JANE DEE HULL
GOVERNOR
STATE OF ARIZONA

June 18, 1998

Administrator
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244

Rick Fenton
Deputy Director of Family and Children's Health Programs Group
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244

Richard Chambers
Associate Regional Administrator
Health Care Financing Administration
Medicaid State Operations Branch
75 Hawthorne Street, 5th Floor
San Francisco, CA 94105

Dear Administrator, Mr. Fenton and Mr. Chambers:

I am pleased to submit Arizona's Title XXI State Plan which will enable the state to provide health care coverage to over 70,000 targeted, low income children once the program is fully established.

The State Plan is the culmination of many months of meetings and the result of a consultative process to build consensus about the structure of the program. Before my proposal was suggested to the legislature, I wanted significant community involvement to help the state design this program. Therefore, I convened a Task Force on KidsCare which represented the interested parties and reflected a broad spectrum of constituencies. This Task Force met several times prior to the introduction of legislation to discuss policy issues. I also encouraged three subcommittees to meet separately to focus on outreach, the eligibility process and cost sharing issues.

Representatives from Arizona's 21 Tribes were invited to meet with my staff to discuss issues specific to tribal lands. Additionally, the Arizona Health Care Cost Containment

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System (AHCCCS) held two public hearings to discuss the State Plan and met with many interested parties to discuss the program. The legislature was very involved in the development of the KidsCare program. The Health Committee and Appropriations Committees held many meetings to discuss the issues and to afford the public an opportunity to comment on the state legislation.

The effective date for the State Plan is October 1, 1997 which will enable AHCCCS to begin building the infrastructure for the program prior to enrollment. AHCCCS will begin delivering services within 60 days after HCFA approves the State Plan. Once the State Plan is approved and implemented, Arizona will submit additional amendments that will request HCFA approval for Title XXI funding for: a sliding fee scale premium for families with income above 150% of the federal poverty level, an option to offer Medical Savings Accounts as an alternative to the benchmark coverage and the authority to pay for employer-sponsored health care coverage for eligible children. In addition to the Title XXI funding, the state will use $8 million in 100 percent state funds to provide direct services in community health care centers and hospitals which predominately serve low income children.

We look forward to working with you to implement our Title XXI program. If you have any questions about the KidsCare State Plan, please contact AHCCCS and speak to Lynn Dunton, Assistant Director, Office of Policy Analysis and Coordination at (602) 417-4534.

Sincerely,

JANE DEE HULL
Governor

cc: Debi Wells
John H. Kelly
Lynn Dunton

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

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

State/Territory: **Arizona**

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

_____ 6/18/98
(Signature of Governor of State/Territory, Date Signed)

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

ACKNOWLEDGMENTS

The Title XXI State Plan will enable Arizona to implement a KidsCare Program for targeted, low income children. It has been a consultative process with the participation of the Governor's Office, state legislators, advocacy groups, business leaders, hospital and medical organizations, medical providers, other state agencies, tribal organizations and tribal representatives and community health care clinics. The Governor's Office and the AHCCCS Administration are grateful to more than 400 individuals and organizations who provided input for this State Plan and the state legislation. Clearly, this submittal would not be possible without their assistance, expertise and commitment to provide health care services to over 70,000 uninsured children in Arizona.

In addition, we wish to thank the Arizona legislators who approved Senate Bill 1008 and provided the authority to enact the KidsCare Program.

The State Plan is located at the AHCCCS' Internet home page:

http://www.ahcccs.state.az.us./Content/resources/Publications/publications.htm

In addition, hard copies of the State Plan may be obtained by contacting:

Arizona Health Care Cost Containment System
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, Arizona 85034
(602) 417-4534

Table of Contents

Section 1	General Description and Purpose of the State Child Health Insurance Plan	1
Section 2	General Background and Description of State Approach to Child Health	4
Section 3	General Contents of State Child Health Plan	11
Section 4	Eligibility Standards and Methodology	16
Section 5	Outreach and Coordination	26
Section 6	Coverage Requirements for Children's Health Insurance	35
Section 7	Quality and Appropriateness of Care	45
Section 8	Cost Sharing and Payment	51
Section 9	Strategic Objectives and Performance Goals for the Plan	55
Section 10	Annual Reports and Evaluations	62
Attachment A	Legislation	
Attachment B	Demographic Chart	
Attachment C	Description of Programs	
Attachment D	Children By Eligibility Category	
Attachment E	AHCCCS Health Plans	
Attachment F	Commercial Health Maintenance Organizations	
Attachment G	Family and Income Overview	
Attachment H	State Health Benefits Letter	
Attachment I	Tribal Entities	

Attachment J Eligibility Hierarchy

Attachment K Description of Benefits Package

Attachment L Quality Improvement Initiative Quarterly Report

Attachment M Copayment Schedule

Attachment N KidsCare Implementation Structure

Attachment O Governor's Task Force Members

Attachment P Community Support for KidsCare

Attachment Q Public Comments and AHCCCS Responses

Attachment R Community Presentations and Meetings

Attachment S KidsCare Budget

Glossary

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

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

1.1. ☒ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**

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

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 will be 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 is submitting this 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 is October 1, 1997 which will enable the state to prepare for the implementation of the program. Services will be delivered within 60 days from HCFA approval of the State Plan. Income thresholds will be set at 150% of federal poverty level (FPL) at the beginning of the program; 175% of FPL beginning July 1, 1999 and 200% of FPL beginning July 1, 2000 through September 30, 2007. Arizona will not impose a resource test for this population. AHCCCS will perform all KidsCare eligibility determinations for new applicants and redeterminations of eligibility based on a simplified eligibility process. A process will be implemented to determine whether a child is eligible for Medicaid prior to a determination of eligibility for KidsCare.

Arizona will provide KidsCare services through established AHCCCS health plans and the state employee Health Maintenance Organizations (HMOs) who elect to participate in the program. These entities are referred to as contractors throughout this document. In the second year of the program, the state will use Title XXI funding for direct services provided by participating community health care clinics and hospitals which predominately serve low income children.

All children will 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 Center (IHS), 638 tribal facilities or one of the contractors. The KidsCare service package offered by the contractors will be the same service package offered to state employees by the least expensive commercial HMO. Dental and vision services have been added to the state employee package for children eligible for KidsCare. AHCCCS will coordinate outreach activities with the assistance of safety net providers, other state agencies, tribal entities and organizations, advocacy groups and other appropriate entities.

In the first year of the program, copayments will be assessed for all members; in the second year of the program, families with income above 150% of FPL will also be assessed premiums. However, the total cost for premiums and copayments will not exceed 5 percent of the family income.

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

Once the State Plan is approved, Arizona will submit additional amendments that will request HCFA approval for Title XXI funding for: Title XXI funding above the 10% cap for direct services provided by community health centers and hospitals which predominately serve children, a sliding fee scale premium for families with income above 150% of the federal poverty level, an option to offer Medical Savings Accounts as an alternative to benchmark coverage and the authority to pay for employer-sponsored health care coverage for eligible children. It is also possible that Arizona will request approval to pay for family coverage with Title XXI funds.

AHCCCS will coordinate 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 six months before eligibility will be granted for KidsCare.

Section 2. General Background and Description of State Approach to Child Health Coverage 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 section 2110(c)(2)). 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).

As discussed in the Instructions for the State Plan, Attachment B provides the information requested in 2.1.

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

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 AND STATE-ONLY CHILD 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 managed care Medicaid program, four 100 percent state-funded medical programs for low income persons and numerous public health programs which provide health care services to children. The four state programs are the Medically Indigent/Medically Needy (MI/MN) program; Eligible Assistance Children (EAC) and Eligible Low Income Children (ELIC) programs and the State Emergency Services (SES) program. Each of these programs is discussed in detail in Attachment C.

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. These efforts will intensify with the implementation of KidsCare.

As of June 1, 1998, AHCCCS health plans provided Medicaid services to 372,823 acute care Medicaid members and 24,904 long term care members enrolled in the Arizona Long Term Care System. Acute care members are individuals who are eligible for Medicaid based on categorical eligibility and who are enrolled with the AHCCCS health plans.

Acute care members can receive long term services for up to 90 days during a contract year. If long term care services are needed for more than 90 days and the individual meets all other Arizona Long Term Care System financial and medical criteria, the individual can apply for the long term care program. Included in the acute care population were 50,968 Native Americans who elected to receive Medicaid services from the IHS. Arizona currently serves 235,346 children under the age of 19 through the Medicaid and the 100 percent state-funded programs. Please see Attachment D for the number of children in each eligibility category.

The state has several agencies who perform eligibility functions. The Arizona Department of Economic Security (DES) processes applications and determines eligibility for all Medicaid groups, except the SSI Cash and SSI-Medical Assistance Only (MAO) groups and the Medicare cost sharing programs. For SSI-Cash, the Social Security Administration performs the eligibility determinations; AHCCCS performs eligibility for SSI-MAO and the Medicare cost sharing programs. Applications received at county eligibility offices are screened for potential Medicaid eligibility prior to determining eligibility for the state programs. The applications received by the counties for pregnant women, infants, and children who are potentially eligible for Medicaid are taken by county eligibility workers and referred to DES for a Medicaid eligibility determination.

AHCCCS administers four 100% state-funded programs for persons who do not qualify for Medicaid. The programs are funded entirely with state and county funds to provide services for 25,095 persons who did not qualify for Medicaid as of June 1, 1998. Applicants for state-funded programs apply in their county of residence, with the exception of EAC who apply for eligibility at DES.

EFFORTS TO IDENTIFY AND ENROLL CHILDREN IN PUBLIC INSURANCE PROGRAMS

In addition to Medicaid and state administered health insurance programs, Arizona has six public initiatives which identify and help enroll children in programs that serve children. AHCCCS will coordinate 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, in health centers, 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 will submit a completed application to the appropriate eligibility office.

Direct Health Services

Direct health services are provided by county public health departments based on a sliding fee scale.

Community Health Centers

Arizona has 27 community health centers which 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 outreach 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 health care 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.

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:

Unlike some states, Arizona does not have major public-private partnerships with insurers which offer child health insurance products. However, Arizona does have one public-private partnership that is an outreach effort, and one public-private partnership that is a four year premium sharing pilot program. Children who are ineligible for KidsCare will be referred to the Premium Sharing program for an eligibility determination. These programs are explained in further detail below.

BABY ARIZONA

In December 1996, the Baby Arizona Project was one of five programs across the country to receive a national Achievement Award from Healthy

Mothers, Healthy Babies. The program was created by a public-private partnership in 1994 in response to a steady decline in the early entry of mothers into prenatal care. The project, which is overseen by AHCCCS, uses a comprehensive approach to raise awareness about the importance of early prenatal care for Medicaid eligible mothers. A streamlined eligibility process is used to encourage women to apply for Medicaid.

In 1997, nearly 6,000 pregnant women called the ADHS hotline in response to the Baby Arizona campaign -- an increase of 25 percent over the last year. The project's marketing campaign was a success, with more than 60 percent of the callers requesting information about Baby Arizona. Approximately 68 percent of callers reported that they were in their first trimester or were not sure if they were pregnant. The hotline provided referrals to medical care and information about how to apply for AHCCCS through the Baby Arizona's streamlined eligibility process.

In addition to a successful prenatal outreach program, AHCCCS initiated a process to allow expectant mothers to apply for the Baby Arizona program at physician offices and clinics. The program is now implemented statewide in Arizona's 15 counties with 350 physicians and certified nurse-midwives, or approximately 80 percent of all AHCCCS maternity care providers, participating in the streamlined Baby Arizona application process.

AHCCCS' experience with outreach in connection with its Baby Arizona program has prepared it to successfully conduct outreach for the KidsCare Program. Baby Arizona will also be a vehicle for outreach activities. Mothers who have children who are ineligible for Medicaid but who may be eligible for KidsCare will be provided with an application for the program.

PREMIUM SHARING PILOT PROGRAM

In 1996, the legislature authorized funding for a Premium Sharing Pilot (PSP) program for the working poor, funded entirely with state funds and minimal monthly premiums assessed to the enrollee. The 1996 legislation was enacted to define the parameters of the program which is limited to persons who reside in one of the four counties chosen for the pilot. The program began delivering services on February 1, 1998. Applicants for the program can have household income up to 200 percent of FPL; persons who are chronically ill and who have been enrolled in the 100% state-funded MI/MN program for the previous 12 months, may have household income up to 400 percent of the FPL.

The PSP is administered by the Healthcare Group which offers health care coverage to over 19,000 employed individuals in Arizona. The three

contractors who participate in Healthcare Group provide the PSP coverage to persons who elect to enroll in the program.

The PSP program is funded with $60 million in state funds, $20 million for each year of the pilot. The funding is capped; therefore, if the cost of the program exceeds the available funding, enrollment will be suspended. As members disenroll, applicants will be enrolled from a waiting list on a first-come, first-served basis.

According to state law, targeted low income children who are apply for the PSP will be screened for KidsCare eligibility and, if eligible, will be provided with an application for the KidsCare Program.

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: ***(Section 2102)(a)(3)***

Arizona's primary goal in submitting this State Plan is to increase the number of uninsured, targeted low income children who receive health care services. In order to ensure that this program is targeted to low income, uninsured children, the state will maximize all existing health care resources by identifying, referring and enrolling children who are not eligible for KidsCare into other publicly funded programs.. The steps Arizona will take to obtain creditable health care coverage are addressed in great detail in Section 5.2. Please refer to this section.

Section 3. General Contents of State Child Health Plan (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:*** **(Section 2102(a)(4))**

AHCCCS will administer the Title XXI KidsCare Program. The program will use Title XXI funding to provide targeted, low income children with a choice of one of the 12 prepaid, capitated AHCCCS health plans, one of the state employee HMOs who choose to participate in the KidsCare Program or the Indian Health Service or P.L. 638 tribal facilities who elect to participate in the program.

AHCCCS HEALTH PLANS

In partnership with AHCCCS, the AHCCCS health plans have been delivering quality, managed care services for many 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 will be eligible to participate in the KidsCare Program.

For the AHCCCS health plans, AHCCCS will amend the existing contracts which will enable KidsCare eligible children to enroll with one of the AHCCCS health plans. The contract amendments will specify the terms and conditions of the KidsCare Program and the standards that must be adhered to by the health plans.

AHCCCS health plans have been very successful in assuring access to care. Over 80 percent of the 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 will be 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. Below 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 will set the rates based on an actuarial analysis.

AHCCCS monitors health plans through 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
Outreach efforts
Medical studies
Frequent meetings with contractors' executive management.

Commercial Carriers

As of October 1, 1998, the state will have contracts with four commercial HMOs who offer health insurance coverage to state employees. The HMOs are: Intergroup, PacifiCare, HealthPartners and CIGNA. Each of these entities is regulated by the Department of Insurance and has attained NCQA certification. Pursuant to state law, the HMOs may elect to participate in the KidsCare Program and must follow all of the requirements delineated in federal and state law, regulations and the State Plan for the KidsCare Program. Please see Attachment F for a description of the commercial HMOs.

The Department of Administration (DOA) is the responsible state agency which awards contracts to the HMOs for state employee health care coverage. The process to procure the HMOs includes a Request for Proposal and an evaluation performed by DOA. AHCCCS will coordinate with the DOA to establish the process whereby the commercial carriers can elect to participate in the KidsCare Program. AHCCCS will establish an actuarially sound rate that will be used to reimburse the health plans and the HMOs on a capitated basis with age and sex adjusted rates.

Before a commercial HMO can participate in the KidsCare Program, AHCCCS will perform a readiness review to ensure that the network is sufficient and all other requirements for the program have been met.

Other Intergovernmental Agreements

In addition to amending health plan contracts, AHCCCS will amend 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 new KidsCare population and to reimburse ADHS for services provided to KidsCare eligible special needs children who are also enrolled in the CRS program. The amendment with DES is necessary to direct foster children eligible for KidsCare to the Comprehensive Medical and Dental Program, which is the current health plan for foster care children.

Indian Health Services/638 Tribal Facilities

AHCCCS will also enable 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 the state employee HMOs.

Ten Percent Cap

In the first year of the program, AHCCCS will use Title XXI funding which is capped at 10% of the expenditures for the program for administrative costs and outreach activities. In 1999, Arizona will use some of the 10% funding for direct services provided by community health centers or hospitals which predominately serve low income children.

***3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children*: (Section 2102)(a)(4))**

AHCCCS has a managed care system which relies on many strategies to provide appropriate and medically necessary services. Children enrolled in the KidsCare Program will have a choice to enroll with any of the available contractors in their Geographic Service Area and will also have the right to choose a primary care provider (PCP) from the available practitioners. The PCP is contractually responsible for coordinating the care of members and approving referrals for medically necessary specialty services.

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

Contractors must have a 24-hour telephone number staffed by health care professionals who advise members about the appropriate use of the emergency room and how to use urgent care centers.

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

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

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

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

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

4.1.2. ☒ **Age**: KidsCare is available to children under 19 years of age. A child reaches age 19 the day before the anniversary of the date of birth. Coverage will continue through the month in which the child turns age 19.

4.1.3. ☒ **Income**: The combined gross income of the family household members may not exceed 150% of the FPL for state fiscal year 1999, 175% of the FPL for the state fiscal year 2000, and 200% of the FPL for state fiscal year 2001 through 2007. As required by HCFA, certain payments and grants as specified at 20 CFR Part 416, the Appendix to Subpart K, will be excluded when determining gross income.

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

4.1.4. ☐ **Resources (including any standards relating to spend-downs and disposition of resources)**. No resource test.

4.1.5. ☒ **Residency**: Arizona residency is required. An Arizona resident is a person who currently lives in Arizona and intends to remain in the state indefinitely. A signature on the application will be required declaring that the family lives in Arizona.

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

4.1.7. ☒ **Access to or coverage under other health coverage:** A child will not be 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 six months and the health insurance coverage was terminated for a reason other than involuntary loss of employment. This exclusion does not apply to newborns or to persons with group health insurance who resigned from employment to avoid termination of employment.

4.1.8. ☒ **Duration of eligibility:**

AHCCCS will complete an eligibility determination for KidsCare applications no later than 30 days from the date of receipt of a signed, completed application in an AHCCCS eligibility office. Every effort will be made by the agency to make an eligibility determination within seven calendar days from the date the applicant or representative provides all information required to establish eligibility.

The agency will determine eligibility within the 30 day standard except in unusual circumstances. For example:

1. When the agency can not reach a decision because the applicant failed to provide required information or take required actions.
2. If a child appears to be Medicaid eligible and further verification is needed to make the Medicaid determination.

AHCCCS will document the reasons for the delay in the applicant's case record.

Applicants will be given ten calendar days to provide any information necessary to enable AHCCCS to determine the applicant's eligibility. A notice will be provided to the applicant or

the representative outlining the information required and the time frame for providing the information.

Management reports will track all pending applications and the date that the application was received. These management reports will be continually monitored to ensure that action is timely on all pending applications.

All applications will be registered in the automated tracking system within 24-hours of the date of receipt by AHCCCS.

For eligibility determinations completed by the 25th day of the month, KidsCare eligibility will begin 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 will be eligible for the program the first day of the second month following the determination of eligibility.

A child who has been determined eligible for KidsCare will be guaranteed an initial 12 months of continuous coverage unless the child:

- 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 be ineligible at time of approval.
- Obtains private or group health insurance.
- Is adopted and no longer qualifies for KidsCare.

AHCCCS will redetermine eligibility annually based on the same criteria which was used in the initial determination of eligibility. Continuing eligibility after the initial 12-month guaranteed period will be for a 12-month period unless the member no longer meets the KidsCare eligibility criteria. If AHCCCS determines that the child no longer meets the eligibility criteria, or the child, parent or legal guardian fails to respond or cooperate with the redetermination of eligibility, coverage will be terminated. AHCCCS will send reminder letters to the child, parent or legal

guardian about the impending redetermination. In addition, follow-up phone calls will be made to those households who do not respond to the reminder letters.

4.1.9. ☒ **Other standards (identify and describe):**

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

Assignment of Rights. A child's parent or any individual who has the legal authority to execute assignment of payments for medical care from any first or third party, must make the assignment to AHCCCS.

Social Security Number. The application for KidsCare will be a joint application for Medicaid and KidsCare. AHCCCS will request a Social Security Number on the KidsCare application but will 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 will deny 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))

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

4.2.2. ☒ When the gross income levels increase to 175% and 200% of the FPL in the state fiscal years 2000 and 2001, AHCCCS will continue to conduct outreach to all potentially eligible families, including those with children whose income is below 150% of the FPL. Secondly, if the DES denies children for TANF or other Medicaid-MAO groups or 1931 related groups due to income, these children will be screened for KidsCare eligibility.

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

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

The following describes the methods of establishing and continuing eligibility and enrollment.

The child, a family member or legal guardian, will fill out a simple short form application which will be submitted to AHCCCS. If assistance with the application is needed, appropriate personnel will assist the applicant. The short form will also serve as an application for Medicaid. A supplement to the application may be used to obtain additional information necessary to determine Medicaid eligibility if it appears that the child may be eligible for Medicaid. In these instances, specific information may be needed (e.g. resources, proof of deprivation) which is not included on the KidsCare application. AHCCCS will provide assistance in completing the application as needed, both in person and by telephone. The family will submit verification of income and proof of citizenship, or qualified alien status and date of entry, if born outside of the United States.

A newborn of a mother who is eligible and enrolled in the KidsCare Program will be approved for KidsCare coverage unless the newborn is eligible for Medicaid. The newborn's KidsCare will begin with the newborn's date of birth. Prior to approval, the mother will be contacted by telephone to reverify household composition and monthly income. Once approved for KidsCare, the newborn will be enrolled with the mother's provider of care. The mother will be notified by mail of the newborn's enrollment into KidsCare and will be given an opportunity to change providers.

If a member of a family is enrolled in KidsCare and another child is born to the family, the newborn will enrolled in KidsCare if the family income meets the KidsCare criteria. Eligibility will be prospective on the same basis as the preceding paragraph. The same process will apply to a child who may be reunited with a family.

The child, family member, or legal guardian will be given information about the different providers who are available to provide KidsCare services. The KidsCare providers are:

- AHCCCS health plans, which includes CMDP.
- Any of the state employee HMOs who elect to participate.
- For Native Americans, any of the above or the Indian Health Service or a 638 tribal facility.

Applicants must choose a contractor or the IHS before enrollment into the KidsCare Program. In addition, children eligible for KidsCare can elect to receive

direct services from community health centers which will be funded with 100 percent state funds and not Title XXI funds. At a later time, if the child, parent or legal guardian who selected a community health center wants services from a KidsCare contractor, the child will be allowed to enroll with a contractor and receive all KidsCare services. Beginning October 1, 1999, the state will use a portion of the 10% Title XXI funds for direct services. In the Year 2000, the state may request a waiver of the 10% limitation in order to use more funds for direct services.

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

The applicant must enter their choice of a provider on the application. Once the application is approved, the applicant will be enrolled with their chosen provider and a notice confirming the choice and a member identification card will be sent to the member. Following enrollment, the contractor will provide a member handbook to the member which contains important information about how to access health care for KidsCare eligible children.

In order to qualify for the KidsCare Program, applicants must permit AHCCCS to release personal and financial information from the application and supporting documents to the DES to determine eligibility for Medicaid, if applicable.

AHCCCS will perform automated system database checks to verify that a child is not covered by Medicaid. The application will include questions concerning other health insurance coverage. A declaration on the application will be accepted confirming that there is no other health insurance coverage. Eligibility workers will review each application and determine if all eligibility factors are met. Information that is missing will be requested in person, by phone or by mail.

AHCCCS will publish 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.

A member will be 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 will be based on the member's anniversary date which will be 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, will be included. The member, or parent of the child, will have

three weeks to change contractors. If a change is requested, the effective date is a year from the anniversary date. Enrollees must notify AHCCCS of a change in address or other circumstances that could affect continued eligibility or enrollment.

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

4.4. Describe the procedures that assure:

4.4.1. Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))

AHCCCS will ensure that a child who is not eligible for Medicaid or other creditable coverage, but who meets KidsCare eligibility criteria, is enrolled in KidsCare. AHCCCS will administer both the Medicaid and KidsCare Program. Records of KidsCare eligibility will be maintained in a data base that is also used for Medicaid eligibility. The data base will be checked for current Medicaid eligibility before determining KidsCare eligibility. Medicaid eligibility will always override KidsCare eligibility.

A family member, legal representative or the child will be required to report changes in employer insurance coverage or eligibility for group health insurance or other creditable insurance.

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

AHCCCS will administer both Medicaid and the KidsCare Program and will ensure that any child eligible for Medicaid is enrolled in Medicaid. The application form used for KidsCare will initiate an application for Medicaid which will be determined simultaneously. As mentioned above, Medicaid eligibility will always override KidsCare eligibility.

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

The application process will request information about group health plan coverage within the past six months. If a child is covered by group health insurance or was covered and the coverage was voluntarily discontinued in the past six months, the child will not be eligible for KidsCare. Exceptions to the six month bare provision will be granted if the coverage was dropped due to involuntary loss of employment, for newborns and for persons who are transitioning from the Premium Sharing Program, Medicaid or the state-funded programs. Involuntary loss of employment includes situations where a person resigns from employment to avoid termination of employment.

An eligibility worker will review the application and ask the parent or responsible party to make a declaration whether the family member or an employer has discontinued employer-sponsored dependent insurance coverage in order to allow a child to participate in the KidsCare Program.

4.4.4. ***The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))***

Meetings to discuss the KidsCare Program and outreach strategies have been and will 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. AHCCCS has held subsequent meetings with the tribes to discuss outreach strategies designed to enroll eligible Native American children into KidsCare. 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 will be available at IHS and appropriate tribal locations. AHCCCS will also use 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 KidsCare application, training will be provided by AHCCCS.

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

4.4.5. ***Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))***

Please refer to Section 2.2.

Section 5. Outreach and Coordination (Section 2102(c))

5.1 Describe the procedures used by the state to accomplish outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program:

Arizona is designing an outreach program which will 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 outreach and coordination procedures as required by Title XXI.

The Governor's Outreach Work Group, with representatives from the following agencies/organizations, has met several times to develop a comprehensive outreach 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

Prior to the implementation of the KidsCare Program, the Governor will designate an Arizona KidsCare day. This announcement will be the kick-off for the KidsCare campaign. The campaign will involve a private and public partnership to increase awareness of the KidsCare Program.

The Governor's Office and AHCCCS are working 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 Sections 4.4.4 and 5.2 for a description of the Native American Outreach activities.

AHCCCS has established an Outreach Coordinator position to assume major responsibility for KidsCare outreach activities. The Coordinator will ensure that coordinated outreach efforts will include Medicaid, state-only funded programs such as the Premium Sharing Pilot, and the KidsCare Program. In addition, AHCCCS is working with community agencies/organizations to develop and implement a KidsCare outreach strategy. The Outreach Coordinator will facilitate and coordinate a KidsCare coalition to assist AHCCCS with outreach strategies.

Outreach will include awareness methods proven successful for other child-related programs (e.g., Baby Arizona, Maternal Child Health Block Grants and Women, Infants and Children Program [WIC]). Outreach efforts and the distribution of applications will be targeted to those agencies, organizations and other entities who currently serve targeted low income children. These awareness efforts will 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
State Education Association
Subsidized Housing Agencies

Tribal health care and social service programs
YMCA/YWCA.

AHCCCS, and other interested parties, will develop outreach strategies and materials in English and Spanish. The state will use numerous methods to reach families of children likely to be eligible for the KidsCare Program, including:

Radio
Television advertisement
Brochures
Flyers
Video
Toll-free hotline number
Presentations throughout the state

In addition to the traditional safety net provider identified above, outreach materials will be distributed through:

AHCCCS participating doctors (approximately 80 percent of all physicians in Arizona)
Churches
Community centers
Day care centers
Grocery stores
Other medical providers
Public health offices
Schools
Other appropriate locations

Outreach will be conducted through cooperative arrangements with other state, county and city agencies and programs which conduct outreach programs in rural and inner-city areas.

The outreach campaign will inform families about the availability of the KidsCare Program, provide basic information about KidsCare and instruct families about how and where to apply for the program. Information about Medicaid and the state-funded programs will be included in the outreach campaign.

Organizations distributing the applications and information about KidsCare will be offered training to assist with completing the application form and collecting information when necessary.

An applicant will also receive assistance to complete the application form by calling the AHCCCS 24-hour toll-free number. Applications may be mailed to the AHCCCS KidsCare Unit.

To specifically target low income children of migrant workers, the Arizona Interagency Farmworkers Coalition has agreed to include information about KidsCare in their newsletters and has requested a KidsCare presentation by AHCCCS at their executive board meeting. The Coalition has relationships with a number of the prominent growers in the state who employ farmworkers. Through the Coalition, AHCCCS will explore distributing KidsCare and Medicaid outreach materials with paychecks distributed 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 outreach campaign.

As a part of the simplified mail in application process, an applicant may call into an 800 hotline number 24 hours a day, 7 days a week. AHCCCS is committed to using culturally sensitive staff and bilingual staff for the outreach programs. The applicant may speak with an AHCCCS staff person who will:

- Explain the application process, including those items which will require verification.

- Explain enrollment and advise the applicant, or parent, that the contractor or direct service provider must be chosen before the application can be approved.

- 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.

The applicant can mail the completed application to the AHCCCS KidsCare Unit for the eligibility determination. AHCCCS will track the distribution and disposition of all applications and modify outreach efforts as needed.

Based on the Outreach Work Group meetings held to date, there are several organizations, agencies and provider offices who have staff who will help applicants complete the application. AHCCCS will provide training for these staff members.

In addition to other outreach efforts, a mailing of outreach material will be sent to:

- Current AHCCCS eligible households with older, currently ineligible children
- Families denied Medicaid coverage due to excess income or resources
- Children older than the S.O.B.R.A. age
- State-only applicants denied MI/MN coverage for excess income or resources
- Previously eligible AHCCCS households with children
- Current WIC and Medical Home Project recipients

5.2. Describe how children who are determined to be eligible for Medicaid or another state - only children's health insurance program will be referred to and enrolled into that program.

Section 2.2.1 and Attachment C outline the Medicaid and state-only funded programs available in Arizona. Section 2 describes the coordination efforts between Medicaid and state-only programs after the implementation of KidsCare.

In addition, an explanation of the AHCCCS eligibility hierarchy for the primary eligibility groups, including KidsCare, is contained in Attachment J. This Attachment contains a chart displaying the hierarchy and income limits of the eligibility groups and gives examples. Please note that most of the MI/MN, EAC and ELIC eligible children under the age of 19 will be covered under the KidsCare Program. The exception will be if a child who has family income above the income thresholds for KidsCare but who qualifies for the MI/MN program by using medical bills to spend-down income.

COORDINATION WITH MEDICAID

A newly developed, simplified joint application will capture sufficient information to allow an eligibility determination for KidsCare and Medicaid. Each KidsCare application will be screened for Medicaid eligibility. It is anticipated that Arizona's Medicaid population will increase due to a "woodwork effect" that may be created by increased outreach efforts.

1931 Group

The AHCCCS Prepaid Medical Management Information System (PMMIS) automated system will capture the eligibility data on both Medicaid and the KidsCare Program. If a child appears to meet Medicaid eligibility criteria, such as the 1931 group, a copy of the application and all obtained verification will be forwarded to the DES for an expedited review and eligibility determination. A face-to-face interview will not be necessary if the applicant has provided all necessary information. AHCCCS will establish a process to expedite the Medicaid eligibility determination. In the interim period prior to a determination of Medicaid eligibility, AHCCCS will enroll the child into KidsCare. If the child is Medicaid eligible, Medicaid funding, rather than KidsCare funding, will be claimed back to the date of Medicaid eligibility.

S.O.B.R.A.

