER'S PARENT OR LEGAL GUARDIAN, SHALL SELECT AN AVAILABLE HEALTH PLAN IN THE MEMBER'S GEOGRAPHIC SERVICE AREA OR A QUALIFYING HEALTH PLAN OFFERED IN THE COUNTY, AND MAY SELECT A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER FROM AMONG THE AVAILABLE PHYSICIANS AND PRACTITIONERS PARTICIPATING WITH THE CONTRACTOR IN WHICH THE MEMBER IS ENROLLED. THE CONTRACTORS SHALL ONLY REIMBURSE SERVICES OR COSTS OF RELATED SERVICES PROVIDED BY OR UNDER REFERRAL FROM A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER PARTICIPATING IN THE CONTRACT IN WHICH THE MEMBER IS ENROLLED, EXCEPT FOR EMERGENCY SERVICES THAT SHALL BE REIMBURSED PURSUANT TO SECTION 36-2987. THE DIRECTOR SHALL ESTABLISH REQUIREMENTS AS TO THE MINIMUM TIME PERIOD THAT A MEMBER IS ASSIGNED TO SPECIFIC CONTRACTORS. AN ELIGIBLE CHILD, OR THAT CHILD'S PARENT OR GUARDIAN, MAY ELECT TO RECEIVE DIRECT, SLIDING FEE

SCALE MEDICAL AND HEALTH CARE SERVICES FROM QUALIFYING HEALTH CENTERS PURSUANT TO SECTION 36-2907.06, SUBSECTION G, AND FROM HOSPITALS PURSUANT TO SECTION 36-2907.08. AN ELIGIBLE CHILD, OR THAT CHILD'S PARENT OR GUARDIAN, WHO ELECTS DIRECT SERVICES SHALL NOT BE ENROLLED WITH A QUALIFYING PLAN UNLESS THE CHILD, OR THAT CHILD'S PARENT OR GUARDIAN, ELECTS TO RECEIVE SERVICES PURSUANT TO THIS ARTICLE.

G. ELIGIBILITY FOR THE PROGRAM SHALL BE COUNTED AS CREDITABLE COVERAGE AS DEFINED IN SECTION 20-1379.

H. ON APPLICATION FOR ELIGIBILITY FOR THE PROGRAM, THE MEMBER, OR IF THE MEMBER IS A MINOR, THE MEMBER'S PARENT OR GUARDIAN, SHALL RECEIVE AN APPLICATION FOR AND A PROGRAM DESCRIPTION OF THE PREMIUM SHARING DEMONSTRATION PROJECT IF THE MEMBER RESIDES IN A COUNTY CHOSEN TO PARTICIPATE IN THAT PROJECT.

I. NOTWITHSTANDING SECTION 36-2983, THE ADMINISTRATION MAY PURCHASE FOR A MEMBER EMPLOYER SPONSORED GROUP HEALTH INSURANCE WITH STATE AND FEDERAL MONIES AVAILABLE PURSUANT TO THIS ARTICLE, SUBJECT TO ANY RESTRICTIONS IMPOSED BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION. THIS SUBSECTION DOES NOT APPLY TO MEMBERS WHO ARE ELIGIBLE FOR HEALTH BENEFITS COVERAGE UNDER A STATE HEALTH BENEFITS PLAN BASED ON A FAMILY MEMBER'S EMPLOYMENT WITH A PUBLIC AGENCY IN THIS STATE.

36-2983. Eligibility for the program

A. THE ADMINISTRATION SHALL ESTABLISH A STREAMLINED ELIGIBILITY PROCESS FOR APPLICANTS TO THE PROGRAM AND SHALL ISSUE A CERTIFICATE OF ELIGIBILITY AT THE TIME ELIGIBILITY FOR THE PROGRAM IS DETERMINED. ELIGIBILITY SHALL BE BASED ON GROSS HOUSEHOLD INCOME FOR A MEMBER AS DEFINED IN SECTION 36-2981. THE ADMINISTRATION SHALL NOT APPLY A RESOURCE TEST IN THE ELIGIBILITY DETERMINATION OR REDETERMINATION PROCESS.

B. THE ADMINISTRATION SHALL USE A SIMPLIFIED ELIGIBILITY FORM THAT MAY BE MAILED TO THE ADMINISTRATION. ONCE A COMPLETED APPLICATION IS RECEIVED, INCLUDING ADEQUATE VERIFICATION OF INCOME, THE ADMINISTRATION SHALL EXPEDITE THE ELIGIBILITY DETERMINATION AND ENROLLMENT ON A PROSPECTIVE BASIS.

C. THE DATE OF ELIGIBILITY IS THE FIRST DAY OF THE MONTH FOLLOWING A DETERMINATION OF ELIGIBILITY IF THE DECISION IS MADE BY THE TWENTY-FIFTH DAY OF THE MONTH. A PERSON WHO IS DETERMINED ELIGIBLE FOR THE PROGRAM AFTER THE TWENTY-FIFTH DAY OF THE MONTH IS ELIGIBLE FOR THE PROGRAM THE FIRST DAY OF THE SECOND MONTH FOLLOWING THE DETERMINATION OF ELIGIBILITY.

D. AN APPLICANT FOR THE PROGRAM MUST HAVE A SOCIAL SECURITY NUMBER OR SHALL APPLY FOR A SOCIAL SECURITY NUMBER WITHIN THIRTY DAYS AFTER THE APPLICANT SUBMITS AN APPLICATION FOR THE PROGRAM.

E. IN ORDER TO BE ELIGIBLE FOR THE PROGRAM, A PERSON SHALL BE A RESIDENT OF THIS STATE AND SHALL MEET TITLE XIX REQUIREMENTS FOR UNITED STATES CITIZENSHIP OR QUALIFIED ALIEN STATUS IN THE MANNER PRESCRIBED IN SECTION 36-2903.03.

F. IN DETERMINING THE ELIGIBILITY FOR ALL QUALIFIED ALIENS PURSUANT TO THIS ARTICLE, THE INCOME AND RESOURCES OF A PERSON WHO EXECUTED AN AFFIDAVIT OF SUPPORT PURSUANT TO SECTION 213A OF THE IMMIGRATION AND NATIONALITY ACT ON BEHALF OF THE QUALIFIED ALIEN AND THE INCOME AND RESOURCES OF THE SPOUSE, IF ANY, OF THE SPONSORING INDIVIDUAL SHALL BE COUNTED AT THE TIME OF APPLICATION AND FOR THE REDETERMINATION OF ELIGIBILITY FOR THE DURATION OF THE ATTRIBUTION PERIOD AS SPECIFIED IN FEDERAL LAW.

G. PURSUANT TO FEDERAL LAW, A PERSON IS NOT ELIGIBLE FOR THE PROGRAM IF THAT PERSON IS:

1. ELIGIBLE FOR TITLE XIX OR OTHER FEDERALLY OPERATED OR FINANCED HEALTH CARE INSURANCE PROGRAMS, EXCEPT THE INDIAN HEALTH SERVICE.

2. COVERED BY ANY GROUP HEALTH PLAN OR OTHER HEALTH INSURANCE COVERAGE AS DEFINED IN SECTION 2791 OF THE PUBLIC HEALTH SERVICE ACT. GROUP HEALTH PLAN OR OTHER HEALTH INSURANCE COVERAGE DOES NOT INCLUDE COVERAGE TO PERSONS WHO ARE DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISION (a), (c) OR (h) OR THE PREMIUM SHARING PROGRAM.

3. A MEMBER OF A FAMILY THAT IS ELIGIBLE FOR HEALTH BENEFITS COVERAGE UNDER A STATE HEALTH BENEFIT PLAN BASED ON A FAMILY MEMBER'S EMPLOYMENT WITH A PUBLIC AGENCY IN THIS STATE.

4. AN INMATE OF A PUBLIC INSTITUTION OR A PATIENT IN AN INSTITUTION FOR MENTAL DISEASES. THIS PARAGRAPH DOES NOT APPLY TO SERVICES FURNISHED IN A STATE OPERATED MENTAL HOSPITAL OR TO RESIDENTIAL OR OTHER TWENTY-FOUR HOUR THERAPEUTICALLY PLANNED STRUCTURED SERVICES.

H. A CHILD WHO IS COVERED UNDER AN EMPLOYER'S GROUP HEALTH INSURANCE PLAN OR THROUGH FAMILY OR INDIVIDUAL HEALTH CARE COVERAGE SHALL NOT BE ENROLLED IN THE PROGRAM. IF THE HEALTH INSURANCE COVERAGE IS DISCONTINUED FOR ANY REASON, EXCEPT FOR THE LOSS OF HEALTH INSURANCE DUE TO LOSS OF EMPLOYMENT, THE CHILD IS NOT ELIGIBLE FOR THE PROGRAM FOR A PERIOD OF SIX MONTHS FROM THE DATE THAT THE HEALTH CARE COVERAGE WAS DISCONTINUED.

I. PURSUANT TO FEDERAL LAW, A PRIVATE INSURER, AS DEFINED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SHALL NOT LIMIT ENROLLMENT BY CONTRACT OR ANY OTHER MEANS BASED ON THE PRESUMPTION THAT A CHILD MAY BE ELIGIBLE FOR THE PROGRAM.

36-2984. <u>Family coverage; payment of premiums; creditable coverage</u>

A. THE CONTRACTORS SHALL OFFER HEALTH INSURANCE COVERAGE TO THE PARENT OR LEGAL GUARDIAN OF A CHILD WHO IS ELIGIBLE FOR THE PROGRAM. THE CONTRACTORS SHALL ESTABLISH RATES THAT ARE APPROVED BY THE ADMINISTRATION. THE CONTRACTORS SHALL INCLUDE PROVISIONS FOR PREEXISTING CONDITIONS AND ANY OTHER MEDICAL UNDERWRITING CONSIDERATIONS THAT ARE NECESSARY TO PROTECT THE CONTRACTORS FROM ADVERSE RISK.

B. A PARENT OR LEGAL GUARDIAN WHO SELECTS COVERAGE PURSUANT TO SUBSECTION A OF THIS SECTION SHALL PAY THE FULL COST OF THE PREMIUM.

C. HEALTH INSURANCE COVERAGE UNDER THIS SECTION IS CREDITABLE COVERAGE AS DEFINED IN SECTION 20-1379.

D. TITLE XXI FEDERAL MONIES SHALL NOT BE USED TO SUBSIDIZE THE USE OF FAMILY COVERAGE.

36-2985. Enrollment cap; program termination; spending limitation

A. IF THE DIRECTOR DETERMINES THAT MONIES MAY BE INSUFFICIENT FOR THE PROGRAM THE DIRECTOR SHALL IMMEDIATELY NOTIFY THE GOVERNOR, THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES. AFTER CONSULTING WITH THE GOVERNOR, THE ADMINISTRATION SHALL STOP PROCESSING NEW APPLICATIONS FOR THE PROGRAM UNTIL THE ADMINISTRATION IS ABLE TO VERIFY THAT FUNDING IS SUFFICIENT TO BEGIN PROCESSING APPLICATIONS AND THE GOVERNOR AGREES THAT THE ADMINISTRATION MAY BEGIN PROCESSING APPLICATIONS.

B. IF THE FEDERAL GOVERNMENT ELIMINATES FEDERAL FUNDING FOR THE PROGRAM OR SIGNIFICANTLY REDUCES THE FEDERAL FUNDING BELOW THE ESTIMATED FEDERAL EXPENDITURES, THE ADMINISTRATION SHALL IMMEDIATELY STOP PROCESSING ALL APPLICATIONS AND SHALL PROVIDE AT LEAST THIRTY DAYS' ADVANCE NOTICE TO CONTRACTORS AND MEMBERS THAT THE PROGRAM WILL TERMINATE.

C. THE TOTAL AMOUNT OF STATE MONIES THAT MAY BE SPENT IN ANY FISCAL YEAR BY THE ADMINISTRATION FOR HEALTH CARE PROVIDED UNDER THIS ARTICLE SHALL NOT EXCEED THE AMOUNT APPROPRIATED OR AUTHORIZED BY SECTION 35-173.

D. THIS ARTICLE DOES NOT IMPOSE A DUTY ON AN OFFICER, AGENT OR EMPLOYEE OF THIS STATE TO DISCHARGE A RESPONSIBILITY OR TO CREATE ANY RIGHT IN A PERSON OR GROUP IF THE DISCHARGE OR RIGHT WOULD REQUIRE AN EXPENDITURE OF STATE MONIES IN EXCESS OF THE EXPENDITURE AUTHORIZED BY LEGISLATIVE APPROPRIATION FOR THAT SPECIFIC PURPOSE.

36-2986. Administration; powers and duties of director

A. THE DIRECTOR HAS FULL OPERATIONAL AUTHORITY TO ADOPT RULES OR TO USE THE APPROPRIATE RULES ADOPTED FOR ARTICLE 1 OF THIS CHAPTER FOR ANY OF THE FOLLOWING:

1. CONTRACT ADMINISTRATION AND OVERSIGHT OF CONTRACTORS.

2. DEVELOPMENT OF A COMPLETE SYSTEM OF ACCOUNTS AND CONTROLS FOR THE PROGRAM INCLUDING PROVISIONS DESIGNED TO ENSURE THAT COVERED HEALTH AND MEDICAL SERVICES PROVIDED THROUGH THE SYSTEM ARE NOT USED UNNECESSARILY OR UNREASONABLY INCLUDING INPATIENT BEHAVIORAL HEALTH SERVICES PROVIDED IN A HOSPITAL.

