

August 17, 2001

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Mail Stop S201-16
Baltimore, Maryland 21244-1850

Linda Minamoto
Associate Regional Administrator
Center for Medicare and Medicaid Services
Medicaid State Operations Branch
75 Hawthorne Street, 5th Floor
San Francisco, CA 94105

Dear Ms. Barraza-Cannon and Ms. Minamoto:

Enclosed is State Plan Amendment (SPA) 01-01 which reflects changes and additions as a result of Arizona Senate Bill 1087--"Relating to the Children's Health Insurance Program."

The changes and additions are as follows:

1. Expansion of covered services:
 - Removes eyeglass limitation;
 - Adds non-emergency transportation; and
 - Makes behavioral health services the same as the state employees benefit package (removes 30 day in & outpatient limitations);
2. Reduces the bare period from six to three months;
 - Waives the bare requirement for a child who is seriously or chronically ill; and
3. Establishes a process for a hardship exemption to the disenrollment process.

In addition, the legislation requires AHCCCS to apply for a KidsCare waiver to include the parents of the children. AHCCCS anticipates submitting a waiver by November 2001.

If you have any questions about the enclosed SPA, please contact me at (602) 417-4447.

Sincerely,

**Unable to provide signature due to electronic format
If you are in need of a copy that includes a signature,
Please contact AHCCCS at (602) 417-4534.**

Lynn Dunton
Assistant Director
Office of Policy Analysis and Coordination
Enclosure

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Section 1



General Description and Purpose of the State Child Health Insurance Plan

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

The state uses 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 is referred to as KidsCare (see Attachment A). The passage of the legislation was the culmination of many meetings convened by Governor Jane Dee Hull and legislative hearings which provided a venue for the public to testify about the proposal. Additionally, staff from AHCCCS, Arizona's Medicaid program, have met continually with interested parties to discuss the implementation of the program.

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

Arizona provides KidsCare services through established AHCCCS health plans and any state employee Health Maintenance Organizations (HMOs) who elect to participate in the program. These entities are referred to as contractors throughout this document.

All children have a choice of available contractors and primary care providers in a Geographic Service Area. Additionally, Native Americans can elect to receive services through the Indian Health Center (IHS), 638 tribal facilities or one of the contractors. The KidsCare service package offered by the contractors is the same service package offered to Medicaid recipients. AHCCCS coordinates outreach activities with the assistance of safety net providers, other state agencies, tribal entities and organizations, advocacy groups and other appropriate entities.

Copayments are assessed for all members. In addition, families with income above 150% of FPL are assessed premiums. However, at no time will a Native American or an Alaska Native be charged a copayment or a premium. 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.

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

- 1. Have exceeded their lifetime insurance limit;
- 2. Are newborns;
- 3. Are transitioning Title XIX members;
- 4. Are applicants who are seriously or chronically ill under A.R.S. § 36-2983 and 9 A.A.C. 31, Article 1;
- 5. Are Title XXI members who lose insurance coverage;
- 6. Are enrolled with Children's Rehabilitative Services; or

7. Are Native American members receiving services from IHS or a 638 Tribal Facility.

Section 2



General Background and Description of State Approach to Child Health

Section 2. General Background and Description of State Approach to Child Health Coverage 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 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 approval for a Waiver expansion, and numerous public health programs which provide health care services to children.

Formal referral processes are in place between governmental and community agencies which aid in the identification, referral and enrollment of uninsured children in the appropriate program. For example, by state law, children and pregnant women must be screened for Medicaid eligibility before applying for state-funded public programs or private programs. 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 Medicaid.

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.

EFFORTS TO IDENTIFY AND ENROLL CHILDREN IN PUBLIC INSURANCE PROGRAMS

In addition to Medicaid, Arizona has five public initiatives which identify and help enroll children in programs that serve children. AHCCCS 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.

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 PROGRAM

In 2001, 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 2001 legislation was enacted to define the parameters and establish PSP as a statewide program. As of October 1, 2001, applicants for the program can have household income up to 250 percent of FPL; persons who are chronically ill as defined in rule, may have household income up to 400 percent of the FPL.

The PSP is administered by AHCCCS 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 funding is capped; 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 4



Eligibility Standards and Methodology

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

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

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

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, and 200% of the FPL beginning October 1, 1999. 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. All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

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

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

4.1.5. **Residency:** 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~~-three 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. This exclusion also does not apply to children who:
 - 1. Have exceeded their lifetime insurance limit;
 - 2. Are newborns;
 - 3. Are transitioning Title XIX members;
 - 4. Are applicants who are seriously or chronically ill under A.R.S. § 36-2983 and R9-31-101;
 - 5. Are Title XXI members who lose insurance coverage;
 - 6. Are enrolled with Children's Rehabilitative Services; or
 - 7. Are Native American members receiving services from IHS or a 638 Tribal Facility.

4.1.8. **Duration of eligibility:**

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, or the child's parent or legal guardian fails to cooperate in meeting the requirements of the program.
- The child's whereabouts are unknown.