If a KidsCare eligibility worker determines that a child meets the S.O.B.R.A. poverty level program criteria, AHCCCS has an agreement with the DES to directly input the member data into their automated Arizona Technical Eligibility Computer System (AZTECS). The system will automatically determine eligibility and transmit the eligibility and member demographic information (host to host) to the AHCCCS PMMIS data base and the child will be immediately enrolled with a contractor. AHCCCS will establish a process to expedite the Medicaid eligibility determination. In the interim period prior to a determination of Medicaid eligibility, AHCCCS will enroll the child into KidsCare. If the child is Medicaid eligible, Medicaid funding, rather than KidsCare funding, will be claimed back to the date of Medicaid eligibility.

SSI Cash and SSI-MAO

KidsCare applications will be screened for potential eligibility for SSI cash or SSI-MAO eligibility. A child potentially eligible for SSI cash will be referred to the Social Security Administration to apply for SSI-Cash. In the interim, the KidsCare application will be referred to the AHCCCS SSI-MAO eligibility unit, located in the same building, to contact the family and obtain any additional information required such as resources and disability verification.

AHCCCS will establish a process to expedite the Medicaid eligibility determination. In the interim period prior to a determination of Medicaid eligibility, AHCCCS will enroll the child into KidsCare. However, if the child is subsequently determined SSI-Cash or SSI-MAO eligible, the AHCCCS automated system, PMMIS, will automatically override the KidsCare eligibility with Medicaid eligibility. Medicaid funding, rather than KidsCare funding, will be claimed back to the effective date of Medicaid eligibility for any overlapping eligibility period.

Federal Emergency Services

If the child does not meet the citizenship/qualified alien requirement, the child will be considered for eligibility in the Medicaid Federal Emergency Services.

COORDINATION WITH STATE FUNDED GROUPS

MI/MN, ELIC and EAC

It is unlikely that a child applying for the KidsCare Program will be eligible for a state-funded program. This is because income thresholds for the state-funded programs are lower than KidsCare income thresholds (e.g. 40 percent of the FPL for MI/MN and 100 percent FPL for EAC or ELIC). The only likely scenario would be if the family income was too high for KidsCare but the family had large

medical bills enabling them to spend-down into the state-funded Medically Needy program. In this case, the family would be referred to the appropriate county eligibility office.

All eligibility agencies, AHCCCS, the DES and the counties will work together to ensure that all eligible low-income children are determined eligible under the most appropriate program. Children who are enrolled in one of the state-funded groups and who are eligible for KidsCare will be converted to the KidsCare Program.

STATE EMERGENCY SERVICES (SES)

All undocumented children, qualified or non-qualified, who entered the country after August 21, 1996, and who are ineligible for Medicaid or KidsCare will be screened and referred for SES coverage.

Describe how Medicaid eligibility workers will refer non-Medicaid eligible children to the new Children's Health Insurance Program.

1931 Group Referral

The DES determines eligibility for the 1931 groups, 1931 MAO-related categories and the S.O.B.R.A. groups. If, during the DES eligibility determination or redetermination process, it is determined that a child no longer qualifies for Medicaid due to income, resources, age for poverty level groups or other variables, the AZTECS system will evaluate the child for KidsCare eligibility and, if eligible, approve the child and transmit the Medicaid ineligibility and KidsCare eligibility to the AHCCCS PMMIS. The child will remain enrolled with the same contractor.

AHCCCS and DES will work closely together to make the eligibility process for the two programs as "seamless" as possible for the targeted population.

S.O.B.R.A. and State Funded Programs Referral

In Arizona, county eligibility staff also take applications for the S.O.B.R.A. programs and forward the applications to DES. Additionally, the counties will refer any other applicant who appears to be Medicaid eligible. If the child appears to be Title XXI eligible, the county eligibility staff will forward the state-funded program application to AHCCCS to enable a KidsCare eligibility worker to process the application. If the child is KidsCare eligible, this eligibility will take precedence over the 100% state-funded groups.

Other Health Insurance Programs

DES and county eligibility staff are outstationed in FQHCs, major hospitals, CRS offices, and clinics where the volume of children who may be eligible for Medicaid is high. These staff will also provide KidsCare applications and outreach materials. DES eligibility staff use the FQHCs as itinerant sites or are "on call" to go to the sites to take Medicaid applications as necessary.

Outreach materials related to KidsCare will be in all the current sites where Medicaid outreach materials are located. Refer to Section 5.1 for list of agencies/organizations where outreach materials will be distributed. In addition, AHCCCS will provide information and present the KidsCare Program to over 350 nurses and other health professionals at the Annual School Health Nursing Seminar from August 5 through 7, 1998.

The Baby Arizona Project described in Section 2.2.2 is the early identification and outreach for S.O.B.R.A. pregnant mothers. If the pregnant mother is ineligible for S.O.B.R.A. and has other children ineligible for S.O.B.R.A. due to income limits, the children will be screened automatically by DES for KidsCare eligibility.

KidsCare outreach materials will be available in the offices of physicians participating in the Baby Arizona Project. AHCCCS will work with the providers to encourage them to assist a family in completing the application.

In the first year of the program, KidsCare applicants can have gross family income up to 150% of FPL; in the second year income levels will be up to 175% of FPL and, in the third and subsequent years of the program, the income threshold will be raised to 200% of FPL. Children who have income in excess of the KidsCare income threshold will be referred to the Premium Sharing Program described in Section 2.2.2, or in the case of high medical bills, to the counties for a determination under the MN program.

AHCCCS and DES will coordinate with the Department of Juvenile Corrections to screen and take Medicaid applications for juveniles being released from correctional facilities before the child's release. The plan is to approve the child for health care coverage on the day of the child's release if the child meets appropriate eligibility criteria.

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.) Intergroup

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 least expensive state employees' HMO benefit package with the addition of dental and vision services. Please see Attachment K for a description of the benefits offered to state employees by Intergroup, which is the least expensive benefit package. Any limitations on the covered services are discussed in this section and will be delineated in the Office of the Medical Director's Policy Manual. The cost sharing requirements are specified in Section 8 of the State Plan.

The benchmark service package chosen by the state differs from the current AHCCCS package in two major areas: there will be no non-emergency transportation in the KidsCare Program and behavioral health services are limited to 30 days of inpatient services per year and 30 outpatient visits per year. Members who enroll in the KidsCare Program who select an AHCCCS health plan or one of the state employee HMOs, if any elect to participate in the program, will receive the following KidsCare services, subject to the limitations described below:

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 and are limited to 30 days per each 12 month period of eligibility. 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 behavioral health professional according to federal and state law.

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

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

Only psychiatrists, psychologists, psychiatric nurse practitioners may bill independently for behavioral health services. Other behavioral health professionals and behavioral health technicians shall be affiliated with a qualified agency, and services provided by these individuals 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 are limited to 30 days of inpatient care for each 12-month period of eligibility.

b. 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.

c. 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.

d. Partial care services are included as part of the inpatient benefit and are subject to the 30 day limitation for each 12-month period of eligibility. If partial care services are provided the benefit is as follows: each half day partial care service will equal one-quarter inpatient day; each full day partial care service will equal one-half inpatient day.

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. All outpatient behavioral health services are limited to 30 visits per 12-month period of eligibility.

b. 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.

c. 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. Eyeglasses are limited to one pair per each 12-month period of eligibility.

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

Disposable medical supplies include consumable items covered under Medicare that are not reusable.

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

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

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

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

A physician shall provide written certification of necessity of abortion.

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

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

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

Inpatient substance abuse treatment is limited to acute detoxification.

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

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

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

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

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

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

Therapy services are covered when necessary to prevent or ameliorate a condition, illness or injury, to prevent or correct abnormalities detected by screening or diagnostic procedures or to maintain a level of ability.

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

Hospice services for a terminally ill member.

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

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

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

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

Emergency ambulance transportation if a medically necessary emergency exists. Non-emergency medically necessary transportation is not covered.

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

All printed materials will be in English and Spanish. Outreach services will be available through AHCCCS, and others as specified in Sections 4.4.4 and 5.

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

1. Nursing facility services for a maximum of 90 days when the medical condition of the person indicates that nursing facility 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 or psychiatric nurse practitioners, all nonphysician behavioral health professional services shall be provided by professionals affiliated with an approved behavioral health setting in accordance with rules and AHCCCS policies and procedures.

5. Home health services
   a. Home health services when necessary to prevent re-hospitalization or institutionalization, and may include home health nursing services, therapies, personal care, medical supplies, equipment and appliances and home health aide services.
   b. Nursing service and home health aide if provided on an intermittent or part time basis by a home health agency. When no home health agency exists, nursing services may be provided by a registered nurse.
   c. Therapy services.

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

6.3. Waivers - Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it shall request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state shall address the following: **(Section 2105(c)(2) and(3))**

6.3.1. ☐ Cost Effective Alternatives. 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:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures shall 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))

6.3.1.2. The cost of such coverage shall 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))

6.3.1.3. The coverage shall 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(d)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii))

6.3.2. ☐ Purchase of Family Coverage. Describe the plan to provide 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))

6.3.2.1. 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))

6.3.2.2. 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))

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))

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

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

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. ☒ Performance measurement

AHCCCS will require contractors to meet the AHCCCS performance measures which were defined using HEDIS 3.0 as a guide. The indicators are included in the Quality Initiative Report which is submitted quarterly to HCFA (see Attachment L). 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 under age two who were continuously enrolled for 12 months and received recommended immunizations.
2. Annual Dental Exam	The percent of members age 3-19 with at least one dental visit in the reporting year.

Indicator Continued	Summary Description Continued
3. Well Child Visits Under 15 Months	The percent of children under the age of 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.

7.1.2. ☒ Quality standards

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

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

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

Each contractor will conduct one clinical study annually. The study shall be specific for children and may encompass such topics as management of children with asthma or otitis media.

AHCCCS will monitor compliance with quality assurance standards on an annual basis through an established process of operational and financial reviews for the Medicaid program. The reviews will be conducted by a review team comprised of AHCCCS staff and will be specific to the KidsCare Program. 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.

7.1.3. ☒ Information strategies

All contractors shall inform new members about services within ten days of enrollment. Information will include:

- Benefits of preventive care
- A complete description of services available
- How to obtain these services and assistance with scheduling of appointments
- A statement that there is no copayment or charge for certain services

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

7.1.4. ☒ Quality improvement strategies

AHCCCS began a Quality Improvement Initiative in 1995 designed to use encounter data to monitor quality and to test new concepts of quality of care based on many of the recommendations for measurement from the Quality Assurance Reform Initiative (QARI) and HEDIS 3.0. The major components of the Initiative include:

Performance Measures as listed in subsection 7.1.1.

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, both the Quality Improvement System for Managed Care (QISMC) and the Consumer Assessment of Health Plans Survey (CAHPS) data may be incorporated into the Quality Improvement Initiative, as well as any new reporting requirements which may be developed.

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))

AHCCCS will require all contractors to have sufficient provider capacity to absorb the additional KidsCare enrollment. Currently, all rural AHCCCS members have a choice of at least two contractors, except in Apache and Navajo counties where enrollment is capped for one of the two contractors. Members may choose from six contractors in Maricopa County (Phoenix) and four in Pima County (Tucson). It is also possible that additional contractors will be approved for the KidsCare Program.

Contractors are required to meet the AHCCCS contractual standards for network capacity for primary care providers (PCPs). The contractor's number of enrolled members to a full-time equivalent PCP shall not exceed a ratio of 1:1200 for children 12 and younger and 1:1800 for children over 12. If the PCP contracts with more than one contractor, the ratio shall be adjusted by the contractor to ensure that the total number of KidsCare and Medicaid members assigned to a PCP does not exceed the above ratio.

Contractors shall 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. The contractor will also monitor the adequacy, accessibility and availability of the provider network and provide encounter data in a form specified by AHCCCS.

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

Contractors will 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 operational and financial reviews, will monitor contractor compliance with these quality standards.

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?

8.1.1. ☒ **YES**
8.1.2. ☐ **NO, skip to question 8.5.**

8.2. Describe the amount of cost-sharing and any sliding scale based on income: (Section 2103(e)(1)(A))

8.2.1. Premiums:

The state will submit an amendment to the approved State Plan requesting permission to impose monthly premiums for members with income above 150% of the FPL beginning July 1, 1999. The copayments and premiums will not exceed 5 percent of the family's gross income.

8.2.2. Deductibles: Not applicable

8.2.3. Coinsurance: Not applicable

8.2.4. Other: Copayments

AHCCCS will use the same copayments and procedures which have been approved for the Medicaid program. The following copayments will be assessed for all members who are eligible for KidsCare (see Attachment M):

$1 for each physician visit, laboratory and x-ray procedure
$5 for non-emergency surgery
$5 for non-emergency use of the emergency room.

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

Information about cost-sharing will be included in the outreach application materials and KidsCare contractors will provide information on copayment requirements in the Member Handbook.

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

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

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

8.4.3 ☐ **No child in a family with income less than 150% of the FPL will incur cost-sharing that is not permitted under 1916(b)(1).**

AHCCCS will impose copayments in conformance with the approved 1115 Research and Demonstration Waiver.

8.4.4. ☒ **No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))**

8.4.5. ☒ **No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5)**

8.4.6. ☒ **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))**

8.4.7. ☒ **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)).**

8.4.8. ☒ **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))**

8.4.9. ☒ **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 in section 8.4.8, above). (Section 2105)(c)(7)(A))**

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 annual income for the year involved: (Section 2103(e)(3)(B))**

This information will be submitted in an amendment to the State Plan. Premiums will not be assessed until July 1, 1999. Due to the nominal amount of the copayments, the five percent cap will not be an issue in the first year of the program.

8.6. **The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:**

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

8.6.2. ☐ **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 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:**

Section 9. Strategic Objectives and Performance Goals for the 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))

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))

- 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.
- Improve the number of KidsCare eligible children who receive preventive and primary care by meeting the goals below:

  1. 80% percent of children under two will receive age appropriate immunizations
  2. 60% percent of children under 15 months will receive the recommended number of well child visits
  3. 60% percent of three, four, five, and six year olds will have at least one well-child visit during the year
  4. 50% percent of children will have at least one dental visit during the year

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

  1. 100% of enrolled children will be assigned a PCP

2. 70% of KidsCare children will see a PCP at least once during the first 12 months of enrollment.

- Screen 100% of applications to determine if the child was covered by employer sponsored insurance within the last six months.

- Coordinate with other health care programs providing services to children to ensure a seamless system of coverage.

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))

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

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

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

AHCCCS will report comparable quality indicators for KidsCare. This will be a separate report from the reports submitted for Medicaid.

9.3.8. ☐ Performance measures for special targeted populations.

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

9.5. ☒The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (see Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))

Annual Reports

AHCCCS will perform the annual assessments and evaluations required in Section 10.1. The annual report will include an assessment and update on the operation of the KidsCare Program, including the increase in the percentage of Medicaid eligible children enrolled in Medicaid and the reduction in the percentage of uninsured children. The baseline number of uninsured children will be calculated from CPS data.

As addressed in Section 7.1.2, 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. These reviews will be distinct from the Medicaid reviews.

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

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

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

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

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

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

9.8.4. ☒ **Section 1115 (relating to waiver authority)**

AHCCCS has an 1115 Research and Demonstration Waiver

9.8.5. ☒ **Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI**

9.8.6. ☒ **Section 1124 (relating to disclosure of ownership and related information)**

9.8.7. ☒ **Section 1126 (relating to disclosure of information about certain convicted individuals)**

9.8.8. ☒ **Section 1128A (relating to civil monetary penalties)**

9.8.9. ☒ **Section 1128B(d) (relating to criminal penalties for certain additional charges)**

9.8.10. ☒ **Section 1132 (relating to periods within which claims shall 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))**

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. The Attachment does not include the many questions which were asked and answered.

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

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

The legislation also established a Joint Legislative Study Committee on the Integration of Health Care Services which will report on how best to integrate and maximize services for children in this state.

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 the 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).

The Governor's Office and AHCCCS have made numerous presentations to the community on the KidsCare Program (see Attachment R).

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

See Attachment S for the KidsCare budget. The state share of the program will be funded with monies from the Tobacco Tax Fund.

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))

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

10.1.2. ☒ Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

10.2. ☒ State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))

10.2.1. ☒ An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. ☒ A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1. ☒ The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

10.2.2.2. ☒ The quality of health coverage provided including the types of benefits provided;

10.2.2.3. ☒ The amount and level (including payment of part or all of any premium) of assistance provided by the state;

10.2.2.4. ☒ The service area of the state plan;

10.2.2.5. ☒ The time limits for coverage of a child under the state plan;

10.2.2.6. ☒ **The state's choice of health benefits coverage and other methods used for providing child health assistance, and**

10.2.2.7. ☒ **The sources of non-Federal funding used in the state plan.**

10.2.3. ☒ **An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.**

10.2.4. ☒ **A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.**

10.2.5. ☒ **An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.**

10.2.6. ☒ **A description of any plans the state has for improving the availability of health insurance and health care for children.**

10.2.7. ☒ **Recommendations for improving the program under this Title.**

10.2.8. ☒ **Any other matters the state and the Secretary consider appropriate.**

10.3. ☒ **The state assures it will comply with future reporting requirements as they are developed.**

10.4. ☒ **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.**

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. <u>Qualifying community health centers; contracts; requirements; definition</u>

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.

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

1 SCALE MEDICAL AND HEALTH CARE SERVICES FROM QUALIFYING HEALTH CENTERS
2 PURSUANT TO SECTION 36-2907.06, SUBSECTION G, AND FROM HOSPITALS PURSUANT TO
3 SECTION 36-2907.08. AN ELIGIBLE CHILD, OR THAT CHILD'S PARENT OR GUARDIAN,
4 WHO ELECTS DIRECT SERVICES SHALL NOT BE ENROLLED WITH A QUALIFYING PLAN
5 UNLESS THE CHILD, OR THAT CHILD'S PARENT OR GUARDIAN, ELECTS TO RECEIVE
6 SERVICES PURSUANT TO THIS ARTICLE.
7 G. ELIGIBILITY FOR THE PROGRAM SHALL BE COUNTED AS CREDITABLE COVERAGE
8 AS DEFINED IN SECTION 20-1379.
9 H. ON APPLICATION FOR ELIGIBILITY FOR THE PROGRAM, THE MEMBER, OR IF
10 THE MEMBER IS A MINOR, THE MEMBER'S PARENT OR GUARDIAN, SHALL RECEIVE AN
11 APPLICATION FOR AND A PROGRAM DESCRIPTION OF THE PREMIUM SHARING
12 DEMONSTRATION PROJECT IF THE MEMBER RESIDES IN A COUNTY CHOSEN TO PARTICIPATE
13 IN THAT PROJECT.
14 I. NOTWITHSTANDING SECTION 36-2983, THE ADMINISTRATION MAY PURCHASE
15 FOR A MEMBER EMPLOYER SPONSORED GROUP HEALTH INSURANCE WITH STATE AND FEDERAL
16 MONIES AVAILABLE PURSUANT TO THIS ARTICLE, SUBJECT TO ANY RESTRICTIONS
17 IMPOSED BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION. THIS SUBSECTION
18 DOES NOT APPLY TO MEMBERS WHO ARE ELIGIBLE FOR HEALTH BENEFITS COVERAGE UNDER
19 A STATE HEALTH BENEFITS PLAN BASED ON A FAMILY MEMBER'S EMPLOYMENT WITH A
20 PUBLIC AGENCY IN THIS STATE.
21 36-2983. Eligibility for the program
22 A. THE ADMINISTRATION SHALL ESTABLISH A STREAMLINED ELIGIBILITY
23 PROCESS FOR APPLICANTS TO THE PROGRAM AND SHALL ISSUE A CERTIFICATE OF
24 ELIGIBILITY AT THE TIME ELIGIBILITY FOR THE PROGRAM IS DETERMINED.
25 ELIGIBILITY SHALL BE BASED ON GROSS HOUSEHOLD INCOME FOR A MEMBER AS DEFINED
26 IN SECTION 36-2981. THE ADMINISTRATION SHALL NOT APPLY A RESOURCE TEST IN
27 THE ELIGIBILITY DETERMINATION OR REDETERMINATION PROCESS.
28 B. THE ADMINISTRATION SHALL USE A SIMPLIFIED ELIGIBILITY FORM THAT MAY
29 BE MAILED TO THE ADMINISTRATION. ONCE A COMPLETED APPLICATION IS RECEIVED,
30 INCLUDING ADEQUATE VERIFICATION OF INCOME, THE ADMINISTRATION SHALL EXPEDITE
31 THE ELIGIBILITY DETERMINATION AND ENROLLMENT ON A PROSPECTIVE BASIS.
32 C. THE DATE OF ELIGIBILITY IS THE FIRST DAY OF THE MONTH FOLLOWING A
33 DETERMINATION OF ELIGIBILITY IF THE DECISION IS MADE BY THE TWENTY-FIFTH DAY
34 OF THE MONTH. A PERSON WHO IS DETERMINED ELIGIBLE FOR THE PROGRAM AFTER THE
35 TWENTY-FIFTH DAY OF THE MONTH IS ELIGIBLE FOR THE PROGRAM THE FIRST DAY OF
36 THE SECOND MONTH FOLLOWING THE DETERMINATION OF ELIGIBILITY.
37 D. AN APPLICANT FOR THE PROGRAM MUST HAVE A SOCIAL SECURITY NUMBER OR
38 SHALL APPLY FOR A SOCIAL SECURITY NUMBER WITHIN THIRTY DAYS AFTER THE
39 APPLICANT SUBMITS AN APPLICATION FOR THE PROGRAM.
40 E. IN ORDER TO BE ELIGIBLE FOR THE PROGRAM, A PERSON SHALL BE A
41 RESIDENT OF THIS STATE AND SHALL MEET TITLE XIX REQUIREMENTS FOR UNITED
42 STATES CITIZENSHIP OR QUALIFIED ALIEN STATUS IN THE MANNER PRESCRIBED IN
43 SECTION 36-2903.03.

1 F. IN DETERMINING THE ELIGIBILITY FOR ALL QUALIFIED ALIENS PURSUANT
2 TO THIS ARTICLE, THE INCOME AND RESOURCES OF A PERSON WHO EXECUTED AN
3 AFFIDAVIT OF SUPPORT PURSUANT TO SECTION 213A OF THE IMMIGRATION AND
4 NATIONALITY ACT ON BEHALF OF THE QUALIFIED ALIEN AND THE INCOME AND RESOURCES
5 OF THE SPOUSE, IF ANY, OF THE SPONSORING INDIVIDUAL SHALL BE COUNTED AT THE
6 TIME OF APPLICATION AND FOR THE REDETERMINATION OF ELIGIBILITY FOR THE
7 DURATION OF THE ATTRIBUTION PERIOD AS SPECIFIED IN FEDERAL LAW.
8 G. PURSUANT TO FEDERAL LAW, A PERSON IS NOT ELIGIBLE FOR THE PROGRAM
9 IF THAT PERSON IS:
10 1. ELIGIBLE FOR TITLE XIX OR OTHER FEDERALLY OPERATED OR FINANCED
11 HEALTH CARE INSURANCE PROGRAMS, EXCEPT THE INDIAN HEALTH SERVICE.
12 2. COVERED BY ANY GROUP HEALTH PLAN OR OTHER HEALTH INSURANCE COVERAGE
13 AS DEFINED IN SECTION 2791 OF THE PUBLIC HEALTH SERVICE ACT. GROUP HEALTH
14 PLAN OR OTHER HEALTH INSURANCE COVERAGE DOES NOT INCLUDE COVERAGE TO PERSONS
15 WHO ARE DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 4,
16 SUBDIVISION (a), (c) OR (h) OR THE PREMIUM SHARING PROGRAM.
17 3. A MEMBER OF A FAMILY THAT IS ELIGIBLE FOR HEALTH BENEFITS COVERAGE
18 UNDER A STATE HEALTH BENEFIT PLAN BASED ON A FAMILY MEMBER'S EMPLOYMENT WITH
19 A PUBLIC AGENCY IN THIS STATE.
20 4. AN INMATE OF A PUBLIC INSTITUTION OR A PATIENT IN AN INSTITUTION
21 FOR MENTAL DISEASES. THIS PARAGRAPH DOES NOT APPLY TO SERVICES FURNISHED IN
22 A STATE OPERATED MENTAL HOSPITAL OR TO RESIDENTIAL OR OTHER TWENTY-FOUR HOUR
23 THERAPEUTICALLY PLANNED STRUCTURED SERVICES.
24 H. A CHILD WHO IS COVERED UNDER AN EMPLOYER'S GROUP HEALTH INSURANCE
25 PLAN OR THROUGH FAMILY OR INDIVIDUAL HEALTH CARE COVERAGE SHALL NOT BE
26 ENROLLED IN THE PROGRAM. IF THE HEALTH INSURANCE COVERAGE IS DISCONTINUED
27 FOR ANY REASON, EXCEPT FOR THE LOSS OF HEALTH INSURANCE DUE TO LOSS OF
28 EMPLOYMENT, THE CHILD IS NOT ELIGIBLE FOR THE PROGRAM FOR A PERIOD OF SIX
29 MONTHS FROM THE DATE THAT THE HEALTH CARE COVERAGE WAS DISCONTINUED.
30 I. PURSUANT TO FEDERAL LAW, A PRIVATE INSURER, AS DEFINED BY THE
31 SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SHALL
32 NOT LIMIT ENROLLMENT BY CONTRACT OR ANY OTHER MEANS BASED ON THE PRESUMPTION
33 THAT A CHILD MAY BE ELIGIBLE FOR THE PROGRAM.
34 36-2984. Family coverage; payment of premiums; creditable
35 coverage
36 A. THE CONTRACTORS SHALL OFFER HEALTH INSURANCE COVERAGE TO THE PARENT
37 OR LEGAL GUARDIAN OF A CHILD WHO IS ELIGIBLE FOR THE PROGRAM. THE
38 CONTRACTORS SHALL ESTABLISH RATES THAT ARE APPROVED BY THE ADMINISTRATION.
39 THE CONTRACTORS SHALL INCLUDE PROVISIONS FOR PREEXISTING CONDITIONS AND ANY
40 OTHER MEDICAL UNDERWRITING CONSIDERATIONS THAT ARE NECESSARY TO PROTECT THE
41 CONTRACTORS FROM ADVERSE RISK.
42 B. A PARENT OR LEGAL GUARDIAN WHO SELECTS COVERAGE PURSUANT TO
43 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 7. DEVELOPMENT OF AN OUTREACH PROGRAM. THE ADMINISTRATION SHALL
2 COORDINATE WITH PUBLIC AND PRIVATE ENTITIES TO PROVIDE OUTREACH SERVICES FOR
3 CHILDREN UNDER THIS ARTICLE. PRIORITY SHALL BE GIVEN TO THOSE FAMILIES WHO
4 ARE MOVING OFF WELFARE. OUTREACH ACTIVITIES SHALL INCLUDE STRATEGIES TO
5 INFORM COMMUNITIES, INCLUDING TRIBAL COMMUNITIES, ABOUT THE PROGRAM, ENSURE
6 A WIDE DISTRIBUTION OF APPLICATIONS AND PROVIDE TRAINING FOR OTHER ENTITIES
7 TO ASSIST WITH THE APPLICATION PROCESS.
8 8. COORDINATION OF BENEFITS PROVIDED UNDER THIS ARTICLE FOR ANY
9 MEMBER. THE DIRECTOR MAY REQUIRE THAT CONTRACTORS AND NONCONTRACTING
10 PROVIDERS ARE RESPONSIBLE FOR THE COORDINATION OF BENEFITS FOR SERVICES
11 PROVIDED UNDER THIS ARTICLE. REQUIREMENTS FOR COORDINATION OF BENEFITS BY
12 NONCONTRACTING PROVIDERS UNDER THIS SECTION ARE LIMITED TO COORDINATION WITH
13 STANDARD HEALTH INSURANCE AND DISABILITY INSURANCE POLICIES AND SIMILAR
14 PROGRAMS FOR HEALTH COVERAGE. THE DIRECTOR MAY REQUIRE MEMBERS TO ASSIGN TO
15 THE ADMINISTRATION RIGHTS TO ALL TYPES OF MEDICAL BENEFITS TO WHICH THE
16 PERSON IS ENTITLED, INCLUDING FIRST PARTY MEDICAL BENEFITS UNDER AUTOMOBILE
17 INSURANCE POLICIES. THE STATE HAS A RIGHT OF SUBROGATION AGAINST ANY OTHER
18 PERSON OR FIRM TO ENFORCE THE ASSIGNMENT OF MEDICAL BENEFITS. THE PROVISIONS
19 OF THIS PARAGRAPH ARE CONTROLLING OVER THE PROVISIONS OF ANY INSURANCE POLICY
20 THAT PROVIDES BENEFITS TO A MEMBER IF THE POLICY IS INCONSISTENT WITH THIS
21 PARAGRAPH.
22 9. DEVELOPMENT AND MANAGEMENT OF AN ELIGIBILITY AND ENROLLMENT SYSTEM
23 INCLUDING A PROCESS FOR QUALITY CONTROL.
24 10. ESTABLISHMENT AND MAINTENANCE OF AN ENCOUNTER CLAIMS SYSTEM THAT
25 ENSURES THAT NINETY PER CENT OF THE CLEAN CLAIMS ARE PAID WITHIN THIRTY DAYS
26 AFTER RECEIPT AND NINETY-NINE PER CENT OF THE REMAINING CLEAN CLAIMS ARE PAID
27 WITHIN NINETY DAYS AFTER RECEIPT BY THE ADMINISTRATION OR CONTRACTOR UNLESS
28 AN ALTERNATIVE PAYMENT SCHEDULE IS AGREED TO BY THE CONTRACTOR AND THE
29 PROVIDER. FOR THE PURPOSES OF THIS PARAGRAPH, "CLEAN CLAIMS" HAS THE SAME
30 MEANING PRESCRIBED IN SECTION 36-2904, SUBSECTION H.
31 11. ESTABLISHMENT OF STANDARDS FOR THE COORDINATION OF MEDICAL CARE AND
32 MEMBER TRANSFERS.
33 12. REQUIRE CONTRACTORS TO SUBMIT ENCOUNTER DATA IN A FORM SPECIFIED
34 BY THE DIRECTOR.
35 B. NOTWITHSTANDING ANY OTHER LAW, IF CONGRESS AMENDS TITLE XXI OF THE
36 SOCIAL SECURITY ACT AND THE ADMINISTRATION IS REQUIRED TO MAKE CONFORMING
37 CHANGES TO RULES ADOPTED PURSUANT TO THIS ARTICLE, THE ADMINISTRATION SHALL
38 REQUEST A HEARING WITH THE JOINT HEALTH COMMITTEE OF REFERENCE FOR REVIEW OF
39 THE PROPOSED RULE CHANGES.
40 C. THE DIRECTOR MAY SUBCONTRACT DISTINCT ADMINISTRATIVE FUNCTIONS TO
41 ONE OR MORE PERSONS WHO MAY BE CONTRACTORS WITHIN THE SYSTEM.
42 D. THE DIRECTOR SHALL REQUIRE AS A CONDITION OF A CONTRACT WITH ANY
43 CONTRACTOR THAT ALL RECORDS RELATING TO CONTRACT COMPLIANCE ARE AVAILABLE FOR
44 INSPECTION BY THE ADMINISTRATION AND THAT THESE RECORDS BE MAINTAINED BY THE

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

DIRECTOR. NOTWITHSTANDING THE PROVISIONS OF A CONTRACT, IF THE ADMINISTRATION FINDS THAT THE PUBLIC HEALTH, SAFETY OR WELFARE REQUIRES EMERGENCY ACTION, IT MAY OPERATE AS THE CONTRACTOR ON NOTICE TO THE CONTRACTOR AND PENDING AN ADMINISTRATIVE HEARING, WHICH IT SHALL PROMPTLY INSTITUTE.