3. ESTABLISHMENT OF PEER REVIEW AND UTILIZATION REVIEW FUNCTIONS FOR ALL CONTRACTORS.

4. DEVELOPMENT AND MANAGEMENT OF A CONTRACTOR PAYMENT SYSTEM.

5. ESTABLISHMENT AND MANAGEMENT OF A COMPREHENSIVE SYSTEM FOR ASSURING QUALITY OF CARE.

6. ESTABLISHMENT AND MANAGEMENT OF A SYSTEM TO PREVENT FRAUD BY MEMBERS, CONTRACTORS AND HEALTH CARE PROVIDERS.

1 CONTRACTOR FOR FIVE YEARS. THE DIRECTOR SHALL ALSO REQUIRE THAT THESE
2 RECORDS ARE AVAILABLE BY A CONTRACTOR ON REQUEST OF THE SECRETARY OF THE
3 UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.
4 E. SUBJECT TO EXISTING LAW RELATING TO PRIVILEGE AND PROTECTION, THE
5 DIRECTOR SHALL PRESCRIBE BY RULE THE TYPES OF INFORMATION THAT ARE
6 CONFIDENTIAL AND CIRCUMSTANCES UNDER WHICH THIS INFORMATION MAY BE USED OR
7 RELEASED, INCLUDING REQUIREMENTS FOR PHYSICIAN-PATIENT CONFIDENTIALITY.
8 NOTWITHSTANDING ANY OTHER LAW, THESE RULES SHALL BE DESIGNED TO PROVIDE FOR
9 THE EXCHANGE OF NECESSARY INFORMATION FOR THE PURPOSES OF ELIGIBILITY
10 DETERMINATION UNDER THIS ARTICLE. NOTWITHSTANDING ANY OTHER LAW, A MEMBER'S
11 MEDICAL RECORD SHALL BE RELEASED WITHOUT THE MEMBER'S CONSENT IN SITUATIONS
12 OF SUSPECTED CASES OF FRAUD OR ABUSE RELATING TO THE SYSTEM TO AN OFFICER OF
13 THIS STATE'S CERTIFIED ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM FRAUD
14 CONTROL UNIT WHO HAS SUBMITTED A WRITTEN REQUEST FOR THE MEDICAL RECORD.
15 F. THE DIRECTOR SHALL PROVIDE FOR THE TRANSITION OF MEMBERS BETWEEN
16 CONTRACTORS AND NONCONTRACTING PROVIDERS AND THE TRANSFER OF MEMBERS WHO HAVE
17 BEEN DETERMINED ELIGIBLE FROM HOSPITALS THAT DO NOT HAVE CONTRACTS TO CARE
18 FOR THESE PERSONS.
19 G. TO THE EXTENT THAT SERVICES ARE FURNISHED PURSUANT TO THIS ARTICLE
20 A CONTRACTOR IS NOT SUBJECT TO THE PROVISIONS OF TITLE 20 UNLESS THE
21 CONTRACTOR IS A QUALIFYING PLAN AND HAS ELECTED TO PROVIDE SERVICES PURSUANT
22 TO THIS ARTICLE.
23 H. AS A CONDITION OF A CONTRACT, THE DIRECTOR SHALL REQUIRE CONTRACT
24 TERMS THAT ARE NECESSARY TO ENSURE ADEQUATE PERFORMANCE BY THE CONTRACTOR.
25 CONTRACT PROVISIONS REQUIRED BY THE DIRECTOR INCLUDE THE MAINTENANCE OF
26 DEPOSITS, PERFORMANCE BONDS, FINANCIAL RESERVES OR OTHER FINANCIAL SECURITY.
27 THE DIRECTOR MAY WAIVE REQUIREMENTS FOR THE POSTING OF BONDS OR SECURITY FOR
28 CONTRACTORS WHO HAVE POSTED OTHER SECURITY, EQUAL TO OR GREATER THAN THAT
29 REQUIRED BY THE ADMINISTRATION, WITH A STATE AGENCY FOR THE PERFORMANCE OF
30 HEALTH SERVICE CONTRACTS IF MONIES WOULD BE AVAILABLE FROM THAT SECURITY FOR
31 THE SYSTEM ON DEFAULT BY THE CONTRACTOR.
32 I. THE DIRECTOR SHALL ESTABLISH SOLVENCY REQUIREMENTS IN CONTRACT THAT
33 MAY INCLUDE WITHHOLDING OR FORFEITURE OF PAYMENTS TO BE MADE TO A CONTRACTOR
34 BY THE ADMINISTRATION FOR THE FAILURE OF THE CONTRACTOR TO COMPLY WITH A
35 PROVISION OF THE CONTRACT WITH THE ADMINISTRATION. THE DIRECTOR MAY ALSO
36 REQUIRE CONTRACT TERMS ALLOWING THE ADMINISTRATION TO OPERATE A CONTRACTOR
37 DIRECTLY UNDER CIRCUMSTANCES SPECIFIED IN THE CONTRACT. THE ADMINISTRATION
38 SHALL OPERATE THE CONTRACTOR ONLY AS LONG AS IT IS NECESSARY TO ASSURE
39 DELIVERY OF UNINTERRUPTED CARE TO MEMBERS ENROLLED WITH THE CONTRACTOR AND
40 TO ACCOMPLISH THE ORDERLY TRANSITION OF MEMBERS TO OTHER CONTRACTORS OR UNTIL
41 THE CONTRACTOR REORGANIZES OR OTHERWISE CORRECTS THE CONTRACT PERFORMANCE
42 FAILURE. THE ADMINISTRATION SHALL NOT OPERATE A CONTRACTOR UNLESS, BEFORE
43 THAT ACTION, THE ADMINISTRATION DELIVERS NOTICE TO THE CONTRACTOR PROVIDING
44 AN OPPORTUNITY FOR A HEARING IN ACCORDANCE WITH PROCEDURES ESTABLISHED BY THE

1 DIRECTOR. NOTWITHSTANDING THE PROVISIONS OF A CONTRACT, IF THE
2 ADMINISTRATION FINDS THAT THE PUBLIC HEALTH, SAFETY OR WELFARE REQUIRES
3 EMERGENCY ACTION, IT MAY OPERATE AS THE CONTRACTOR ON NOTICE TO THE
4 CONTRACTOR AND PENDING AN ADMINISTRATIVE HEARING, WHICH IT SHALL PROMPTLY
5 INSTITUTE.
6 J. FOR THE SOLE PURPOSE OF MATTERS CONCERNING AND DIRECTLY RELATED TO
7 THIS ARTICLE, THE ADMINISTRATION IS EXEMPT FROM SECTION 41-192.
8 K. THE DIRECTOR MAY WITHHOLD PAYMENTS TO A NONCONTRACTING PROVIDER IF
9 THE NONCONTRACTING PROVIDER DOES NOT COMPLY WITH THIS ARTICLE OR ADOPTED
10 RULES THAT RELATE TO THE SPECIFIC SERVICES RENDERED AND BILLED TO THE
11 ADMINISTRATION.
12 L. THE DIRECTOR SHALL:
13 1. PRESCRIBE UNIFORM FORMS TO BE USED BY ALL CONTRACTORS AND FURNISH
14 UNIFORM FORMS AND PROCEDURES, INCLUDING METHODS OF IDENTIFICATION OF MEMBERS.
15 THE RULES SHALL INCLUDE REQUIREMENTS THAT AN APPLICANT PERSONALLY COMPLETE
16 OR ASSIST IN THE COMPLETION OF ELIGIBILITY APPLICATION FORMS, EXCEPT IN
17 SITUATIONS IN WHICH THE PERSON IS DISABLED.
18 2. BY RULE, ESTABLISH A GRIEVANCE AND APPEAL PROCEDURE THAT CONFORMS
19 WITH THE PROCESS IN ARTICLE 1 OF THIS CHAPTER. IF THE PROGRAM IS SUSPENDED
20 OR TERMINATED PURSUANT TO SECTION 36-2985, AN APPLICANT OR MEMBER IS NOT
21 ENTITLED TO CONTEST THE DENIAL, SUSPENSION OR TERMINATION OF ELIGIBILITY FOR
22 THE PROGRAM.
23 3. APPLY FOR AND ACCEPT FEDERAL MONIES AVAILABLE UNDER TITLE XXI OF
24 THE SOCIAL SECURITY ACT. AVAILABLE STATE MONIES APPROPRIATED TO THE
25 ADMINISTRATION FOR THE OPERATION OF THE PROGRAM SHALL BE USED AS MATCHING
26 MONIES TO SECURE FEDERAL MONIES PURSUANT TO THIS SUBSECTION.
27 M. THE ADMINISTRATION IS ENTITLED TO ALL RIGHTS PROVIDED TO THE
28 ADMINISTRATION FOR LIENS AND RELEASE OF CLAIMS AS SPECIFIED IN SECTIONS
29 36-2915 AND 36-2916.
30 N. THE DIRECTOR SHALL FOLLOW THE SAME PROCEDURES FOR REVIEW
31 COMMITTEES, IMMUNITY AND CONFIDENTIALITY THAT ARE PRESCRIBED IN ARTICLE 1 OF
32 THIS CHAPTER.
33 36-2987. Reimbursement for the program
34 A. FOR INPATIENT HOSPITAL SERVICES, THE ADMINISTRATION SHALL REIMBURSE
35 THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY FOR INPATIENT HOSPITAL
36 SERVICES BASED ON THE REIMBURSEMENT RATES FOR THE INDIAN HEALTH SERVICE AS
37 PUBLISHED ANNUALLY IN THE FEDERAL REGISTER. FOR OUTPATIENT SERVICES, THE
38 ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY
39 BASED ON THE CAPPED FEE-FOR-SERVICE SCHEDULE ESTABLISHED BY THE DIRECTOR.
40 IF CONGRESS AUTHORIZES ONE HUNDRED PER CENT PASS-THROUGH OF TITLE XXI MONIES
41 FOR SERVICES PROVIDED IN AN INDIAN HEALTH SERVICE FACILITY OR A TRIBAL
42 FACILITY, THE ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR THE
43 TRIBAL FACILITY WITH THIS ENHANCED FEDERAL FUNDING BASED ON THE REIMBURSEMENT

RATES FOR THE INDIAN HEALTH SERVICE OR THE TRIBAL FACILITY AS PUBLISHED ANNUALLY IN THE FEDERAL REGISTER.

B. CONTRACTORS SHALL REIMBURSE INPATIENT AND OUTPATIENT SERVICES BASED ON THE REIMBURSEMENT METHODOLOGY ESTABLISHED IN SECTION 36-2904 OR THE HOSPITAL REIMBURSEMENT PILOT PROGRAM ESTABLISHED BY THIS STATE.

C. FOR SERVICES RENDERED ON AND AFTER OCTOBER 1, 1998, THE ADMINISTRATION AND THE CONTRACTORS SHALL PAY A HOSPITAL'S RATE ESTABLISHED ACCORDING TO THIS SECTION SUBJECT TO THE FOLLOWING:

1. IF THE HOSPITAL'S BILL IS PAID WITHIN THIRTY DAYS AFTER THE DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY NINETY-NINE PER CENT OF THE RATE.

2. IF THE HOSPITAL'S BILL IS PAID AFTER THIRTY DAYS BUT WITHIN SIXTY DAYS AFTER THE DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY ONE HUNDRED PER CENT OF THE RATE.

3. IF THE HOSPITAL'S BILL IS PAID ANY TIME AFTER SIXTY DAYS AFTER THE DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY ONE HUNDRED PER CENT OF THE RATE PLUS A FEE OF ONE PER CENT A MONTH FOR EACH MONTH OR PORTION OF A MONTH FOLLOWING THE SIXTIETH DAY OF RECEIPT OF THE BILL UNTIL THE DATE OF PAYMENT.

D. THE ADMINISTRATION AND THE CONTRACTORS SHALL PAY CLAIMS PURSUANT TO THE METHODOLOGY, DEFINITIONS AND TIME FRAMES SPECIFIED FOR CLEAN CLAIMS IN SECTION 36-2904, SUBSECTION H.

E. THE DIRECTOR SHALL SPECIFY ENROLLMENT PROCEDURES INCLUDING NOTICE TO CONTRACTORS OF ENROLLMENT. THE ADMINISTRATION SHALL SPECIFY IN CONTRACT WHEN A PERSON WHO HAS BEEN DETERMINED ELIGIBLE WILL BE ENROLLED WITH A CONTRACTOR AND THE DATE ON WHICH THE CONTRACTOR WILL BE FINANCIALLY RESPONSIBLE FOR HEALTH AND MEDICAL SERVICES TO THE PERSON.

F. THE DIRECTOR SHALL MONITOR ANY THIRD PARTY PAYMENT COLLECTIONS COLLECTED BY CONTRACTORS AND NONCONTRACTING PROVIDERS ACCORDING TO THE SAME PROCEDURES SPECIFIED FOR TITLE XIX PURSUANT TO SECTION 36-2903.01, SUBSECTION M.

G. ON ORAL OR WRITTEN NOTICE FROM THE MEMBER, OR THE MEMBER'S PARENT OR LEGAL GUARDIAN, THAT THE MEMBER, PARENT OR LEGAL GUARDIAN BELIEVES A CLAIM SHOULD BE COVERED BY THE PROGRAM, A CONTRACTOR OR NONCONTRACTING PROVIDER SHALL NOT DO EITHER OF THE FOLLOWING UNLESS THE CONTRACTOR OR NONCONTRACTING PROVIDER HAS VERIFIED THROUGH THE ADMINISTRATION THAT THE PERSON IS INELIGIBLE FOR THE PROGRAM, HAS NOT YET BEEN DETERMINED ELIGIBLE OR, AT THE TIME SERVICES WERE RENDERED, WAS NOT ELIGIBLE OR ENROLLED IN THE PROGRAM:

1. CHARGE, SUBMIT A CLAIM TO OR DEMAND OR OTHERWISE COLLECT PAYMENT FROM A MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE.

2. REFER OR REPORT A MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE TO A COLLECTION AGENCY OR CREDIT REPORTING AGENCY FOR THE FAILURE OF THE MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE TO PAY CHARGES FOR COVERED