J. FOR THE SOLE PURPOSE OF MATTERS CONCERNING AND DIRECTLY RELATED TO THIS ARTICLE, THE ADMINISTRATION IS EXEMPT FROM SECTION 41-192.

K. THE DIRECTOR MAY WITHHOLD PAYMENTS TO A NONCONTRACTING PROVIDER IF THE NONCONTRACTING PROVIDER DOES NOT COMPLY WITH THIS ARTICLE OR ADOPTED RULES THAT RELATE TO THE SPECIFIC SERVICES RENDERED AND BILLED TO THE ADMINISTRATION.

L. THE DIRECTOR SHALL:

1. PRESCRIBE UNIFORM FORMS TO BE USED BY ALL CONTRACTORS AND FURNISH UNIFORM FORMS AND PROCEDURES, INCLUDING METHODS OF IDENTIFICATION OF MEMBERS. THE RULES SHALL INCLUDE REQUIREMENTS THAT AN APPLICANT PERSONALLY COMPLETE OR ASSIST IN THE COMPLETION OF ELIGIBILITY APPLICATION FORMS, EXCEPT IN SITUATIONS IN WHICH THE PERSON IS DISABLED.

2. BY RULE, ESTABLISH A GRIEVANCE AND APPEAL PROCEDURE THAT CONFORMS WITH THE PROCESS IN ARTICLE 1 OF THIS CHAPTER. IF THE PROGRAM IS SUSPENDED OR TERMINATED PURSUANT TO SECTION 36-2985, AN APPLICANT OR MEMBER IS NOT ENTITLED TO CONTEST THE DENIAL, SUSPENSION OR TERMINATION OF ELIGIBILITY FOR THE PROGRAM.

3. APPLY FOR AND ACCEPT FEDERAL MONIES AVAILABLE UNDER TITLE XXI OF THE SOCIAL SECURITY ACT. AVAILABLE STATE MONIES APPROPRIATED TO THE ADMINISTRATION FOR THE OPERATION OF THE PROGRAM SHALL BE USED AS MATCHING MONIES TO SECURE FEDERAL MONIES PURSUANT TO THIS SUBSECTION.

M. THE ADMINISTRATION IS ENTITLED TO ALL RIGHTS PROVIDED TO THE ADMINISTRATION FOR LIENS AND RELEASE OF CLAIMS AS SPECIFIED IN SECTIONS 36-2915 AND 36-2916.

N. THE DIRECTOR SHALL FOLLOW THE SAME PROCEDURES FOR REVIEW COMMITTEES, IMMUNITY AND CONFIDENTIALITY THAT ARE PRESCRIBED IN ARTICLE 1 OF THIS CHAPTER.

36-2987. <u>Reimbursement for the program</u>

A. FOR INPATIENT HOSPITAL SERVICES, THE ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY FOR INPATIENT HOSPITAL SERVICES BASED ON THE REIMBURSEMENT RATES FOR THE INDIAN HEALTH SERVICE AS PUBLISHED ANNUALLY IN THE FEDERAL REGISTER. FOR OUTPATIENT SERVICES, THE ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY BASED ON THE CAPPED FEE-FOR-SERVICE SCHEDULE ESTABLISHED BY THE DIRECTOR. IF CONGRESS AUTHORIZES ONE HUNDRED PER CENT PASS-THROUGH OF TITLE XXI MONIES FOR SERVICES PROVIDED IN AN INDIAN HEALTH SERVICE FACILITY OR A TRIBAL FACILITY, THE ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR THE TRIBAL FACILITY WITH THIS ENHANCED FEDERAL FUNDING BASED ON THE REIMBURSEMENT

1 RATES FOR THE INDIAN HEALTH SERVICE OR THE TRIBAL FACILITY AS PUBLISHED
2 ANNUALLY IN THE FEDERAL REGISTER.
3 B. CONTRACTORS SHALL REIMBURSE INPATIENT AND OUTPATIENT SERVICES BASED
4 ON THE REIMBURSEMENT METHODOLOGY ESTABLISHED IN SECTION 36-2904 OR THE
5 HOSPITAL REIMBURSEMENT PILOT PROGRAM ESTABLISHED BY THIS STATE.
6 C. FOR SERVICES RENDERED ON AND AFTER OCTOBER 1, 1998, THE
7 ADMINISTRATION AND THE CONTRACTORS SHALL PAY A HOSPITAL'S RATE ESTABLISHED
8 ACCORDING TO THIS SECTION SUBJECT TO THE FOLLOWING:
9 1. IF THE HOSPITAL'S BILL IS PAID WITHIN THIRTY DAYS AFTER THE DATE
10 THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY NINETY-NINE PER CENT OF
11 THE RATE.
12 2. IF THE HOSPITAL'S BILL IS PAID AFTER THIRTY DAYS BUT WITHIN SIXTY
13 DAYS AFTER THE DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY ONE
14 HUNDRED PER CENT OF THE RATE.
15 3. IF THE HOSPITAL'S BILL IS PAID ANY TIME AFTER SIXTY DAYS AFTER THE
16 DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY ONE HUNDRED PER CENT
17 OF THE RATE PLUS A FEE OF ONE PER CENT A MONTH FOR EACH MONTH OR PORTION OF
18 A MONTH FOLLOWING THE SIXTIETH DAY OF RECEIPT OF THE BILL UNTIL THE DATE OF
19 PAYMENT.
20 D. THE ADMINISTRATION AND THE CONTRACTORS SHALL PAY CLAIMS PURSUANT
21 TO THE METHODOLOGY, DEFINITIONS AND TIME FRAMES SPECIFIED FOR CLEAN CLAIMS
22 IN SECTION 36-2904, SUBSECTION H.
23 E. THE DIRECTOR SHALL SPECIFY ENROLLMENT PROCEDURES INCLUDING NOTICE
24 TO CONTRACTORS OF ENROLLMENT. THE ADMINISTRATION SHALL SPECIFY IN CONTRACT
25 WHEN A PERSON WHO HAS BEEN DETERMINED ELIGIBLE WILL BE ENROLLED WITH A
26 CONTRACTOR AND THE DATE ON WHICH THE CONTRACTOR WILL BE FINANCIALLY
27 RESPONSIBLE FOR HEALTH AND MEDICAL SERVICES TO THE PERSON.
28 F. THE DIRECTOR SHALL MONITOR ANY THIRD PARTY PAYMENT COLLECTIONS
29 COLLECTED BY CONTRACTORS AND NONCONTRACTING PROVIDERS ACCORDING TO THE SAME
30 PROCEDURES SPECIFIED FOR TITLE XIX PURSUANT TO SECTION 36-2903.01,
31 SUBSECTION M.
32 G. ON ORAL OR WRITTEN NOTICE FROM THE MEMBER, OR THE MEMBER'S PARENT
33 OR LEGAL GUARDIAN, THAT THE MEMBER, PARENT OR LEGAL GUARDIAN BELIEVES A CLAIM
34 SHOULD BE COVERED BY THE PROGRAM, A CONTRACTOR OR NONCONTRACTING PROVIDER
35 SHALL NOT DO EITHER OF THE FOLLOWING UNLESS THE CONTRACTOR OR NONCONTRACTING
36 PROVIDER HAS VERIFIED THROUGH THE ADMINISTRATION THAT THE PERSON IS
37 INELIGIBLE FOR THE PROGRAM, HAS NOT YET BEEN DETERMINED ELIGIBLE OR, AT THE
38 TIME SERVICES WERE RENDERED, WAS NOT ELIGIBLE OR ENROLLED IN THE PROGRAM:
39 1. CHARGE, SUBMIT A CLAIM TO OR DEMAND OR OTHERWISE COLLECT PAYMENT
40 FROM A MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE.
41 2. REFER OR REPORT A MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE
42 TO A COLLECTION AGENCY OR CREDIT REPORTING AGENCY FOR THE FAILURE OF THE
43 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.

1 G. THE DIRECTOR MAY NEGOTIATE AT ANY TIME WITH A HOSPITAL ON BEHALF
2 OF A CONTRACTOR FOR INPATIENT HOSPITAL SERVICES AND OUTPATIENT HOSPITAL
3 SERVICES PROVIDED PURSUANT TO THE REQUIREMENTS SPECIFIED IN SECTION 36-2904.
4 H. A CONTRACTOR MAY REQUIRE THAT SUBCONTRACTING PROVIDERS OR
5 NONCONTRACTING PROVIDERS BE PAID FOR COVERED SERVICES, OTHER THAN HOSPITAL
6 SERVICES, ACCORDING TO THE CAPPED FEE-FOR-SERVICE SCHEDULE ADOPTED BY THE
7 ADMINISTRATION OR AT LOWER RATES AS MAY BE NEGOTIATED BY THE CONTRACTOR.
8 I. THE ADMINISTRATION AND CONTRACTORS SHALL NOT CONTRACT FOR ANY
9 SERVICES OR FUNCTIONS RELATED TO THIS ARTICLE WITH A SCHOOL DISTRICT
10 INCLUDING CONTRACTING FOR THE DELIVERY OF SERVICES, SCREENING, OUTREACH OR
11 INFORMATION THAT INVOLVES THE USE OF SCHOOL STAFF AND FACILITIES.
12 J. THE ADMINISTRATION IS EXEMPT FROM THE PROCUREMENT CODE PURSUANT TO
13 SECTION 41-2501.
14 36-2989. Covered health and medical services; modifications;
15 related delivery of service requirements
16 A. EXCEPT AS PROVIDED IN THIS SECTION, THE DIRECTOR SHALL ESTABLISH
17 A SPECIFIC HEALTH BENEFITS COVERAGE PACKAGE THAT IS AS NEARLY AS PRACTICABLE
18 THE SAME AS THE LEAST EXPENSIVE HEALTH BENEFITS COVERAGE PLAN OR PLANS THAT
19 ARE OFFERED THROUGH A HEALTH CARE SERVICES ORGANIZATION AVAILABLE TO STATE
20 EMPLOYEES UNDER SECTION 38-651. THE PACKAGE SHALL INCLUDE THE FOLLOWING
21 COVERED SERVICES:
22 1. INPATIENT HOSPITAL SERVICES THAT ARE ORDINARILY FURNISHED BY A
23 HOSPITAL FOR THE CARE AND TREATMENT OF INPATIENTS, THAT ARE MEDICALLY
24 NECESSARY AND THAT ARE PROVIDED UNDER THE DIRECTION OF A PHYSICIAN OR A
25 PRIMARY CARE PRACTITIONER. FOR THE PURPOSES OF THIS PARAGRAPH, INPATIENT
26 HOSPITAL SERVICES EXCLUDE SERVICES IN AN INSTITUTION FOR TUBERCULOSIS OR
27 MENTAL DISEASES UNLESS AUTHORIZED BY FEDERAL LAW.
28 2. OUTPATIENT HEALTH SERVICES THAT ARE MEDICALLY NECESSARY AND
29 ORDINARILY PROVIDED IN HOSPITALS, CLINICS, OFFICES AND OTHER HEALTH CARE
30 FACILITIES BY LICENSED HEALTH CARE PROVIDERS. FOR THE PURPOSES OF THIS
31 PARAGRAPH, "OUTPATIENT HEALTH SERVICES" INCLUDES SERVICES PROVIDED BY OR
32 UNDER THE DIRECTION OF A PHYSICIAN OR A PRIMARY CARE PRACTITIONER.
33 3. OTHER LABORATORY AND X-RAY SERVICES ORDERED BY A PHYSICIAN OR A
34 PRIMARY CARE PRACTITIONER.
35 4. MEDICATIONS THAT ARE MEDICALLY NECESSARY AND ORDERED ON
36 PRESCRIPTION BY A PHYSICIAN, A PRIMARY CARE PRACTITIONER OR A DENTIST
37 LICENSED PURSUANT TO TITLE 32, CHAPTER 11.
38 5. MEDICAL SUPPLIES, EQUIPMENT AND PROSTHETIC DEVICES.
39 6. TREATMENT OF MEDICAL CONDITIONS OF THE EYE INCLUDING ONE EYE
40 EXAMINATION EACH YEAR FOR PRESCRIPTIVE LENSES AND THE PROVISION OF ONE SET
41 OF PRESCRIPTIVE LENSES EACH YEAR FOR MEMBERS.
42 7. MEDICALLY NECESSARY DENTAL SERVICES.
43 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

COST INCURRED IN UNDERTAKING THESE SPECIAL EFFORTS AND SHALL DEDUCT THAT AMOUNT FROM ANY PAYMENT OWED TO THE CONTRACTOR.

36-2991. Fraud; penalties; enforcement; violation; classification

A. A PERSON SHALL NOT PROVIDE OR CAUSE TO BE PROVIDED FALSE OR FRAUDULENT INFORMATION ON AN APPLICATION FOR ELIGIBILITY PURSUANT TO THIS ARTICLE.

B. A PERSON WHO VIOLATES SUBSECTION A OF THIS SECTION, WHO IS DETERMINED ELIGIBLE FOR SERVICES PURSUANT TO THIS ARTICLE AND WHO WOULD HAVE BEEN DETERMINED INELIGIBLE IF THE PERSON HAD PROVIDED TRUE AND CORRECT INFORMATION IS SUBJECT, IN ADDITION TO ANY OTHER PENALTIES THAT MAY BE PRESCRIBED BY FEDERAL OR STATE LAW, TO A CIVIL PENALTY OF NOT MORE THAN THE AMOUNT INCURRED BY THE SYSTEM, INCLUDING CAPITATION PAYMENTS MADE ON BEHALF OF THE PERSON. IN ADDITION, THE PERSON'S ELIGIBILITY MAY BE DISCONTINUED IN ACCORDANCE WITH RULES ADOPTED BY THE DIRECTOR.

C. IN ADDITION TO THE REQUIREMENTS OF STATE LAW, ANY APPLICABLE FRAUD AND ABUSE CONTROLS THAT ARE ENACTED UNDER FEDERAL LAW APPLY TO PERSONS WHO ARE ELIGIBLE FOR SERVICES UNDER THIS ARTICLE AND TO CONTRACTORS AND NONCONTRACTING PROVIDERS WHO PROVIDE SERVICES UNDER THIS ARTICLE.

D. THE DIRECTOR SHALL MAKE THE DETERMINATION TO ASSESS A CIVIL PENALTY AND IS RESPONSIBLE FOR COLLECTION OF THE PENALTY. THE DIRECTOR MAY ADOPT RULES THAT PRESCRIBE PROCEDURES FOR THE DETERMINATION AND COLLECTION OF CIVIL PENALTIES. THE DIRECTOR MAY COMPROMISE CIVIL PENALTIES IMPOSED UNDER THIS SECTION IN ACCORDANCE WITH CRITERIA ESTABLISHED IN RULES.

E. THE DIRECTOR SHALL ADOPT RULES PROVIDING FOR THE APPEAL OF A DECISION BY A PERSON ADVERSELY AFFECTED BY A DETERMINATION MADE BY THE DIRECTOR UNDER THIS SECTION. THE DIRECTOR'S FINAL DECISION IS SUBJECT TO JUDICIAL REVIEW PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.

F. AMOUNTS PAID BY THE STATE AND RECOVERED UNDER THIS SECTION SHALL BE DEPOSITED IN THE STATE GENERAL FUND, AND ANY APPLICABLE FEDERAL SHARE SHALL BE RETURNED TO THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

G. IF A CIVIL PENALTY IMPOSED PURSUANT TO SUBSECTION D OF THIS SECTION IS NOT PAID, THE STATE MAY FILE AN ACTION TO COLLECT THE CIVIL PENALTY 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 IS PRESENTED.

H. A PERSON WHO KNOWINGLY AIDS OR ABETS ANOTHER PERSON PURSUANT TO SECTION 13-301, 13-302 OR 13-303 IN THE COMMISSION OF AN OFFENSE UNDER THIS 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.

Sec. 9. Annual report

Beginning on January 1, 2000, the Arizona health care cost containment system administration shall annually report the following information relating to the children's health insurance program established pursuant to title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act, to the governor, president of the senate, speaker of the house of representatives, secretary of state and director of the department of library, archives and public records:

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 year will be sufficient to provide services at the current percentage of the federal poverty level or whether an enrollment cap may be needed.

5. Any recommendations for changes to the program.

Sec. 10. Direct services; qualifying community health centers; hospitals; eligibility screening

A child who receives services pursuant to section 36-2907.05, section 36-2907.06, subsection A or section 36-2907.08, subsection A, Arizona Revised Statutes, shall be screened for potential eligibility by the qualifying community health center or hospital that contracts with the department of health services pursuant to section 36-2907.06 or section 36-2907.08, Arizona Revised Statutes. If it appears that the child may be eligible, the qualifying community health center or hospital may provide services and shall refer the child for an eligibility determination by the Arizona health care cost containment system administration.

Sec. 11. Exemption from rule making; procurement code

A. The Arizona health care cost containment system administration and the department of health services are exempt from the rule making requirements of title 41, chapter 6, Arizona Revised Statutes, for one year after the effective date of this act to implement this act. The administration and the department shall hold hearings to give the public an opportunity to comment on the proposed rules. The administration and the department shall hold at least one of these hearings in a county with a population of less than five hundred thousand persons according to the most recent United States decennial census.

B. The department of health services is exempt from the provisions of title 41, chapter 23, Arizona Revised Statutes, relating to the procurement code, for the purpose of procuring contracts with qualifying health centers pursuant to section 36-2907.06, subsection G, Arizona Revised Statutes, or hospitals pursuant to section 36-2907.08, subsection H, Arizona Revised 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

monies remaining unexpended and unencumbered on October 1, 1999 revert to the children's health insurance program fund.

Sec. 18. Reimbursement for contractors

Before the implementation of the children's health insurance program authorized in title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act, the Arizona health care cost containment system shall develop actuarially sound rates that shall be used to reimburse the contractors as defined in section 36-2981, Arizona Revised Statutes, as added by this act.

Sec. 19. Medical savings accounts; direct service contracts

A. Within one hundred twenty days after the approval of the title XXI state plan submitted to the federal health care financing administration, the Arizona health care cost containment system administration shall submit a medical savings account amendment to the joint legislative study committee on the integration of health care services. The committee shall review the amendment and provide input on the amendment. Once the joint legislative study committee on the integration of health care services reviews the amendment, the Arizona health care cost containment system administration shall submit the amendment to the federal health care financing administration requesting approval to offer medical savings accounts 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.

B. On or before July 1, 1999, the Arizona health care cost containment system administration shall submit a direct service contracts amendment to the title XXI state plan to the joint legislative study committee on the integration of health care services. The study committee shall review the amendment and provide input on the amendment. Once the study committee reviews the amendment, the Arizona health care cost containment system administration shall submit the amendment to the federal health care financing administration to secure title XXI funding to reimburse qualifying health centers and hospitals that contract with the department of health services pursuant to sections 36-2907.06 and 36-2907.08, Arizona Revised Statutes.

C. On or before July 1, 2000, the Arizona health care cost containment system administration shall submit a direct service contracts amendment for waiver authorization to spend more than ten per cent of the monies for administration, outreach and direct services to the joint legislative study committee on the integration on health care services. The study committee shall review the amendment and provide input on the amendment. Once the study committee reviews the amendment, the Arizona health care cost containment system administration shall submit the amendment to the federal health care financing administration requesting waiver authorization to offer 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 and other health coverage expansions as precise and accurate as possible:

- The family 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 [1] Weighted Percent Applied to 1998 Census Bureau Population Projection for Arizona [2]

	TYPE OF COVERAGE							
	Uninsured		Medicaid and Other Public[3]		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	**32.12%**	**424,683**
6 through 14	8.38%	110,798	11.24%	148,612	24.87%	328,825	**44.49%**	**588,236**
15 through 18	5.01%	66,241	2.72%	35,963	8.95%	118,335	**16.68%**	**220,539**
Total	**20.68%**	**273,426**	**27.41%**	**362,408**	**51.91%**	**686,341**	**100.00%**	**1,322,175**
FPL Level								
< 31%	2.96%	39,136	3.70%	48,920	0.98%	12,957	**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%**	**202,028**
151% - 175%	1.58%	20,890	1.36%	17,982	2.43%	32,129	**5.37%**	**71,001**
176% - 200%	1.70%	22,477	0.55%	7,272	4.18%	55,267	**6.43%**	**85,016**
>200%	4.35%	57,515	5.79%	76,554	37.95%	501,765	**48.09%**	**635,834**
Total	**20.68%**	**273,426**	**27.41%**	**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%**	**45,615**
Hispanic	12.49%	165,140	9.32%	123,227	13.18%	174,263	**34.99%**	**462,629**
White Non-Hispanic	7.42%	98,105	13.51%	178,626	35.44%	468,579	**56.37%**	**745,310**
Black Non-Hispanic	0.27%	3,570	2.11%	27,898	1.26%	16,659	**3.64%**	**48,127**
Other Non-Hispanic	0.08%	1,058	0.11%	1,454	1.34%	17,717	**1.53%**	**20,229**
Total	**20.68%**	**273,426**	**27.41%**	**362,408**	**51.89%**	**686,077**	**99.98%**	**1,321,911**
Location								
Urban/Suburban[5]	14.94%	197,533	20.29%	268,269	45.15%	596,962	**80.38%**	**1,062,764**
Rural	5.75%	76,025	7.12%	94,139	6.74%	89,115	**19.61%**	**259,279**
Total	**20.69%**	**273,558**	**27.41%**	**362,408**	**51.89%**	**686,077**	**99.99%**	**1,322,043**

[1]Data reflects calendar years 1993 - 1995.

[2]"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 Kids 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 [1] Unweighted Cell Counts

	TYPE OF COVERAGE			
	Uninsured	Medicaid and Other Public[2]	Private/Group	Total
Age Group				
<1	17	32	30	**79**
1 through 5	78	128	199	**405**
6 through 14	113	145	309	**567**
15 through 18	70	33	103	**206**
Total	**278**	**338**	**641**	**1,257**
FPL Level				
< 31%	41	43	14	**98**
32% - 100%	75	137	23	**235**
101% - 150%	69	62	67	**198**
151% - 175%	21	17	27	**65**
176% - 200%	20	8	53	**81**
>200%	52	71	457	**580**
Total	**278**	**338**	**641**	**1,257**
Race/Ethnicity[3]				
American Indian	7	26	8	**41**
Hispanic	185	147	219	**551**
White 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**	**1,257**

[1]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.

[3]American 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 [1] Weighted Percent Applied to 1998 Census Bureau Population Projection for Arizona [2]

	TYPE OF COVERAGE							
	Uninsured		Medicaid and Other Public[3]		Private/Group		Total	
	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Eligibility Category								
Title XIX (AHCCCS) Eligible[4]	8.85%	117,012	16.12%	213,135	3.29%	43,500	**28.26%**	**373,647**
Title XXI Eligible[5]								
Eligible up to 150% FPL	4.21%	55,664	3.59%	47,466	4.05%	53,548	**11.85%**	**156,678**
Eligible up to 175% FPL	1.58%	20,890	1.36%	17,982	2.43%	32,129	**5.37%**	**71,001**
Income > 175% FPL	6.05%	79,992	6.34%	83,826	42.13%	557,032	**54.52%**	**720,850**
Total	**20.69%**	**273,558**	**27.41%**	**362,408**	**51.90%**	**686,209**	**100.00%**	**1,322,175**

[1]Data reflects calendar years 1993 - 1995.

[2]"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 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.

[5]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 [1] Unweighted Cell Counts

	TYPE OF COVERAGE			
	Uninsured	Medicaid and Other Public[2]	Private/Group	Total
Eligibility Category				
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	**65**
Income > 175% FPL	72	79	510	**661**
Total	**278**	**338**	**641**	**1,257**

[1]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.

[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 current AHCCCS eligibility level.

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

Attachment C

Description of Programs

ATTACHMENT C
DESCRIPTION OF PROGRAMS

MEDICAID ELIGIBILITY GROUPS

AHCCCS covers all mandatory Medicaid groups and several optional Medicaid groups. The four major eligibility groups are:

1. Section 1931 of the Social Security Act, formerly Aid to Families with Dependent Children (AFDC)
2. The Sixth Omnibus Budget Reconciliation Act groups (S.O.B.R.A.)
3. Supplemental Security Income (SSI) and SSI-related groups (e.g., SSI Cash and Medical Assistance Only [MAO])
4. Federal emergency services for non-citizens who do not meet the alien status requirements for full Medicaid coverage.

To successfully coordinate efforts to increase the number of children with creditable health coverage, it is important to understand Arizona's current public program and the process to apply for each program. The following information highlights each of the programs in the following ways:

1. Who is served by the program
2. Where the individual applies
3. The time frames for processing an application
4. Funding sources
5. Income and resource limits
6. Citizenship and alien status requirements
7. Arizona residency requirements
8. Social Security number requirements
9. Deprivation requirements.

1931 Group

The 1931 group is eligible based on income and resource limits established by the state legislature according to federal guidelines as summarized below.

1931 GROUP

Where to Apply		**Application Timeframes**	**Reviews**		**Funding Sources**
DES/FAA Offices		45 days	Every 6 months		Federal and State
Monthly Net Income by Household	**Resource Limits (equity)**	**U.S. Citizenship & Alien Status**	**Arizona Residency**	**SS#**	**Deprivation**
1 - $204 2 - $275 3 - $347 4 - $418	$2000	Citizen or Qualified Alien	Required	Yes	Absence Death Disability Unemployment or underemployment of a parent in a 2 parent household

CHILDREN UNDER 18 - STUDENT/QUALIFIED ADULTS

Where to Apply	Application Timeframes	Reviews	Funding Sources
DES/FAA Offices	45 days	Every 6 months	Federal and State

Monthly Net Income by Household	Resource Limits (equity)	U.S. Citizenship & Alien Status	Required Arizona Residency	Required SS#	Deprivation
1 - $ 204 2 - $ 275 3 - $ 347 4 - $ 418	$2000	Citizen or Qualified Alien	Yes	Yes	N/A for below 18. Required for age 18 & qualified adults

Sixth Omnibus Budget Reconciliation Act Groups (S.O.B.R.A)

DES processes applications and determines eligibility for S.O.B.R.A. which is available to pregnant women throughout the 60 days postpartum period and children born after September 30, 1983 based on income levels established by the state. In addition, on August 1, 1995, AHCCCS began providing 24 months of family planning services to women who lose S.O.B.R.A. eligibility after the 60 days post partum period. The following charts describe the four S.O.B.R.A. groups.

S.O.B.R.A. PREGNANT WOMEN 140 PERCENT FPL

Where to Apply	Application Timeframes	Reviews	Funding Sources
DES/FAA Offices, County Eligibility Offices or Baby Arizona providers	45 days	After the 60 days post partum period	Federal and State

Monthly Net Income by Household	Resource Limits (equity)	U.S. Citizenship & Alien Status	Required Arizona Residency	Required SS#	Deprivation
1 - $ 940 2 - $1266 3 - $1593 4 - $1920	N/A	Citizen or Qualified Alien	Yes	Yes	N/A

CHILDREN UNDER 1 - 140 PERCENT FPL

Where to Apply	Application Timeframes	Reviews	Funding Sources
DES/FAA or county eligibility offices	45 days	Every 6 months	Federal and State

Monthly Net Income by Household	Resource Limits (equity)	U.S. Citizenship & Alien Status	Required Arizona Residency	Required SS#	Deprivation
1 - $ 940 2 - $1266 3 - $1593 4 - $1920	N/A	Citizen or Qualified Alien	Yes	Yes	N/A

CHILDREN UNDER AGE 6 - 133 PERCENT FPL

Where to Apply	Application Timeframes	Reviews	Funding Sources
DES/FAA or county eligibility Offices	45 days	Every 6 months	Federal and State

Monthly Net Income by Household	Resource Limits (equity)	U.S. Citizenship & Alien Status	Required Arizona Residency	Required SS#	Deprivation
1 - $ 893 2 - $1203 3 - $1513 4 - $1824	N/A	Citizen or Qualified Alien	Yes	Yes	N/A

CHILDREN AGE 6 OR OVER BORN AFTER 9/30/83 - 100 PERCENT FPL

Where to Apply	Application Timeframes	Reviews	Funding Sources
DES/FAA Offices and county eligibility offices	45 days	Every 6 months	Federal and State

Monthly Net Income by Household	Resource Limits (equity)	U.S. Citizenship & Alien Status	Required Arizona Residency	Required SS#	Deprivation
1 - $ 671 2 - $ 905 3 - $1138 4 - $1371	N/A	Citizen or Qualified Alien	Yes	Yes	N/A

SSI Cash and SSI-MAO

The Social Security Administration (SSA) determines eligibility for the SSI cash program and AHCCCS determines eligibility for the SSI-MAO program. Income criteria established by the federal government for persons eligible for SSI-Cash and SSI-MAO groups are summarized below.

SSI CASH

Where to Apply	Application Timeframes	Reviews	Funding Sources
SSA	45 days aged & blind or 90 days if disabled	Annually	Federal and State

Monthly Net Income by Household	Resource Limits (equity)	U.S. Citizenship & Alien Status	Arizona Residency	SS#	Deprivation
Individual $494 Couple $741	Individual $2000 Couple $3000	Citizen or Qualified Alien	Required	Yes	N/A

SSI-MAO

Where to Apply	Application Timeframes	Reviews	Funding Sources
AHCCCS ALTCS Offices	Prior to term. SSI Cash 45 days Aged/Blind 90 days if disabled	Annually	Federal and State

Monthly Net Income by Household	Resource Limits (equity)	U.S. Citizenship & Alien Status	Arizona Residency	SS#	Deprivation
Individual $494 Couple $741	Individual $2000 Couple $3000	Citizen or Qualified Alien	Required	Yes	N/A

Federal Emergency Services (FES)

The Federal Emergency Services (FES) program provides emergency services to three general categories:

1. Individuals who do not qualify for full Medicaid services because of INS alien classification. Non-qualified aliens (PRUCOL) who entered the U.S. prior to August 22, 1996.
2. Certain qualified aliens who entered the country on or after August 22, 1996.
3. Illegal immigrants.

These non-citizens must meet all other Medicaid eligibility requirements. For the eligibility requirements, refer to the preceding charts for the 1931 group, S.O.B.R.A., SSI-Cash, and SSI-MAO programs.

STATE-FUNDED GROUPS

The state funded program is funded entirely with state and county funds to provide services for 25,095 persons (as of June 1, 1998) who do not qualify for Medicaid. Applicants for one of the state-funded programs apply in their county of residence, with the exception of Eligible Assistance Children (EAC) program which is done by DES. The four state-funded programs are:

1. Medically Indigent/Medically Needy
2. Eligible Low Income Children
3. Eligible Assistance Children
4. State Emergency Services.

Medically Indigent/Medically Needy (MI/MN)

A person who is eligible for the MI program must have household income which is at or below $3,200 per year. A Medically Needy person must have sufficient medical bills to "spend-down" household income to $3,200 per year. Arizona's state-only spend- down criteria is not the same as the federal medically needy criteria, and Arizona does not cover the federally medically needy option for the Medicaid population. As of June 1, 1998, MI/MNs comprise approximately 93 percent of the state-funded enrollment in AHCCCS. The MI/MN criteria are summarized below.

MI/MN

Where to Apply	Application Timeframes	Reviews	Funding Sources
County Eligibility Offices	30 days	Every 6 months	State & County

Monthly Net Income by Household	Resource Limits (equity)	U.S. Citizenship & Alien Status	County and Arizona Residency	SS#	Deprivation
1 - $266 2 - $355 3 - $400 4 - $446	$50,000 Liquid/ Non Liquid $5,000 Liquid	Citizen or qualified alien	Yes	No	N/A

Eligible Low Income Children (ELIC)

Children who are under the age of 14 and who have household income that exceeds the MI/MN income standard, but does not exceed 100% of the FPL are eligible for ELIC. As of June 1, 1998, ELICs comprise approximately 2 percent of the state-funded enrollment in AHCCCS. The criteria are summarized below.

ELIC

Where to Apply	Application Timeframes	Reviews	Funding Sources
County Eligibility Office	30 days	Every 6 months	State and County

Monthly Net Income by Household	Resource Limits (equity)	U.S. Citizenship & Alien Status	County and Arizona Residency	SS#	Deprivation
1 - $ 671 2 - $ 905 3 - $1138 4 - $1371	$50,000 Liquid/ Non Liquid $5,000 Liquid	Citizen or Qualified Alien	Yes	Yes	N/A

Eligible Assistance Children (EAC)

Children under the age of 14 who are recipients of food stamps are eligible for the EAC program if they are ineligible for the S.O.B.R.A. program. As of June 1, 1998, EACs comprise approximately 4 percent of the state-funded enrollment in AHCCCS. The EAC criteria are summarized below.

EAC

Where to Apply	Application Timeframes	Reviews	Funding Sources
DES/FAA Offices	30 days	Every 6 months	State

Monthly Net Income by Household	Resource Limits (equity)	U.S. Citizenship & Alien Status	Arizona Residency	SS#	Deprivation
1 - $ 671 2 - $ 905 3 - $1138 4 - $1371	$2000	Citizen or Legal Alien	Required	Yes	N/A

State Emergency Services (SES)

Undocumented persons and certain legal immigrants who are ineligible for Medicaid but who meet the income and resource criteria for the MI/MN or ELIC program may be eligible for the SES program. Persons eligible for SES are not enrolled with AHCCCS health plans and receive only emergency services on a fee-for-service basis. As of June 1, 1998, SES eligible persons comprised less than 1 percent of the state-funded enrollment in AHCCCS. Pregnant women that lawfully entered the United States before August 22, 1996 (PRUCOLs), may receive prenatal care in addition to emergency services.

Attachment D

Children by Eligibility Category

ATTACHMENT D
CHILDREN BY ELIGIBILITY CATEGORY

AHCCCS CHILDREN* ENROLLED IN MEDICAID PROGRAM (as of June 1, 1998)	
TANF	96,940
SSI	10,896
SOBRA Child	119,670
SOBRA Woman	2,426
Extended Family Planning	2,298
TOTAL	**232,230**

AHCCCS CHILDREN* ENROLLED IN STATE-FUNDED PROGRAM	
Medically Indigent / Medically Needy (MN/MI)	1,609
Eligible Assistance Children (EAC)	1,077
Eligible Low Income Children (ELIC)	430
TOTAL	**3,116**
GRAND TOTAL (Medicaid and State Funded)	**235,346**

* Under the age of 19.

Attachment E

AHCCCS Health Plans

ATTACHMENT E
AHCCCS HEALTH PLANS
(As of October 1, 1997)

NAME	OWNER/OPERATOR	CORPORATE STRUCTURE	AHCCCS CONTRACT COMMENCED	COUNTIES OF OPERATION	ENROLL-MENT	SERVICE MODEL
Arizona Health Concepts	Managed Care Solutions, Inc.	Corporation For Profit	10/1/92	LaPaz/Mohave	7,099	IPA
Arizona Physicians IPA	Health Partners of Arizona	Corporation For profit	10/1/82	Coco/Yava, Cochise/Santa Cruz, Graham/Greenlee, LaPaz/Mohave, Maricopa, Navajo/Apache, Pima, Yuma	121,837	IPA
CIGNA Community Choice, Inc.	CIGNA HealthCare of Arizona, Inc.	Corporation For profit	10/1/94	Maricopa	25,231	IPA, Group Staff
Comprehensive Medical and Dental Program	DES, State of AZ	Government Not for profit	10/1/90	Statewide	6,115	IPA
Doctor's Health Plan	Three rural AZ physicians	Corporation For profit	10/1/83	Graham/Greenlee	2,322	IPA
Family Health Plan of Northeastern Arizona	12 rural physicians	Corporation For profit	10/1/83	Navajo/Apache (capped)	3,249	IPA
Health Choice Arizona	Tenet Healthcare	Corporation For profit	10/1/89	Maricopa, Pima	33,323	IPA
Maricopa County Health Plan	Maricopa County Government	Government Not for profit	10/1/84	Maricopa	23,436	IPA, Staff
Mercy Care Plan	Mercy Healthcare Arizona (Phoenix) Carondelet Health Care Group (Tucson)	Corporation Not for profit	10/1/85	Cochise/Santa Cruz, Coconino/Yavapai, Gila/Pinal, Maricopa, Pima, Yuma	63,804	IPA
Phoenix Health Plan/ Community Connection	Phoenix Memorial Hosp. Health Services Network	Corporation Not for profit	10/1/83	Maricopa, Gila/Pinal	43,750	IPA
Pima Health Plan	Pima County Government	Government Not for profit	10/1/82	Pima (capped)	11,113	Mixed
University Family Care	University Physicians Inc.	Corporation Not for profit	10/1/97	Pima	8,266	Mixed

Attachment F

Commercial Health Maintenance Organizations

ATTACHMENT F
STATE EMPLOYEE HMOs
(As of May 27, 1998)

NAME	OWNER/OPERATOR	CORPORATE STRUCTURE	DOA CONTRACT COMMENCED	COUNTIES OF OPERATION	ENROLL-MENT	SERVICE MODEL
Blue Cross Blue Shield of Arizona "Blue Select"	Blue Cross Blue Shield of Arizona	Corporation Not For Profit	10/1/97 - 9/30/98	All	7,879	IPA
CIGNA Health Plan of Arizona	CIGNA Health Plan of Arizona Inc.	Corporation For profit	10/1/97	All	15,077	IPA Start Mixed
HealthPartners Direct Access	Health Partners Health Plans Inc.	Corporation For profit	10/1/97	All	737	Mixed
HealthPartners HMO	Health Partners Health Plans Inc.	Corporation For profit	10/1/97	All	1,544	Mixed
Intergroup HMO	Intergroup of Arizona	Corporation For profit	10/1/97	All	19,894	Mixed
PacificCare HMO	PacificCare Health Systems	Corporation For profit	10/1/97	All	642	Group IPA

Attachment G

Family and Income Overview

ATTACHMENT G
FAMILY & INCOME OVERVIEW

Total gross monthly income will be determined at the time of application and redetermination. 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. A child living with a grandparent or other relative instead of a parent will be its own household.

INCOME

- The families' total gross monthly income after excluding any payments and grants, as specified in 20 CFR Part 416, the Appendix to Subpart K, will be counted. No other income deductions or disregards will be applied when determining gross income.
- In determining the eligibility for a qualified alien, 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, shall be counted as family household income.
- The agency will require verification of earned income by the employer, and of unearned income by the payer. Income from self employment will be verified using the self employed person's tax records accompanied by the person's statement that current income is consistent with income indicated in those records. If tax records are unavailable or income is not consistent, self employment income will be verified using other records of proceeds and verification of expenses provided by vendors or other creditors.

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

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

Inter-Tribal Health Care of Greater Tucson
Ms. Corrine Jymm, Executive Director
307 East University Blvd
Tucson, AZ 85705
(520) 882-0555 fax: (520) 623-6529

Native Americans for Community Action
Family Health Center
Ms. Patty Holst, Director
1355 N. Beaver St., Suite 160
Flagstaff, AZ 86001-3101
(520) 773-1245 fax: (520) 773-9429

Indian Rehabilitation, Inc.
650 N. 2nd Avenue
Phoenix, AZ 85003
(602) 254-3247

American Indian Chamber of Commerce
(602) 545-1298

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

Phoenix Indian Center
Leland Leonard, Exec. Dir.
2601 N. 3rd St, Suite 100
Phoenix, AZ 85004
(602) 263-1017

Tucson Indian Center
Mr. Fred Lomayesva
131 East Broadway
Tucson, AZ
(520) 884-7131

Native Americans for Community Action
2717 N. Steves Blvd.
Suite 11
Flagstaff, AZ 86004-3959
(520) 526-2968 fax: (520) 526-0708

Attachment J

Eligibility Hierarchy

Attachment J

Eligibility Hierarchy

Individuals may become eligible for AHCCCS covered services by meeting eligibility requirements for one or more eligibility groups. If an individual meets the eligibility requirements of more than one group, the individual is placed in the group that is higher on the eligibility hierarchy.

For example, an individual who meets the requirements of the State-funded Premium Sharing Project and Kids Care will be placed in Kids Care. The chart below and graphs on the following page shows this.

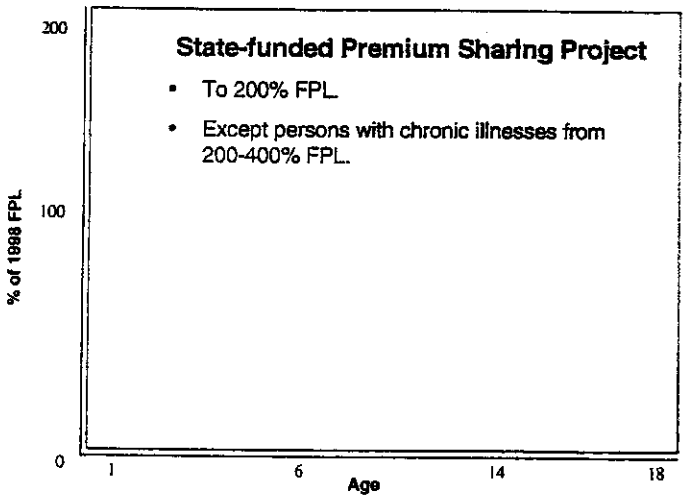
% FPL	Description	Age
30	Medicaid/Children (1931 Group)	0-18
30	Medicaid/Children (Ribicoff)	15-18
100	Medicaid/Children (SOBRA)	6-14
133	Medicaid/Children (SOBRA)	1+ to < 6
140	Medicaid/Mothers and Children (SOBRA)	<1
150	Title XXI/Kids Care	0<19
200	State-funded Premium Sharing Project	0<19

Exceptions

Individuals who meet the SSI Cash and SSI-MAO eligibility requirements up to 75% of the FPL will not be considered for placement in other eligibility groups.

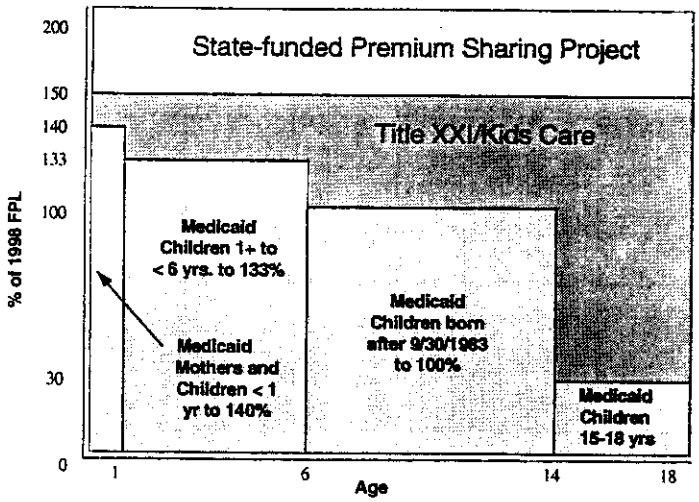
Most MN/MI, EAC and ELIC eligible children under 18 will be covered under Kids Care. However, if they are ineligible for Kids Care due to income, they may qualify for MN/MI or ELIC due to "spenddown".

Persons with chronic illnesses with incomes from 200-400% of the FPL may qualify for the State-funded Premium Sharing Project.



Example One

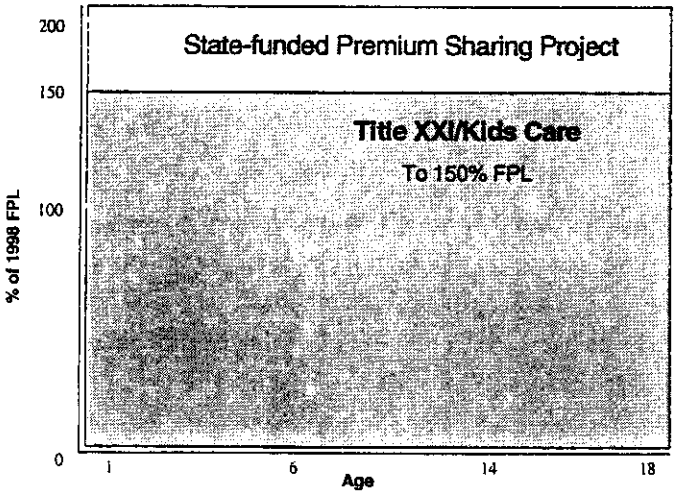
If an individual meets the eligibility requirements of both the State-funded Premium Sharing Project and Title XXI/Kids Care programs, the individual is placed in Title XXI/Kids Care.



Example Three

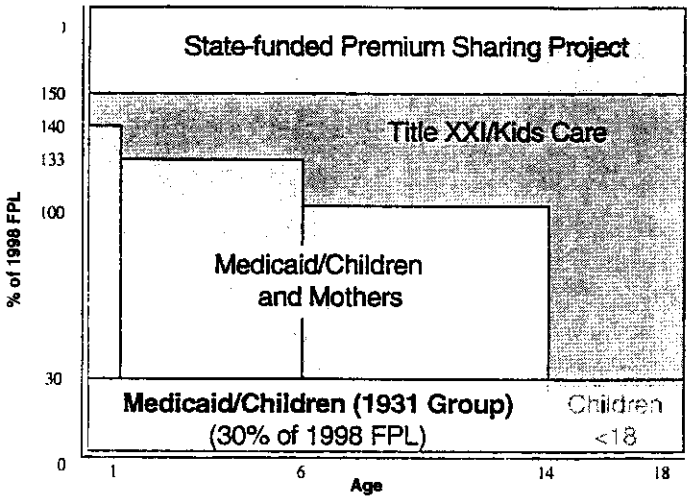
If an individual meets the eligibility requirements of the Medicaid/Children (1931 group) and any other group, the individual is placed in Medicaid/Children (1931 group).

Individuals who meet the eligibility requirements of more than one group are always placed in the group higher on the Eligibility Hierarchy.



Example Two

If an individual meets the eligibility requirements of the state-funded Premium Sharing Project, Kids Care and/or a Medicaid Childrens group, the individual is placed in the Medicaid Childrens group.



Attachment K

Description of Benefits Package

DESCRIPTION OF BENEFITS

STATE OF ARIZONA

MEMBERS PLEASE NOTE:

SELECTED SERVICES AND TREATMENTS UNDER THIS HEALTH PLAN REQUIRE PREAUTHORIZATION IN ORDER TO BE COVERED. TO ENSURE MAXIMUM COVERAGE PLEASE CONSULT WITH YOUR PRIMARY CARE PHYSICIAN, OTHER HEALTH PROFESSIONAL, OR INTERGROUP CONCERNING PREAUTHORIZATION REQUIREMENTS.

IF YOU HAVE QUESTIONS CONCERNING YOUR BENEFITS, PLEASE CONTACT THE INTERGROUP CUSTOMER SERVICE DEPARTMENT AT 1-800-977-7484.

TABLE OF CONTENTS

SECTION II

I. DESCRIPTION OF BENEFITS 59
- Hospital -- Inpatient and Outpatient Services 59
- Physician Office Visits 60
  - Preventive Health Exams and Immunizations for Children 61
  - Adult Female Preventive Health Services 62
  - Adult Male Preventive Health Services 63
  - Adult Immunization Schedule 64
- Ambulance Services 65
- Chiropractic Services 65
- Dental Services 65
- Dialysis Services 66
- Durable Medical Equipment (DME), Support Devices and Braces 66
  - Prosthetics 76
- Emergency Services 68
  - Ambulance Services 65
  - Hospital Services 59
  - Urgent Care Services 80
- Fertility, Infertility and Family Planning Services 70
- Health Education Services 71
- Hearing Services 72
- Home Health Care Services 72
- Hospice Care Services 73
- Maternity Care Services 74
- Medical Supplies 75
- Mental Health Services 75
  - Enhanced Mental Health Benefits 99
- Prescription Drug Enhanced Benefits 101
- Prosthetic Services 76
- Reconstructive Surgery Services 76
- Rehabilitation Services 77
- Skilled Nursing Facility Services 78
- Speech and Language Services 78
- Substance Abuse Services 79
  - Enhanced Substance Abuse Benefits 100
- Transplant Services-- Organ and Tissue 79
- Urgent Care Services 80
- Vision Services 82
  - Enhanced Vision Benefits 103
- X-Ray and Laboratory Services 82
- Intergroup Enhanced Benefits 83

II EXCLUSIONS AND LIMITATIONS 85
(Exclusions and Limitations are listed in alphabetical order)

III. SCHEDULE OF MEDICAL COPAYMENTS AND MAXIMUM BENEFITS 93

IV. ENHANCED BENEFITS PURCHASED BY THE STATE OF ARIZONA 99
- Mental Health and Substance Abuse Benefit 101
- Outpatient Prescription Drug Benefit 103
- Vision Care Benefit 103

SECTION II

DESCRIPTION OF BENEFITS

DESCRIPTION OF BENEFITS

HOSPITAL - INPATIENT AND OUTPATIENT SERVICES

Hospital Services, whether Inpatient or Outpatient, must be arranged through your Primary Care Physician ***except for Emergency situations.*** If Emergency care is needed, your Primary Care Physician must be contacted within forty-eight (48) hours or as soon thereafter as is reasonably possible.

Inpatient Services

Selected Inpatient services and treatments require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Covered Services include, but are not limited to, the following:

- Semiprivate room and board
- Private room when Medically Necessary
- Medications and biologicals ❶
- General nursing care (Special duty nursing when Medically Necessary)
- Inhalation treatment
- Special diets when Medically Necessary
- Meals
- ICU, CCU and other special care units
- Anesthesia
- Radiation treatment
- Operating room and related Facilities
- Oxygen and related services
- Chemotherapy
- Whole blood and blood plasma and its administration
- X-Ray, laboratory and other diagnostic tests
- Physician, and hospital personnel, and services as required

❶ Medications and biologicals are covered while confined in the Hospital. Medications prescribed for use after discharge from an Inpatient Facility must be obtained from a Participating Pharmacy. Prescriptions obtained from an Inpatient Facility will not be covered.

Outpatient Surgery and Ambulatory Surgical Facilities

All Outpatient and Ambulatory Surgical Facility services must be preauthorized in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Covered Services include, but are not limited to, the following:

- X-Ray services
- Oxygen services
- Surgical services
- Chemotherapy
- Inhalation treatment
- Diagnostic tests
- Laboratory
- Anesthesia
- Whole blood and blood plasma and the cost of administration
- Radiation treatment
- Medications and biologicals ❶

❶ Medications prescribed through an Outpatient Facility are subject to the provisions of the "Outpatient Prescription Drug Benefit" purchased by your Group. For detailed information, please refer to the "Outpatient Prescription Drug Benefit".

SECTION II

DESCRIPTION OF BENEFITS

PHYSICIAN OFFICE VISITS

All diagnostic treatments and services by the Primary Care Physician are covered if deemed Medically Necessary. ***Selected services and treatments require prior authorization by Intergroup, or the Medical Group Medical Director in order to be covered.***

Diagnostic treatments and services from a Specialist are also covered ***provided the Member obtains an authorized referral through the Primary Care Physician, or Medical Group, before specialty services are rendered.*** Intergroup allows the following exceptions to the referral requirements:

- Once each Plan Year, female Members may self-refer to a gynecologist within Member's Medical Group, or an Intergroup affiliated gynecologist if none is available within the Member's Medical Group, for a well-woman exam. *This annual exam does not require preauthorization from Intergroup, nor does it require a referral through your Primary Care Physician.* Continued, or follow-up care, from your gynecologist will require a referral through your Primary Care Physician.

- Once each Plan Year, diabetic Members may self-refer to an eye care professional for the purpose of receiving an eye exam for the detection of eye disease. Diabetic Members may self-refer to an ophthalmologist within their Medical Group, or an Intergroup affiliated ophthalmologist if none is available within the Member's Medical Group. *This annual exam does not require preauthorization from Intergroup, nor does it require a referral through your Primary Care Physician.* Continued, or follow-up care, from your ophthalmologist will require a referral through your Primary Care Physician.

- ***All other visits to a Specialist must be Preauthorized or have an approved referral through the Member's Primary Care Physician, Medical Group, or Intergroup before specialty services can be received.***

Visits to your Primary Care Physician include:

- Periodic health assessments as recommended by your Primary Care Physician, or as deemed Medically Necessary. Members are entitled to a health assessment by the Primary Care Physician within twelve (12) months after Coverage begins.

- Immunizations as recommended by your Primary Care Physician, or as deemed Medically Necessary.

- Allergy testing, allergens, and their administration in accordance with accepted medical practice, as deemed Medically Necessary.

- Vision screening for all Members. Your Group Health Plan has purchased enhanced vision benefits. For detailed information on vision services covered, please refer to the "Vision Services Benefit".

- Hearing screenings to determine hearing loss and/or to diagnose and treat a suspected disease or injury to the ear. Your Group Health Plan has purchased enhanced hearing benefits. For detailed information on hearing services covered, please refer to the "Hearing Services" section.

- Treatments of an illness or injury.

PHYSICIAN OFFICE VISITS - Continued

PREVENTIVE HEALTH EXAMS AND IMMUNIZATIONS FOR CHILDREN

The following physical examinations and immunizations will be covered by Intergroup. Additional examinations and immunizations will be covered if deemed Medically Necessary. ***The following preventive care services have been adopted by Intergroup as guidelines only and are not intended to replace clinical medical judgment.***

Health Exams for Children

AGE	EXAMINATION
Newborn through 4 days	One Examination
1 Month	One Examination
2 through 6 Months	One Examination at each 2 Month interval
9 through 15 Months	One Examination at 3 Month intervals
18 Months	One Examination
24 Months	One Examination
2 through 6 Years	One Examination each Year
7 through 18 Years	One Examination every 2 Years

Childhood Immunization Schedule

VACCINE	AGE	IMMUNIZATIONS
Hepatitis B-1	Birth through 2 Months	One
Hepatitis B-2	2 through 4 Months	One
Hepatitis B-3	6 through 18 Months	One
	11 through 12 Years	Three
Diphtheria, Tetanus, Pertussis (DTP)	2 through 6 Months	Three
DTP or Dtap	12 through 18 Months	One
Td Booster	11 through 18 Years	Every 10 Years
H, influenza b (Hib)	2 through 6 Months	Three
	12 through 15 Months	One
Polio (OPV)	2 through 4 Months	Two
	6 through 18 Months	One
	4 through 6 Years	One
Measles, Mumps, Rubella (MMR)	12 through 15 Months	One
	4 through 6 Years	One
	11 through 12 Years	One
Varicella Zoster Virus Vaccine (VZV)	12 through 18 Months	One
	11 through 12 Years	One

SECTION II

PHYSICIAN OFFICE VISITS - Continued

ADULT FEMALE PREVENTIVE HEALTH SERVICES

The following physical examinations will be covered by Intergroup. Additional examinations will be covered if deemed Medically Necessary. ***The following preventive care services have been adopted by Intergroup as guidelines only and are not intended to replace clinical medical judgment.***

Physical Exams	Ages 19 through 39	One exam every 3 years *
	Ages 40 through 60	One exam every 2 years
	Ages 61 and over	One exam each year
Total Cholesterol Screening (for level of blood cholesterol)	Ages 19 and over	One screening every 1 to 3 years depending on risk
Pap Smear and Pelvic Exam (for cervical cancer)	Ages 19 through 39	One exam every 1 to 3 years depending on risk
	Ages 40 and over	One exam each year
Clinical Breast Exam (for breast cancer screening)	Ages 19 through 39	One exam every 1 to 3 years depending on risk
	Ages 40 and over	One exam each year
Mammography (for breast cancer screening)	Ages 35 through 39	One baseline mammogram
	Ages 40 through 49	One mammogram every 2 years, or more frequently based on the recommendation of the Physician
	Ages 50 and over	One exam each year
Fecal Occult Blood (for colorectal cancer)	Ages 40 through 64	One screening every 1 to 3 years depending on risk
	Ages 65 and over	One screening each year
Flexible Sigmoidoscopy (for colorectal cancer)	Ages 50 and over	One screening every 3 to 5 years *
HIV Testing (for HIV Virus)		Periodic testing depending on risk factors

*** Based on High Risk Indicators one to three years**

PHYSICIAN OFFICE VISITS - Continued

ADULT MALE PREVENTIVE HEALTH SERVICES

The following physical examinations will be covered by Intergroup. Additional examinations will be covered if deemed Medically Necessary. ***The following preventive care services have been established by Intergroup as guidelines only and are not intended to replace clinical medical judgment.***

Physical Exams	Ages 19 through 39	One exam every 1 to 3 years *
	Ages 40 through 60	One exam every 2 years
	Ages 61 and over	One exam each year
Total Cholesterol Screening (for level of blood cholesterol)	Ages 19 and over	One screening every 1 to 3 years depending on risk
Fecal Occult Blood (for colorectal cancer)	Ages 40 through 64	One screening every 1 to 3 years depending on risk
	Ages 65 and over	One screening each year
Flexible Sigmoidoscopy (for colorectal cancer)	Ages 50 and over	One screening every 3 to 5 years *
Testicular Exam (for testicular cancer)	Ages 19 and over	Part of physical exams as indicated above
Rectal Exam (for prostate cancer)	Ages 40 and over	One exam each year
Prostrate Specific Antigen (PSA)	Ages 50 and over	One blood test each year *
HIV Testing (for HIV Virus)		Periodic testing depending on risk factors

*** Based on High Risk Indicators one to three years**

SECTION II

PHYSICIAN OFFICE VISITS - Continued

ADULT IMMUNIZATION SCHEDULE

The following immunizations will be covered by Intergroup. Additional immunizations will be covered if deemed Medically Necessary. ***The following schedules have been adopted by Intergroup as guidelines only and are not intended to replace clinical medical judgment.***

Td (Tetanus/Diphtheria)	One booster every 10 years.
Pneumococcal Vaccine	Recommended once for adults over 65 and adults of any age with significant medical conditions. Booster 6 years after prior dose. *
Influenza Vaccine	Recommended yearly for adults over 65 and adults of any age with significant medical conditions and care givers of patients with chronic medical conditions.
Measles/Mumps Vaccine	Recommended for adults born after 1956 without documentation of immunization.
Rubella Vaccine	Recommended for young adults, especially women without documentation of immunization or of seropositivity.
Hepatitis B Vaccine	Recommended for health care workers whose occupation puts them at risk and other Members who are sexually active with more than one partner.
Tuberculin Screening	Recommended for health care workers, persons with HIV, persons with medical conditions that increase risk of TB and foreign persons from countries where TB is common.
Varicella Vaccine	Two doses recommended for healthy adults with no history of previous vaccines or the varicella infection.

*** Based on Medical Necessity as determined by the Primary Care Physician and Medical Group Medical Director**

DESCRIPTION OF BENEFITS

AMBULANCE SERVICES

Selected Ambulance Services require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

- ***Ambulance services rendered in an "emergency" situation do not require preauthorization.***
- Ambulance services when preauthorized through the Primary Care Physician, or Medical Group, are covered.
- Ambulance services which do not meet the emergency criteria and were not preauthorized are not covered.
- Scheduled air evacuation must be preauthorized by Intergroup or Member's Medical Group.
- Emergency evacuation is covered if deemed Medically Necessary.
- Ground or air ambulance travel must be provided by a duly licensed ground or air ambulance service.

CHIROPRACTIC SERVICES

Chiropractic services and treatments are not covered under this Health Plan.

DENTAL SERVICES

Selected Dental Services and treatments require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

THIS IS NOT DENTAL COVERAGE. Covered Dental Services are those services and treatments received in connection with an injury or congenital defect. ***Services normally associated with general dental care or restorative treatments are not covered.***

Medically Necessary covered Dental Services are:

- The repair, but not replacement of Sound Natural Teeth damaged as a result of an accident.
- The reduction or manipulation of fractures of facial bones including the jawbone and supporting tissues due to an accidental injury.
- Oral surgery for the excision of lesions, cysts, or tumors.
- Reconstruction or repair of the mouth or cleft lip necessary to correct anatomical functional impairment caused by congenital defect.

Dental Services do not include:

- Routine care of teeth or dental structures.
- Extraction of impacted teeth and services related to malocclusion or malposition of the teeth or jaw.
- Temporomandibular Joint Disorder (TMJ) except for Medically Necessary services in connection with acute dislocation of the mandible. See "Exclusions and Limitations" section for more details.
- Accidental injury to the teeth or gums caused by chewing.
- Treatment of problems or complications relating to TMJ, including the removal of TMJ implantation.

DESCRIPTION OF BENEFITS

DIALYSIS

Dialysis services require preauthorization in order to be covered. Please consult with your Primary Care Physician, kidney Specialist, or Intergroup concerning preauthorization requirements.

Covered Services include, but are not limited to, the following:

- Medical and Hospital Services for dialysis for renal disease.
- Hemodialysis for Chronic Health Conditions are covered only in Intergroup affiliated Facilities approved for participation in the Medicare program.
- Equipment, training, and medical supplies required for home peritoneal dialysis.
- Maintenance of dialysis equipment required for home peritoneal dialysis.
- A maximum of six (6) out-of-area dialysis treatments per Plan Year are provided when preauthorization has been obtained from both the Medical Group, and an Intergroup Medical Director.

DURABLE MEDICAL EQUIPMENT (DME), SUPPORT DEVICES AND BRACES

Selected equipment, support devices and braces require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup, concerning preauthorization requirements.

Durable Medical Equipment (DME) :

- Coverage includes, but is not limited to, crutches, canes, walkers, standard size manual wheelchairs and manual hospital beds.
- A standard power operated wheelchair will also be covered when deemed Medically Necessary. Standard power operated wheelchairs will be replaced only once during any five (5) year period following a determination by Utilization Management that repair of the unit is not cost effective.
- Glucometers are covered for both insulin-dependent and non insulin-dependent Members when necessary for medical management as determined by the Primary Care Physician.
- Peak flow meters are covered when prescribed by a Participating Physician.
- Any equipment issued to a Member may be subject to a nominal deposit which will be refunded upon the return of the equipment in satisfactory condition.
- DME items must be obtained from a Participating Provider of DME to be covered.
- DME does not become the property of the Member and must be returned when use is no longer necessary. If the equipment is not returned by the Member or is returned in poor condition, the Member may be responsible for the cost to replace or repair the equipment.

DURABLE MEDICAL EQUIPMENT (DME) - Continued

Durable Medical Equipment (DME) - Continued

- Intergroup retains the right to determine if DME items shall be leased or purchased.
- More than one (1) DME device designed to provide essentially the same functional assistance is not covered.
- Repair and/or replacement of equipment or parts worn out due to normal wear are covered when approved by Utilization Review. Repair or replacement of equipment or parts due to misuse, abuse, adjustment, model upgrades and duplicates are not covered.
- A Member may request specialized equipment but the extra cost associated with such specialized equipment will be the responsibility of the Member.

Support Devices:

- Coverage is limited to rigid or semi-rigid devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part.
- Custom made or molded support devices, as deemed Medically Necessary, will be covered.

Braces:

- Coverage is limited to therapeutic braces dispensed, prescribed and authorized through a Participating Physician, which cannot be reused by another person and are necessary for a Member to engage in the activities of normal daily living.
- Replacement of braces is covered only when deemed Medically Necessary and result from a change in a Member's medical condition such as physical growth. Maintenance and repairs are limited to Medical Necessity and require preauthorization.
- Replacement, maintenance and repairs is not covered for abuse or misuse of braces.
- Over-the-counter braces and prophylactic braces used primarily for sports activities are not covered.