1 SERVICES UNLESS SPECIFICALLY AUTHORIZED BY THIS ARTICLE OR RULES ADOPTED
2 PURSUANT TO THIS ARTICLE.
3 H. THE ADMINISTRATION MAY CONDUCT POSTPAYMENT REVIEW OF ALL PAYMENTS
4 MADE BY THE ADMINISTRATION AND MAY RECOUP ANY MONIES ERRONEOUSLY PAID. THE
5 DIRECTOR MAY ADOPT RULES THAT SPECIFY PROCEDURES FOR CONDUCTING POSTPAYMENT
6 REVIEW. CONTRACTORS MAY CONDUCT A POSTPAYMENT REVIEW OF ALL CLAIMS PAID TO
7 PROVIDERS AND MAY RECOUP MONIES THAT ARE ERRONEOUSLY PAID.
8 I. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE MAY EMPLOY AND SUPERVISE
9 PERSONNEL NECESSARY TO ASSIST THE DIRECTOR IN PERFORMING THE FUNCTIONS OF THE
10 PROGRAM.
11 36-2988. Delivery of services; health plans; requirements
12 A. TO THE EXTENT POSSIBLE, THE ADMINISTRATION SHALL USE CONTRACTORS
13 THAT HAVE A CONTRACT WITH THE ADMINISTRATION PURSUANT TO ARTICLE 1 OF THIS
14 CHAPTER OR QUALIFYING PLANS TO PROVIDE SERVICES TO MEMBERS WHO QUALIFY FOR
15 THE PROGRAM.
16 B. THE ADMINISTRATION HAS FULL AUTHORITY TO AMEND EXISTING CONTRACTS
17 AWARDED PURSUANT TO ARTICLE 1 OF THIS CHAPTER.
18 C. AS DETERMINED BY THE DIRECTOR, REINSURANCE MAY BE PROVIDED AGAINST
19 EXPENSES IN EXCESS OF A SPECIFIED AMOUNT ON BEHALF OF ANY MEMBER FOR COVERED
20 EMERGENCY SERVICES, INPATIENT SERVICES OR OUTPATIENT SERVICES IN THE SAME
21 MANNER AS REINSURANCE PROVIDED UNDER ARTICLE 1 OF THIS CHAPTER. SUBJECT TO
22 THE APPROVAL OF THE DIRECTOR, REINSURANCE MAY BE OBTAINED AGAINST EXPENSES
23 IN EXCESS OF A SPECIFIED AMOUNT ON BEHALF OF ANY MEMBER.
24 D. NOTWITHSTANDING ANY OTHER LAW, THE ADMINISTRATION MAY PROCURE,
25 PROVIDE OR COORDINATE COVERED SERVICES BY INTERAGENCY AGREEMENT WITH
26 AUTHORIZED AGENCIES OF THIS STATE FOR DISTINCT GROUPS OF MEMBERS, INCLUDING
27 PERSONS ELIGIBLE FOR CHILDREN'S REHABILITATIVE SERVICES THROUGH THE
28 DEPARTMENT OF HEALTH SERVICES AND MEMBERS ELIGIBLE FOR COMPREHENSIVE MEDICAL
29 AND DENTAL BENEFITS THROUGH THE DEPARTMENT OF ECONOMIC SECURITY.
30 E. AFTER CONTRACTS ARE AWARDED PURSUANT TO THIS SECTION, THE DIRECTOR
31 MAY NEGOTIATE WITH ANY SUCCESSFUL BIDDER FOR THE EXPANSION OR CONTRACTION OF
32 SERVICES OR SERVICE AREAS.
33 F. PAYMENTS TO CONTRACTORS SHALL BE MADE MONTHLY AND MAY BE SUBJECT
34 TO CONTRACT PROVISIONS REQUIRING THE RETENTION OF A SPECIFIED PERCENTAGE OF
35 THE PAYMENT BY THE DIRECTOR, A RESERVE FUND OR ANY OTHER CONTRACT PROVISIONS
36 BY WHICH ADJUSTMENTS TO THE PAYMENTS ARE MADE BASED ON UTILIZATION
37 EFFICIENCY, INCLUDING INCENTIVES FOR MAINTAINING QUALITY CARE AND MINIMIZING
38 UNNECESSARY INPATIENT SERVICES. RESERVE MONIES WITHHELD FROM CONTRACTORS
39 SHALL BE DISTRIBUTED TO PROVIDERS WHO MEET PERFORMANCE STANDARDS ESTABLISHED
40 BY THE DIRECTOR. ANY RESERVE FUND ESTABLISHED PURSUANT TO THIS SUBSECTION
41 SHALL BE ESTABLISHED AS A SEPARATE ACCOUNT WITHIN THE ARIZONA HEALTH CARE
42 COST CONTAINMENT SYSTEM.

G. THE DIRECTOR MAY NEGOTIATE AT ANY TIME WITH A HOSPITAL ON BEHALF OF A CONTRACTOR FOR INPATIENT HOSPITAL SERVICES AND OUTPATIENT HOSPITAL SERVICES PROVIDED PURSUANT TO THE REQUIREMENTS SPECIFIED IN SECTION 36-2904.

H. A CONTRACTOR MAY REQUIRE THAT SUBCONTRACTING PROVIDERS OR NONCONTRACTING PROVIDERS BE PAID FOR COVERED SERVICES, OTHER THAN HOSPITAL SERVICES, ACCORDING TO THE CAPPED FEE-FOR-SERVICE SCHEDULE ADOPTED BY THE ADMINISTRATION OR AT LOWER RATES AS MAY BE NEGOTIATED BY THE CONTRACTOR.

I. THE ADMINISTRATION AND CONTRACTORS SHALL NOT CONTRACT FOR ANY SERVICES OR FUNCTIONS RELATED TO THIS ARTICLE WITH A SCHOOL DISTRICT INCLUDING CONTRACTING FOR THE DELIVERY OF SERVICES, SCREENING, OUTREACH OR INFORMATION THAT INVOLVES THE USE OF SCHOOL STAFF AND FACILITIES.

J. THE ADMINISTRATION IS EXEMPT FROM THE PROCUREMENT CODE PURSUANT TO SECTION 41-2501.

36-2989. Covered health and medical services; modifications; related delivery of service requirements

A. EXCEPT AS PROVIDED IN THIS SECTION, THE DIRECTOR SHALL ESTABLISH A SPECIFIC HEALTH BENEFITS COVERAGE PACKAGE THAT IS AS NEARLY AS PRACTICABLE THE SAME AS THE LEAST EXPENSIVE HEALTH BENEFITS COVERAGE PLAN OR PLANS THAT ARE OFFERED THROUGH A HEALTH CARE SERVICES ORGANIZATION AVAILABLE TO STATE EMPLOYEES UNDER SECTION 38-651. THE PACKAGE SHALL INCLUDE THE FOLLOWING COVERED SERVICES:

1. INPATIENT HOSPITAL SERVICES THAT ARE ORDINARILY FURNISHED BY A HOSPITAL FOR THE CARE AND TREATMENT OF INPATIENTS, THAT ARE MEDICALLY NECESSARY AND THAT ARE PROVIDED UNDER THE DIRECTION OF A PHYSICIAN OR A PRIMARY CARE PRACTITIONER. FOR THE PURPOSES OF THIS PARAGRAPH, INPATIENT HOSPITAL SERVICES EXCLUDE SERVICES IN AN INSTITUTION FOR TUBERCULOSIS OR MENTAL DISEASES UNLESS AUTHORIZED BY FEDERAL LAW.

2. OUTPATIENT HEALTH SERVICES THAT ARE MEDICALLY NECESSARY AND ORDINARILY PROVIDED IN HOSPITALS, CLINICS, OFFICES AND OTHER HEALTH CARE FACILITIES BY LICENSED HEALTH CARE PROVIDERS. FOR THE PURPOSES OF THIS PARAGRAPH, "OUTPATIENT HEALTH SERVICES" INCLUDES SERVICES PROVIDED BY OR UNDER THE DIRECTION OF A PHYSICIAN OR A PRIMARY CARE PRACTITIONER.

3. OTHER LABORATORY AND X-RAY SERVICES ORDERED BY A PHYSICIAN OR A PRIMARY CARE PRACTITIONER.

4. MEDICATIONS THAT ARE MEDICALLY NECESSARY AND ORDERED ON PRESCRIPTION BY A PHYSICIAN, A PRIMARY CARE PRACTITIONER OR A DENTIST LICENSED PURSUANT TO TITLE 32, CHAPTER 11.

5. MEDICAL SUPPLIES, EQUIPMENT AND PROSTHETIC DEVICES.

6. TREATMENT OF MEDICAL CONDITIONS OF THE EYE INCLUDING ONE EYE EXAMINATION EACH YEAR FOR PRESCRIPTIVE LENSES AND THE PROVISION OF ONE SET OF PRESCRIPTIVE LENSES EACH YEAR FOR MEMBERS.

7. MEDICALLY NECESSARY DENTAL SERVICES.

8. WELL CHILD, IMMUNIZATIONS AND PREVENTION SERVICES.

9. FAMILY PLANNING SERVICES THAT DO NOT INCLUDE ABORTION OR ABORTION COUNSELING. IF A CONTRACTOR ELECTS NOT TO PROVIDE FAMILY PLANNING SERVICES, THIS ELECTION DOES NOT DISQUALIFY THE CONTRACTOR FROM DELIVERING ALL OTHER COVERED HEALTH AND MEDICAL SERVICES UNDER THIS ARTICLE. IN THAT EVENT, THE ADMINISTRATION MAY CONTRACT DIRECTLY WITH ANOTHER CONTRACTOR, INCLUDING AN OUTPATIENT SURGICAL CENTER OR A NONCONTRACTING PROVIDER, TO DELIVER FAMILY PLANNING SERVICES TO A MEMBER WHO IS ENROLLED WITH A CONTRACTOR WHO ELECTS NOT TO PROVIDE FAMILY PLANNING SERVICES.

10. PODIATRY SERVICES THAT ARE PERFORMED BY A PODIATRIST LICENSED PURSUANT TO TITLE 32, CHAPTER 7 AND THAT ARE ORDERED BY A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER.

11. MEDICALLY NECESSARY PANCREAS, HEART, LIVER, KIDNEY, CORNEA, LUNG AND HEART-LUNG TRANSPLANTS AND AUTOLOGOUS AND ALLOGENEIC BONE MARROW TRANSPLANTS AND IMMUNOSUPPRESSANT MEDICATIONS FOR THESE TRANSPLANTS ORDERED ON PRESCRIPTION BY A PHYSICIAN LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17.

12. MEDICALLY NECESSARY EMERGENCY TRANSPORTATION.

13. INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES. INPATIENT BEHAVIORAL HEALTH SERVICES ARE LIMITED TO NOT MORE THAN THIRTY DAYS FOR EACH TWELVE MONTH PERIOD FROM THE DATE OF INITIAL ENROLLMENT OR THE REDETERMINATION OF ELIGIBILITY. OUTPATIENT BEHAVIORAL SERVICES ARE LIMITED TO NOT MORE THAN THIRTY VISITS FOR EACH TWELVE MONTH PERIOD FROM THE DATE OF INITIAL ENROLLMENT OR THE REDETERMINATION OF ELIGIBILITY.

B. THE ADMINISTRATION SHALL PAY NONCONTRACTING PROVIDERS ONLY FOR HEALTH AND MEDICAL SERVICES AS PRESCRIBED IN SUBSECTION A OF THIS SECTION.

C. TO THE EXTENT POSSIBLE AND PRACTICABLE, THE ADMINISTRATION AND CONTRACTORS SHALL PROVIDE FOR THE PRIOR APPROVAL OF MEDICALLY NECESSARY SERVICES PROVIDED PURSUANT TO THIS ARTICLE.

D. THE DIRECTOR SHALL MAKE AVAILABLE HOME HEALTH SERVICES IN LIEU OF HOSPITALIZATION PURSUANT TO CONTRACTS AWARDED UNDER THIS ARTICLE.

E. EXCEPT FOR MEMBERS WHO ARE EIGHTEEN YEARS OF AGE AND WHO ARE NOT SERIOUSLY MENTALLY ILL, BEHAVIORAL HEALTH SERVICES SHALL BE PROVIDED TO MEMBERS THROUGH THE ADMINISTRATION'S INTERGOVERNMENTAL AGREEMENT WITH THE DIVISION OF BEHAVIORAL HEALTH IN THE DEPARTMENT OF HEALTH SERVICES. THE DIVISION OF BEHAVIORAL HEALTH IN THE DEPARTMENT OF HEALTH SERVICES SHALL USE ITS ESTABLISHED DIAGNOSTIC AND EVALUATION PROGRAM FOR REFERRALS OF CHILDREN WHO ARE NOT ALREADY ENROLLED PURSUANT TO THIS ARTICLE AND WHO MAY BE IN NEED OF BEHAVIORAL HEALTH SERVICES. IN ADDITION TO AN EVALUATION, THE DIVISION OF BEHAVIORAL HEALTH SHALL ALSO IDENTIFY CHILDREN WHO MAY BE ELIGIBLE UNDER SECTION 36-2901, PARAGRAPH 4, SUBDIVISION (b) OR SECTION 36-2931, PARAGRAPH 5 AND SHALL REFER THE CHILDREN TO THE APPROPRIATE AGENCY RESPONSIBLE FOR MAKING THE FINAL ELIGIBILITY DETERMINATION. MEMBERS WHO ARE EIGHTEEN YEARS OF AGE AND WHO ARE NOT SERIOUSLY MENTALLY ILL SHALL BE REFERRED TO THE CONTRACTORS FOR BEHAVIORAL HEALTH SERVICES.

F. THE DIRECTOR SHALL ADOPT RULES FOR THE PROVISION OF TRANSPORTATION SERVICES FOR MEMBERS. PRIOR AUTHORIZATION IS NOT REQUIRED FOR MEDICALLY NECESSARY AMBULANCE TRANSPORTATION SERVICES RENDERED TO MEMBERS INITIATED BY DIALING TELEPHONE NUMBER 911 OR OTHER DESIGNATED EMERGENCY RESPONSE SYSTEMS.

G. THE DIRECTOR MAY ADOPT RULES TO ALLOW THE ADMINISTRATION TO USE A SECOND OPINION PROCEDURE UNDER WHICH SURGERY MAY NOT BE ELIGIBLE FOR COVERAGE PURSUANT TO THIS ARTICLE WITHOUT DOCUMENTATION AS TO NEED BY AT LEAST TWO PHYSICIANS OR PRIMARY CARE PRACTITIONERS.

H. ALL HEALTH AND MEDICAL SERVICES PROVIDED UNDER THIS ARTICLE SHALL BE PROVIDED IN THE COUNTY OF RESIDENCE OF THE MEMBER, EXCEPT:

1. EMERGENCY SERVICES AND SPECIALTY SERVICES.

2. THE DIRECTOR MAY PERMIT THE DELIVERY OF HEALTH AND MEDICAL SERVICES IN OTHER THAN THE COUNTY OF RESIDENCE IN THIS STATE OR IN AN ADJOINING STATE IF IT IS DETERMINED THAT MEDICAL PRACTICE PATTERNS JUSTIFY THE DELIVERY OF SERVICES IN OTHER THAN THE COUNTY OF RESIDENCE OR A NET REDUCTION IN TRANSPORTATION COSTS CAN REASONABLY BE EXPECTED. NOTWITHSTANDING SECTION 36-2981, PARAGRAPH 7 OR 12, IF SERVICES ARE PROCURED FROM A PHYSICIAN OR PRIMARY CARE PRACTITIONER IN AN ADJOINING STATE, THE PHYSICIAN OR PRIMARY CARE PRACTITIONER SHALL BE LICENSED TO PRACTICE IN THAT STATE PURSUANT TO LICENSING STATUTES IN THAT STATE THAT ARE SIMILAR TO TITLE 32, CHAPTER 13, 15, 17 OR 25.

I. COVERED OUTPATIENT SERVICES SHALL BE SUBCONTRACTED BY A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER TO OTHER LICENSED HEALTH CARE PROVIDERS TO THE EXTENT PRACTICABLE FOR PURPOSES OF MAKING HEALTH CARE SERVICES AVAILABLE TO UNDERSERVED AREAS, REDUCING COSTS OF PROVIDING MEDICAL CARE AND REDUCING TRANSPORTATION COSTS.

J. THE DIRECTOR SHALL ADOPT RULES THAT PRESCRIBE THE COORDINATION OF MEDICAL CARE FOR MEMBERS AND THAT INCLUDE A MECHANISM TO TRANSFER MEMBERS AND MEDICAL RECORDS AND INITIATE MEDICAL CARE.

K. THE DIRECTOR SHALL ADOPT RULES FOR THE REIMBURSEMENT OF SPECIALTY SERVICES PROVIDED TO THE MEMBER IF AUTHORIZED BY THE MEMBER'S PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER.