DESCRIPTION OF BENEFITS

EMERGENCY SERVICES

Treatments and services received in an "emergency" situation do not require preauthorization in order to be covered. Coverage applies to both Participating and Non-Participating Providers and Facilities.

Emergency is defined as a condition or illness which, if not immediately diagnosed and treated, would result in extended or permanent physical impairment or loss of life, and which requires the Member to seek immediate medical attention necessary for the relief of acute pain, repair of accidental injury, initial treatment of infection or the relief of illness. Examples of emergency include a severe burn, profuse bleeding, a suspected heart attack, sudden acute pain in the chest, a severe allergic reaction or suspected poisoning. Members having any of these symptoms should go directly to a hospital emergency room or dial 911.

Emergency Services are defined as those covered services which are provided by a Health Professional to treat a medical emergency condition. Emergency Services are provided 24 hours a day, 7 days a week, **worldwide.**

Emergency Services :

- ***do not require preauthorization in order to be covered.***
- include an initial medical screening examination and any immediate necessary stabilization treatment or services. Additional treatments or services may be retrospectively reviewed for Medical Necessity.
- require the Member to notify the Primary Care Physician within 48 hours after emergency services are provided by a non-Participating Provider, or as soon thereafter as is medically possible. Intergroup may transfer a Member to a Participating Hospital for continued care if it is medically appropriate.
- *do not include non-emergent, continuing, routine or follow-up care unless authorized through the Primary Care Physician or Intergroup.*
- require the Member to provide full details, including medical records of emergency services rendered by a Non-Participating Provider, if requested by this Health Plan. Costs associated with emergency services will be reimbursed only after Intergroup receives and reviews the emergency medical records and determines that such services were Medically Necessary. Member will be financially responsible for any emergency room charges for any non-emergency services as determined by Intergroup. Services which have been preauthorized will not be retrospectively denied during the review of charges incurred.
- Emergency copayments will be waived if the Member is admitted to the Hospital.

EMERGENCY SERVICES - Continued

Emergency Services Received Outside the Service Area

- Members who sustain an injury or become ill while away from the Service Area may receive emergency services as provided above. Benefits are limited to situations which require immediate attention.
- Services for pregnancy, outside of the Service Area, do not include Term Delivery (37 weeks or more), or routine prenatal visits. Unforeseen complications of pregnancy, or an unexpected delivery, are covered. Member is required to contact the Primary Care Physician, as soon as is reasonably possible, in such cases.
- Emergency copayments will be waived if the Member is admitted to the Hospital.

Emergency Follow-Up Services Outside the Service Area

- Members requiring emergency or urgent care services, while located outside of the Service Area, may receive follow-up care from a non-Participating Provider outside the Service Area, subject to the following provisions.
- Follow-up services are limited to those services or treatments received ***following, and directly related to, an emergency or urgent care situation which occurred outside the Service Area.***
- Follow-up services received outside the Intergroup Service Area are limited to a maximum benefit of Five Hundred Dollars ($500.00) per Plan Year. This benefit limitation shall apply to services received following an emergency or urgent care situation only, or a combination thereof. Preauthorization from your Primary Care Physician is not required, however, claims or reimbursement for services may be retrospectively denied by Intergroup if such follow-up treatment or services are determined to be routine care and not directly connected to an emergency or urgent care situation, which occurred while the Member was located outside of the Service Area. Emergency and urgent care situations must meet the criteria as defined within this Evidence of Coverage.
- Charges for a Member's initial visit to the emergency room or urgent care facility shall not apply to the benefit limitation for follow-up care.
- Charges for routine care received by a Member outside of the Service Area are not covered.
- For purposes of this sub-section, "outside of the Service Area" shall be defined as outside of the State of Arizona.

FERTILITY, INFERTILITY AND FAMILY PLANNING SERVICES

Fertility, Infertility and Family Planning Services must be preauthorized through the Primary Care Physician, Medical Group, or Intergroup in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Fertility, Infertility and Family Planning services are covered as provided below, with respect to Member's family only, and when determined to be Medically Necessary due to physiological dysfunction.

Covered Fertility / Infertility Services include, but are not limited to, the following:

- Physical examinations / medical history
- Sperm count, to determine the cause of infertility
- Endometrial biopsy
- Surgery or other treatment for endometriosis, diagnosed or identified in the course of fertility or infertility treatment
- Hysterosalpingography
- Diagnostic laproscopy
- Artificial insemination. Services are limited to one (1) treatment period of up to six (6) cycles per lifetime
- ***50% Copayment required on all Fertility / Infertility Services***

Covered Family Planning Services include, but are not limited to, the following:

- **Sterilization Procedures**
  Tubal Ligation and Vasectomy procedures are covered under the "Outpatient Surgery Benefit".

- **Genetic Testing**
  Diagnostic genetic testing is covered when deemed Medically Necessary and authorized through the Primary Care Physician, or referring Specialist. Genetic testing for the purposes of determining the gender of a fetus is not covered.

- **Contraceptives - Implants, Insertions and Removals**
  Voluntary contraceptive implants, insertions and removals are limited to the following:
  - Implants and insertions are limited to one (1) in every three (3) year period while covered under this Health Plan.
  - Coverage is limited to either an IUD or Norplant.
  - Removals are limited to one (1) non-Medically Necessary contraceptive removal in every three (3) year period while covered under this Health Plan
  - ***50% Copayment required on contraceptive implants, insertions and devices.***

- **Contraceptives - Oral and Injection**
  - Prescribed diaphragms and oral contraceptives, including birth control pills, are covered under the "Outpatient Prescription Drug Benefit".
  - Depoprovera injections are covered when administered through the Primary Care Physician. Please refer to the Section entitled "Physician Office Visits".

FERTILITY, INFERTILITY AND FAMILY PLANNING SERVICES - Continued

The following procedures and services are not covered:

- In vitro fertilization
- Embryo or ovum transfer
- Zygote transfers
- Gamete transfers
- GIFT procedure
- Cost of donor sperm
- Reversal of elective sterilization
- Foams
- Condoms
- Artificial insemination services are not covered in the event the Member has a voluntary sterilization procedure
- Medications used to treat infertility
- Medications whose primary purpose is to achieve pregnancy

HEALTH EDUCATION SERVICES

Health Education Services are provided for specific conditions on an as needed basis. These services include instruction on achieving and maintaining physical and mental health and preventing illness or injury. Some services may be provided in the Physician's office or during hospitalization. Services or education may also be received from other sources when preauthorized.

Health Education Services include, but are not limited to, the following:

- Health promotion for stress reduction
- Mother and baby prenatal classes
- Nutritional classes
- Congestive heart failure counseling
- Instructions on prevention of illness or injuries
- Sex education and prevention of sexually transmitted disease
- Smoking cessation classes
- Lamaze classes
- Weight Management classes
- Asthma counseling
- Disease Management

A nominal fee may be charged for optional Health Education Services furnished by Intergroup. The benefits available under this subsection are different from and should not be confused with Intergroup's Worksite health promotion programs which are offered to employers for their employees.

HEARING SERVICES

Selected Hearing Services and treatments require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Hearing Screening and Examinations

- Hearing screenings to determine hearing loss and/or to diagnose and treat a suspected disease or injury to the ear are covered when such services are performed through the Primary Care Physician.
- Referrals to a Specialist are covered, when authorized through the Primary Care Physician, when an initial consultation and/or audiogram is determined to be Medically Necessary.

Hearing Aids

- *Hearing aids are covered at 100%, up to a maximum benefit of $1,000.00 per ear, per Plan Year, when preauthorized through the Primary Care Physician, referring Specialist or Intergroup.*
- Repair and/or replacement of hearing aids is not provided for abuse, misuse and/or loss of parts. Model upgrades are not covered.
- Hearing aids must be obtained from a Medical Group affiliated Provider, or as directed by the Medical Group, to be a covered benefit.

Cochlear implants

- Cochlear implants are covered when deemed Medically Necessary by the Primary Care Physician or referring Specialist.

HOME HEALTH CARE SERVICES

Home Health Care Services require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Coverage includes:

- Nursing care under the supervision of a registered nurse, rehabilitative therapy and IV therapy, are provided when prescribed, authorized or ordered through the Primary Care Physician and provided by a Home Health Agency within the Service Area.

- Custodial Care, as defined in the "Definition" section, is not covered.

HOSPICE CARE SERVICES

Hospice Care Services require preauthorization by the Medical Group, or Intergroup in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Members who are diagnosed as having an illness giving them a life expectancy of six (6) months or less, may request Hospice Care. All Hospice Care must be provided by licensed participating hospices. Services include Inpatient and Outpatient care related to the terminal condition and family counseling.

Hospice Care Providers must be able to provide:

- Licensed nursing care
- Physical therapy
- Respiratory therapy
- Medical social services
- Medical supplies
- Medications
- Home health aide
- Physician Services
- Short-Term Inpatient care
- Care for pain control
- Care for acute and chronic symptom management
- Counseling/bereavement services
- Appliances
- Homemaker services
- Services of volunteers

DESCRIPTION OF BENEFITS

MATERNITY CARE SERVICES

Selected Maternity Care Services and treatments require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

All Medically Necessary services relating to prenatal, delivery and post-partum care are covered. Maternity Care benefits include, but are not limited to, the following:

- Prenatal and post-partum care
- Birth services
- Delivery room
- Operations
- Anesthesia
- Injectables
- Ultrasound
- X-Ray and laboratory services
- Special procedures such as a Caesarean Section
- Prenatal diagnostic procedures in cases of high risk pregnancy or as otherwise Medically Necessary

- **Subscriber must notify Intergroup within thirty one (31) days of the birth of a newborn child to ensure Dependent coverage.**

- The expenses of the natural mother of any child legally adopted by the Subscriber, or a child placed for adoption with the Subscriber, within one (1) year of birth, are covered, provided that:
  - The Subscriber must be legally obligated to pay the costs of such birth;
  - The Subscriber must pay all required Copayments for such care;
  - The Subscriber must otherwise be eligible for Coverage;
  - Subscriber must notify Intergroup of his/her acceptability to adopt within thirty-one (31) days after approval of the adoption, placement for adoption, or enrollment in this Plan, whichever event first occurs;
  - Subscriber must notify Intergroup of the existence and extent of any coverage the natural mother may have. If the natural mother has maternity benefits under another health Plan, those benefits will be primary. Intergroup's benefits will be secondary, if needed.
  - Adopted children, or children placed for adoption, will be covered by Intergroup to the same extent that such coverage applies to other Members of the family. Subscriber shall pay any applicable Premium, if required.

- Medically Necessary services, including Hospital services, are also provided for the newborn child, (including legally adopted newborn children and children who have been placed for adoption with the Subscriber), immediately after birth. In addition, medical services for the newborn child shall be provided for the first thirty-one (31) days following birth. Extended coverage beyond the first thirty-one (31) days following birth is subject to the enrollment requirements and receipt by Intergroup of any required premiums, if applicable.

MEDICAL SUPPLIES

Selected Medical Supplies require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Medical Supplies covered include, but are not limited to, the following:

- Therapeutic oxygen and equipment for the administration of oxygen
- Casts and splints
- Surgical dressings are limited to those provided under the supervision of a Home Health Agency and prescribed or preauthorized
- Colostomy supplies and catheters
- Outpatient tube feeding supplies are covered up to thirty (30) days per Member, per lifetime
- Most Medical Supplies are issued for a thirty-one (31) day supply at a time

Medical Supplies not covered, include but are not limited to, the following:

- Food supplements and formulas which are provided in an ambulatory, outpatient or home setting.
- Over-the-counter dressings and soft goods, such as ace wraps, not provided in the Primary Care Physician's office.

MENTAL HEALTH SERVICES

Mental Health Benefits must be preauthorized by Catalina Behavioral Health Services in order to be covered. To access benefits available, please contact Catalina Behavioral Health Services at 1-800-977-0281.

Your Group Health Plan has purchased enhanced Mental Health benefits. For detailed information on covered services and treatments provided, please refer to the "Mental Health and Substance Abuse Services Benefit" following the "Schedule of Medical Copayments and Maximum Benefits" within this Section.

PROSTHETIC SERVICES

Prosthetic Services are covered when determined to be Medically Necessary. These services require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Coverage includes, but is not limited to, the following:

- Prosthetic Devices are covered when they are the initial purchase after an illness, injury or surgery which is covered under this Health Plan. Coverage includes the initial fitting and purchase of a standard model unless Member's medical needs cannot be met, then upgrade as Medically Necessary. Repair, replacement and servicing is covered if deemed Medically Necessary and results from a change in Member's physical condition.
- Artificial limbs including the initial purchase, and subsequent purchases due to physical growth, for a Covered Member that meets all other screening criteria. Artificial limbs must be obtained from a Participating Provider to be covered. Coverage is limited to limbs that are necessary because of an illness or injury which occurred while the person was a Member of this Health Plan. Model upgrades, repairs and/or replacement of parts, or devices worn out due to normal wear or misuse, are not covered.
- The first pair of contacts or corrective lenses following cataract surgery, treatment of keratoconus or corneal transplantation are covered; including a frame allowance up to Seventy-Five Dollars ($75.00).
- Breast prosthesis following a covered mastectomy and up to two (2) external postoperative prostheses per breast and two (2) mastectomy bras per lifetime are covered. *This benefit does not require preauthorization to be covered.*

RECONSTRUCTIVE SURGERY

Reconstructive Surgical Services are covered when determined to be Medically Necessary. Selected services require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Reconstructive Surgical Services include:

- Cosmetic, Plastic and related Reconstructive Surgeries are limited to the correction of congenital birth defects and effects of disease or injury which cause anatomical functional impairment. Authorization of surgical procedures shall be based upon the reasonable expectation that the condition or disease will be corrected.
- Surgical services for breast reconstruction and for external post-operative prostheses incidental to mastectomy are covered. *External post-operative prostheses incidental to mastectomy do not require preauthorization by Intergroup.* Replacement will be made when prostheses are no longer functional. Custom made prostheses will be provided only when Medically Necessary.
- Reconstructive surgery to correct an abnormal structure resulting from trauma or disease when there is no restorative function is not covered.

REHABILITATION SERVICES

Rehabilitation Services are covered when determined to be Medically Necessary. These services require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Rehabilitation Services and treatments for Acute conditions when significant improvements can be expected in a predictable period of time are covered. A "predictable period of time" means sixty (60) consecutive days beginning from the date of the initial treatment for any separate and distinct injury or condition. Continued rehabilitation beyond the sixty (60) day limit is covered if determined to be Medically Necessary through the Primary Care Physician or referring Physician.

Rehabilitative Services include, but are not limited to, the following:

- Physical therapy
- Occupational therapy
- Cardiac rehabilitation
- Other rehabilitative services when determined to be Medically Necessary through the Primary Care Physician or referring Physician
- Pulmonary rehabilitation

Limitations:

- Services and treatment must be for impairment of capacity or development due to accidental injury or other medical conditions.
- Services are provided on either an Outpatient or Inpatient basis as determined through the Primary Care Physician, or referring Physician.
- Rehabilitative Services provided in any setting (Inpatient Rehabilitation or Outpatient Facility, or any combination thereof) are limited to sixty (60) consecutive days per condition or injury.
- Continued rehabilitation beyond the sixty (60) consecutive day limit is covered if determined to be Medically Necessary by the Primary Care Physician or referring Physician. Continued rehabilitation is subject to copayments. See the "Schedule of Medical Copayments and Maximum Benefits". This benefit does not apply to Mental Health or Substance Abuse Services. For a detailed description of the Mental Health and Substance Abuse services, please refer to the "Mental Health and Substance Abuse Services Benefit".
- Rehabilitative services for the purpose of maintaining physical condition, or for a Chronic Condition, are not covered services.

SKILLED NURSING FACILITY SERVICES

Skilled Nursing Facility Services are covered when determined to be Medically Necessary. These services require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

Skilled Nursing Services include, but are not limited to, the following:

- Admission to a Skilled Nursing Facility.
- Medical care and treatment, including room and board in semi-private accommodations at a Skilled Nursing Facility which is a Participating Provider for non Custodial Care.
- Skilled Nursing services shall be of a temporary nature. Services must be supported by a treatment plan.
- Services must be approved in advance through the Primary Care Physician as Medically Necessary, with expectations of rehabilitation and increased ability to function.
- Custodial or domiciliary care is not covered.

SPEECH AND LANGUAGE SERVICES

Selected Speech and Language services require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup concerning preauthorization requirements.

- Speech and Language Services (speech therapy) are limited to corrections of speech impairment related to an accident, injury, stroke or surgical procedure that occurred while Member is covered under this Health Plan.
- Speech and language services are limited to treatment for conditions which in the judgment of the Participating Physician are subject to significant improvement within sixty (60) consecutive days per condition. Continued rehabilitation beyond the sixty (60) day limit is covered if determined to be Medically Necessary by the Primary Care Physician or referring Physician. Continued rehabilitation is subject to copayments. See the "Schedule of Medical Copayments and Maximum Benefits".

SUBSTANCE ABUSE SERVICES

Substance Abuse Benefits must be preauthorized by Catalina Behavioral Health Services in order to be covered. To access benefits available, please contact Catalina Behavioral Health Services at 1-800-977-0281.

Diagnosis and medical treatment for alcohol and drug abuse, including Inpatient or Outpatient detoxification, is provided. Please refer to the "Mental Health and Substance Abuse Services Benefit" for detailed information on services and treatments provided under this Group Health Plan.

TRANSPLANT SERVICES - ORGAN AND TISSUE

All Organ and Tissue Transplants must be preauthorized through the Primary Care Physician and an Intergroup Medical Director to be covered. Please consult with your Primary Care Physician, or an Intergroup Case Manager, concerning preauthorization requirements.

Authorization for transplants is based on specific medical and eligibility criteria. The Primary Care Physician and an Intergroup Medical Director must determine the Medical Necessity of the transplant. Intergroup reserves the right to determine which Physician, Hospitals or other Providers may be utilized to provide transplants and all services relating to transplants.

Intergroup uses established medical criteria from contracted Medical Centers of Excellence when determining benefits and Coverage for internal organ and tissue transplants. Intergroup will provide Coverage for all Medical and Hospital Services in connection with Medically Necessary transplant surgery based on current criteria. The following organ and tissue transplants are covered:

- Heart
- Lung
- Simultaneous Heart / Lung
- Autologous and Allogenic Bone Marrow Stem Cell
- Cornea
- Liver
- Kidney
- Simultaneous Kidney / Pancreas

- Donor searches for bone marrow transplants are covered. ***Donor searches are limited to $5,000.00 per organ per lifetime.*** Coverage includes Medically Necessary services, supplies and medications provided to a donor whether or not the donor is a Member of Intergroup. Such Coverage is only available for the purpose of obtaining organs or other tissue for transplants where the recipient is an Intergroup Member.
- Transplants which are considered Experimental or Investigational are not covered.

DESCRIPTION OF BENEFITS

URGENT CARE SERVICES

Selected Urgent Care services and treatments require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup for preauthorization requirements.

Urgent Care is defined as those services which are provided for the relief of acute pain, initial treatment of acute infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Examples of urgent care services would include minor sprains, fractures, pain, heat exhaustion, and breathing difficulties, other than those of sudden onset and persistent severity. An individual patient's Urgent condition may become emergent upon evaluation by a Participating Provider.

Urgent Care Facility is defined as any licensed Facility that provides Physician services for the immediate treatment only of an injury or disease, and which has contracted with Intergroup to provide Members such services. Urgent Care Services are provided at Intergroup affiliated or non-affiliated Urgent Care Facilities, or Physician Offices.

To ensure the maximum benefits available under this Health Plan, Members seeking Urgent Care Services should contact their Primary Care Physician before seeking treatment. The Primary Care Physician, or his designee, will discuss the illness or injury in question and will instruct you on the appropriate care which should be taken. This may include medical advice over the telephone, or you may be directed to the nearest Urgent Care Facility for treatment.

Urgent Care Services :

- include treatment for unforeseen medical situations (initial visit only) *worldwide;*
- *do not include continuing, routine or follow-up care unless such services are preauthorized through the Primary Care Physician or Intergroup;*
- require the Member to provide full details, including medical records of urgent care services rendered by a Non-Participating Provider, if requested by this Health Plan. Costs associated with urgent care services will be reimbursed only after Intergroup receives and reviews the urgent care medical records and determines that such services were Medically Necessary. Services which have been preauthorized will not be retrospectively denied during the review of charges incurred.
- ***Urgent Care Services which have been preauthorized through the Primary Care Physician or Intergroup, and are received at an Intergroup affiliated Provider within the Service Area, shall not be subject to a copayment. Urgent Care Services which are received at a non-affiliated Provider are subject to a $50.00 copayment.***

URGENT CARE SERVICES - Continued

Urgent Care Services Received Outside the Service Area

- Members who sustain an injury or become ill while away from the Service Area may receive urgent care services as provided above.
- Services and treatments received in Urgent Care Facilities outside the Service Area are subject to a $50.00 copayment.

Urgent Care Follow-Up Services Outside the Service Area

- Members requiring urgent care services, while located outside the Service Area, may receive follow-up care from a non-Participating Provider outside the Service Area, subject to the following provisions.
- Follow-up services are limited to those services or treatments received ***following, and directly related to, an emergency or urgent care situation which occurred outside the Service Area.***
- Follow-up services received outside the Intergroup Service Area are limited to a maximum benefit of Five Hundred Dollars ($500.00) per Plan Year. This benefit limitation shall apply to services received following an emergency or urgent care situation only, or a combination thereof. Preauthorization from your Primary Care Physician is not required, however, claims or reimbursement for services may be retrospectively denied by Intergroup if such follow-up treatment or services are determined to be routine care and not directly connected to an emergency or urgent care situation, which occurred while the Member was located outside of the Service Area. Emergency and urgent care situations must meet the criteria as defined within this Evidence of Coverage.
- Charges for a Member's initial visit to the emergency room or urgent care facility shall not apply to the benefit limitation for follow-up care.
- Charges for routine care received by a Member outside of the Service Area are not covered.
- For purposes of this sub-section, "outside of the Service Area" shall be defined as outside of the State of Arizona.

VISION SERVICES

One (1) vision exam by a Participating Specialist Physician is covered as provided in the "Schedule of Medical Copayments and Maximum Benefits".

Your Group Health Plan has purchased enhanced Vision benefits. For detailed information on services and treatments provided, please refer to the "Vision Care Services Benefit".

X-RAY AND LABORATORY SERVICES

Selected X-Ray and Laboratory services may require preauthorization in order to be covered. Please consult with your Primary Care Physician, other Health Professional, or Intergroup for preauthorization requirements.

All X-Ray and Laboratory tests, services and materials are covered including, but not limited to, the following:

- Diagnostic X-rays
- X-Ray therapy
- Fluoroscopy
- Laboratory tests
- Portable X-Rays
- Electrocardiograms
- Therapeutic Radiology Services ●
- Mammography

● . Therapeutic radiology requires preauthorization

INTERGROUP ENHANCED BENEFITS

The following enhanced benefits are provided by Intergroup:

- ***"Baby Beeper" Digital Pagers.*** Intergroup offers expectant Members the free use of a digital pager during the last month of pregnancy. *Contact the Intergroup Customer Service Department at 1-800-977-7484 for information.*

- ***"Car Seat Rebate".*** Intergroup offers its Members a rebate up to $25.00 on the purchase of a child car seat. The following restrictions apply:

  - Rebate is limited to one car seat per child (age 4 or under) covered under this Health Plan.
  - Car seat must be purchased while Member is covered under this Health Plan.
  - *Contact the Intergroup Customer Service Department at 1-800-977-7484 for rebate forms.*

- ***"Safety Helmet Rebate".*** Intergroup offers its Members a rebate up to $25.00 on the purchase of safety helmets. The following restrictions apply:

  - Rebate is limited to safety helmets (not hats);
  - Helmets must be approved for its intended use. Bike helmets must be ANSI/SNELL approved; helmets for rock climbing must be UIAA or ANSI approved; motorcycle helmets must be DOT or SNELL approved; equestrian helmets must be ASTM and SEI approved. Prior to purchasing helmets Members should verify with the purchaser that the helmets meet the proper certification, approval or standards;
  - One helmet (per type) per Member;
  - The helmet must be purchased while the Member is covered under this Health Plan.
  - *Contact the Intergroup Customer Service Department at 1-800-977-7484 for rebate forms.*

- ***"Discounts on Health Club Memberships".*** Selected fitness centers offer Intergroup Members discounts on Membership. *Please contact the Intergroup Customer Service Department for a list of participating fitness facilities.*

- ***"Member Newsletter".*** As a Member of Intergroup you will receive newsletters throughout the year with information about good health and news about how to get the most from your Intergroup membership.

Contact the Intergroup Customer Service Department at 1-800-977-7484 with questions about these benefits.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS AND LIMITATIONS

In addition to those Exclusions and Limitations described in the "Description of Benefits" section of this Evidence of Coverage, ***the following services are not covered or are limited in benefit application:***

1. **Abortions**
   Abortions are not covered, unless the abortion is necessary to save the life of the woman.

2. **Altered Gender Characteristics**
   Any procedure or treatment designed to alter physical characteristics of the Member from the Member's biologically determined gender to those of another gender, regardless of any diagnosis of gender role disorientation or psychosexual orientation. Furthermore, the treatment for hermaphroditism and any studies or treatment related to gender transformation or hermaphroditism are not covered.

3. **Abuse/Addiction (Treatment of)**
   Abuse of, or addiction to, alcohol, narcotics or other drugs, except as specifically stated or covered in the Group Enrollment Agreement and described in this Evidence of Coverage. Except in cases of Emergency, services resulting from such abuse are not covered unless preauthorized by Catalina Behavioral Health Services.

4. **Benefits/Services (Non-Covered)**
   Services, supplies, or accommodations which are not Medically Necessary and not specifically listed as a Covered Service in this Evidence of Coverage. Services that are incident or attendant to a non-covered service are not covered.

5. **Breast Implants**
   Non-Medically Necessary removal of breast implants and replacement of breast implants are not covered.

6. **Chiropractic Care**
   Chiropractic services and treatment are not covered under this Health Plan.

7. **Circumcision**
   Non-Medically Necessary circumcisions after the newborn period are not covered.

8. **Cosmetic Surgery or Reconstructive Surgery**
   Cosmetic or Reconstructive surgery, which in the opinion of Intergroup is, performed to alter an abnormal or normal structure solely to render it more esthetically pleasing where no significant anatomical functional impairment exists is considered cosmetic and is not covered. The following are examples of non-covered services:

   - Rhinoplasty and associated surgery
   - Rhytidectomy or rhytidoplasty
   - Breast augmentation
   - Blepharoplasty without visual impairment
   - Breast reduction which is not Medically Necessary
   - Otoplasty
   - Skin lesions without functional impairment, suspicion of malignancy or located in area of high friction
   - Keloids

Cosmetic Surgery or Reconstructive Surgery - Continued

- Treatment of cavernous hemagiomas unless Medically Necessary
- Procedures utilizing an implant which does not alter physiologic function
- Treatment or surgery for sagging or extra skin
- Liposuction

This exclusion does not apply to birth abnormalities of a Covered Dependent relating to medically diagnosed congenital defects, birth abnormalities or prematurity. This exclusion does not apply to breast reconstruction incident to a covered mastectomy.

9. **Custodial Care**
Any service, supply, care or treatment that Intergroup determines to be incurred for rest, domiciliary, convalescent or Custodial Care are not Covered Services. Examples of non-covered services include the following:

- Any assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medications.
- Any care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse.
- Non- Covered Custodial Care Services shall be excluded no matter who provides, prescribes, recommends or performs those services. The fact that certain Covered Services are provided while the Member is receiving Custodial Care does not require Intergroup to cover Custodial Care.

10. **Dental Services**
Routine dental care and dental X-rays, dental appliances and orthodontia. Medical treatments relating to orthognatic and/or arthroplastic surgery. Dental splints, implants and prosthesis. Services related to tooth or gum damage caused by or arising out of the act of chewing. All dental services, except oral surgery, as provided in this Evidence of Coverage, are excluded.

11. **Durable Medical Equipment**
Durable Medical Equipment which has not been specifically stated as being a covered item in this Evidence of Coverage, is excluded. Examples of non-covered services include the following:

- exercise equipment, Jacuzzi and whirlpools and hygienic equipment
- items used in a Member's home or an institution, such as oxygen tents and hospital beds, unless these items have been preauthorized by Intergroup

12. **Emergency Services**
Emergency Services for non-Emergency purposes.

13. **Ex-Member (Services for)**
Benefits and services provided to an ex-Member after termination of the ex-Member pursuant to the Group Enrollment Agreement.

14. **Experimental/Investigational Procedures**
Experimental and/or Investigational medical, surgical or other experimental health care procedures, services or supplies. Experimental and/or Investigational procedures, services or supplies are those which, in the judgment of Intergroup:
    - are in a testing stage or in field trials on animals or humans;
    - do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed;
    - are not in accordance with generally accepted standards of medical practice; or
    - have not yet been shown to be consistently effective for the diagnosis or treatment of the Member's condition.

15. **Experimental/Investigational Medications**
Medications, devices, equipment or substances deemed to be experimental by Intergroup including; Medications or substances used for other than FDA approved indications; or Medications labeled "Caution, Limited by Federal Law to Investigational Use".

16. **Family Member (Services Provided by)**
Services provided by a Member's immediate family, (or a spouse's immediate family if applicable), will not be covered. For purposes of clarification, "immediate family" shall include spouse, children, brothers, sisters, parents and grandparents.

17. **Food Supplements**
Food supplements and formulas are not covered when provided in the ambulatory/outpatient/home setting.

18. **Gastric Stapling**
Gastric Stapling and other similar restrictive gastrointestinal surgery.

19. **Genetic Testing**
Genetic testing which is not deemed to be Medically Necessary. Genetic testing for the purposes of determining the gender of a fetus is not covered.

20. **Governmental Hospital Services**
    - Services received in a Veteran's, Marine, or other federal Hospital;
    - Care for conditions that federal, state, or local law requires be treated in a public Facility;
    - Any service received for which a Member has no responsibility to pay, including conditions covered by Worker's Compensation, whether or not the Member claims compensation.

21. **Hair Analysis**
Testing using a patient's hair except for the detection of lead or arsenic poisoning.

22. **Heavy Metal Screening and Mineral Studies**
All cost for such screening or studies is excluded. Screening for lead poisoning is covered when authorized and directed through the Primary Care Physician.

23. **Household Equipment**
Purchase or rental of household equipment which have customary purposes other than medical. Examples of non-covered services include exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds.

24. **Household Fixtures**
Fixtures. Examples of non-covered services include the purchase or rental of escalators or elevators, ramps, saunas, swimming pools or other household fixtures.

25. **Immunizations**
    - Immunizations for foreign travel and medications related to such foreign travel;
    - Immunizations for employment;
    - Immunizations not deemed Medically Necessary.

26. **Lost Wages**
Lost wages for any reasons.

27. **Medical Supplies**
Medical Supplies, consumable or disposable, (except as provided for in the Evidence of Coverage). Examples of non-covered Medical Supplies include elastic stockings, ace bandages, gauze, alcohol swabs and dressings.

28. **Mental Health**
Any Mental Health Services not specifically listed as a Covered Service in the Group Enrollment Agreement and described in this Evidence of Coverage are excluded. Also excluded are treatments or services for learning disorders and Mental Health Service required by court order, or as a condition of parole or probation, marriage counseling, and child custody evaluations.

29. **Military Service Connected Conditions (Care of)**
Care of military service connected conditions for which the Member is legally entitled to services and for which Facilities are reasonably accessible to the Member. This includes illness or injury that developed while in the military service.

30. **Missed Appointments**
Charges made to Member by a Provider for not keeping or the late cancellation of appointments.