36-2990. <u>Quality of health care monitoring standard; development; adoption; use; additional monitoring; costs</u>

A. THE ADMINISTRATION SHALL DEVELOP STANDARDS OF CARE THAT EACH CONTRACTOR SHALL USE TO MONITOR THE QUALITY OF HEALTH CARE RECEIVED BY MEMBERS.

B. THE DIRECTOR SHALL PERIODICALLY DETERMINE WHETHER EACH CONTRACTOR HAS PROPERLY ADOPTED AND IMPLEMENTED STANDARDS TO ENSURE THE QUALITY OF HEALTH CARE. IF THE DIRECTOR DETERMINES THAT A CONTRACTOR IS OUT OF COMPLIANCE, THE DIRECTOR SHALL UNDERTAKE ADDITIONAL EFFORTS TO MONITOR AND ASSESS THE QUALITY OF HEALTH CARE PROVIDED BY THAT CONTRACTOR FOR THE PERIOD OF TIME THAT THE DIRECTOR DEEMS NECESSARY. THE DIRECTOR SHALL DETERMINE THE

1 COST INCURRED IN UNDERTAKING THESE SPECIAL EFFORTS AND SHALL DEDUCT THAT
2 AMOUNT FROM ANY PAYMENT OWED TO THE CONTRACTOR.
3 36-2991. Fraud; penalties; enforcement; violation;
4 classification
5 A. A PERSON SHALL NOT PROVIDE OR CAUSE TO BE PROVIDED FALSE OR
6 FRAUDULENT INFORMATION ON AN APPLICATION FOR ELIGIBILITY PURSUANT TO THIS
7 ARTICLE.
8 B. A PERSON WHO VIOLATES SUBSECTION A OF THIS SECTION, WHO IS
9 DETERMINED ELIGIBLE FOR SERVICES PURSUANT TO THIS ARTICLE AND WHO WOULD HAVE
10 BEEN DETERMINED INELIGIBLE IF THE PERSON HAD PROVIDED TRUE AND CORRECT
11 INFORMATION IS SUBJECT, IN ADDITION TO ANY OTHER PENALTIES THAT MAY BE
12 PRESCRIBED BY FEDERAL OR STATE LAW, TO A CIVIL PENALTY OF NOT MORE THAN THE
13 AMOUNT INCURRED BY THE SYSTEM, INCLUDING CAPITATION PAYMENTS MADE ON BEHALF
14 OF THE PERSON. IN ADDITION, THE PERSON'S ELIGIBILITY MAY BE DISCONTINUED IN
15 ACCORDANCE WITH RULES ADOPTED BY THE DIRECTOR.
16 C. IN ADDITION TO THE REQUIREMENTS OF STATE LAW, ANY APPLICABLE FRAUD
17 AND ABUSE CONTROLS THAT ARE ENACTED UNDER FEDERAL LAW APPLY TO PERSONS WHO
18 ARE ELIGIBLE FOR SERVICES UNDER THIS ARTICLE AND TO CONTRACTORS AND
19 NONCONTRACTING PROVIDERS WHO PROVIDE SERVICES UNDER THIS ARTICLE.
20 D. THE DIRECTOR SHALL MAKE THE DETERMINATION TO ASSESS A CIVIL PENALTY
21 AND IS RESPONSIBLE FOR COLLECTION OF THE PENALTY. THE DIRECTOR MAY ADOPT
22 RULES THAT PRESCRIBE PROCEDURES FOR THE DETERMINATION AND COLLECTION OF CIVIL
23 PENALTIES. THE DIRECTOR MAY COMPROMISE CIVIL PENALTIES IMPOSED UNDER THIS
24 SECTION IN ACCORDANCE WITH CRITERIA ESTABLISHED IN RULES.
25 E. THE DIRECTOR SHALL ADOPT RULES PROVIDING FOR THE APPEAL OF A
26 DECISION BY A PERSON ADVERSELY AFFECTED BY A DETERMINATION MADE BY THE
27 DIRECTOR UNDER THIS SECTION. THE DIRECTOR'S FINAL DECISION IS SUBJECT TO
28 JUDICIAL REVIEW PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.
29 F. AMOUNTS PAID BY THE STATE AND RECOVERED UNDER THIS SECTION SHALL
30 BE DEPOSITED IN THE STATE GENERAL FUND, AND ANY APPLICABLE FEDERAL SHARE
31 SHALL BE RETURNED TO THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN
32 SERVICES.
33 G. IF A CIVIL PENALTY IMPOSED PURSUANT TO SUBSECTION D OF THIS SECTION
34 IS NOT PAID, THE STATE MAY FILE AN ACTION TO COLLECT THE CIVIL PENALTY IN THE
35 SUPERIOR COURT IN MARICOPA COUNTY. MATTERS THAT WERE RAISED OR COULD HAVE
36 BEEN RAISED IN A HEARING BEFORE THE DIRECTOR OR IN AN APPEAL PURSUANT TO
37 TITLE 12, CHAPTER 7, ARTICLE 6 MAY NOT BE RAISED AS A DEFENSE TO THE CIVIL
38 ACTION. AN ACTION BROUGHT PURSUANT TO THIS SUBSECTION SHALL BE INITIATED
39 WITHIN SIX YEARS AFTER THE DATE THE CLAIM IS PRESENTED.
40 H. A PERSON WHO KNOWINGLY AIDS OR ABETS ANOTHER PERSON PURSUANT TO
41 SECTION 13-301, 13-302 OR 13-303 IN THE COMMISSION OF AN OFFENSE UNDER THIS
42 SECTION OR SECTION 13-3713 IS GUILTY OF A CLASS 5 FELONY.

36-2992. Duty to report fraud or abuse: immunity: unprofessional conduct

A. ALL CONTRACTORS AND NONCONTRACTING PROVIDERS SHALL ADVISE THE DIRECTOR OR THE DIRECTOR'S DESIGNEE IMMEDIATELY IN A WRITTEN REPORT OF ANY CASES OF SUSPECTED FRAUD OR ABUSE. THE DIRECTOR SHALL REVIEW THE REPORT AND CONDUCT A PRELIMINARY INVESTIGATION TO DETERMINE IF THERE IS A SUFFICIENT BASIS TO WARRANT A FULL INVESTIGATION. IF THE FINDINGS OF A PRELIMINARY INVESTIGATION GIVE THE DIRECTOR REASON TO BELIEVE THAT AN INCIDENT OF FRAUD OR ABUSE HAS OCCURRED, THE MATTER SHALL BE REFERRED TO THE ATTORNEY GENERAL.

B. ANY PERSON MAKING A COMPLAINT OR FURNISHING A REPORT, INFORMATION OR RECORDS IN GOOD FAITH PURSUANT TO THIS SECTION IS IMMUNE FROM ANY CIVIL LIABILITY BY REASON OF THAT ACTION UNLESS THAT PERSON HAS BEEN CHARGED WITH OR IS SUSPECTED OF THE REPORTED FRAUD OR ABUSE.

C. ANY HEALTH CARE PROVIDER WHO FAILS TO REPORT PURSUANT TO THIS SECTION COMMITS AN ACT OF UNPROFESSIONAL CONDUCT AND IS SUBJECT TO DISCIPLINARY ACTION BY THE PROVIDER'S LICENSING BOARD OR DEPARTMENT.

36-2993. Prohibited acts: penalties

A. A PERSON SHALL NOT PRESENT OR CAUSE TO BE PRESENTED TO THIS STATE OR TO A CONTRACTOR:

1. A CLAIM FOR A MEDICAL SERVICE OR ANY OTHER ITEM THAT THE PERSON KNOWS OR HAS REASON TO KNOW WAS NOT PROVIDED AS CLAIMED.

2. A CLAIM FOR A MEDICAL SERVICE OR ANY OTHER ITEM THAT THE PERSON KNOWS OR HAS REASON TO KNOW IS FALSE OR FRAUDULENT.

3. A CLAIM FOR PAYMENT THAT THE PERSON KNOWS OR HAS REASON TO KNOW MAY NOT BE MADE BY THE ADMINISTRATION BECAUSE:

(a) THE PERSON WAS TERMINATED OR SUSPENDED FROM PARTICIPATION IN THE PROGRAM ON THE DATE FOR WHICH THE CLAIM IS BEING MADE.

(b) THE ITEM OR SERVICE CLAIMED IS SUBSTANTIALLY IN EXCESS OF THE NEEDS OF THE INDIVIDUAL OR OF A QUALITY THAT FAILS TO MEET PROFESSIONALLY RECOGNIZED STANDARDS OF HEALTH CARE.

(c) THE PERSON WAS NOT A MEMBER ON THE DATE FOR WHICH THE CLAIM IS BEING MADE.

4. A CLAIM FOR A SERVICE OR AN ITEM BY A PERSON WHO KNOWS OR HAS REASON TO KNOW THAT THE INDIVIDUAL WHO FURNISHED OR SUPERVISED THE FURNISHING OF THE SERVICE:

(a) WAS NOT LICENSED AS A PHYSICIAN OR ANOTHER HEALTH CARE PROFESSIONAL REQUIRING STATE LICENSURE.

(b) OBTAINED THE INDIVIDUAL'S LICENSE THROUGH A MISREPRESENTATION OF MATERIAL FACT.

(c) REPRESENTED TO THE MEMBER AT THE TIME THE SERVICE WAS FURNISHED THAT THE PHYSICIAN WAS CERTIFIED IN A MEDICAL SPECIALTY BY A MEDICAL SPECIALTY BOARD IF THE INDIVIDUAL WAS NOT CERTIFIED.

5. A REQUEST FOR PAYMENT THAT THE PERSON KNOWS OR HAS REASON TO KNOW IS IN VIOLATION OF AN AGREEMENT BETWEEN THE PERSON AND THIS STATE OR THE ADMINISTRATION.

B. A PERSON WHO VIOLATES THIS SECTION IS SUBJECT, IN ADDITION TO ANY OTHER PENALTIES THAT MAY BE PRESCRIBED BY LAW, TO A CIVIL PENALTY OF NOT MORE THAN TWO THOUSAND DOLLARS FOR EACH ITEM OR SERVICE CLAIMED AND IS SUBJECT TO AN ASSESSMENT OF NOT MORE THAN TWICE THE AMOUNT CLAIMED FOR EACH ITEM OR SERVICE.

C. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE SHALL MAKE THE DETERMINATION TO ASSESS CIVIL PENALTIES AND IS RESPONSIBLE FOR THE COLLECTION OF PENALTY AND ASSESSMENT AMOUNTS. THE DIRECTOR SHALL ADOPT RULES THAT PRESCRIBE PROCEDURES FOR THE DETERMINATION AND COLLECTION OF CIVIL PENALTIES AND ASSESSMENTS. CIVIL PENALTIES AND ASSESSMENTS IMPOSED UNDER THIS SECTION MAY BE COMPROMISED BY THE DIRECTOR OR THE DESIGNEE IN ACCORDANCE WITH CRITERIA ESTABLISHED IN RULES. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE MAY MAKE THIS DETERMINATION IN THE SAME PROCEEDING TO EXCLUDE THE PERSON FROM PARTICIPATION IN THE PROGRAM.

D. A PERSON ADVERSELY AFFECTED BY A DETERMINATION OF THE DIRECTOR OR THE DIRECTOR'S DESIGNEE UNDER THIS SECTION MAY APPEAL THAT DECISION IN ACCORDANCE WITH PROVIDER GRIEVANCE PROVISIONS PRESCRIBED BY RULE. THE FINAL DECISION IS SUBJECT TO JUDICIAL REVIEW PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.

E. THE ADMINISTRATION SHALL TRANSMIT MONIES COLLECTED PURSUANT TO THIS SECTION TO THE STATE TREASURER FOR DEPOSIT IN THE STATE GENERAL FUND. THE AMOUNT OF THE PENALTY OR ASSESSMENT MAY BE DEDUCTED FROM ANY AMOUNT THEN OR LATER OWING BY THE ADMINISTRATION OR THIS STATE TO THE PERSON AGAINST WHOM THE PENALTY OR ASSESSMENT HAS BEEN IMPOSED.

F. IF A CIVIL PENALTY OR ASSESSMENT IMPOSED PURSUANT TO THIS SECTION IS NOT PAID, THIS STATE OR THE ADMINISTRATION SHALL FILE AN ACTION TO COLLECT THE CIVIL PENALTY OR ASSESSMENT IN THE SUPERIOR COURT IN MARICOPA COUNTY. MATTERS THAT WERE RAISED OR COULD HAVE BEEN RAISED IN A HEARING BEFORE THE DIRECTOR OR IN AN APPEAL PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6 MAY NOT BE RAISED AS A DEFENSE TO THE CIVIL ACTION. AN ACTION BROUGHT PURSUANT TO THIS SUBSECTION SHALL BE INITIATED WITHIN SIX YEARS AFTER THE DATE THE CLAIM WAS PRESENTED.

36-2994. Monthly financial report

A. THE DIRECTOR SHALL INCLUDE IN THE MONTHLY REPORT SUBMITTED TO THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES PURSUANT TO SECTION 36-2920 THE FOLLOWING INFORMATION ABOUT THE PROGRAM:

1. THE ACTUAL YEAR TO DATE EXPENDITURES AND PROJECTED ANNUAL EXPENDITURES.

2. THE ACTUAL MEMBER MONTHS.

3. MONIES RECOVERED MONTHLY FROM THIRD PARTY PAYORS.

4. THE AMOUNT AND ORIGIN OF ANY DONATION OR GRANT FROM A PRIVATE ENTITY AND THE IMPACT ON THE IMPLEMENTATION OF THE PROGRAM.

B. THE REPORT SHALL BE SUBMITTED ON OR BEFORE THE TWENTY-FIFTH DAY OF THE FOLLOWING MONTH.

C. THE DIRECTOR SHALL PROVIDE A COPY OF THE MONTHLY REPORT TO THE CHAIRMEN OF THE HOUSE OF REPRESENTATIVES AND SENATE STANDING COMMITTEES ON APPROPRIATIONS AND HEALTH.

36-2995. Children's health insurance program fund; sources of monies; use; reversion; claims

A. THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND IS ESTABLISHED. THE ADMINISTRATION SHALL ADMINISTER THE FUND AND SHALL USE FUND MONIES TO PAY ADMINISTRATIVE AND PROGRAM COSTS ASSOCIATED WITH THE OPERATION OF THE PROGRAM ESTABLISHED BY THIS ARTICLE.

B. SEPARATE ACCOUNTING SHALL BE MADE FOR EACH SOURCE OF MONIES RECEIVED PURSUANT TO SUBSECTION C OF THIS SECTION FOR EXPENSES AND INCOME ACTIVITY ASSOCIATED WITH THE PROGRAM ESTABLISHED PURSUANT TO THIS ARTICLE.