31. **Non-Participating Provider (Services Rendered by)**
Benefits and services from Non-Participating Providers, except in the case of a medical Emergency or services Preauthorized in advance by Intergroup.

32. **Obesity (Treatment of)**
Treatment of obesity. Examples of non-covered services include, weight reduction programs including related supplies, Liposuction and laboratory tests included in such programs, balloon insertion and removal, gastric stapling and other procedures and complications arising therefrom. Weight Management classes, through Intergroup, are covered.

33. **Orthotics**
Orthotics which are not specifically identified as covered in this Evidence of Coverage. Examples of non-covered services include shoe lifts, arch supports, corrective shoes, and non-custom made or molded support devices, are excluded.

34. **Out-of-Service Area Services**
Services received outside of the Service Area, except for Emergency and Urgent Care Services as defined in this Evidence of Coverage, are not covered, unless preauthorized in advance by Intergroup. Examples of non-covered services include the following:

- Services or treatments which could have been provided by Intergroup within the Service Area;
- Services which were furnished after the Member's condition would permit the Member to return to the Service Area for continued care;
- Services which were connected with conditions resulting during travel which had been advised against because of health reasons such as impending surgery and/or delivery;
- Treatment in progress by a Participating Provider;

35. **Over-the-Counter Medications**
Over-the-counter medications.

36. **Personal Comfort Items**
Personal comfort or convenience items, including services such as, guest meals and accommodations, telephone charges, travel expenses, take-home supplies, barber or beauty services, radio, television and private rooms unless the private room is Medically Necessary.

37. **Physical and Psychiatric Exams**
Physical, psychiatric or psychological examinations or testing, and vaccinations, immunizations, treatments, or testing for purposes of:

- Obtaining or maintaining employment
- Premarital and pre-adoptive purposes by court order
- Obtaining or maintaining insurance
- Otherwise relating to employment or insurance
- Obtaining or maintaining license of any type
- Relating to judicial or administrative proceeding
- Medical research
- Travel in foreign countries
- School physicals

EXCLUSIONS AND LIMITATIONS

38. **Prescription Medications**
    Take home prescription drugs and medications from a Hospital or other Inpatient Facility are not covered.

39. **Private Duty Nursing**
    Private duty nursing and private rooms except when Medically Necessary. Private duty nursing does not include non-skilled care, custodial care, or respite care.

40. **Radial Keratotomy**
    Radial Keratotomy and other refractive eye surgery.

41. **Reconstructive Surgery**
    Reconstructive Surgery to correct an abnormal structure resulting from trauma or disease when there is no restorative function expected. This exclusion does not apply to breast reconstruction following a covered mastectomy, nor does it apply to birth abnormalities of a covered Dependent relating to medically diagnosed congenital defects, birth abnormalities or prematurity.

42. **Rehabilitation Services**
    Rehabilitation Services, maintenance therapies, or therapies where a significant and measurable improvement of a condition cannot be expected in a reasonable and generally predictable period of time. Any combination of physical and occupation therapies, which exceed a period of sixty (60) consecutive days beginning from the date of the initial evaluation for any separate or distinct injury or condition, must be deemed Medically Necessary and preauthorized through the Primary Care Physician, other Health Professional, or Intergroup. Please refer to the "Description of Benefits" for limitations.

43. **Routine Foot Care**
    Routine foot care. Examples of non-covered services include trimming of corns, calluses and nails, except those services related to systemic conditions.

44. **Speech and Language Services**
    Speech therapy services, except as specifically described in this Evidence of Coverage.

45. **Skin Titration Testing**
    Skin Titration (Wrinkle Method), Cytotoxicity Testing (Bryans Test), RAST Testing, MAST Testing, Urine Auto-injection, Provocative and Neutralization Testing for allergies.

46. **Structural Imbalance (Care in Connection with)**
    Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and its effects, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

47. **Temporomandibular Joint Disorder (Treatment of)**
Services are not covered for temporomandibular joint syndrome, except for Medically Necessary services in connection with: acute dislocation of the mandible (but not dislocation of the cartilage without dislocation of the mandible) from direct and immediate extrinsic trauma, fractures, neoplasm's, rheumatoid arthritis, ankylosing spondylitis and disseminated lupus erythematosus. Also excluded are: dental splints, dental prosthesis or any treatment on, or to the teeth, gums, or jaws and other services customarily provided by a dentist or dental specialist. Treatment of pain or infection due to a dental cause, surgical correction of malocclusion, maxilla facial orthognathic and prognathic surgery, orthodontia treatment, including hospital and related costs resulting from these services when determined to relate to malocclusion are excluded. Services related to injuries caused by or arising out of the act of chewing are also excluded.

48. **Thermography**
Costs associated with thermography or thermograms are excluded. Thermogram is defined as a regional temperature map of the surface of a part of the body, obtained by infrared sensing device; it measures radiant heat, and thus subcutaneous blood flow, if the environment is constant.

49. **Transportation Services**
Transportation of a Member to or from any location for treatment or consultation, except for ambulance services associated with an Emergency condition, or as Authorized by a Physician.

50. **Unauthorized Services**
Services or medical supplies which have not been performed, prescribed or arranged through the Primary Care Physician, and preauthorized by Intergroup, as required by the Group Enrollment Agreement. Services necessary to treat a medical Emergency shall be covered without prior authorization.

51. **Vocational Programs/Employment Counseling**
Vocational Programs and counseling for employment are not covered, including counseling provided by a Provider during mental or substance abuse rehabilitation.

ENHANCED BENEFITS
PURCHASED BY

THE STATE OF ARIZONA

SECTION II

STATE OF ARIZONA

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BENEFIT

MENTAL HEALTH SERVICES BENEFIT

All services for Mental Health must be Preauthorized by Catalina Behavioral Health Services in order to be covered. To access benefits available, please contact Catalina Behavioral Health Services at 1-800-977-0281.

Mental Health Services are provided for those illnesses which are responsive to intervention. Physician visits for psychiatric medicine level checks (med checks) are covered and are not subject to Copayment, nor do they count towards the annual Outpatient visit limitation. Psychological testing, as it relates to diagnostic evaluation, is covered if deemed Medically Necessary by Catalina Behavioral Health Services.

I. Outpatient Services

- ***Outpatient Mental Health Services are limited to twenty (20) visits per Plan Year.***
- Outpatient Mental Health Services shall be in the least restrictive setting as may be necessary and appropriate for evaluation.

II. Inpatient Services

- ***Inpatient Mental Health Services, when combined with Inpatient Substance Abuse Services, shall not exceed thirty (30) days per Plan Year.***
- Inpatient Mental Health Services must be received in a Participating Hospital or Facility. Hospitalization will be subject to review proceedings by Intergroup Utilization Management.
- If partial hospitalization is provided, the benefit will be calculated as follows:

  Four (4) or less hours a day will equal one-fourth (1/4) of an inpatient day
  Five (5) or more hours a day will equal one half (1/2) of an inpatient day

III. No Show/Cancellation Policy

- Appointments for professional services for Mental Health conditions must be canceled at least twenty-four (24) hours in advance.
- Coverage is not provided for missed appointments or appointments not canceled twenty-four (24) hours in advance.
- Members will be required to pay the Copayment amount for missed appointments.

IV. Specific Exclusions and Limitations:

- Court ordered testing will not be covered
- Psychological testing for ability, aptitude, intelligence or interest
- Behavior problems not related to illness
- Relationship / communication issues not related to illness

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BENEFIT

SUBSTANCE ABUSE SERVICES BENEFIT

All services for Substance Abuse must be Preauthorized by Catalina Behavioral Health Services in order to be covered. To access benefits available, please contact Catalina Behavioral Health Services at 1-800-977-0281.

Diagnosis and medical treatment for alcohol and drug abuse is provided, including Inpatient or Outpatient detoxification, as Medically Necessary. Detoxification shall be defined as the removal of the toxic substance or substances from the system. Continuation of treatment will be subject to review by Intergroup Utilization Management.

I. Outpatient Services

- ***Outpatient Substance Abuse Services are limited to thirty (30) visits per Plan Year.***

II. Inpatient Services

- ***Inpatient Substance Abuse Services, when combined with Inpatient Mental Health Services, shall not exceed thirty (30) days per Plan Year.***
- Inpatient Substance Abuse Services must be preauthorized by Catalina Behavioral Health Services, except for an emergency condition. If hospitalization is due to a medical emergency, Member must contact Catalina Behavioral Health Services within forty-eight (48) hours of admission, or as soon as is reasonably possible, to ensure coverage. Emergency Services which are preauthorized will not be retrospectively denied.

III. Specific Exclusions and Limitations:

- Methadone maintenance, except when prescribed by a Physician
- Long term services, except for detoxification
- Continuation in a course of counseling for patients who are disruptive or physically abusive
- House calls, unless preauthorized by Catalina Behavioral Health Services, or Intergroup, who determines that necessary care can best be provided in the home
- Referral for non-medical ancillary services such as vocational programs or employment counseling will not be covered
- Court ordered testing will not be covered

OUTPATIENT PRESCRIPTION DRUG BENEFITS

The following Outpatient Prescription Drug Benefits are hereby added and shall become a part of the Evidence of Coverage. ***This benefit applies only to Prescription Drugs which are prescribed on an Outpatient basis.***

I. Specific Requirements for Coverage:

- Drugs must be included on the Intergroup formulary
- All prescription Drugs must be prescribed by a Participating Physician
- All prescription Drugs must be obtained from a Participating pharmacy
- Prescriptions are provided up to a thirty-four (34) day supply
- Refills are covered only when authorized by a Participating Physician

II. Copayments

Copayment - $ 5.00 for up to a thirty-four (34) day supply of each prescription or refill
Copayment - $10.00 for a mail order supply of ninety-three (93) days or less for each prescription or refill

III. Mail Order for Maintenance Prescriptions

Where available, a Member may choose the Intergroup Mail Order Prescription Provider to purchase prescriptions. Prescriptions, either initial or refills, will be allowed for up to a three month (93 day) supply. Contact the Intergroup Customer Service Department at 1-800-977-7484 for mail order forms.

IV. Brand vs. Generic

Prescription Drugs will be dispensed in generic form when available. Brand name drugs are covered; however, if a generic equivalent is available, the Member may be responsible for the difference in cost between the brand and generic products in addition to the Copayment amount required. This applies when either the Physician or the Member requests a brand which has a generic equivalent. It also applies to both mail order as well as retail pharmacy prescription drugs.

V. Quantity Limitations

The following quantity limits apply to retail pharmacy and mail order prescriptions:

Diabetic Supplies and Medications

- Glucose test strips and lancets require a written prescription from a Participating Physician. Glucose test strips are limited to a supply of fifty (50) per Copayment. Lancets are limited to a supply of one hundred (100) per Copayment.
- Syringes for insulin dependent diabetic Members require a written prescription from a Participating Physician and are limited to one hundred (100) per Copayment.
- Insulin requires a written prescription from a Participating Provider. Up to two (2) vials of insulin per Copayment are covered.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Quantity Limitations (continued)

Miscellaneous Supplies and Medications

- Spacers and holding chambers for inhaled medications are limited to one (1) per six (6) months per Copayment.
- Up to two (2) inhalers (nasal or oral) per Copayment are covered.

VI. Contraceptives

Oral contraceptives and diaphragms included on the Intergroup formulary are covered.

VII. Specific Exclusions

In addition to the Exclusions and Limitations listed in the Evidence of Coverage, the following are not covered under this Outpatient Prescription Drug Benefit:

- Drugs obtained out of the Service Area
- Drugs obtained at a non-Participating Pharmacy
- Any drug labeled "Caution - Limited by Federal Law to Investigational Use"
- Drugs deemed Experimental by Intergroup
- Drugs used to treat infertility
- Over-the-counter drugs and supplies except as indicated under Diabetic supplies
- Drugs not approved by the FDA for a specific medical condition
- Self-injectable Drugs, excluding insulin. Self-injectable Drugs are classified as part of the Medical Benefit and require Medical Group authorization to be covered
- Any Drug consumed at the place where it is dispensed or that is dispensed or administered by the Physician
- Vitamins, except those included on the formulary
- Nutritional replacements and dietary supplements
- Drugs prescribed for non-Covered Services
- Take home Drugs. Drugs prescribed for use after discharge from a Hospital, Nursing Home, Skilled Nursing Facility or other Inpatient facility must be obtained from a Participating Pharmacy, not from the Inpatient facility
- Drugs which are not included on the Plan's drug formulary

VIII. General

The Health Plan reserves the right to waive any of the program limitations or provisions, if, in the opinion of the Provider, it is necessary for the Member's welfare.

All other provisions of the Group Enrollment Agreement and Evidence of Coverage apply to this Outpatient Prescription Drug Benefit.

Nothing in this Outpatient Prescription Drug Benefit shall vary, alter, waive, or extend any terms, conditions, provision, agreements, exclusions or limitations of the Group Enrollment Agreement or Evidence of Coverage.

STATE OF ARIZONA

VISION CARE BENEFITS

The following Vision Care Benefits are hereby added and shall become a part of the Evidence of Coverage.

I. Members are entitled to the following Vision Care Benefit services when received from a Participating Provider.

- One (1) pair of standard single vision, bifocal or trifocal lenses every twelve (12) months. The Participating Provider will order and fit the proper lenses. The Participating Provider will provide single vision, bifocal, or trifocal lenses fabricated to exacting standards from ophthalmic laboratories.

- One (1) frame, within the Plan's allowance, once every twelve (12) months. If the wholesale price of the frame exceeds the Member's frame allowance, the Member will pay a designated amount based on the difference between the wholesale price and the Plan's frame allowance.

  Copayment - $10.00

- Elective contact lenses, once every twelve (12) months if a Member chooses contact lenses for elective reasons. The Plan will provide an allowance towards the cost in lieu of an examination, spectacle lenses and a frame from the remainder of the frequency period.

  Allowance - $100.00 (Copayment does not apply)

- Medically Necessary contact lenses, once every twelve (12) months. The Plan will provide an allowance towards the cost in lieu of an examination, spectacle lenses, frame or elective contact lenses. The determination of "Medically Necessary" versus "elective" contact lenses shall be determined by Intergroup Vision Services (IVS).

  Allowance - $250.00 (Copayment does not apply)

- *If a Member elects additional services or materials not covered by the Plan, the cost and charges will be Member's responsibility to pay. Arrangements should be made directly between the Member and Participating Provider.*

II. How to Use This Benefit

- Select any Participating Provider from the Provider Directory and schedule an initial appointment. Provider Directories are available at your benefits administrator's office or you may call a toll-free number to obtain a directory at 1-800-443-4994.

- Pay the Copayment to the Participating Provider and receive services and optical materials (when necessary). You must sign the Benefit Form at the end of the examination. Covered Services for minor Dependents will require the Benefit Form to be signed by a parent or guardian.

VISION CARE BENEFITS

III. Exclusions and Limitations

In addition to the Exclusions and Limitation listed in the Evidence of Coverage, the following are not covered services under the Vision Benefit:

- Services provided by Non-Participating Providers
- Orthoptics or vision training
- Sub-normal vision aids
- Plano (non-prescription) lenses
- Two pair of lenses in lieu of bifocals
- Lenses that exceed the program allowance
- Any medical or surgical treatment of the eyes
- Any eye examination required by an employer as a condition of employment
- Oversize lenses
- Elective contact lenses that exceed the program allowance
- Blended or progressive multi-focal lenses
- High index or aspheric lenses
- Laminated lenses
- Photo chromatic or tinted lenses
- Coated lenses
- Frames which cost more than the program allowance
- Replacement of lenses or frames which are lost or broken, except when the Member is normally eligible for services
- Services or materials provided as a result of any Workers' Compensation Law, or required by any governmental agency

IV. General

The Health Plan reserves the right to waive any of the program limitations or provisions, if, in the opinion of the Provider, it is necessary to the Member's visual welfare.

All other provisions of the Group Enrollment Agreement and Evidence of Coverage apply to this Vision Care Benefit.

This Vision Care Benefit will terminate upon termination of the Group Enrollment Agreement.

Nothing on the Vision Care Benefits shall vary, alter, waive, or extend any terms, conditions, provisions, agreements, exclusion or limitations of the Group Enrollment Agreement or Evidence of Coverage.

DEFINITIONS

"Actively Employed" means working full-time as determined by the employer, in the performance of regular duties of the employer's business. A person is also considered to be Actively Employed on each day of a regular paid vacation, medical leave or other approved company leave.

"Acute" means the sudden onset of an illness or injury, or a sudden change in a person's health status, requiring prompt medical attention, but which is of limited duration.

"Agreement" means the Group Agreement between Intergroup and the Group employer, including the Group Enrollment Agreement, the Evidence of Coverage, the "Schedule of Medical Copayments and Maximum Benefits", any enhanced benefits purchased by the Group, Individual Enrollment Forms, Statements of Health and all subsequent amendments to any of the above.

"Alcoholism" means the disease which is classified as Alcoholism in the International Classification of Diseases of the U.S. Department of Health and Human Services.

"Allowable, Eligible or Covered Expense" means the necessary, usual, reasonable, and customary item of expense for health care, when the item of expense is a Covered Service. When Intergroup provides services, the reasonable cash value of each service is the Allowable Expense.

"Ambulatory Surgical Facility" means a Facility that meets the states' professionally recognized standards and provides all that follow:

1. It mainly provides a setting for Outpatient surgeries; and,
2. It does not provide more than two days of Inpatient service; and,
3. It has all of the medical equipment needed to support the surgery performed; X-Ray and laboratory diagnostic Facilities; and emergency equipment and supplies for use in life threatening events; and,
4. It has a medical staff that is supervised full-time by a Physician and includes a registered nurse at all times when patients are in the Facility; and,
5. It maintains a medical record for each patient; and,
6. It has a written agreement with a local Hospital for the immediate transfer of patients who require greater care than can be furnished at the Facility; and,
7. It complies with all state and/or federal licensing and other requirements; and,
8. It is not the office or clinic of one or more Physicians.

"Amend/Modify" means adding, deleting, changing, correcting or rephrasing any of the terms or provisions to the Evidence of Coverage, Group Enrollment Agreement, or Amendments. Such amendment or modification may include, but are not limited to, a change in the Copayments, deductibles, Coverages, and the policies or practices of Intergroup.

"Anniversary Date" means the Effective Date of the Group Enrollment Agreement and each subsequent annual renewal date thereafter.

"Application(s)" means all forms required to be completed by the employer, Eligible Employee or Dependent.

DEFINITIONS

"Authorized/Approved" means that Intergroup, or its designee, has determined that the medical treatment or service is a Medically Necessary covered benefit. ***Even though a medical treatment or service may be a covered benefit, selected services and treatments require preauthorization to be covered.*** Members should consult with their Primary Care Physician, or Intergroup concerning preauthorization requirements on benefits in question. The terms "authorized and /or approved" may be used interchangeably throughout this document.

"Behavioral Health Representative" means an individual employed by the participating behavioral health Facility or group who is coordinating behavioral health services for covered Members. The designated Behavioral Health Representative under this Health Plan is Catalina Behavioral Health Services.

"Calendar Year" means January 1, 12:01 a.m. to January 1, 12:01 a.m. of the following year.

"Chronic Health Conditions" means those conditions in which the patient's condition is either stabilized at a functional level or progressively deteriorating to the point where the Health Professional has determined that active Short-Term health treatment will not result in any reasonable expectation for improvement.

"Chronic Mental Health Condition(s)" means those conditions in which a patient is either stabilized at a functional level or progressively deteriorating to the point where continued mental health treatment would not result in any reasonable expectation for improvement.

"Claims" means invoices or other standard billing documents containing details of health care services provided to a Member, that a Provider of health care services submits for payments.

"Company" means Intergroup of Arizona, Inc., a Health Maintenance Organization licensed by the State of Arizona. Intergroup is a for profit corporation.

"Congenital Anomaly" means a defective development or formation of a part of the body which is determined to have been present at the time of birth.

"Contract Year" means each twelve (12) consecutive month period commencing on the Effective Date and each Anniversary Date thereafter during which the Group Enrollment Agreement is in effect. The Contract Year of this Health Plan is October 1 through September 30.

"Copayment" means the fixed or portioned amount of out-of-pocket expenses a Member is required to pay a Participating Provider to receive Covered Services at the time services and treatments are rendered.

"Copayment Limit" means the maximum amount of out-of-pocket expenses within the Plan Year a Member is required to pay. When the Copayment Limit is reached, Intergroup will pay 100% of all remaining charges for Covered Services.

"Coverage" means health care services and treatments which are covered under this Evidence of Coverage.

DEFINITIONS

"Covered Dependent" means a Subscriber's legal spouse or child whom Intergroup determines meets all applicable eligibility and enrollment requirements of the Group Enrollment Agreement, and who is enrolled in Intergroup, and for whom the Premium payments required under the Agreement have been received and accepted by Intergroup.

"Covered Member" means a person who has met all applicable eligibility and enrollment requirements as determined by Intergroup, and for whom Premium payments have been received and accepted by Intergroup.

"Covered Service(s)" means those Medically Necessary services, supplies or benefits described in this Evidence of Coverage and any Amendments. *Even though a medical treatment or service may be a covered benefit, selected services and treatments may require preauthorization in order to be covered.*

"Custodial Care" means provision of room and board, nursing care (excluding skilled nursing care), personal care designated to assist an individual who in the opinion of Intergroup's Medical Director has reached the maximum level of recovery. Custodial Care also includes rest cures, respite care, and home care that is or can be performed by family members or non-medical personnel.

"Dependent" means a lawful spouse or child, including adopted children and children placed for adoption, who meet the full definition and requirement of a legal Dependent as described in the "Eligibility" section.

"Drugs, or Prescription Drugs" means only those pharmaceutical substances approved by the Food and Drug Administration (FDA) and required, under federal or state law, to be dispensed only by a prescription.

"Durable Medical Equipment or DME" means durable items or appliances which, as determined by Intergroup, are:

1. Able to withstand repeated use; and
2. Are designed to serve a medical purpose; and,
3. Generally are not useful to a person in the absence of a medical condition, illness or injury; and,
4. Are not disposable; and,
5. Are not customarily found in a Physician's office; and,
6. Are needed for functional rather than cosmetic reasons.

"Effective Date" means with respect to the Group Enrollment Agreement, the date stated as the Effective Date in the Group Enrollment Agreement between Intergroup and the Group. With respect to a Covered Member, the date Coverage under this Plan became effective.

"Eligible Employee" means an individual who satisfies the Group's employer requirements for Coverage as provided to Intergroup in the Group Enrollment Agreement.

DEFINITIONS

"Emergency" means a condition or illness which, if not immediately diagnosed and treated would result in extended or permanent physical impairment or loss of life, and requires the Member to seek immediate medical attention necessary for the relief of acute pain, repair of accidental injury, initial treatment of infection, or the relief of illness.

"Emergency Services" means Covered Services rendered by a Health Professional to treat a medical Emergency condition. Covered Emergency Services include an initial medical screening examination and any immediate necessary stabilization treatment or services. Emergency Services do not include use of a Hospital emergency room or other emergency medical Facility for routine services, or follow-up or continuing care, unless prescribed by a Primary Care Physician.

"Enrollment Form" means the form required by Intergroup to be completed, signed and submitted by the Group to Intergroup, for the purpose of enrollment, or altering the enrollment of the Subscriber and the Subscriber's Covered Dependents as Members, and/or for notifying Intergroup of any applicable changes.

"Experimental/Unproved or Investigational Procedures" means medical, surgical or psychiatric procedures, treatments, supplies or pharmacological regimes not generally accepted by the medical community associated with Intergroup. This includes: procedures, services, equipment, devices or supplies which are in a testing state or in field trials on animals or humans, or do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed, or are not in accordance with generally accepted standards of medical practice, or have not yet been shown to be consistently effective for the diagnosis or treatment of a Member's condition.

"Facility/Facilities" means institutions operating pursuant to state and/or federal statutes and regulations which are primarily engaged in providing Short-Term medical care and treatments of sick and injured persons. ("Facilities" also include licensed institutions which provide diagnosis on an Outpatient basis.)

"Full-Time Student" means an individual who

1. is nineteen (19) years of age or older, but less than the limiting age indicated in the "Schedule of Medical Copayments and Maximum Benefits"; and
2. is enrolled full-time (twelve (12) credit hours or more) as a student in an accredited educational institution; and
3. from time to time, upon Intergroup's request, provides Intergroup with a Registrar's letter or student status confirmation; and
4. is dependent upon the Subscriber or Subscriber's legal spouse for his/her economic support.

"Grace Period" means a period of thirty-one (31) days following the Premium due date during which Premium may be paid without a lapse in Coverage.

"Group" means the industry, corporation, company, partnership, union, enterprise, or other defined or otherwise legally constituted group of individuals which is named in and has entered into the Group Agreement with Intergroup to allow the Group's employees (of which the Subscriber is one), the opportunity of selecting Intergroup's prepaid health services and benefits.

DEFINITIONS

"Group Agreement / Group Enrollment Agreement" means the written agreement entered into between Intergroup and the employer.

"Health Plan" means the benefits described in this Evidence of Coverage and provided by Intergroup.

"Health Professional" means a health care Provider who is appropriately licensed, certified or otherwise qualified to deliver health services pursuant to state law and who has contracted with Intergroup to render Medical Services to Members of Intergroup.

"Home Health (Care) Agency" means an agency or organization that is duly licensed by the appropriate licensing authority to provide skilled nursing services and other therapeutic services in the state or locality in which it is located.

"Home Health Care" means medical care provided by a Participating Provider from an approved Home Health Care Agency which is provided on an interim basis, or in lieu of hospitalization.

"Hospice Care or Services" means a program of care that is approved by Intergroup and which focuses on a palliative rather than a curative treatment for Members who have a life expectancy of six (6) months or less.

"Hospital" means an institution operated pursuant to state or federal statutes and regulations and primarily engaged in providing medical care and treatment of sick and injured persons through medical and diagnostic procedures.

"Hospital Services" means those Medically Necessary services for registered inpatients which are customarily rendered in an acute care general Hospital, or psychiatric specialty Hospital, and prescribed or directed by a Participating Physician.

"Intergroup of Arizona, Inc." (hereinafter referred to as "Intergroup") is an Arizona for profit corporation organized and operated as a health care services organization pursuant to the laws of the State of Arizona.

"Lifetime Maximum" means the maximum amount of covered benefits, services or treatments a Member can receive while covered under this Evidence of Coverage. Lifetime Maximums may be applied to either dollar amounts or benefit amounts or both.

"Medical Director" means a Physician or Doctor, designated by Intergroup, who is responsible for the administration of medical programs.

"Medical Group" means any Physician Group practice or organization which has entered into a written agreement with Intergroup for the provision of Medical Services to Members under this Evidence of Coverage. Intergroup's Agreement with a Medical Group may terminate, and the Member may be required to select another Medical Group, Primary Care Physician or other Participating Provider to be primarily responsible for providing and coordinating a Member's Medical Services.

DEFINITIONS

"Medical Services" means those professional services of a Physician and allied Health Professionals, including medical, surgical, diagnostic, and therapeutic services which are included in the "Description of Benefits", and which are performed, prescribed or directed by a Participating Physician.

"Medically Necessary" means those services required to identify or treat an illness that is either diagnosed or reasonably suspected. To be Medically Necessary, a service must:

1. Be required to treat an illness or injury; and,
2. Be consistent and appropriate for the diagnosis and treatment of the Member's conditions; and,
3. Be in accordance with the standards of accepted principles of medical practice in the United States; and,
4. Be performed at the most appropriate level of care for the Member as determined by the Member's medical condition and not the Member's financial or family situations, or the distance the Member lives from the Hospital, or any other non-medical factor; and,
5. Be approved as reasonable and necessary by the Health Care Financing Administration under the Medicare program; and,
6. Not be for the convenience of the Member, nor the Member's family, support network, Physician or another Health Professional; and,
7. Not Experimental or Investigational or furnished in connection with medical or other research.

"Medicare" means "The Health Insurance for the Aged Act", Title XVIII of the Social Security Act and all amendments.

"Medicaid" means Title XIX of the Social Security Act, as amended. In the State of Arizona, Medicaid is administered by the Arizona Health Care Cost Containment System (AHCCCS).

"Member" means any person enrolled in this Health Plan as a Subscriber or Dependent.

"Mental Health Services" means all services (including Hospital stays) provided by psychiatrists, psychologists, or other mental health Providers, including, but not limited to, social workers and psychiatric nurses, even if the services are provided for the treatment of a condition that is organic in origin.

"Non-Participating Provider" means any Provider which has not contracted with Intergroup to provide health care services to any Member.

"Open Enrollment Period" means those periods of time established by the Group and Intergroup, periodically, but at least every twelve (12) consecutive months, during which Eligible Employees and their Dependents may enroll or change status as Members.

"Orthotics" means rigid or semi-rigid devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part.

DEFINITIONS

"Out-of-Area (Service Area)" means those services and supplies provided outside Intergroup's Service Area.

"Out-of-Pocket Expenses" means the portion of Covered Services, (either Copayments or coinsurance), which a Member is required to pay at the time services and treatments are received. Out-of-Pocket Expenses apply to Covered Services only. Medical Services and treatments, which are not covered by this Plan, not Medically Necessary, or are elective, are not included in determining Out-of-Pocket Expenses.

"Out-of-Pocket Maximums" means the total dollar amount of Out-of-Pocket Expenses which a Member will be required to pay for Covered Services during a period of time. Out-of-Pocket Maximums are determined for Covered Services and not for any Medical Services or treatments which are elective, not Medically Necessary, or not covered. When the Out-of-Pocket Maximum(s) is reached, Intergroup will provide Coverage at 100% of the Covered Services.

"Participating Hospital" means a Hospital which has an agreement with Intergroup to provide Hospital Services to Members.

"Participating Physician" means a Physician who has entered into an agreement, or on whose behalf an agreement has been entered into, with Intergroup to provide Medical Services to Members.

"Participating Provider(s)" means any person or entity that has entered into a contract with Intergroup to provide Covered Services to Members including but not limited to, Hospitals, Urgent Care Facilities, Physicians, pharmacies, and other Health Professionals within Intergroup's Service Area.

"Payor(s)" means an insurer, health maintenance organization, no-fault liability insurer, self-insurer, governmental program, or other entity or program that provides or pays for health care benefits.

"Physician" means any Doctor of Medicine (MD.), or Doctor of Osteopathy (DO.), who is duly licensed and qualified under the state law or jurisdiction in which treatment is received.

"Plan" means any health care entity which provides health care service and treatment coverage.

"Plan Year" means the Calendar or Contract Year of the Group Service Agreement and indicated therein. *The Plan Year for this Health Plan is October 1 through September 30.*

"Preauthorized" means the prior authorization by Intergroup, or its designee, for those services or treatments which require authorization to be given ***before*** the services or treatments are rendered. Members should contact the Intergroup Customer Service Department at 1-800-977-7484, with questions concerning the preauthorization requirements for specific services or treatments.

"Premium" means the payment, including any contributions made by Subscribers, which the Group must pay to Intergroup for Coverage provided by the Group Agreement.

DEFINITIONS

"Primary Care Physician (PCP)" means the Participating Physician who is engaged in the practice of family or general medicine, internal medicine, or pediatrics and provides, arranges and coordinates a Member's health care. Upon enrollment, a Member selects a Physician from among the list of Participating Physicians. PCP's include Physicians in the areas of Family Practice, General Practice, Internal Medicine, Pediatrics, and during pregnancy, Obstetrics. A PCP's relationship with Intergroup may terminate, and the Member may be required to select another PCP who will be responsible for providing and coordinating a Member's total health care. A list of PCP's, their locations and hours of operation, is available to each Member upon enrollment. Such lists shall be revised periodically as deemed necessary by Intergroup.