C. MONIES IN THE FUND ARE COMPRISED OF:

1. FEDERAL MONIES AVAILABLE TO THIS STATE FOR THE OPERATION OF THE PROGRAM.

2. TOBACCO TAX MONIES APPROPRIATED AS STATE MATCHING MONIES.

3. GIFTS, DONATIONS AND GRANTS FROM ANY SOURCE.

4. INTEREST PAID ON MONIES DEPOSITED IN THE FUND.

5. THIRD PARTY LIABILITY RECOVERIES.

D. IF A GIFT, A DONATION OR A GRANT OF OVER TEN THOUSAND DOLLARS RECEIVED FROM ANY PRIVATE SOURCE CONTAINS A CONDITION, THE ADMINISTRATION SHALL FIRST MEET WITH THE JOINT LEGISLATIVE STUDY COMMITTEE ON THE INTEGRATION OF HEALTH CARE SERVICES TO REVIEW THE CONDITION BEFORE IT SPENDS THAT GIFT, DONATION OR GRANT.

E. ALL MONIES IN THE FUND OTHER THAN MONIES APPROPRIATED BY THIS STATE DO NOT LAPSE.

F. MONIES APPROPRIATED FROM THE MEDICALLY NEEDY ACCOUNT OF THE TOBACCO TAX AND HEALTH CARE FUND PURSUANT TO SECTION 36-2921 ARE EXEMPT FROM SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS. NOTWITHSTANDING SECTION 35-191, SUBSECTION B, THE PERIOD FOR ADMINISTRATIVE ADJUSTMENTS EXTENDS FOR ONLY SIX MONTHS FOR APPROPRIATIONS MADE FOR ADMINISTRATION COVERED SERVICES.

G. NOTWITHSTANDING SECTIONS 35-190 AND 35-191, ALL APPROVED CLAIMS FOR SYSTEM COVERED SERVICES PRESENTED AFTER THE END OF THE FISCAL YEAR IN WHICH THEY WERE INCURRED SHALL BE PAID EITHER IN ACCORDANCE WITH THIS SECTION OR IN THE CURRENT FISCAL YEAR WITH THE MONIES AVAILABLE IN THE FUNDS ESTABLISHED BY THIS SECTION.

H. CLAIMS FOR COVERED SERVICES THAT ARE DETERMINED TO BE VALID BY THE DIRECTOR AND THE GRIEVANCE AND APPEAL PROCEDURE SHALL BE PAID FROM THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND.

I. ALL PAYMENTS FOR CLAIMS FROM THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND SHALL BE ACCOUNTED FOR BY THE ADMINISTRATION BY THE FISCAL YEAR IN WHICH THE CLAIMS WERE INCURRED, REGARDLESS OF THE FISCAL YEAR IN WHICH THE PAYMENTS WERE MADE.

J. NOTWITHSTANDING ANY OTHER LAW, COUNTY OWNED OR CONTRACTED PROVIDERS ARE SUBJECT TO ALL CLAIMS PROCESSING AND PAYMENT REQUIREMENTS OR LIMITATIONS OF THIS CHAPTER THAT ARE APPLICABLE TO NONCOUNTY PROVIDERS.

Sec. 6. Laws 1997, chapter 186, section 6 is amended to read:

Sec. 6. Reporting requirements

A. Beginning on April 1, 1998, the director of the Arizona health care cost containment system administration shall report semiannually to the premium sharing demonstration project oversight committee on the implementation and operation of the premium sharing demonstration project. The administration shall submit the report to the governor, the president of the senate and the speaker of the house of representatives. The director of the administration shall include in the report recommendations on shifting premium sharing demonstration project enrollees who have incomes that are less than one hundred per cent of the federal poverty guidelines as published annually by the United States department of health and human services into the new plan, when the federal waiver for eligibility based on one hundred per cent of the federal poverty level is approved by the health care financing administration.

B. Beginning on April 1, 1998, the Arizona legislative council shall submit a report semiannually to the premium sharing demonstration project oversight committee. The report shall contain the following information regarding the demonstration project:

1. An analysis of client satisfaction.
2. Program enrollment information.
3. The average annual income of the enrollee.
4. The annual medical service expenditure.
5. The total monies collected from enrollees.
6. Information necessary to analyze and evaluate the project's effectiveness or impact.
7. A review of the actual medical costs incurred and the premiums charged.

C. On or before January 1, ~~1999~~ 2000, the premium sharing demonstration project oversight committee shall submit a report to the governor, the speaker of the house of representatives and the president of the senate containing its findings regarding the overall success of the demonstration project and recommending its continuation or discontinuation.

Sec. 7. Laws 1997, chapter 186, section 8 is amended to read:

Sec. 8. Delayed repeal

Sections 3 through 7 of this act are repealed from and after September 30, ~~2000~~ 2001.

1 Sec. 8. Joint legislative study committee on the integration of
2 health care services
3 A. The joint legislative study committee on the integration of health
4 care services is established consisting of five members of the house of
5 representatives appointed by the speaker of the house of representatives and
6 five members of the senate appointed by the president of the senate. Not
7 more than three members of the house of representatives or senate may
8 represent the same political party.
9 B. The committee shall meet on the call of either cochairperson.
10 C. The committee shall:
11 1. Determine the feasibility of integrating health care services
12 offered pursuant to title 36, chapter 29, article 4, Arizona Revised
13 Statutes, as added by this act, Laws 1997, chapter 186, sections 3 through
14 8 and proposition 203, as passed by the voters in the 1996 general election,
15 and for those who are classified as medically indigent pursuant to section
16 11-297, Arizona Revised Statutes, and for those classified as medically needy
17 pursuant to section 36-2905, Arizona Revised Statutes.
18 2. Examine the benefits of and determine the fiscal impact of
19 integrating the programs identified in paragraph 1.
20 3. Study the impact on the eligibility requirements of each program
21 identified in paragraph 1.
22 4. Study proposals to maximize health insurance coverage for families
23 through the use of existing federal, state and local resources in order to
24 receive the highest benefit from investment of those resources.
25 5. Study the covered health and medical services to be provided under
26 section 36-2989, Arizona Revised Statutes, as added by this act, and compare
27 these services with the health and medical service benefit packages allowed
28 under the federal and state children's health insurance program legislation
29 including the benefit package currently offered to state employees and their
30 dependents.
31 6. Review other state children's health insurance program proposals.
32 7. Examine the use of vouchers, tax credits and the use of private
33 health insurance for the program including coverage provided to the parent
34 or legal guardian.
35 8. Determine the coverage of children under the program who are
36 covered under a health care insurance plan, including employer sponsored
37 health care coverage.
38 D. The committee shall report its findings and recommendations to the
39 governor, the speaker of the house of representatives, the president of the
40 senate, the secretary of state and the director of the department of library,
41 archives and public records on or before December 15, 1999 and shall submit
42 a preliminary report on or before December 15, 1998.

1 Sec. 9. Annual report
2 Beginning on January 1, 2000, the Arizona health care cost containment
3 system administration shall annually report the following information
4 relating to the children's health insurance program established pursuant to
5 title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this
6 act, to the governor, president of the senate, speaker of the house of
7 representatives, secretary of state and director of the department of
8 library, archives and public records:
9 1. The number of children served by the program.
10 2. The state and federal expenditures for the program for the previous
11 fiscal year.
12 3. A comparison of the expenditures for the previous fiscal year with
13 the expected federal funding for the next fiscal year.
14 4. Whether the federal funding for the next fiscal year will be
15 sufficient to provide services at the current percentage of the federal
16 poverty level or whether an enrollment cap may be needed.
17 5. Any recommendations for changes to the program.
18 Sec. 10. Direct services; qualifying community health centers;
19 hospitals; eligibility screening
20 A child who receives services pursuant to section 36-2907.05, section
21 36-2907.06, subsection A or section 36-2907.08, subsection A, Arizona Revised
22 Statutes, shall be screened for potential eligibility by the qualifying
23 community health center or hospital that contracts with the department of
24 health services pursuant to section 36-2907.06 or section 36-2907.08, Arizona
25 Revised Statutes. If it appears that the child may be eligible, the
26 qualifying community health center or hospital may provide services and shall
27 refer the child for an eligibility determination by the Arizona health care
28 cost containment system administration.
29 Sec. 11. Exemption from rule making; procurement code
30 A. The Arizona health care cost containment system administration and
31 the department of health services are exempt from the rule making
32 requirements of title 41, chapter 6, Arizona Revised Statutes, for one year
33 after the effective date of this act to implement this act. The
34 administration and the department shall hold hearings to give the public an
35 opportunity to comment on the proposed rules. The administration and the
36 department shall hold at least one of these hearings in a county with a
37 population of less than five hundred thousand persons according to the most
38 recent United States decennial census.
39 B. The department of health services is exempt from the provisions of
40 title 41, chapter 23, Arizona Revised Statutes, relating to the procurement
41 code, for the purpose of procuring contracts with qualifying health centers
42 pursuant to section 36-2907.06, subsection G, Arizona Revised Statutes, or
43 hospitals pursuant to section 36-2907.08, subsection H, Arizona Revised
44 Statutes.

Sec. 12. Intent

It is the intent of the legislature that the Arizona health care cost containment system administration submit a state plan requesting approval from the federal health care financing administration to implement a title XXI children's health care program that will provide health insurance coverage for uninsured, low income children who are under nineteen years of age. Subject to an appropriation by the legislature, tobacco tax monies will be used as the state matching monies. The program will operate within the funding allocated by the legislature, and a cap may be imposed on enrollment if it appears the program will exceed the available funding. If federal monies become unavailable, the program is repealed and services will be terminated.

Sec. 13. Additional employees; authorization

The Arizona health care cost containment system administration is authorized to hire up to fifty-nine additional full-time equivalent employees to perform eligibility determinations and other requirements of this act.

Sec. 14. Conditional effective date

This act is effective from and after September 30, 1997 but only if the Arizona health care cost containment system administration's application for a title XXI state children's health insurance program is approved by the federal health care financing administration. If the federal health care financing administration does not approve this act as of October 1, 1998, this act is effective on the date that agency notifies the administration of its approval. The administration shall notify the director of the Arizona legislative council of the date of this notification.

Sec. 15. Delayed repeal

Section 8 of this act, relating to the joint legislative study committee on the integration of health care services, is repealed from and after December 31, 2001.

Sec. 16. Conditional repeal

This act is repealed on the date the Arizona health care cost containment system administration determines that federal monies are not available for the program pursuant to section 36-2984, Arizona Revised Statutes, as added by this act. The director of the administration shall notify the director of the Arizona legislative council of this date. The legislature shall submit legislation to restore any statutory sections affected by this conditional repeal.

Sec. 17. Appropriation

The sum of $38,400,000 is appropriated from the children's health insurance program fund established pursuant to section 36-2995, Arizona Revised Statutes, as added by this act, to the Arizona health care cost containment system for fiscal year 1998-1999 for the purpose of implementing the children's health insurance program established pursuant to title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act. All

1 monies remaining unexpended and unencumbered on October 1, 1999 revert to the
2 children's health insurance program fund.
3 Sec. 18. Reimbursement for contractors
4 Before the implementation of the children's health insurance program
5 authorized in title 36, chapter 29, article 4, Arizona Revised Statutes, as
6 added by this act, the Arizona health care cost containment system shall
7 develop actuarially sound rates that shall be used to reimburse the
8 contractors as defined in section 36-2981, Arizona Revised Statutes, as added
9 by this act.
10 Sec. 19. Medical savings accounts; direct service contracts
11 A. Within one hundred twenty days after the approval of the title XXI
12 state plan submitted to the federal health care financing administration, the
13 Arizona health care cost containment system administration shall submit a
14 medical savings account amendment to the joint legislative study committee
15 on the integration of health care services. The committee shall review the
16 amendment and provide input on the amendment. Once the joint legislative
17 study committee on the integration of health care services reviews the
18 amendment, the Arizona health care cost containment system administration
19 shall submit the amendment to the federal health care financing
20 administration requesting approval to offer medical savings accounts as an
21 option to the services that are provided to eligible children under title 36,
22 chapter 29, article 4, Arizona Revised Statutes, as added by this act.
23 B. On or before July 1, 1999, the Arizona health care cost containment
24 system administration shall submit a direct service contracts amendment to
25 the title XXI state plan to the joint legislative study committee on the
26 integration of health care services. The study committee shall review the
27 amendment and provide input on the amendment. Once the study committee
28 reviews the amendment, the Arizona health care cost containment system
29 administration shall submit the amendment to the federal health care
30 financing administration to secure title XXI funding to reimburse qualifying
31 health centers and hospitals that contract with the department of health
32 services pursuant to sections 36-2907.06 and 36-2907.08, Arizona Revised
33 Statutes.
34 C. On or before July 1, 2000, the Arizona health care cost containment
35 system administration shall submit a direct service contracts amendment for
36 waiver authorization to spend more than ten per cent of the monies for
37 administration, outreach and direct services to the joint legislative study
38 committee on the integration on health care services. The study committee
39 shall review the amendment and provide input on the amendment. Once the
40 study committee reviews the amendment, the Arizona health care cost
41 containment system administration shall submit the amendment to the federal
42 health care financing administration requesting waiver authorization to offer
43 services through direct service contracts as an option to the services that

are provided to eligible children under title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act.

Sec. 20. Qualifying plans

A. A qualifying plan, as defined in section 36-2981, Arizona Revised Statutes, as added by this act, may elect to participate in the children's health insurance program established pursuant to title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act, subject to all requirements established in that article and in accordance with section 36-2989, subsection A, Arizona Revised Statutes, as added by this act.

B. The director of the Arizona health care cost containment system shall establish the terms and conditions that shall be used to exercise the option to participate.

Sec. 21. Tobacco lawsuit; use of settlement or compromise

A reasonable portion of any monies that this state receives from a judgement, settlement or compromise of any action or claim against tobacco companies, related parties, less litigation related expenses, shall be used to maintain existing proven health care programs.

Sec. 22. Appropriations; purpose; exemption

A. The sum of $5,000,000 is appropriated from the tobacco tax and health care fund medically needy account to the department of health services for fiscal year 1998-1999 for grants to contracting qualifying health centers pursuant to section 36-2907.06, subsection G, Arizona Revised Statutes.

B. The sum of $3,000,000 is appropriated from the tobacco tax and health care fund medically needy account to the department of health services for fiscal year 1998-1999 for grants to contracting hospitals pursuant to section 36-2907.08, subsection H, Arizona Revised Statutes.

C. The appropriations made in subsections A and B of this section shall be used for medical and health care services to children who are under nineteen years of age and have income at or below one hundred fifty per cent of the federal poverty level.

D. The appropriations made in subsections A and B of this section are exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.

Sec. 23. Direct service contracts; reporting

The director of the department of health services shall provide to the legislature the following information for services provided pursuant to sections 36-2907.06 and 36-2907.08, Arizona Revised Statutes:

1. The number of members served.
2. The number of encounters and the average cost for each encounter.
3. The number of services and the average cost for each service.
4. The actual year to date expenditures and projected annual expenditures.