"Primary Plan/Secondary Plan" means the order of benefit determination rules, as designated by the Arizona Administrative Code R20-6-217, that determines the Payor, with respect to another Health Plan, covering the person. When Intergroup is the Primary Plan, the benefits are provided or paid without considering the other Plan's benefits. When Intergroup is the Secondary Plan, the benefits are provided or paid considering the other Plan's benefits.

"Prosthetics/Prosthetic Devices" means the mechanical devices that replace the function of an internal or external body part by an artificial substitute which may or may not be surgically implanted.

"Provider" means a licensed Physician, dentist, podiatrist, psychologist, Hospital or Facility, social worker holding a master degree in social work for child(ren) development, marriage and family counseling or other licensed medical practitioner practicing within the lawful scope of his/her license.

"Qualified Medical Child Support Order" or "Administrative Order" means any order that creates or recognizes an alternate payment right to receive benefits for which a person is eligible under a Group Plan. This order can be issued by a court or administrative agency that has jurisdiction for such matters. This term shall be applicable to Subscriber's unmarried child, including any stepchild, legally adopted child, child who has been placed for adoption with Subscriber, or a child eligible for Coverage pursuant to a qualified medical child support order, under the Limiting Age.

"Referral" means a request made through the Primary Care Physician for authorization of specialty services or equipment on behalf of a Member. Referrals must be approved by the Medical Group's Medical Director, prior to Member receiving specialty services or equipment, in order to be covered.

"Replacement Plan" means a similar health benefits policy or Plan which was issued to the employer and is being replaced by this policy.

"Routine Medical Care" includes, but is not limited to, conditions such as colds, flu, sore throats, superficial injuries, minor infections, follow-up care and preventive care. Treatment for these conditions should be sought from a Primary Care Physician and are not considered an Emergency condition.

"Service Area" means the geographic area serviced by Intergroup, as authorized by the State of Arizona, and designated by Intergroup for the provision of Covered Services. These areas may change from time to time as designated by Intergroup.

DEFINITIONS

"Short-Term" means the reasonable period of time, not to exceed sixty (60) consecutive days from the initial date of treatment, in which the Participating Health Professional has determined that the provision of therapy or treatment will result in significant, documented, continued improvement in a Member's condition.

"Skilled Nursing Facility" means an extended care Facility which is licensed as a Skilled Nursing Facility and operated in accordance with the laws of the state in which the Member resides in and is approved by Medicare.

"Sound Natural Teeth" means teeth that are free of active or Chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

"Specialist/Specialist Physician" means a duly licensed Participating Physician, other than the Primary Care Provider, under contract with Intergroup to provide professional services when Preauthorized.

"Statement of Health" means the form required by Intergroup which each employee shall on his/her behalf and on behalf of his/her Dependents be required to complete, when applying for membership with Intergroup other than during the Group's Open Enrollment, or the employee's initial eligibility period.

"Subscriber" means an employee of the Group who meets all applicable eligibility requirements of the Group Agreement, and whose Enrollment Form and applicable Premium payment have been received in accordance with the enrollment requirements.

"Support Devices" are the rigid or semi-rigid devices, custom made or molded, such as braces or splints, used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part.

"Term Delivery" means a delivery occurring at thirty-seven (37) weeks gestation or more.

"Totally Disabled or Total Disability" means a Subscriber is prevented because of injury or disease, from performing his/her regular or customary occupational duties and is not engaged in any work or other gainful activity for compensation or profit. For a Covered Dependent, that he/she is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and gender in good health.

"Urgent Care" means services provided for the relief of acute pain, initial treatment of acute infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion, and breathing difficulties, other than those of sudden onset and persistent severity. An individual patient's Urgent condition may become emergent upon evaluation by a Participating Provider.

"Urgent Care Facility" means any licensed Facility that provides Physician services for the immediate treatment only of an injury or disease, and which has contracted with Intergroup to provide Members such services.

"Urgent Care Situation" is an incident requiring medical care within twenty-four (24) hours to prevent serious health deterioration resulting from unforeseen illness or injury.

DEFINITIONS

"Usual, Reasonable and Customary Fee" means the fee which a Physician or other Provider of a particular service usually charges his patients for the same service and which is within the range of fees usually charged by other Physicians or other Providers located within the immediate geographic area where the service is received under similar or comparable circumstances or, when applied to a Participating Provider, the amount allowed under a Participating Provider's agreement with Intergroup or a Medical Group, whichever is less.

"Utilization Management" is a process whereby requests for service under this Plan are reviewed:

1. for Medical Necessity and appropriateness;
2. for verification that the service is a covered benefit;
3. for verification where benefits have a predetermined limit that Medical Services have not been exceeded, or are being appropriately applied, or applied in a timely manner consistent with the diagnosis and treatment;
4. for verification that the requested Provider of services is affiliated with the Medical Group and this Plan; and
5. for verification that Member is eligible for services under the benefit plan. Any utilization review conducted before provision of a health care service, is subject to the terms and conditions of the Group Agreement. For example, if an individual's Coverage is terminated effective prior to the date of a service, the service will not be covered.

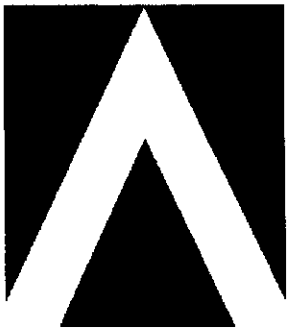
"We" means Intergroup of Arizona, Inc.

"You/Your" means a Subscriber or Member.

Attachment L

Quality Improvement Initiative Quarterly Report

Quality Improvement Initiative Quarterly Report



AHCCCS

January - March 1998

May 1998

TABLE OF CONTENTS

ACTIVITY SUMMARY	1
QUALITY MANAGEMENT IN AHCCCS	2
FOUNDATION OF THE AHCCCS QUALITY MANAGEMENT SYSTEM	2
QUALITY IMPROVEMENT INITIATIVE	8
QUALITY INDICATORS	9
ACUTE CARE INDICATORS	9
ALTCS ELDERLY AND PHYSICALLY DISABLED INDICATORS	12
ALTCS DEVELOPMENTALLY DISABLED INDICATORS	14
NATIONAL CORE INDICATORS PROJECT	15
BEHAVIORAL HEALTH INDICATORS	15
FINANCIAL INDICATORS	17
MEMBER SATISFACTION SURVEY	17
PROVIDER SATISFACTION SURVEY	18
DECISION SUPPORT SYSTEM (DSS)	18
DENTAL CARE TASK FORCE	19
APPENDIX A	

ACTIVITY SUMMARY
JANUARY - MARCH 1998 QUARTER

The Fifth Annual Immunization Report was completed on February 3. The findings for the period from October 1, 1996 through September 30, 1997 indicate that all rates were over 75%, except for DTP which was 69%. The combined DTP, OPV and MMR rate was 65%, two percentage points higher than for 1995/96.

Through the combined efforts of ADHS/BHS and AHCCCS, the corrective action plan to improve the quality and quantity of behavioral health encounters has been very successful. Many of the missing encounters have been transmitted to AHCCCS. Efforts continue to remedy the remainder of encounter submission failures.

A determination was made that AHCCCS will not be able to produce the indicator on Frequency of Ongoing Prenatal Care at this time. A review of AHCCCS generated encounter data revealed two global codes, both of which cover multiple antepartum care visits and are not included in HEDIS 3.0 specifications. These facts impose a major obstacle to obtaining data on the frequency of prenatal visits through encounter data.

On February 19, 1998 three Acute and Long Term Care Utilization Reports and one Long Term Care Utilization Report were completed and forwarded to HCFA.
The four reports are:

- Physician Services
- Other Practitioner Services
- Transportation Services
- Hospice Services

Additionally, on March 30, 1998 three Acute and Long Term Care Utilization Reports and four Long Term Care Utilization Reports were completed and forwarded to HCFA.
The seven reports are:

- Laboratory Services
- Radiology Services
- HCFA-416 EPSDT Utilization
- Institutional Services
- HCB Services
- Therapy Services
- Pharmacy LTC Services

Additional information on these subjects is provided in the following report.

QUALITY MANAGEMENT IN AHCCCS

Quality of care is a very important component of the AHCCCS program. In its 15 years of operation, AHCCCS has developed a mature quality management system which focuses on the performance of health plans and program contractors. Although this approach is effective, AHCCCS, in partnership with the Health Care Financing Administration (HCFA) and the AHCCCS health plans and program contractors, sought ways to incorporate other innovative elements into the quality management program which were tailored for a managed care environment. A proposal to implement a Quality Management Initiative was approved by HCFA in December 1994 as a multi-year project which will:

- Develop clinical and long term care quality management indicators to measure health outcomes and quality of care.
- Use financial indicators for financial performance and solvency standards.
- Conduct Member Satisfaction surveys that assess access to care, availability of care and overall member satisfaction.
- Assess provider satisfaction.

FOUNDATION OF THE AHCCCS QUALITY MANAGEMENT SYSTEM

Nationally, oversight of quality of care under the Medicaid program has been based on fee-for-service care and compliance with regulatory requirements designed to review claims after services were provided. As managed care developed under Medicaid, there were attempts to ensure quality of care through the mandatory use of independent entities, such as external quality review organizations, who conducted retrospective reviews of claims. This focus on claims is neither dynamic nor does it provide the feedback necessary to improve health care outcomes. AHCCCS attempted to overcome the limitations of the Medicaid requirements and built a quality management process that was more suitable for a statewide, managed care system. The quality management system relies on the following activities:

Operational and Financial Reviews. AHCCCS performs annual, on-site operational and financial reviews of all health plans and program contractors, and operational readiness reviews of all new health plans and program contractors. These reviews are conducted with AHCCCS staff from the Office of Managed Care, Office of the Medical Director, Office of Grievance and Appeals and the Office of Program Integrity in conjunction with staff from the health plan or program contractor under review. AHCCCS also monitors operational and financial reviews that the ADHS/Behavioral Health Services (ADHS/BHS) performs on the Regional Behavioral Health Authorities (RBHAs). In 1995, AHCCCS completed an operational and financial review on ADHS/BHS and will conduct a second review during contract year 1997/98. These operational reviews provide an excellent opportunity for AHCCCS to understand the operational practices of each health plan or program contractor and to recognize areas of noteworthy performance as well as any problem areas. If deficiencies are found during the review, AHCCCS issues a report and works with the health plan or program contractor to correct the issues. If areas of particular excellence are found, the results are shared with the other health plans or program contractors. While conducting the operational reviews, the AHCCCS team conducts interviews with appropriate health plan personnel and reviews documentation in the following program areas:

- Executive Management
- Dental Services
- Quality Management
- Medical Direction
- Early Periodic Screening Diagnosis and Treatment
- Behavioral Health Services
- Regional Offices
- Provider Network Development
- Member Services
- Utilization Management
- Maternal Health/Family Planning
- Provider Services and Network Management
- Grievance and Appeals
- Accounting Systems

Quality Management and Utilization Review. Each health plan and program contractor must adhere to specific contractual requirements for quality management and utilization review activities. These requirements include maintaining a Quality Management/Utilization Committee chaired by the Medical Director who is responsible for oversight of the following activities: performing annual clinical studies; designating a registered nurse as the Quality Management Coordinator; and, conducting concurrent review of inpatient care. Health plans must submit clinical study proposals and methodologies to AHCCCS for approval. Examples of clinical studies performed by health plans are:

1. Prenatal care services which identify women entering prenatal care in the first trimester.

2. Asthma Guideline Compliance which determines the level of compliance by the primary care provider with the Asthma Treatment Guidelines established by the Health Plan Task Force on the Treatment of Obstructive Lung Disease.

3. Mammography: Member Compliance and Provider Practices which evaluate the factors associated with compliance by members with mammography screening and recent physician practices related to notification and follow-up of mammograms.

Practice Pattern Analysis Reports. All health plans and program contractors, including the RBHAs, are required to submit quarterly Quality Management and Practice Pattern Analysis Reports and utilization review plans which provide detailed information on how the organization will concurrently and retrospectively determine the appropriateness of placements in institutionalized settings.

Annual Immunization Study. Beginning with FY 1992/93 AHCCCS has been conducting an annual immunization study which focuses on immunization completion rates for children in the first 24 months. The most recent Immunization Study was completed in January 1997. Over the four years of annual evaluations, the rates of immunizations have shown dramatic improvement. DTP improved by 17%; OPV by 18%; MMR by 14%; and HIB by 50%. The bench marks developed from these annual studies have been incorporated into the Request for Proposal as an established goal that health plans must meet.

Annual Medical Audits. For the 1997 Medical Audit, AHCCCS contracted with HSAG to conduct a Diabetes Clinical Focused Quality of Care Study which provided baseline data on the management of diabetes for members of AHCCCS health plans. This data is used for quality improvement plans to improve timeliness and quality of care for diabetic members. The services provided were evaluated to assess compliance with 16 diabetic indicators which were grouped into three categories: 1) planning intervention strategies; 2) physical examination an laboratory screening/testing indicators; and 3) diabetes/health education indicators.

The audit identified that a high percentage of members with diabetes were receiving services such as referrals for retinal exams (93%) and medication education (79%). However, there were other services, such as lipid profiles and foot exams, which were being provided to only one-third or fewer of the diabetic members. In 1998, the health plans are individually required to submit a diabetes clinical study focusing on at least one of the 16 quality indicators. The health plans are to implement an intervention aimed at improving the quality of care provided to diabetic members. Subjects of Annual Medical Audits in previous years have included: Member Satisfaction of Maternity Services (1994); Mortality in the ALTCS Program (1995); and Pressure Ulcers (1996). The 1998 Medical Audit will be conducted on the Children's EPSDT Program.

Annual Clinical Study Proposals. Each health plan is required to submit two clinical study proposals annually. AHCCCS selected diabetes as the topic for one required study, the plans choose the second study area.

The health plan studies included such topics as:

- Behavioral health referrals and the relationship between perinatal events and children's behavioral health symptoms
- Participation in dental programs (choice of 3 health plans)
- ER utilization of children with Otitis Media
- Evaluation of effectiveness of asthma and migraine headache treatment guidelines
- Cervical and breast cancer screening related studies (choice of 4 health plans)

Of the 16 diabetes quality indicators reported in the AHCCCS baseline study, the health plans each selected one indicator and developed an intervention to be implemented during the current contract year. The objective of the studies is to improve performance over the baseline findings. Normally, the study results would be due by the end of the year. However, health plans which are using claims data have been granted an extension to allow adequate time to collect data.

During next quarter, AHCCCS will offer a clinical study proposal development workshop for the health plans' quality management staff who are responsible for writing the clinical study proposals.

External Quality Review Organization (EQRO). AHCCCS has a contract with HSAG, a Medicare EQRO, for external and concurrent reviews. HSAG performs external reviews for AHCCCS for the FFS population which includes the following individuals:

- Those who received covered health care services in the prior quarter before eligibility.

- Native Americans who elect to enroll with the Indian Health Services (IHS) but who are referred off-reservation by IHS for some services.

- Undocumented persons who only receive emergency services.

HSAG also performs the following functions:

- On-site concurrent reviews of fee-for-service for inappropriate admissions or levels of care, the appropriateness of the length of stay and the discharge needs of the member.
- Retrospective reinsurance audits of the health plans and program contractors for expensive and complicated cases.
- Annual external medical audit of the health plans.

- Annual immunization audit of the health plans.
- Consultative services to AHCCCS such as: physician review for those cases which raise quality of care issues, expert advice on the efficacy of experimental techniques or alternative methods of care and reviews of prior authorization denials.
- Technical assistance and recommendations for improvements that are shared with the health plans and program contractors.
- Investigation of outliers that are found when AHCCCS analyzes health plan/program contractor utilization data to identify any pattern of underutilization or overutilization of services.
- Special reviews, at the request of the health plans.
- Testimony as an expert witness in grievance hearings, when necessary.
- Case file reviews during the operational reviews.
- Development of practice guidelines for the health plans.

Health Plan Quality and Utilization Management Plans. Quality management plans (QMPs), and any modifications to those plans, must be submitted to AHCCCS for prior approval and must adhere to the following standards:

- Systematic monitoring, evaluation, and improvement in the quality and appropriateness of care to members through quality of care studies and related activities.
- Accountability and participation by the health plan management and the governing body in the monitoring, evaluation and improvement of care.
- An identifiable, structured Quality Assessment and Improvement Committee responsible for performing quality management functions within the health plan.
- Designated senior executive who is responsible for the implementation of the QMP. The organization's Medical Director must have substantial involvement in the quality assessment and improvement activities.
- Sufficient material resources, and staff with the appropriate education, experience, or training to effectively carry out the QMP functions. The Quality Management Coordinator shall be a Registered Nurse, with a current Arizona license, or physician, physician assistant, or certified nurse practitioner.
- Process to inform health plan physicians and other providers about the QMP.
- Process to determine whether professional practitioners, who are licensed by the state and who are under contract with the health plan, are qualified to perform their services.
- Description of member rights and how responsibilities are defined, implemented and monitored.
- Description of service availability and accessibility.
- Standards for medical records.
- Systems to ensure that utilization of services is monitored and evaluated.
- Systems which promote continuity of care.

- Systems which document quality of care for all services, service areas and treatment modalities. Documentation includes studies, reports, protocols, standards, worksheets, minutes and corrective action plans.

- Processes to coordinate other performance monitoring activities, including utilization management, risk management, resolution and monitoring of member complaints and grievances.

Each acute care health plan submitted a revised QM/UM plan for the current contract year as well as evaluations for the previous year's QM/UM performance. The revised QM/UM plans are in compliance with the RFP requirements and the criteria identified in the Office of Managed Care policies and procedures. The areas where the health plans experienced the greatest variability was in their evaluation of the previous year's activities and the completeness of Work Plans for the current year. Several health plans provided detailed accounts of quality studies which they had undertaken, with detailed results, and intervention strategies planned for the current year. However, a few plans provided only basic discussion of studies and results. In some cases, AHCCCS had to request additional information to clarify the evaluations. AHCCCS has provided feedback to the health plans to help them strengthen their Work Plans in the future.

Program Contractor Quality and Utilization Management Plans. Program contractors must adhere to the same quality management and utilization management requirements as discussed above for the health plans, with the exception of the service availability standard which is different under long term care.

Quality Management and Independent Quality Audit of the RBHAs. ADHS/BHS submits an annual statewide Quality Management/Utilization Management plan for behavioral health services to AHCCCS and provides a quarterly status report and an annual system evaluation. ADHS/BHS also commissions an independent quality audit of the RBHAs on an annual basis and reports findings and recommendations to AHCCCS.

Periodic Member Surveys. AHCCCS has conducted several member surveys. In 1995, AHCCCS surveyed 1,500 women to determine their perception about, and satisfaction with, all aspects of maternity care received while enrolled in a health plan. Overall, 85% of survey respondents were very satisfied with AHCCCS, almost 87% were very satisfied with the health plans, over 90% were very satisfied with the AHCCCS doctors and close to 84% were very satisfied with the hospitals. In 1996, AHCCCS completed a member telephone survey of more than 14,000 individuals who rated the ambulatory care provided by health plans. The results from the Member Satisfaction Survey are discussed in greater detail later in this report.

Baseline Medical Pilot Study. Two health plans participated in a medical record review and claims data review to identify all HIV/AIDS members to determine the best data sources to identify this population and to identify treatment protocols and subsequent outcomes. The study covered the period from October 1995 to September 1996. Preliminary results of the study were that:

- Administrative data inaccurately identified members with HIV/AIDS. Twenty-seven percent of members initially identified by administrative data as having HIV/AIDS, did not have this diagnosis validated by medical records and 15% of members initially identified as having HIV/AIDS by medical records had no claims data to support that diagnosis.

- Staging of disease data were not consistently documented at time of enrollment. In the event the PCP did not stage the illness, RNs used an approved set of criteria to determine what stage of the illness the member was in, based on available medical record data.

- Treatment protocols were not consistently documented in the medical records

During the upcoming months the pilot study will include:

- Performing additional analysis based on recommendations from AHCCCS' HIV/AIDS experts.
- Identifying pertinent quality indicators in the care and management of HIV/AIDS members.
- Developing a subsequent study incorporating the refined quality indicators.

Fee-For-Service Quality and Utilization Management Policies. AHCCCS has some members who receive their services on a fee-for-service basis. Therefore, utilization management must be in place for these populations in addition to utilization management requirements for health plans and program contractors. The fee-for-service quality utilization management practices which AHCCCS conducts are the same as for health plans and program contractors. Utilization management assesses care, services, procedures and facilities, including medical necessity, appropriateness of care, cost-effectiveness of the admissions to institutional settings, levels of care, ancillary services, length of stay, discharge and referral, re-admissions, quality of care and revenue, diagnosis, and procedure coding.

The elements of the assessment for both the health plans/program contractors and fee-for-service are:

- Prior authorization which determines in advance whether a service that requires prior approval will be covered based on the initial information received. Prior authorization may be granted provisionally (as a temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria.

- Concurrent review which is performed by HSAG at the onset of, and during the provision of, all acute inpatient hospital stays to assess the appropriate usage of ancillary resources, levels of care and service settings, according to professionally recognized standards of care. Concurrent review validates the necessity for continued stay and ensures quality of care. These reviews are performed at frequent intervals throughout the patient's illness and/or hospitalization.

- Medical claims reviews which are conducted, as appropriate, on specified claims for each AHCCCS eligibility category to verify appropriateness and effectiveness of service utilization. Criteria for these medical claims reviews focus on factors including, but not limited to, diagnosis, utilization pattern, elective surgery and type of admission. Focused medical reviews are conducted on either a pre- or post-payment basis, and may be applied to a sample of claims, or all claims, depending on the reason for conducting the review.

- Other medical reviews which are conducted prospectively on assessment of medical need before care is rendered, determination of the most appropriate health care setting and resource requirements, and verification of privilege status (e.g., approved admitting, treatment or surgical privileges of the admitting or treating physician).

QUALITY IMPROVEMENT INITIATIVE

With the support of HCFA, AHCCCS began a major Quality Improvement Initiative in 1995. The Initiative was designed to use encounter data and test new concepts of quality of care based on many of the measurements and recommendations from the Quality Assurance Reform Initiative (QARI) and Health Plan Employer Data and Information Set (HEDIS) 2.0, 2.5 and 3.0 Reports.

The following are the major components of the Initiative which are discussed in more detail in the remainder of the document:

Quality Indicators: AHCCCS, in collaboration with the health plans and program contractors, developed and refined appropriate quality indicators through an examination of how encounter data can be used to monitor quality.

Financial Indicators: AHCCCS refined measurements of health plan fiscal viability, management of care, timely payment of claims and documentation of medical expenses.

Member Satisfaction Survey: AHCCCS conducted a member survey of acute care members to provide information on access to care, communication between members and providers, and quality of care.

Provider Satisfaction Survey: AHCCCS conducted a focused survey of PCPs to determine their degree of satisfaction with the AHCCCS program. A broader study is planned for the future.

QUALITY INDICATORS

AHCCCS, the health plans and the program contractors formed a partnership to develop and define appropriate indicators to measure quality of care and to analyze how an encounter data reporting system can be used to monitor quality. In order to handle the complex process internally, an interdivisional project committee, directed by the AHCCCS Medical Director, was formed. Separate teams were established for each of the indicator sets and special teams were appointed for specification and development, testing, analysis and distribution. This activity was prioritized into three phases and included the development of indicators and baseline data in the following program areas:

- Acute care (clinical).
- Long term care for the elderly and physically disabled population and for persons with developmental disabilities.
- Behavioral health care.

ACUTE CARE INDICATORS

AHCCCS began developing the acute care indicators for prenatal care, women's health, childhood immunizations and birth outcomes in late 1994. In consultation with the health plans, the indicators were compared with HEDIS 2.0 and 2.5 and modifications were made. AHCCCS participated in the National Committee for Quality Assurance (NCQA) user group, reviewed HEDIS drafts and shared expertise on the Review and Specifications Panel for HEDIS 3.0. Initially, 11 indicators were identified. A year after the project began, the Cesarean Section indicator and the Asthma indicator were eliminated and well-child visits for children older than 1 year were added to conform with more recent HEDIS drafts. The indicators for the initiative are provided in Appendix A.

On September 30, 1996, quality indicator reports were distributed to the health plans for the Phase 1 indicators, which are mammography, dental services, cervical screening and low birth rate based on 1994-1995 data. Health plan representatives validated the AHCCCS data to identify any discrepancies between AHCCCS data and health plan data. After validating the quality indicator reports, health plans were satisfied that the data was an accurate representation of their experience. The reports, which were submitted to HCFA on October 4, 1996, are the baselines against which health plans will be measured in the future. Quality indicator reports covering the 1995-96 period for these same four indicators were completed in May 1997 and were used to evaluate health plans in the 1997 RFP process.

There are two tasks that remain in Phase 1 of the acute care quality indicators project:

1. Gather data and complete report for the 1997 Annual Childhood Immunization Survey. This report is due to be completed at the end of January 1998.

2. Gather 1996-1997 data for Phase 1 acute indicators and prepare a final report.

A brief explanation of several of the indicators is provided below. Appendix A provides a list of all the indicators, including the five which are not described below. All but three of the acute care indicators are due to HCFA in October 1998. Of the three indicators which are not due in October, The Childhood Immunizations was submitted in early February 1998, the Diabetes Management Audit is due at the end of 1999 (also, see the 1997 Annual Medical Audit on Diabetes which was submitted to HCFA earlier this year and is discussed further on page 4 of this). The Adolescent Well Care indicators is on hold and is scheduled for review in 2001.

Annual Immunization Assessment: The fifth annual immunization survey covered the contract year from October 1, 1996 through September 30, 1997 and focused on immunization completion rates among children who reached 24 months of age during the study period. Results of this assessment were released on February 3, 1998. All immunization rates were over 75% except DTP which was 69%. The highest immunization rate was 84% for HBV. The combined DTP, OPV and MMR immunization completion rate was 65%, an increase of two percentage points over last year's rates. Results summarizing missed opportunities, identified DTP as the antigen which could have the most significant impact on improvement in overall AHCCCS immunization rates. Immunization awareness in Arizona has increased, and providers have made a concerted effort to improve the immunization status of AHCCCS members. Much of the observed annual increase in immunizations has been due to the established relationship between AHCCCS, the health plans, program contractors and the providers.

AHCCCS included the immunization goals in the Request for Proposals (RFP) for the 1998 contract year. As stated in the RFP, the AHCCCS long range goal is to reach or exceed the Healthy People 2000 goal of 90% immunization for two year old members. The annual immunization audit helps to ensure that these goals are being reached. If the health plan has not achieved at least the statewide average immunization rates by the end of the contract year, the health plan must submit a corrective action plan to AHCCCS.

Initiation of Prenatal Care Visits: This indicator measures the percent of enrolled women who had a live birth during the reporting year, who were enrolled less then 44 weeks but more than 6 weeks and had their first prenatal visit within six weeks of enrollment. The first baseline report will cover all live births for enrolled women from October 1, 1996 through September 30, 1997 and is expected to be completed in October 1998.

Prenatal Care Visits in the First Trimester: This indicator measures the trimester in which the pregnant member began receiving prenatal care through a health plan and the number of prenatal visits made by the member. Several reviews of the data have been done to examine the compliance of providers with the reporting requirement of trimester of entry into prenatal care (T1, T2 or T3). The reviews indicate that providers are appropriately reporting the trimester of entry as required by AHCCCS policy. The first baseline report will cover all live births for enrolled women from October 1, 1996 through September 30, 1997 and is expected to be completed in October 1998.

Frequency of Ongoing Prenatal Care: This indicator will measure the percent of pregnant women who received the expected number or more than the expected number of prenatal visits during their pregnancy and those who received less than 21%, 21% to 40%, 41% to 60%, 61 to 80% of the expected number of prenatal visits. This report was expected to be completed in October 1998. However, a review of AHCCCS-generated encounter data revealed two global codes, both of which cover multiple antepartum care visits and are not included in the HEDIS 3.0 specifications. This makes it impossible for AHCCCS

to collect the number of individual visits through encounter data. Because of these various obstacles, AHCCCS will not be producing this indicator at this time.

Well-Child 0-15 Months Indicator: The purpose of the reports is to analyze the utilization of preventive visits in this age group. The first report on the Well Child Indicator for 0-15 months was submitted on October 1, 1997 and will be considered a baseline for measuring future reports. The data show that the aggregate utilization rate for all acute care health plans is 55.66%. The rate for Maricopa County is 53.32%, for Pima County it is 62.56% and the overall rate for rural counties is 40.60%. The next report on this indicator is scheduled for submission in October 1998.

Well Child 3, 4, 5 and 6 Years Old: Gathering of data for the Well Child Indicator for 3, 4, 5, and 6 Year Olds has been delayed because AHCCCS wanted to follow the HEDIS 3.0 specifications for annual well child visits for children in this age group. Beginning October 1, 1997 the AHCCCS EPSDT periodicity schedule mandates one annual well child visit for children in this age group instead of the previous specification for one well child visit every other year. The report that will be generated for this indicator will evaluate Health Plan performance following implementation of the this change. The initial report is expected in October 1998.

Adolescent Well Care: AHCCCS implemented a new periodicity schedule on October 1, 1997 which does not recommend an annual well adolescent visit. Focus for the next three years will be on measuring and improving EPSDT visits for the younger age groups. AHCCCS will move incrementally toward measuring adolescent visits.

Acute Care Utilization Reports: The Physician Services, Other Practitioner Services and Transportation Utilization reports covering the period from October 1, 1995 through September 30, 1996 were submitted to HCFA on February 19, 1998, and Lab services, Radiology services, and the HCFA-416 EPSDT Utilization reports were submitted on March 30, 1998. The Pharmacy Acute report which was not due to be completed until mid-October, was completed five months early. There are four utilization reports which are still being worked on and will be completed in May.

The following are some of the findings from the reports. All information is for 1995/96 except Pharmacy (acute) which is for 1996/97.

ANNUALIZED NUMBER OF SERVICES PER 1,000 MEMBER MONTHS					
Physician Services		*Transportation Services* (emergency and non emergency)		*Radiology Services*	
Health plans	8,453	Health plans	80	Health plans	888
FFS	6,267	FFS	113	FFS	951
DD	7,425	DD	771	DD	786
LTC	15,760	LTC	7,966	LTC	2,866

EPSDT Services

- Total number of individuals eligible for services: 432,129
- Number of eligibles receiving at least one initial or periodic service: 151,912
- Participant ratio for infants (under 1 year): 80%

Pharmacy (acute) 1996/97

- The five top therapeutic drug class rankings were the same as in 1995/96
- Central nervous system (CNS) agents were the most frequently prescribed therapeutic drug.
- In 1996/97, anti-infectives represented 14.3% of total costs and an average cost per prescription of $14.82. In 1995/96, anti-infectives represented 22% of total costs and had an average cost of $17.35.

ALTCS ELDERLY AND PHYSICALLY DISABLED INDICATORS

AHCCCS is collecting data on all the indicators for ALTCS-EPD, with the exception of Psychotherapeutic Agents, which is currently on hold. The following information outlines the current status of the ALTCS-EPD quality indicators which were developed in collaboration with program contractors:

Pressure Ulcer: The Sacral/Coccygeal Pressure Ulcer Indicator, which measures the rate of improvement of sacral coccygeal pressure ulcers over a six month period, was the subject of the 1995/1996 Medical Audit which was completed in February 1997. The primary purpose of the audit was to establish a baseline for the indicator by examining the prevalence of pressure ulcers in the ALTCS population by stage classification and site. The audit was an important foundation piece for the Sacral/Coccygeal Pressure Ulcer Indicator. At the end of the six month report period, the results of the indicator showed that 56.1% of the pressure ulcers had healed, mainly due to the fact that Stage II ulcers were reduced by 33.4%. AHCCCS has begun collecting data for the Sacral/Coccygeal Pressure Ulcer Indicator for 1997/1998. The indicator will identify the how many members had pressure ulcers on October 1, 1997 and what the status of the pressure ulcers were on March 31, 1998.