APPROVED BY THE GOVERNOR MAY 20, 1998.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 20, 1998

Attachment B

Demographic Chart

ATTACHMENT B
DESCRIPTION OF DEMOGRAPHIC TABLES

Each table in Attachment B is based on March Current Population Survey (CPS) data. Different years of CPS data are used; however, the methodology for obtaining the estimates contained in the tables is the same. This methodology has been used by Arizona in the population estimates for the 100% of FPL waiver submission and differs from that used by the Census Bureau as described in the next paragraph.

CPS Estimation Methodology

Arizona has made changes in the methodology used to construct the CPS sample on which estimates are based. These changes were instigated by research conducted by the Rand Corporation on problems in using the CPS data to produce state level estimates. The changes in the methodology address concerns raised by Rand researchers, as well as other issues identified through internal conversations after the Rand article was published.

The following changes will make the numbers used in estimating the population eligible for KidsCare andother health coverage expansions as precise and accurate as possible:

The faniily unit is redefined so it more closely resembles AHCCCS eligibility.

The U.S. Department of Health and Human Services (DHHS) poverty guidelines are used to determine poverty level rather than the Census Bureau poverty thresholds used in the CPS.

Three years of CPS data are pooled, excluding re-interviews, rather than taking the average of three years of CPS estimates.

Estimates of low-income and uninsured populations, however defined, are consistently higher by a couple of percentage points than the Census Bureau's estimates. The main difference is attributable to the redefinition of family units. By redefining "family", many family units are separated into several individual families. This often reduces some family's income and thus increases the poverty estimate.

Attachment Tables

Attachment B includes four tables:

B-1: Insurance Coverage of Children in Arizona by Selected Demographic Characteristics, 1994 - 1996 Merged CPS, Weighted Percent Applied to 1998 Census Bureau Population Projection for Arizona

B-2: Insurance Coverage of Children in Arizona by Selected Demographic Characteristics, 1994-1996 Merged CPS, Unweighted Cell Counts

B-3: Insurance Coverage of Children in Arizona by Eligibility Status, 1994 - 1996 Merged CPS, Weighted Percent Applied to 1998 Census Bureau Population Projection for Arizona

B-4: Insurance Coverage of Children in Arizona by Eligibility Status, 1994 1996 Merged CPS, Unweighted Cell Counts

The tables that give unweighted cell counts are for information purposes. They illustrate the small size of the sample for many. of the category estimates. Categories were broken out based on two criteria: resulting cell size and importance of the breakout for policy considerations. Under coverage type "other public" was included with Medicaid because the cell size for "other public was so small as to be meaningless. It is also our understanding that after KidsCare implementation, it is not clear that the CPS data will be able to distinguish between KidsCare enrollees and Medicaid enrollees.

Arizona considers the Native American population important from a policy perspective. Therefore, in order to ensure a large enough cell size for a reliable estimate, anyone in the Native American category who also reported their ethnicity as Hispanic were included. If the Native American who reported Hispanic ethnicity were included with all other Hispanics, it would have reduced the Native American cell size by approximately one-third. Some of the cells still have quite small unweighted counts. Caution should be used in comparing across years when cell sizes are so small - what appears to be a large change may in fact be meaningless.

Because the tables by demographic characteristics only look at one dimension, they do not discern the eligible population, which is defined by age and FPL level. The tables by eligibility status distinguish between those who are currently eligible and those who will be eligible under KidsCare, so that coverage may be tracked across time.

There are some discrepancies in the data with respect to coverage. First, there are a large number of children whose ages and incomes would suggest they are Medicaid eligible, yet they report having no insurance coverage. Secondly, there are large numbers of children whose family income exceeds, 175% of FPL, yet they report having Medicaid coverage. Some of this is undoubtedly Medicare, CHAMPUS, MI/MN (or other state coverage) or IHS. However, some of it is reported Medicaid. There is not a good explanation for these discrepancies except interviewer error or respondent misreporting due to recall problems, confusion over question or deceit.

ATTACHMENT B
Table B-1
Insurance Coverage of Children in Arizona
by Selected Demographic Characteristics
1994 - 1996 Merged CPS
Weighted Percent Applied to
1998 Census Bureau Population Projection for Arizona [2]

	TYPE OF COVERAGE							
	Uninsured		Medicaid and Other Public3		Private/Group		Total	
	Percent	Number	Percent	Number	Percent	Number	Percent'	Number
Age Group								
<1	1.37%	18,114	2.77%	36,624	2.57%	33,980	6.71%	88,718
1 through 5	5.92%	78,273	10.68%	141,208	15.52%	.205,202	32.121/6	424,083
6 through 14	8.38%	110,798	11.24%	148,612	24.87%~	328,825	44. 49%	.688,236
15 through 18	5.01%	66,241	2.72%	35,963	8.95%	118,Z35'	16.68%	.220,539.
Total	20.68%	273,426	27ATIA	362,408	51.91%	686,341	100.00%	.1,322,176
FPL Level,								
<31%	2.96%	39,136	3.70%	48,920	0.98.%	12,9157,	7.64%	.101,014
32%-100%	5.39%	71,265	10.14%	134,069	1.65%	21,816	17.18%	227,150,
101%-150%	4.70%	62,142	5.87%	77,612	4.71%	62.,274.	15.28%	2021010
151%-175%	1.58%	20,890	1.36%	17,982	2.43%	32,129,	6.37%	'71,001
176%-200%	1.70%	22,477	0.55%	7,272	4.1.8%.	55,267	*6.43%*	45,016.
>200%	4.35%	57,515	5.79%	76,554	.37.95%	501,7§5.	48.00%.	635,834
Total	20.68%	273,426	27AI%	362,408	51.90%	686,209.	99.99%	1,322,043
Race/Ethnicity[4]								
American Indian	0.42%	5,553	2.36%	31,203	0.67%	8,859	3.45%	45,616,
Hispanic	12.49%	165,140	9.32%	123,227	13.18%	174,263'	34.99%	462,620.
Mite Non-Hispanic	7.42%	98,105	13.51%	178,626	35.44%	468,579~	56.37%	745,310
Black Non-Hispanic	0.27%		2.11%	27,898	1.26%	16,659	3.640/6	48,127
Other Non-Hispanic	0.08%	1,058	0.11%	1,454	1.34%	17,717	1.530A	20,229
Total	20.68%	273,426	27.41%	362,408	51.89%	686,9077	99.98%	1,321,911
Location								
Urban/Suburban[5]	14.94%	.197,533	20.29%	268,269	45.15%	596,962	80.83%	1,062,764
Rural	5.75%	76,025	7.12%	94,139	.6.74%	89,115	19.61%	259,279
Total	20.69%	273,658	1 27.41%	362,408	51.89%	686,077	99.99%	1,322,043

'Data reflects calendar years 1993 - 1995.

"Population Projections for States: by Age, Sex, Race and Hispanic Origin: 1995 to 2025" (PPL - 47)
Series A

[3]Medicaid and Other Public are collapsed due to small cell size. After I(ids Care implementation, it is unclear whether or not Title XXI enrollees will be distinguishable from Medicaid enrollees.

[4]American Indian includes Hispanic respondents. Hispanic includes all other Hispanic respondents.

[5]Urban/Suburban includes anyone living within a metropolitan statistical area (MSA).

Note: Total percent and number may not sum exactly across categories due to rounding.

ATTACHMENT.B
Table B-2
insurance Coverage of Children in Arizona
by Selected Demographic Characteristics
1994 - 1996 Merged CPS
Unweighted Cell Counts

	TYPE OF COVERAGE			
	Uninsured	Medicaid and Other Public	Private/Group	Total
Age Group				
<1	17	32	30	79
1 through 5	78	128	199	405
6 through 14	113	145	309	667
15 through 18	70	33	103	206
Total	278	338	641	1,257
FFIL Level				
< 1 31%	41	43	14	98
32%-100%	75	137	23	235
101%-150%	69	62	67	198
151%-175%	21	17	27	65
1715%-200%	20	8	53	81
>2130%	52	71	457	580
Total	278	338	641	1,257
Race/Ethnicity[3]				
American Indian	7	26	8	41
Hispanic	185	147	219	551
VVhIte Non-Hispanic	83	142	385	610
Black Non-Hispanic	2	21	14	37
Other Non-Hispanic	1	2	15	18
Total	278	338	641-	1,257
Location				
Urban/Suburban[4]	202	246	546	994
Rural	76	92	95	263
Total	**278**	**338**	**641**	1,267

'Data reflects calendar years 1993 - 1995.

2 Medicaid and Other Public are collapsed due to small cell size. After Kids care implementation, it is unclear whether or not Title XXI enrollees will be distinguishable from Medicaid enrollees.

3American Indian includes Hispanic respondents. Hispanic includes all other Hispanic respondents.

[4]Urban/Suburban includes anyone living within a metropolitan statistical area (MSA).

Note: Total percent and number may not sum exactly across categories due to rounding.

ATTACHMENT B
Table B-3
Insurance Coverage of Children in Arizona by Eligibility Status
1994 - 1996 Merged CPS
Weighted Percent Applied to
1998 Census Bureau Population Projection for Arizona [2]

	TYPE OF COVERAGE							
	Uninsured		Medicaid and Other Public'		Private/Group		Total	
	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Eligibility Category								
Title XIX (AHCCCS) Eligibity	8.85%	117,012	16.12%	213,135	3.29%	43,500	28.26%	373,647
Td-le XXI EilgibleA								
Eligible up to 150% FPL	4.21%	55,664	3.59%	47,466	4.05%	53,548	11.85%	156,078
Eligible up to 175% FPL	1.58%	20,890	1.36%	17,982	2A3-/.'	32,129'.	5.37%	71,001
Income > 175% FPL	6.05%	79,992	6.34%	83,826	42.13%	557.032.	54.52%	120,050
Total	20.69%	273,568	27.41%	362,408	51.90%	686,209	100.00%	1,322,175

'Data reflects calendar years 1993 - 199'5..

2"PopulalJon Projections for States: by Age, Sex, Race and Hispanic Origin: 1995 to 2025!'(PPL - 47) Series A.

'Medicaid and Other Public are collapsed due to small cell size. After Kids Care implementation, it is unclear whether or not Title XXI enrollees will be distinguishable from Medicaid enrollees.

4 Includes children < 1 under 140% FPL, 1 through 5 under 133% FPL, 6 through 14 under 100% FPL and 15 through 18 under 31 % FPL

'income above current AHCCCS eligibility level.

Note: Total percent and number may not sum exactly across categories due to rounding.

ATTACHMENT B
Table B - 4
Insurance Coverage of Children in Arizona by Eligibility Status
1994 - 1996 Merged CPS
Unweighted Cell Counts

	TYPE OF COVERAGE			
	uninsured	Medicaid and Other Public	Private/Group	Total
Eilgibilty Category		I		
Title XIX (AHCCCS) Eligible[3]	121	203	45	369
Title XXI Eligible[4]				
Eligible up to 150% FPL	64	39	59	162
Eligible up to 175% FPL	21	17	27	66
Income > 175%	72	79	510	661
Total	**278**	**338**	**641**	**1,257**

'Data reflects calendar years 1993 - 1995.

2Medicaid and Other Public are collapsed due to small cell size. After Kids Care implementation, it is unclear whether or not roe XXI enrollees will be distinguishable from Medicaid enrollees.

3 Includes children < 1 under 140% FPL, 1 through 5 under 133% FPL, 6 through 14 under 100% FPL and 15 through 18 under 31 % FPL.

4 Income above cu rrent AHCCCS eligibility level.

Note: Total percent and number may not sum exactly across categories due to rounding.

Attachment C

RESERVED

Attachment D

RESERVED

Attachment E

AHCCCS Health Plans

ATTACHMENT E
AHCCCS HEALTH PLANS
(As of October 1, 2003)

NAME	OWNER/OPERATOR	CORPORATE STRUCTURE	DATE OPERATIONS COMMENCED	COUNTIES OF OPERATION	ENROLL-MENT
Arizona Physicians IPA	Americhoice/UnitedHealth Group	Corporation For profit	10/1/82	Apache, Cochise, Coconino, Graham, Greenlee, LaPaz, Mohave, Maricopa, Navajo, Pima, Santa Cruz , Yavapai, Yuma	282,864
Care 1st Healthplan Arizona	Care 1st Health Plan	Corporation For profit	10/01/03	Maricopa	11,500
Comprehensive Medical and Dental Program	Department of Economic Security, State of AZ	Government Not for profit	10/1/90	Statewide	6886
Health Choice Arizona	IASIS Healthcare Corporation	Corporation For profit	10/1/90	Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, Pinal	91,052
Maricopa Managed Care	Maricopa County Government	Government Not for profit	10/1/82	Maricopa	48,711
Mercy Care Plan	Catholic Healthcare West Arizona Carondelet Health Care Group (Tucson)	Corporation Not for profit	10/1/83	Cochise, , Graham, Greenlee, La Paz Maricopa, Pima, , Yavapai, Yuma	199,226
Phoenix Health Plan/ Community Connection	Abrazo Healthcare	Corporation For profit	10/1/83	Gila, Maricopa, Pinal	97,732
Pima Health Plan	Pima County Government	Government Not for profit	10/1/82	Pima, Santa Cruz	20,802
University Family Care	University Physicians Inc.	Corporation Not for profit	10/1/97	Pima	22,473

Attachment F

Reserved

Attachment G

Family and Income Overview

ATTACHMENT G
FAMILY & INCOME OVERVIEW

AHCCCS determines the family's total gross monthly income at the time of application and redetermination.

FAMILY

Family includes the following categories of persons when residing together:

- A married couple and children of either one or both
- An unmarried couple with a common child and other children of either one or both
- A single parent and his or her children
- A child under age 19 who does not live with a parent
- A child and an unborn of the child is included in its parent's household
- Grandparent or other non-parent relatives of a child are not considered part of the household, unless the parent of the child is a minor and lives in the household with the child and grandparent. A child living with a grandparent or other relative instead of a parent is its own household.

INCOME

- AHCCCS counts the families' total gross monthly income after excluding any payments and grants, as specified in 20 CFR Part 416, the Appendix to Subpart K,. No other income deductions or disregards are applied when determining gross income.
- In determining the eligibility for a qualified alien, AHCCCS counts income of any person who executed an affidavit of support on behalf of the qualified alien and the income of the spouse, of the sponsoring individual, as family household income.
- The agency accepts the declaration of income provided on the application. The agency does not perform additional verification, unless there are inconsistencies with information already available to the agency or obtained through data matching or the income is from self-employment.
- For income from self-employment, the agency accepts the self-employed person's income tax records accompanied by the person's statement that current income is consistent with the tax records. In the absence of income tax records, the agency accepts the self-employed person's itemized accounts. When itemized accounts are

not available the agency accepts the self-employed person's declaration of proceeds and subtracts expenses that are verified by vendors or other creditors.