Influenza Immunization: The first report on this indicator covered the period from September 1, 1996 through December 31, 1996. The report identified that 86.8% of the sample population residing in nursing facilities had received an influenza vaccination. The Healthy People 2000 influenza immunization goal for people over 65 is 80%. The next report, which will cover the period 9/97 through 12/97 is scheduled for completion by August 15, 1998.

Changes in Activities of Daily Living (ADL): This indicator was reported on in October 1997 for calendar year 1995 and identified that approximately 50% of the sample ALTCS-EPD population had a decline in ADL capabilities. The decline in ADL capabilities was most evident in two groups: members residing in nursing homes who are 81 years of age or older, and all ALTCS-EPD members diagnosed with dementia. This indicator will be reported for calendar year 1996 in November 1998.

Hospital and Emergency Room Utilization: This indicator was reported on in October 1997 and showed that ALTCS-EPD members who had more than one ER visit during contract year 1993/94, had an average of 4.4 visits and of the 1,414 hospital admissions for the sample population, approximately half originated in an emergency room. The Hospital and ER Indicator was also reported for the DD population and that information is provided later in this document. The next report is due in November 1998 and will cover both 1994/95 and 1995/96.

Fall Related Fractures: This indicator, which was submitted in November, provided data on ALTCS-EPD members who had a fracture secondary to a fall within the assessment period in 1997. In the sample population, 71 members had at least one fracture resulting from a fall. As expected, females had a higher percentage of fractures than males and actually appear to be about twice as likely to fracture a bone when they fall. The next report period for this indicator will be 1997/98 and is due in November 1998.

Psychotherapeutic Drugs: This indicator is on hold and is scheduled for review in 2001.

Long Term Care Utilization Reports: The utilization report on Hospice was submitted on February 19 and the four remaining long term care reports: Institutional Care, HCBS, Therapy, and Pharmacy were completed on March 30.

The following are some of the findings from the reports. All information is for 1995/96.

Institutional Services

The annualized number of institutional services for EPD per 1,000 member months was:

- Urban 360,637
- Rural 359,625

The annualized number of institutional services for DD LTC per 1,000 member months was 269,737.

Home and Community Based Services (HCBS)

THE ANNUALIZED NUMBER OF HCB SERVICES, BY GROUP, PER 1,000 MEMBER MONTHS		
EPD	DD	FFS/LTC
898,642 [Urban 1,007,321 Rural 528,465]	738,008	77,796

Pharmacy (LTC)

THE NUMBER OF PRESCRIPTIONS, BY SETTING, PER MEMBER MONTH					
EPD		DD		FFS/LTC	
Institutional	4.47	Institutional	3.58	Institutional	3.18
HCBS	4.43	HCBS	.35	HCBS	.34
Other	1.81	Other	.21	Other	.42

ALTCS DEVELOPMENTALLY DISABLED INDICATORS

AHCCCS and the DES/Division of Developmental Disabilities (DES/DDD) identified seven indicators for the developmentally disabled (DD) population. All of the indicators are summarized in Appendix A.

Hospital and ER Utilization: Since there is no comparable population, FY 1995 and 1996 data will be compared with the information in the first report which is for FY 1994. The report data on the sample DD population shows that of those members with more than one visit, the average number of visits per member was 3.8, and of the hospital admissions for this population, 33.5% originated in an emergency room. The first report on this indicator was completed in October 1997 and the next report is due in November 1998.

DD Health/Safety in Group Homes: This Indicator was completed in October. The Health/Safety Indicator was based on data collected from January 1995 through June 1997 and indicated that an average of 1.43 health/safety noncompliances were cited during the 372 inspections in 1995. However, for the 238 inspections completed during the first six months of 1997, the average of noncompliances cited per inspection had dropped to 0.28 per inspection. In the four program areas which had a noncompliance percentage that was over 10% in 1995, all had improved over the period of the evaluation, so that none of these areas had a percentage above 3% in 1997. Further reporting on this indicator has been discontinued.

DD Program Monitoring in Group Homes: The Monitoring Indicator, which was completed in October was based on data collected from July 1995 through June 1997. An average of 4.73 noncompliances per review were cited during the first six month evaluation period (July 1, 1995 -December 31, 1995). However, during the last six month evaluation (January 1, 1997 - June 30, 1997), the average noncompliances per review had dropped to 2.14. There were 14 programmatic rules with a frequency of noncompliance at or above 10% during the first review period. All of these had improved by the final review period, with half (7) dropping below a 10% noncompliance rate. Further reporting on this indicator has been discontinued.

National Core Indicators Project

Recently, Arizona was chosen as one of seven states to pilot the National Core Indicators Project (CIP) which is being developed in collaboration with the Human Services Research Institute (HSRI) and the National Association of State Directors of Developmental Disabilities Services, Inc. The DES/DDD will represent Arizona in this program. Because of the time the program will demand from DES/DDD staff, AHCCCS is requesting that the collection and reporting of data for the majority of the quality indicators for ALTCS DD members be suspended for approximately two years.

AHCCCS has suspended activities for most of the indicators, but will continue collecting DD indicator data for: Hospital and ER Utilization, Childhood Immunizations and Members Receiving Dental Services. Reporting for Childhood Immunizations and Dental Services for DD members will be included in the acute indicator reports.

For the CIP, DES/DDD has compiled data from a family survey which was distributed to 1,000 Arizona families with a DD member. The responses from 378 DD families was input into a computer program provided to DES/DDD by HSRI and the results were submitted to HSRI for analysis. A consumer survey, involving 600 face-to-face interviews is still being conducted through the Governor's Council on Developmental and a provider survey was mailed out from which responses were compiled by DES/DDD and submitted to HSRI.

All of the information from the surveys will be analyzed by HSRI and the findings will be reviewed by the pilot states and HSRI to determine what are the best indicators. This information will be used to prepare a refined survey for use by all states. After considerable refining of the tool, which DES/DDD believes will take a couple of years, Arizona hopes to have DD indicators which can be used to compare quality of care from district to district, and perhaps from provider to provider. HSRI plans to have a tool which can be used to compare quality of care from state to state.

BEHAVIORAL HEALTH INDICATORS

In 1995, AHCCCS, in collaboration with the ADHS/Division of Behavioral Health Services (ADHS/BHS), health plan representatives, and other interested participants, began conceptualizing and designing encounter-based quality indicators for the behavioral health program. Of seven potential

indicators, three were chosen as the most accessible and meaningful, and most likely to provide data which could be used to shape policy and clinical care guidelines. These indicators are:

- Ambulatory Follow-up to Inpatient Care
- Inpatient Readmission Rate
- Laboratory Follow-up to Selected Medications

ADHS/BHS Corrective Action Plan for Encounters

ADHS/BHS and AHCCCS met twice to monitor the effectiveness of corrective actions which ADHS/BHS has taken to improve the quality and quantity of data submitted as encounters for behavioral health services. Many of the missing encounters, those which were pended at the ADHS/BHS level of editing, have been successfully transmitted to AHCCCS as a result of these efforts. ADHS/BHS and AHCCCS will continue to meet regularly to examine the remainder of encounter submission failures in order remedy this situation, but are greatly encouraged by the success they have experienced. As a result of these efforts, both the quality indicators and utilization reports should provide a more realistic picture of the behavioral health services delivery system.

Ambulatory Follow-up to Inpatient Care and Inpatient Readmission Rate: These two quality indicators were developed, run and reported to HCFA in July 1997 for the period 1994-1995. Analysis of the results was not possible as the review of the data revealed sizable encounter omission errors. A corrective action plan was required of ADHS/BHS regarding encounter submissions and AHCCCS also required that ADHS/BHS re-run the quality indicators from the ADHS internal claims data information for this same period.

AHCCCS is currently performing data analysis of UBs (Universal Bill type submitted for hospital services) to prepare for reporting of data on the two hospital service based indicators scheduled for reporting in July 1998.

Laboratory Follow-up to Selected Medications: This indicator has been postponed due to encounter omission errors and because, in the process of developing technical specifications for this indicator, it was determined that encounters for two of the laboratory tests used could not be collected solely from the ADHS enrolled member's RBHA service provider. Therefore, the indicator specifications must be redesigned to include identification of health plan PCP involvement in monitoring the laboratory values of shared members. During 1994-95, only the health plans were capitated for these tests so that performing this indicator for that year would not provide a measure of ADHS and RBHA performance to be compared to later years. Measures of this indicator will begin with 1995-1996 data. The target date for submission of reports on this indicator is July 1999, for data from 1995-1996 and 1996-1997.

Behavioral Health Utilization Reports: The utilization reports have been developed and were fashioned, where possible, to match HEDIS reporting guidelines for utilization data. Technical specifications for the first three reports are nearing completion and are scheduled to be reported by August 1998, for data from 1994-1995 and 1995-1996. The service level activity report was previously run on 1994-1995 data, however, it will be run again for that year as well as 1995-1996 to validate encounter omission corrective actions and to provide a basis for comparative analysis.

BEHAVIORAL HEALTH UTILIZATION REPORTS	
UTILIZATION REPORT	**SUMMARY DESCRIPTION**
1. Inpatient Services	1. Number of inpatient hospitalizations for ADHS enrolled members reported per RBHA and statewide, by age grouping and mental health category.
2. Partial Care Services	2. Number of ADHS enrolled members who received basic or intensive partial care services, reported per RBHA and statewide by age grouping and mental health category.
3. Ambulatory Services	3. Number of ADHS enrolled members who received ambulatory mental health services, reported per RBHA and statewide by age grouping and mental health category.
4. Service Level Activity	4. Number of ADHS enrolled members receiving services by activity level and by mental health category reported by RBHA and statewide.

FINANCIAL INDICATORS

Financial indicators were identified as another performance assessment tool. Currently, AHCCCS requires health plans and program contractors to comply with, and report on, a variety of financial standards. Four specific financial indicators were developed by AHCCCS and the health plans in order to evaluate the performance of the health plans. Financial indicators will be calculated using 1997 audited information which will be final in April 1998.

Indicator	**Determines:**
1. Operating income/loss.	If a health plan can remain fiscally viable given current capitation rates.
2. Medical expense ratio.	How well a health plan manages care.
3. Days outstanding received but unpaid claims (RBUC).	If claims are being paid in a timely fashion.
4. Change in reported but unpaid claims and incurred but not reported (IBNR) estimates.	How well a health plan is recording medical expenses.

MEMBER SATISFACTION SURVEY

AHCCCS completed a satisfaction survey of more than 14,000 acute care members by telephone between November 1995 and April 1996 . This survey provided valuable information on access to care, communication between members and providers and the perception of the member regarding quality of care. The purpose for conducting this standardized member survey was to obtain feedback from members to assist AHCCCS in oversight and contracting activities and to assist health plans in identifying areas of excellence and areas in need of improvement.

Overall, the results of the 1996 AHCCCS Member Satisfaction Survey were quite positive. The overall feedback from respondents for six areas show that at least 75% of respondents gave a rating of "good" or

"very good" when asked to judge their health plan, overall quality of care, care from their PCP, specialty care, ability to obtain the care needed and children's dental care. The overall rating given to PCPs by 84% of the respondents was "good" or "very good" and when asked about obtaining appointments when sick, 86% of the respondents rated appointment availability as "good" or "very good". This consumer feedback will be used in combination with other types of information, such as studies of the clinical processes and outcomes, to ensure continued quality improvement.

PROVIDER SATISFACTION SURVEY

As a component of the Quality Improvement Initiative, AHCCCS conducted a small pilot provider satisfaction survey in the first quarter of 1997 as a precursor to the Provider Satisfaction Survey. AHCCCS, in cooperation with HSAG, designed a survey tool to interview 50 providers who were selected based on specialty and volume. The review was conducted in conjunction with the scheduled on-site operational reviews of health plans. The results of the pilot survey helped determine AHCCCS' decision to conduct the survey by mail and to use an independent contractor. Two consultants have been hired, and the design and sampling stage of the project has begun.

DECISION SUPPORT SYSTEM (DSS)

The objective of the DSS is to improve the processes for structuring, accessing, and analyzing AHCCCS PMMIS information. AHCCCS is currently developing a Request for Proposal (RFP) to obtain comprehensive proposals from qualified bidders to provide, install and implement an integrated DSS using PMMIS data. Once the DSS is implemented, operation and maintenance will be the responsibility of AHCCCS staff.

The purpose of the DSS will be to:

- Provide AHCCCS staff with increased availability to information necessary to support the day-to-day administration, planning, and evaluation of the AHCCCS Program
- Enhance data access and analysis capabilities at varying levels of end-user sophistication
- Identify patterns of behavior attributable to eligibles and providers in order to better understand utilization issues and to use this information to design effective cost containment measures
- Apply normative data to measure cost, utilization, and quality of care findings against relevant norms
- Support the continuing rate setting activities of the AHCCCS Program.

The project was given conditional approval from the Arizona Government Information Technology Agency in December. Enhanced funding for the project has been discussed with HCFA, and an Advance Planning Document was submitted on March 16.

DENTAL CARE TASK FORCE

The AHCCCS Dental Care Task Force was created at the request of the Arizona Legislative Dental Care Study Committee to make recommendations on ways to increase: 1) the utilization of dental services by children in AHCCCS, and 2) the number of dental providers who serve AHCCCS members. The final report has been drafted and will be submitted to the Legislature in April.

During their research, the Task Force found that AHCCCS and the health plans have implemented a number of changes in recent months which should have a positive impact on dental utilization rates and

the number of dental providers. For example, as of January 1998, ten of the twelve health plans are contracting directly with individual dentists. This change has resulted in twice as many dentists participating in AHCCCS.

Attachment M

Copayment Schedule

ATTACHMENT M
COPAYMENT SCHEDULE

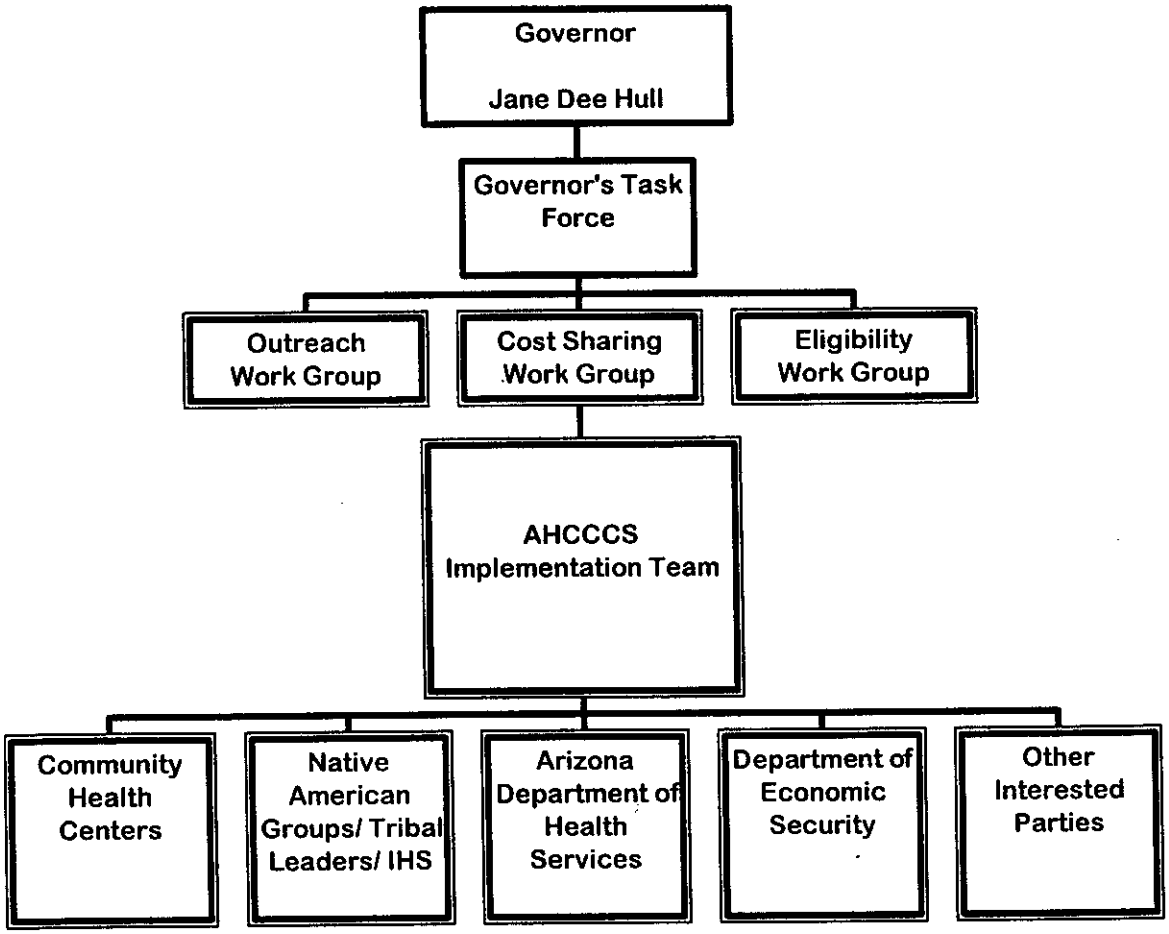
COPAYMENT SCHEDULE	
Health plans are responsible for the collection of copayments from members. The following services are excluded from copayments: • Prescription drugs • Prenatal care including all obstetrical visits • Well baby care • Immunizations • Screening and preventive care services • Members in nursing facilities • Visits scheduled by the PCP or practitioner, which are not requested by the member	
COVERED SERVICES	COPAYMENT
Doctor's office or home visit and all diagnostic and rehabilitative x-ray and laboratory services associated with the visit.	$1.00 per visit.
Non emergency surgery	$5.00 per procedure
Non emergency use of the emergency room.	$5.00 per visit.

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
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American Academy of Pediatrics

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Arizona Prenatal Care Coalition

Attachment P

Community Support for KidsCare

HEALTHY CHILDREN ARIZONA

Businesses and Organizations Endorsing HB2659--*KidsCare*

Updated May 20, 1998

Co-Chair
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Nordensson Lynn
Strategic Marketing Communications

Co-Chair
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American Academy of Pediatrics, Arizona Chapter

DONNA ADAMS
Arizona Nurses Association

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St. Luke's Charitable Health Trust

CHERYL COLLIER BECKER
The Mental Health Association of Arizona

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DAVID LANDRITH
Arizona Medical Association

GIFFORD LODA
Mercy Healthcare Arizona

DEBBIE MCCUNE DAVIS
The Arizona Partnership for Infant Immunization

ALIDA MONTIEL
Inter Tribal Council of Arizona

JANE PEARSON
St. Luke's Charitable Health Trust

ANDREW S. RINDE
Association of Community Health Centers

JOHN RIVERS
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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 *(over)*

Healthy Children Arizona, a project of Children's Action Alliance, is supported by a grant from Murphy Memorial, a fund of St. Luke's Charitable Health Trust with additional funding from Honeywell and the Armstrong Family Foundation, a support foundation of the Arizona Community Foundation.

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 Kids 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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Attachment Q

Public Comments and AHCCCS Responses

ATTACHMENT Q
COMMENTS FROM THE PUBLIC
AND AHCCCS' RESPONSES

The following are the major 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 - AHCCCS will evaluate all children through the various indicators rather than by a diagnosis. AHCCCS contractors must meet the needs of a child 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 operational reviews.

Comment - AHCCCS 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 appointment 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 disenroll from a health plan during the first three months of enrollment.

Response - AHCCCS will provide 12 months of guaranteed enrollment in the first year of enrollment, allow a family to choose the health 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 - AHCCCS 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 - AHCCCS 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 vaccine will be provided.

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

Response - AHCCCS 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 appropriate.

Response - AHCCCS 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 50% 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 KidsCare money?

Response - AHCCCS intends to conduct outreach in all areas of the state, including on-reservation, 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 - IHS is not allowed to impose cost sharing for tribal members. Several members commented that premiums and copayments should not be assessed on Native Americans who receive 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 - AHCCCS 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 informed about the KidsCare Program and encourage tribes to participate in the many meetings. AHCCCS 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 funded 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 638 tribal entity.

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

Response - AHCCCS 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 - AHCCCS needs to provide a portion of the 10% administrative funds to tribal governments to intensify outreach and coordination efforts.

Response - AHCCCS 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 - The demographic information may underestimate the number of Native American children in Arizona.

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 - AHCCCS understands that it is difficult in rural areas to access services when non-emergency 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.

Comment - 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.

Comment - 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

Community Presentations and Meetings

ATTACHMENT R
COMMUNITY PRESENTATIONS

Arizona Association of Community Health Centers

Arizona Association of Industries

Arizona Chamber of Commerce

Arizona Justice Institute

Arizona Nurses' Association

Arizona Physicians, IPA

Center for New Directions

CIGNA Community Choice

Cochise Health Systems

Community Legal Services

County Supervisor's Association

DES/CMDP

Doctor's Health Plan

East Valley Partnership

Family HP of Northeastern Arizona

Health Choice Arizona

Maricopa Managed Care Systems

Mercy Care Plan

Navajo Area IHS

Navajo Nation Council

Pharmaceutical Research and Manufacturing of America

Phoenix Area IHS

Phoenix Chamber of Commerce

Phoenix Health Plan/ Community Connection

Pima Health Plan/Pima Long Term Care

Pima Health Systems

Pinal County Long Term Care

Salt River Indian Community Health Department

San Carlos Health and Human Services

Southern Arizona Legal Aide

St. Vincent De Paul Society

Tohono O'Odham Nation

University Family Care

Ventana Health Systems

Yavapai County Long Term Care

Attachment S

KidsCare Budget

ATTACHMENT S
KIDSCARE BUDGET

Tables 1, 2a, 2b, 3a and 3b summarize cost and caseload estimates for the KidsCare program for fiscal years 1998 to 2001. The program will start October 1, 1998. This plan will cover children in families with income above current Medicaid eligibility levels, up to 150% of the FPL in state fiscal year 1999, up to 175% of the FPL in state fiscal year 2000 then up to 200% of the FPL from fiscal years 2001 to 2007. At the present time, the estimates assume no premium or other cost-sharing, but such an option will be developed and submitted to HCFA for approval, for implementation in July of 1999. All estimates are rounded to the nearest hundred.

I. TABLE 1: KIDSCARE CASELOAD ESTIMATES BY AGE GROUP

Table 1 shows the number of children enrolled in the KidsCare program, by age group for FFYs 1998 through 2001. By FFY 2001, there will be approximately 63,000 children enrolled in the program; 78% of these children will be between the ages of 6 and 18. The following hypotheses were made to compute KidsCare caseload estimates:

- All estimates are based on a three-year average of 1994 - 1996 March Current Population Survey (CPS) data, reflecting years 1993, 1994 and 1995. The percentage estimates by age group were then applied to the most recent Census Bureau projection of the Arizona population for July 1, 1998. It is assumed that the percentages of uninsured children and percentage of children in Arizona remian constant over the 1998 - 2001 period.

- Population growth rates by age categories are based on 1996 U.S. Bureau of the Census' Projections for Arizona.

- It is assumed that 70% of the eligible children will enroll in the program.

- It is assumed that half of the children will enroll on the first day of the program, then will evenly enroll over the next twelve months. All children for the first eligibility tier (150% of FPL) will be enrolled as of October 1999. Enrollment for children for the second tier (175% of FPL) will start July 1, 1999 and conclude by June 30, 2000. Enrollment for children for the third tier (200% of FPL) will start July 1, 2000 and conclude by June 30, 2001.

II. TABLES 2a AND 2b: KIDSCARE COST ESTIMATES

Tables 2.a and 2.b display Arizona's allotments, healthcare expenditures, administrative and outreach expenditures, and total expenditures, as well as the number of children enrolled in the program for FFYs 1998 through 2001. Table 2.a is based on total funds available (both federal and state shares) while Table 2.b only shows the federal share of both the allotments and expenditures. By FFY 2001, total expenditures for the program will reach approximately $88 million. Regardless of the caseload, it is assumed that Arizona will never spend more than the sum of federal and state allotments. Estimating hypotheses are as follows:

- The capitation rates reflect AHCCCS' total acute regular, prospective and reinsurance payments for SFY 1999. The rates also include an estimate for mental health expenditures covered under the program. Capitation rates for the 15 - 18 age groups are adjusted from the AHCCCS rates since AHCCCS makes payments for the actuarial groupings of 14 - 44 age categories only. Rates are pro-rated to correspond to federal fiscal years and are increased for inflation by a four percent factor.

- It is assumed that outreach and administrative expenses will represent ten percent of total expenditures for the program.

- To come up with the Arizona allotment (federal share), HCFA's allotment percentage for Arizona as of FFY 1998 (2.69 percent) is applied to federal net available funds (net of diabetes program and Commonwealth and Territories allotments), until FFY 2001. The allotment figure thus found is divided by the enhanced FMAP for Arizona (75.85 %), to come up with the total funds available for Arizona (state and federal share).

III. TABLES 3a AND 3b: KIDSCARE BUDGET ESTIMATES

Tables 3.a and 3.b display Arizona's allotments, total expenditures and remaining funds ("End Balance") for FFYs 1998 through 2001. Table 3.a is based on total funds available (both federal and state shares) while Table 3.b only shows the federal share of both the allotments and expenditures. The "End Balance" column reflects the funds available to the State by the end of the year, after expenditures and assuming a three-year rollover policy.

TABLE 1
KIDSCARE CASELOAD ESTIMATES BY AGE GROUP
FOR FFY 1998 THROUGH 2001
70 PERCENT PRESENTATION RATE, ONE YEAR PHASE-IN

150 to 200% FPL[1]	<1	1 through 5	6 through 14	15 through 18	All
October 1, 1998 Start Date					
70% Presentation Rate					
FFY 1998	0	0	0	0	0
FFY 1999	1,200	2,200	11,200	14,200	28,800
FFY 2000	1,700	6,400	21,700	20,100	49,900
FFY 2001	2,300	11,700	28,800	20,300	63,100

[1] Eligibility levels: FY 1999: up to 150% FPL; FY 2000: up to 175% FPL; FY 2001 and beyond: up to 200% FPL.

TABLE 2.a
KIDSCARE COST AND CASELOAD ESTIMATES FOR FFY 1998 THROUGH 2001
TOTAL FUNDS

150 to 200% FPL[2]	Total Funds Available	Healthcare Expenditures	Outreach/ Admin. Exp.[1]	Total Expenditures	Number of Children
October 1, 1998 Start Date					
70% Presentation Rate					
FFY 1998	$ 149,397,200	$ -	$ -	$ -	0
FFY 1999	$ 149,160,900	$ 37,643,500	$ 4,182,600	$ 41,826,100	28,800
FFY 2000	$ 149,160,900	$ 63,365,200	$ 7,040,600	$ 70,405,800	49,900
FFY 2001	$ 140,230,300	$ 79,516,900	$ 8,835,200	$ 88,352,100	63,100
TOTAL	$ 587,949,300	$ 180,525,600	$ 20,058,400	$ 200,584,000	

TABLE 2.b
KIDSCARE COST AND CASELOAD ESTIMATES FOR FFY 1998 THROUGH 2001
FEDERAL SHARE

150 to 200% FPL[2]	Arizona Allotment	Healthcare Expenditures	Outreach/ Admin. Exp.[1]	Total Expenditures	Number of Children
October 1, 1998 Start Date					
70% Presentation Rate					
FFY 1998	$ 113,138,500	$ -	$ -	$ -	0
FFY 1999	$ 113,138,500	$ 28,552,600	$ 3,172,500	$ 31,725,100	28,800
FFY 2000	$ 113,138,500	$ 48,062,500	$ 5,340,300	$ 53,402,800	49,900
FFY 2001	$ 106,364,700	$ 60,313,600	$ 6,701,500	$ 67,015,100	63,100
TOTAL	$ 445,780,200	$ 136,928,700	$ 15,214,300	$ 152,143,000	

[1] Computed according to HCFA's 10 percent limit formula: L=Total Computable Expenditures for the fiscal year/9.

[2] Eligibility levels: FY 1999: up to 150% FPL; FY 2000: up to 175% FPL; FY 2001 and beyond: up to 200% FPL.

TABLE 3.a
KIDSCARE BUDGET ESTIMATES FOR FFY 1998 THROUGH 2001
TOTAL FUNDS

150 to 200% FPL[1]	Total Funds Available	Total Expenditures	End Balance	Number of Children
		October 1, 1998 Start Date		
		70% Presentation Rate		
FFY 1998	$ 149,397,200	$ -	$ 149,397,200	0
FFY 1999	$ 149,160,900	$ 41,826,100	$ 256,732,000	28,800
FFY 2000	$ 149,160,900	$ 70,405,800	$ 298,321,700	49,900
FFY 2001	$ 140,230,300	$ 88,352,100	$ 289,391,200	63,100
TOTAL	$ 587,949,300	$ 200,584,000		

TABLE 3.b
KIDSCARE BUDGET ESTIMATES FOR FFY 1998 THROUGH 2001
FEDERAL SHARE

150 to 200% FPL[1]	Arizona Allotment	Total Expenditures	End Balance	Number of Children
		October 1, 1998 Start Date		
		70% Presentation Rate		
FFY 1998	$ 113,138,500	$ -	$ 113,138,500	0
FFY 1999	$ 113,138,500	$ 31,725,000	$ 194,552,000	28,800
FFY 2000	$ 113,138,500	$ 53,402,800	$ 226,277,000	49,900
FFY 2001	$ 106,364,700	$ 67,015,100	$ 219,503,200	63,100
TOTAL	$ 445,780,200	$ 152,142,900		

[1] Eligibility levels: FY 1999: up to 150% FPL; FY 2000: up to 175% FPL; FY 2001 and beyond: up to 200% FPL.

Glossary

GLOSSARY OF ABBREVIATIONS AND ACRONYMS

ADHS	Arizona Department of Health Services
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AHCCCS	Arizona Health Care Cost Containment System
ALTCS	Arizona Long Term Care System
AZTEC	Arizona Technical Eligibility Computer System
CAHPS	Consumer Assessment of Health Plans Survey
CMDP	Children's Medical and Dental Program
CRS	Children's Rehabilitative Services
DES	Department of Economic Security
DDD	Division of Developmental Disabilities
DSS	Decision Support System
EAC	Eligible Assistance Children
ELIC	Eligible Low Income Children
EPD	Elderly and Physically Disabled
EQRO	External Quality Review Organization
FAA Offices	Family Assistance Administration Offices
FES	Federal Emergency Services
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HCG	Healthcare Group
HEDIS	Health Plan Employer Data and Information Set
HSAG	Health Services Advisory Group
IHS	Indian Health Service
IMD	Institution for Mental Diseases
KidsCare	State Children's Health Insurance Program
MAO	Medical Assistance Only
MCH	Maternal and Child Health
MCO	Managed Care Organization
MI/MN	Medically Indigent/Medically Needy
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PIMC	Phoenix Indian Medical Center
PMMIS	Prepaid Medical Management Information System
PRUCOL	Permanently Residing Under Color of Law (An alien who is not a qualified alien)
PSP	Premium Sharing Pilot Program
QARI	Quality Assurance Reform Initiative
QI	Quality Improvement
QMP	Quality Management Plans
QISMC	Quality Improvement System for Managed Care
QM	Quality Management
RBHA	Regional Behavioral Health Authority

GLOSSARY Continued.....

RFP	Request for Proposal
RHC	Rural Health Clinic
SES	State Emergency Services
S.O.B.R.A.	Sixth Omnibus Budget Reconciliation Act
SSI	Supplemental Security Income
SSI-MAO	Supplemental Security Income Medical Assistance Only
WIC	Women, Infants and Children