DETERMINING MONTHLY INCOME

AHCCCS projects monthly income based on a reasonable expectation and knowledge of the family's current, past, and future circumstances. AHCCCS converts income received more frequently than monthly by multiplying:

- Weekly amounts by 4.3;
- Bi-weekly amounts by 2.15; and
- Semi-monthly amounts by 2.

AHCCCS converts income received less frequently than monthly as follows:

- If the amount is received quarterly, divide by 4.
- If the amount is received semi-annually, divide by 6.
- If the amount is received annually, divide by 12.
- If the amount is received to cover a specific period of time, such as educational benefits, prorate the amount over the period intended to cover.

Attachment H

State Health Benefits Letter

Jane Dee Hull
Governor

J. Elliott Hibbs
Director

Arizona Department of Administration
Human Resources Division - Employee Benefits Program
Joanne Carew, Acting Manager
1624 W. ADAMS - PHOENIX, ARIZONA 85007
(602)542-5008 FAX:-(602)542-4744

April 27,1998

Jack H. Kelly, Director
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, Arizona 85034

Dear Mr. Kelly:

Pursuant to Arizona Revised Statutes, the Arizona Department of Administration is'authorized to provide health and accident insurance to officers and employees of the state and their dependents (A.R.S. 38-651), to former employees who have retired and their dependents, and to disabled employees (A.R.S. 38-651-01). Coverage also is available to those eligible pursuant to COBRA regulations.

You may contact the Group Benefits Office at 542-5008 if further details are needed.

Sincerely,

Joanne Carew
Acting Benefits Manager

Attachment I

Tribal Entities

ATTACHMENT I
TRIBAL ENTITIES

John Lewis, Executive Director
Inter Tribal Council of Arizona
2214 N. Central; Suite 100
Phoenix, AZ 85004
(602) 258-4822

Native American Community Health Center
Mr. Marc Harrison, Executive Director
300 North 3rd Street, Suite 310
Phoenix, AZ 85012
(602) 279-5262 fax: (602) 279-5390

Native Americans for Community Action
Family Health Center Clinic
Dana Russell, Chief Executive Officer
1355 N. Beaver St., Suite 160
Flagstaff, AZ 86001-3101
(520) 773-1245 fax: (520) 773-9429

Native Connections
650 N. 2nd Avenue
Phoenix, AZ 85003
(602) 254-3247

American Indian Chamber of Commerce
1301 E. University Drive
Tempe, AZ 85281
(480) 497-1997

Native Scene (newspaper)
2601 N. 3rd
Phoenix, AZ 85012
(602) 212-0741

Phoenix Indian Center

2601 N. 3rd St, Suite 100
Phoenix, AZ 85004
(602) 263-1017

Tucson Indian Center
Mr. Jacob Bernal131 East Broadway
Tucson, AZ
(520) 884-7131

Native Americans for Community Action
Main Office
Dana Russell, Chief Executive Officer
2717 N. Steves Blvd.
Suite 11
Flagstaff, AZ 86004-3959
(520) 526-2968 fax: (520) 526-0708

Attachment J

RESERVED

Attachment K

RESERVED

Attachment L

RESERVED

ATTACHMENT M
COPAYMENT SCHEDULE

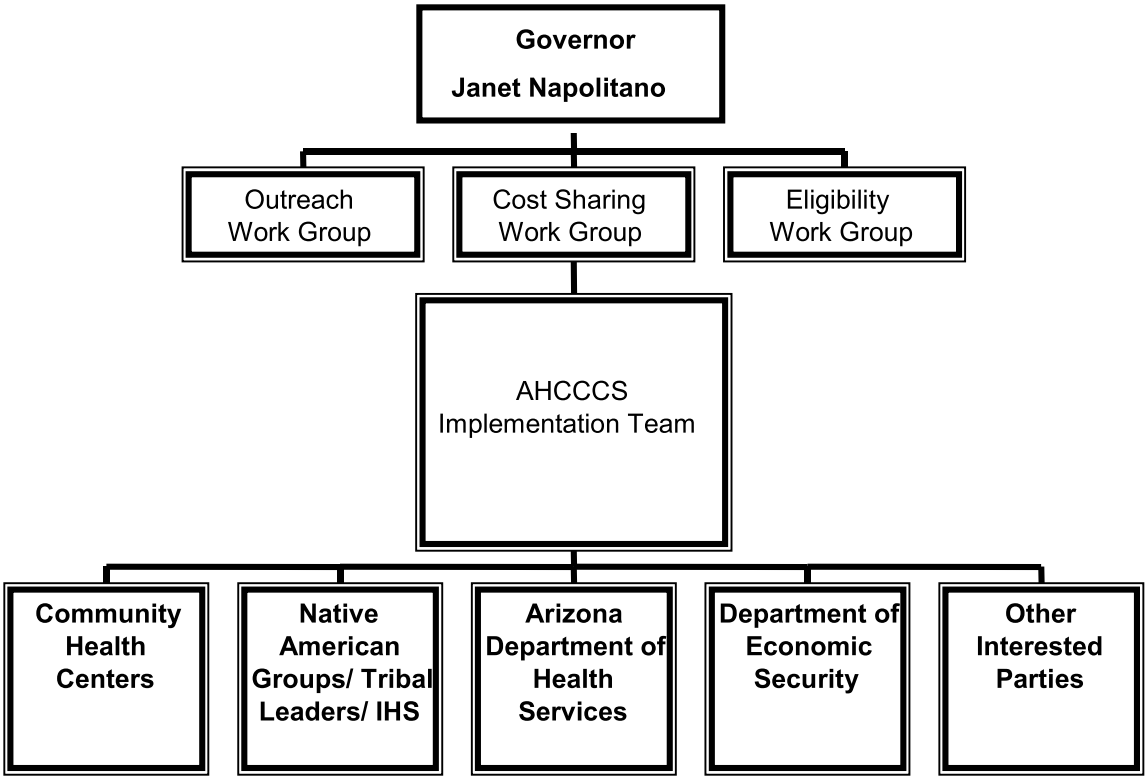
There are no copayments for children receiving benefits under KidsCare.

Attachment N

KidsCare Implementation Structure

ATTACHMENT N

KidsCare Implementation Structure



Attachment O

Governor's Task Force Members

ATTACHMENT O
GOVERNOR'S TASK FORCE

CONVENED BY GOVERNOR JANE DEE HULL

Wendy Baldo
Senate Majority Staff
Arizona State Senate

Mark Barnes
County Supervisor's Association

Cheryl Becker
Mental Health Association of Arizona

Tom Betlach
Governor's Office of Strategic Planning
and Budgeting

Jason Bezozo
Senate Health Analyst
Arizona State Senate

Michael Bradley
House Leadership Staff
House of Representatives

Sue Braga
Executive Director
American Academy of Pediatrics

Carole Brazsky
Maricopa County-Department of Health

Marianna Bridge
Office Chief
ADHS/Maternal and Child Health

Barbara Burkholder
Arizona Public Health Association

Susie Cannata
Williams, LaSota & Miller Law Firm

LeAnn Corbin
American Academy of Pediatrics

Lisa Cotter
Joint Legislative Budget Committee

Senator Ann Day
Arizona State Senate

Monte DuVal, M.D.

Rob Evans
Intertribal Council of Arizona

Elsie Eyer
Bureau Chief
ADHS/Community and Family
Health Services

Michael Fronske
House Staff
House of Representatives

Robert Ganelin, M.D.
Arizona Pediatric Society

Tonia Garrett
Research & Policy Analyst
Greater Phoenix Leadership

Sue Glawe
Director of Public Affairs
Blue Cross Blue Shield

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Attachment P

Community Support for KidsCare

HEALTHY CHILDREN ARIZONA

Businesses and Organizations Endorsing HB2659–*KidsCare*

Updated May 20, 1998

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Businesses

- Arizona Association of Industries
- Arizona Chamber of Commerce
- Bank One, Arizona
- Bashas'
- Breault Research Organization (Tucson)
- Casillas Consulting Services
- Chandler Chamber of Commerce
- China Mist Tea Company
- Corporate/Education Consulting, Inc.
- East Valley Partnership
- Greater Phoenix Leadership
- Greater Tucson Strategic Planning for Economic Development
- Honeywell
- Loews Ventana Canyon Resort (Tucson)
- National Federation of Independent Business
- Nordensson Lynn Strategic Marketing
- Phoenix Chamber of Commerce
- Raytheon Missile Systems Company (Tucson)
- SEBRA Bioindustries (Tucson)
- Summa Associates
- Tucson Electric Power Company
- Tucson Metropolitan Chamber of Commerce
- Tucson Newspapers (TNI Partners)
- Tucson 30

Health Care Organizations

- American Academy of Pediatrics, Arizona Chapter
- American Lung Association of Arizona
- Arizona Association of Behavioral Health Programs
- Arizona Association of Community Health Centers, Inc.
- Arizona Chapter, American College of Emergency Physicians
- Arizona Family Planning Council
- Arizona Hospital and Health Care Assoc.
- Arizona Medical Association
- Arizona Nurses' Association
- Arizona Public Health Association
- Arizona School Health Association
- Arizona State University, School of Health Administration and Policy
- Alpha-Omega Home Health of Arizona (Globe)
- Asthma Care Alliance of Southern Arizona
- Baptist Hospital and Health Systems
- Behavioral Health Agency of Central Arizona (Casa Grande)
- Canyon Pediatrics, P.C. (Tucson)
- Carondelet Health Network (Tucson)
- Catalina Pediatrics, P.C. (Tucson)
- Children's Clinics for Rehabilitative Services (Tucson)
- Coconino County Dept. of Health Services
- Coconino County Medical Assistance
- CODAC Behavioral Health Services
- Community Counseling Centers
- Community Health Services Clinic (sponsored by Arizona State University College of Nursing)
- Community Partnership of Southern Arizona (Tucson)
- Compass Health Care (Tucson)
- Dillenberg and Friends Health Services Consulting, Inc.
- Doctor's Health Plan (Safford)
- Fort Mohave Indian Tribe Health Center
- Flagstaff Medical Center
- Florence Crittendon Services of AZ, Inc.
- Gila County Health Department
- Gila Health Plans
- HealthPartners Health Plans, Inc.
- Healthy Outlook Family Medicine
- Indian Health Services/Colorado River Service Unit, Parker Indian Hospital
- Inner Vision Institute of America
- Kino Community Hospital (Tucson)
- Lake Powell Institute Behavioral Health Services
- Luke Air Force Base Pediatric Clinic
- Little Colorado Behavioral Health Council
- Maricopa County Department of Public Health Community Health Nursing
- Maricopa County Medical Society
- Mariposa Community Health Center (Nogales)
- Medical Professional Associates of Arizona, Inc. ("MedPro")
- The Mental Health Association of Arizona
- Mercy Healthcare Arizona
- Mesa Pediatric Professional Association
- Mohave Mental Health
- New Arizona Family Behavioral Services (Tucson)
- Northwest Medical Center (Tucson)
- Nova Behavioral Services
- Phoenix Area Medical Education Consortium
- Phoenix Children's Hospital
- Phoenix Memorial Health System
- Phoenix Pediatric Society
- Pima County Medical Society
- Pinal Gila Behavioral Health Authority
- Psychiatric Center for Human Concerns
- Saguaro Children's Surgery
- St. Luke's Charitable Health Trust
- Samaritan Health System
- Scottsdale Healthcare (formerly Scottsdale Memorial)
- Scottsdale Memorial Family Care, Granite Reef
- Southeastern Arizona Behavioral Health Services, Inc.
- Southwest Behavioral Health
- Superstition Mtn Mental Health Center

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Health Care Organizations (continued)

- TriCity Behavioral Services
- TMC HealthCare—Tucson Medical Center
- University Medical Center (Tucson)
- Urological Associates of Southern AZ, P.C.
- VSF International Ltd. (Tucson)
- West Yavapai Guidance Clinic
- Youth Evaluation & Treatment Centers, Inc.
- Yuma County Health Department

Children's Organizations

- Alhambra Preschool Center
- Apache County Youth Council
- Arizona's Children Association
- Arizona Children's Behavioral Health Council
- Arizona Education Association
- Arizona Head Start Association
- The AZ Partnership for Infant Immunization
- Association for Family and Child Advocacy, University of Arizona College of Law
- Association for Supportive Child Care
- Boys and Girls Club of the East Valley
- Casa de los Ninos (Tucson)
- Child Abuse Prevention Arizona
- Child and Family Resources, Inc.(Yuma and Tucson)
- Child Crisis Center, East Valley
- Children's Action Alliance
- Children's Council (Prescott)
- Coconino Coalition for Children and Youth
- Colorado River Indian Tribes Head Start (Parker)
- Don Mesendick Elementary (Glendale Elementary School District)
- Fetal Alcohol Syndrome Community Resource Center (Tucson)
- Florence Crittendon Services
- Get It Together People Center
- Give a Parent Support (GAPS) (Tucson)
- The Greater Arizona City Dads
- Healthy Families Arizona
- Healthy Mothers Healthy Babies—Pima County Coalition
- Maricopa Foster Care Review Board #30
- Mentally Ill Kds in Distress (MIKID)
- Miss Connie's Preschool and Child Care (Prescott Valley)
- Nuestra Familia—Arizona Children Association
- Our Town Family Center (Tucson)
- The Parent Connection (Tucson)
- Parents Anonymous of Arizona Parent Leadership
- Parents and Children Together (Tucson)
- Phoenix Day
- Phoenix Elementary School District #1
- Phoenix First Child Care and Learning Center
- Pinal County Cities and Schools
- Pinal Parent Project—U of A Cooperative Extension
- Prevent Child Abuse, Inc. (Prescott)
- Southwest Human Development
- Sunshine Acres Children's Home Inc.
- Tumbleweed
- United Children's Network
- Valley of the Sun Association for the Education of Young Children
- Westside Headstart

Religious, Civic & Community Organizations

- Amazon Foundation (Tucson)
- Arizona Community Action Association
- The Blake Foundation (Tucson)
- Arizona Catholic Conference
- Arizona Center for Disability Law (Tucson)
- Arizona Ecumenical Council
- Arizona Women's Education and Employment, Inc. (AWEE)
- Catholic Social Service
- Central Arizona Shelter Services, Inc.
- Centro De Amistad Incorporado
- Christ United Methodist Church
- Community Foundation for Southern Arizona
- Community Legal Services (Yuma)
- Community Partnership of Southern Arizona
- Coconino County Community Services Department
- Concilio Latino de Salud, Inc.
- Downtown Neighborhood Learning Center
- 51st Avenue Friendship Center
- The Foundation for Senior Living
- General Federation of Women's Clubs—Desert Jade Woman's Club
- Glendale Community Council, Inc.
- Human Services Department, City of Phoenix
- Interfaith Coalition for the Homeless (Tucson)
- Jewish Family & Children's Services
- Kingman Aid to Abused People
- League of Women Voters of Arizona
- Mesa Pediatric Professional Association
- Mesa United Way
- Midwestern University (Glendale)
- National Association of Social Workers—Arizona Chapter
- National Council of Jewish Women
- Northland Family Help Center (Flagstaff)
- Pediatric Associates (Phoenix)
- Phoenix Shanti Group
- Phoenix Violence Prevention Initiative
- Pinal County Board of Supervisors
- Planned Parenthood of Central and Northern Arizona
- Presbyterian Service Agency
- Providence Corporation (Tucson)
- Red Mountain United Methodist Church
- Southeastern Arizona Government Organization (Bisbee)
- Sojourner Center
- The Southwest Community Network (Goodyear)
- Turf Estate's Neighborhood Association
- Tucson Centers for Women and Children
- United Food and Commercial Workers Union, Local 99
- Unitarian Universalist Congregation of Phoenix Social Action Committee
- United Phoenix Fire Fighters' Association
- United Way of Greater Tucson
- University of Arizona Maricopa County Cooperative Extension
- University of Phoenix
- Valle del Sol
- Valley of the Sun YMCA
- Victim Witness Services for Coconino County
- Volunteer Center of Tucson
- Wesley Community Center

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- Norman L. Thompson, M.D. (Phoenix)
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- William R. Webb, M.D. (Flagstaff)
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Attachment Q

Public Comments and AHCCCS Responses

ATTACHMENT Q
COMWNTS FROM THE PUBLIC
AND AHCCCS'RESPONSES

The following are the maior comments that AHCCCS received in the two public hearings on the State Plan and in letters received by the agency. Following the comments are AHCCCS' responses. Please note that these comments do not include questions which were asked and answered in the public hearings.

Some of the persons commenting did not believe that they had sufficient time for public comments. AHCCCS acknowledges that the time for comment on the State Plan was compressed in order to submit the State Plan as quickly as possible. However, the State Plan is a reflection of the federal enactment of the Child Health Insurance Plan. and the state legislation which had significant discussion in the past seven months.

Comment - Under Strategic Goals and Objectives, AHCCCS should include an evaluation of special needs of children and assess the adequacy of the provider networks for this population.

Response - *A*HCCCS will evaluate all children through the indicators rather tim by a diagnosis. AHCCCS contractors must meet the needs of avacnhild and ensure that specialty providers are available. The ' network is a critical component in the evaluation of a contractor's ability to deliver services and will be evaluated by AHCCCS before the KidsCare Program begins and during the annual operati6nal reviews.

Comment - *A*HCCCS may have problems attaining the goal of immunizing 80 percent of the children since there are many locations where a child can be immunized. How will AHCCCS work with the county health departments?

Response: *The* 80 percent goal is one that AHCCCS believes is attainable. Currently, AHCCCS health plans immunize 75% of Medicaid eligible children. Regarding coordination with other entities who immunize children, AHCCCS is part of a group working on an automated system to track immunizations. This ability will improve the reporting of immunizations.

Comment - The **state** Plan states that it will decrease the number of uninsured children in the state. This goal does not take into account that some children may receive clinic services as needed but are not considered uninsured.

Response: Added this comment to the State Plan.

Comment - The proposal to add Medical Savings Accounts in the future may be confusing for the parents and not really an option that makes sense for children.

Response - If HCFA approves this proposal, AHCCCS will try to make this option as clear as possible.

Comment. Concerned that prior authorization requirements will hinder special needs children from accessing specialty care.

Response All KidsCare children must have accessible specialty care. By contract, the AHCCCS health plans must meet strict appointEnent standards. For example, if specialty care is needed on an emergency basis, care must be available within 24-hours of referral. For routine, the care must be available within 30 days of referral.

Comment - Special needs children should be able to di senroll from a health plan during the first three months of enrollment.

Response - A**HCCCS** will provide 12 months of guaranteed enrollment in the first year of enrollment, allow a family to choose the hi~alth plan, commercial carrier, the IHS or 638 tribal facilities and choose an available primary care practitioner. All children will. remain enrolled with their chosen provider until the next 12 month anniversary date. AHCCCS does have special circumstances that allow disenrollment before the anniversary date, such as continuity of care, which will be applied to the KidsCare Program.

Comment - Families may not want their child screened for Medicaid.

Response - A**HCCCS** must ensure that children who are enrolled with KidsCare are not eligible for Medicaid. The family will not be required to enroll a child in Medicaid but KidsCare coverage will not be available for a Medicaid eligible child.

Comment - The immunization package is not as comprehensive as Vaccines for Children coverage. Hepatitis A immunizations should be required for children entering day care.

Response - A**HCCCS** will use the same vaccine schedule that is required under Medicaid. This schedule is more comprehensive than the Intergroup coverage contained in Attachment K. The Hepatitis A vaccme will be provided.

Comment - Requiring a social security number may be a barrier for some families, including tribal members.

Response - A**HCCCS** will request a social security number from KidsCare applicants but will not deny eligibility if the family does not provide the social security number and the child is not Medicaid eligible. However, if the child is eligible for Medicaid, a social security number is required and will be requested. If the family does not provide a social security number, AHCCCS cannot enroll a child into KidsCare who is Medicaid eligible.

Comment - An adequate number of applications must be available throughout the state. Please consider allowing sites to duplicate the applications and be sure that the literacy level is appropriat e.

***Response - A*HCCCS** will ensure that sufficient applications are available throughout the state, including tribal lands, in a literacy level that makes the application easy to complete. Duplication of the application will be allowed.

Comment - There were many comments expressing concern about the limitations on behavioral health services of 30 inpatient days and 30 outpatient days per year.

Response - This was a legislative decision that AHCCCS must follow. It is more generous than the benchmark coverage under Intergroup. The only way to change this limitation is by an amendment to the KidsCare legislation.

Comment - Would like to see an indicator for well-child visits.

Response - Well child visits are two performance measures -that AHCCCS will use. Please refer to Section 7.

Comment - The 5.0% performance goal for dental visits and 70% for visiting a PCP are too low.

Response - The percentages are higher than most other states can attain through Medicaid. AHCCCS understands that it is not optimum and will work with the contractors and community to improve the percentages.

Comment Cost sharing should be kept at a minimum.

Response AHCCCS will develop the premium levels and share that information with the community before implementation of the premium schedule. The legislature clearly intended that families share in the cost of care based on income. AHCCCS is mindful that copayments and premiums cannot exceed 5% of gross household income.

Comment - Native American children should have an equal opportunity to enroll in the KidsCare Program. How will the eligibility cap impact rural areas if the state is running out of YjdsCare money?

Response - AHCCCS intends to conduct outreach in all areas of , the state, including onreservation, to maximize the opportunity for all persons in the state to apply for the program. Secondly, AHCCCS does not believe that the cap will be reached for'several years, if at all.

Comment - IRS is not allowed to impose cost sharing for tribal members. Several members commented that premiums and copayments should not be assessed on Native Americans whoreceive services from the IHS or 638 tribal facilities.

***Response - The* legislature** established copayments and premiums for all KidsCare enrollees. The Inter Tribal Council did testify before the House Health Committee opposing cost sharing for Native Americans. The Committee did not waive Native Americans from this requirement.

AHCCCS has posed the question to HCFA whether cost sharing is allowed under KidsCare for Native Americans who receive services from an IHS or 638 facility. HCFA has verbally said cost sharing was allowed. AHCCCS will request a written response from HCFA on this issue.

Comment - The Inter Tribal Council of Arizona sent a written comment which stated that minimal tribal consultation has taken place and statements in the State Plan about consultation activities are misleading.

***Response - A*HCCCS** is completely perplexed about this comment. As'a member of the Governor's Task Force, the ITCA agreed to facilitate communication, ensure the tribes were iniFormed about the KidsCare Program and encourage tribes to participate in the many meetings. AIJCCCS views ITCA as a key partner in this process and, prior to this letter, neither AHCCCS nor the Governor's Office had been advised that the ITCA believed that communication and consultation with the-tribes was lacking.

The Governor's Office convened a Task Force with Indian representation and established subcommittees to discuss eligibility, outreach and cost sharing for KidsCare. All interested parties were invited. AHCCCS did not ask ITCA if they invited representatives from the tribes to these meetings. Although ITCA did attend some of these meetings, tribes did not participate in these subcommittees.

AHCCCS has provided information about KidsCare in many different forums: a newsletter which was ' mailed to all tribes describing KidsCare with an offer to meet or answer questions, a letter to all tribes offering a presentation on KidsCare and an opportunity for them to comment and meetings with various tribal organizations. AHCCCS then met with any tribe who requested a presentation. AHCCCS also invited all tribes to participate in meetings and outreach strategies and convened a meeting with the Urban Indian Health Care Directors to discuss their issues. The Governor's Office also invited all tribes to attend a special meeting to discuss the KidsCare proposal and any tribal issues. All tribes were sent a copy of the State Plan and were invited to the. two public meetings on the State Plan.

In addition, AHCCCS was contacted by the, ITCA to help with legislation to include 638 tribal facilities in the KidsCare legislation. AHCCCS drafted this legislation for the ITCA and requested that it be included in the final bill, which it was.

Comment - Children should be allowed to disenroll from a contractor and enroll with IHS or a 638 tribal facility.

Response - Agree. Native American children will be allowed to disenroll from a contractor_ upon request and enroll with the IHS or 638 tribal facility.

Comment- IHS and the tribes cannot provide services under the Premium Sharing Program or Baby Arizona. IHS and the tribes have problems getting Medicaid reimbursement

Response - The Baby Arizona Program does not provide services. It is a program that allows staff in physician offices to accept Medicaid applications from pregnant women and. assist applicants in providing required verification. This facilitates DES in expediting eligibility for pregnant women, There is no reimbursement to the physicians for this assistance. The Premium Sharing Program is a 100% state flanded program established by the legislature as a pilot in four counties. If ITCA believes that IHS or tribal facilities should be allowed to provide the services offered under the Premium Sharing Program, they should approach the legislature for an amendment.

Comment - The existing Medicaid enrollment structure will be used and will have a negative impact on enrollment for Native American children.

Response - The existing Medicaid enrollment structure will not be used. Rather, AHCCCS, for the first time, will be performing eligibility for an acute care program. -- The application Will be streamlined, mail-in applications will be accepted and outreach efforts throughout the state, including tribal lands, will be significant. Native American children have all the enrollment options of all other children plus IHS and 638 entities, plus they are allowed to disenroll from a contractor and enroll with IHS a 63 8 tribal entity.

Comment - The cap on the program will be reached before eligible Native American children can be enrolled into KidsCare.

Response - A**HCCCS does** not believe the cap will be reached for several years, if at all. All children in the state will have an equal opportunity to enroll in the KidsCare Program in the first few years. If a cap is imposed at a later date, it will affect all children in the same manner in the state.. AHCCCS understands the need to ensure that Native Americans are informed early about the program, which is why the agency has been working with the tribes on outreach strategies.

Comment - . A**HCCCS** needs to provide a portion of the 10% administrative funds to tribal governments to intensify outreach and coordination efforts.

Response - A**HCCCS** is meeting with tribal representatives to develop strategies that are culturally sensitive and that will be effective for tribal lands and urban Indians. The administrative and outreach funds are extremely tight in the first year of the program. Although no decision has been made to pay for outreach services in any part of the state, AHCCCS is cognizant about tribal resources and will work with the tribes to maximize resources.

Comment -children in Arizona.

The demographic information may underestimate the number of Native American

Response - Agree. However, this is the CPS data provided by the federal government and the best tool we have for estimates.

Comment - Native American children in rural areas do not have access to transportation.

*Response - A*HCCCS understands that it is difficult in rural areas to access services when nonemergency transportation is not provided. Since the legislature decided that the KidsCare Program would not provide non-emergency transportation, AHCCCS cannot pay for this service for any KidsCare eligible child.

Comment - The state must include all state agencies and external agencies who are responsible for children in the outreach activities for Native American children.

Response - AHCCCS agrees that outreach efforts should be as inclusive as possible.

CL7mment - Initial outreach efforts must be expanded to Indian and rural communities.

Response - Strongly agree that outreach is important to Indian communities and rural communities. This is part of the outreach strategy.

Omment - State must continue to work with the tribes, Indian organizations and three IHS offices in disseminating relevant information.

Response - Agree. AHCCCS has every intention of continuing to work not only with the entities listed above but Urban Indian Centers and other appropriate parties.

Comment - The state must ensure the participation of 638 tribal facilities which provide behavioral health services. Prior approval and *referral process* should not hinder services to children.

Response AHCCCS has mailed a letter to each tribe and the 638 Urban Indian Centers advising them about the program and the option for them to use 638 tribal facilities or the Centers to provide care. It will be up to each tribe whether they want to participate. AHCCCS will do all possible to streamline prior approval and referral processes.

Attachment R

Reserved

Attachment S

KidsCare Budget

CHIP Budget Plan

State: Arizona **SPA Number:** AZ-16-0016-CHIP **Federal Fiscal Year (FFY):** 2017	**Federal Fiscal Year Costs**	**Net Change Due to Amendment**
Enhanced FMAP rate:	100.00%	100.00%
Benefit Costs		
Managed care	$92,114,800	$90,438,000
Fee for Service	$5,433,500	$5,358,800
Premium Assistance Insurance Payments	$0	$0
Other	$0	$0
Total Benefit Costs	$97,548,300	$95,796,800
Offsetting beneficiary cost sharing payments	$12,881,700	$12,630,900
Net Benefit Costs	**$84,666,600**	**$83,165,900**
Administration Costs		
Personnel	$7,873,900	$7,734,300
General administration	$602,100	$591,400
Contractors/Brokers (e.g., enrollment contractors)	$0	$0
Claims Processing	$931,300	$914,800
Outreach/marketing costs	$0	$0
Health Services Initiative	$0	$0
Other	$0	$0
Total Administration Costs	$9,407,300	$9,240,500
10% Administrative Cost Ceiling (net benefit costs / 9)	$9,407,400	$9,240,700
Federal Share (multiplied by E-FMAP rate)	$94,073,900	$92,406,400
State Share	$0	$0
TOTAL PROGRAM COSTS	**$94,073,900**	**$92,406,400**

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

Budget Assumptions:

FFY:	**# of eligibles**	**$ PMPM**
Managed Care	30,490	$216.55
Fee for Service	759	$596.71
Total PMPM (Net Benefit)	31,249	$225.78

Source(s) of non-federal funding used for state match: No state match.

Other Assumptions:

Open enrollment effective September 1, 2016.

Phase-in enrollment over 9 months. September 2017: 34,621

Does not show total shortfall (incl. M-CHIP) of: $219,726,200

PMPMs decrease from FFY 2016 to FFY 2017 due to lower Health Insurer Fee and no prior year adjustments