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 have been ineligible at the time of approval.
- Obtains private or group health insurance.
- Is adopted and no longer qualifies for KidsCare.
- Is a patient in an institution for mental diseases.
- Voluntarily withdraws from the program.

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 is a joint application for Medicaid and KidsCare. AHCCCS is requesting 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. AHCCCS will continue to conduct outreach to all potentially eligible families up to 200% of the FPL., 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 be 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.

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

A member is allowed to change contractors on an annual basis and when an individual moves into a new geographic area not served by the current contractor. A member can change PCPs at any time. The option to change contractors is based on the member's anniversary date which is the first day of the month that the member is enrolled into KidsCare. Ten months following the anniversary date, the member will be sent an annual enrollment notice advising that a different contractor may be selected. A list of contractors, with toll-free numbers and the available services, 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 are allowed to disenroll at any time upon request and choose a contractor for all KidsCare services. Similarly, Native American children enrolled with a contractor or other provider 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 ensures that a child who is not eligible for Medicaid or other creditable coverage, but who meets KidsCare eligibility criteria, is enrolled in KidsCare. AHCCCS administers both the Medicaid and KidsCare Program. Records of KidsCare eligibility are maintained in a data base that is also used for Medicaid eligibility. The data base is checked for current Medicaid eligibility before determining KidsCare eligibility. Medicaid eligibility will always override KidsCare eligibility.

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

- 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)***

As stated above, AHCCCS administers both Medicaid and the KidsCare Program and ensures that any child eligible for Medicaid is enrolled in Medicaid. The application form used for KidsCare initiates an application for Medicaid which is determined simultaneously. Medicaid eligibility 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 requests information about group health plan coverage within the past three months. If a child is covered by group health insurance or was covered and the coverage was voluntarily discontinued in the past three months, the child is not eligible for KidsCare unless the child has exceeded the lifetime limit to his or her insurance policy. In such an event, the three months bare will be waived. In addition, exceptions to the three 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. Applicants who are seriously or chronically ill under A.R.S. § 36-2983 and R9-31-101 are also excluded from this provision.

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 are available at IHS and appropriate tribal locations. AHCCCS also uses Native American events, newspapers, and radio stations as a forum for outreach. If IHS or tribal staff are willing to assist applicants in completing the 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 6



Coverage Requirements for Children's Health Insurance

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

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

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

- 6.1.1 **Benchmark coverage; (Section 2103(a)(1))**
 - 6.1.1.1 **FEHBP-equivalent coverage; (Section 2103(b)(1))
(If checked, attach copy of the plan.)**
 - 6.1.1.2 **State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)**
 - 6.1.1.3 **HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)**
- 6.1.2 **Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.**
- 6.1.3 **Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If “existing comprehensive state-based coverage” is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for “existing comprehensive state-based coverage.”**
- 6.1.4 **Secretary-Approved Coverage. (Section 2103(a)(4))**

Arizona will use the same benefits as are provided under the Medicaid State plan. Any limitations on the covered services are discussed in this section and will be delineated in the AHCCCS Medical Policy Manual. The cost sharing requirements are specified in Section 8 of the State Plan.

Members who enroll in the KidsCare Program who select an AHCCCS health plan or the state employee HMO, if the HMO elects to participate in the program, will receive the following KidsCare services, subject to the limitations described below:

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

- 6.2.1 **Inpatient services (Section 2110(a)(1))**
 - a. Inpatient hospital services, including medically necessary ancillary services, and emergency hospital services, if furnished by a licensed hospital and

provided by or under the direction of a PCP or primary care practitioner according to federal and state law, rules, and AHCCCS Policies and Procedures. Inpatient hospital services include services provided in an institution specializing in the care and treatment of members with mental diseases.

- b. Services in an Institution for Mental Diseases (IMD) when the member requires services in an inpatient psychiatric hospital. IMD are available to members who are determined to require these services after enrollment in KidsCare. However, applicants in an IMD at the time of application are excluded from enrollment in KidsCare.
- c. Medically necessary transplant services, which are not experimental, if provided to correct or ameliorate disabilities, physical illnesses or conditions. Transplantation services will be authorized in accordance with AHCCCS transplantation policies.

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

Outpatient hospital services ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient hospital services include services provided by or under the direction of a PCP or primary care practitioner or licensed or certified behavioral health professional according to federal and state law. Certified behavioral health professionals include certified independent social workers, certified marriage/family therapists, and certified professional counselors.

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

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

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

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

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

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

- a. Outpatient services (Section 6.2.2).
- b. Ambulatory services offered by a health center receiving funds under section 330 of the Public Health Services Act.
- c. Rural health clinic services and federally qualified health center services and other ambulatory services.

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

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

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

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

Laboratory, radiological and medical imaging services.

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

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

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

- a. Inpatient behavioral health services, other than inpatient and residential substance abuse treatment services, but including services furnished in a state operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
- b. Services in a state operated mental hospital (e.g., Institution for Mental Diseases). IMD services are only available to members who are determined to require these services after enrollment. Applicants who are receiving IMD services at the time of application are excluded from enrollment in KidsCare.
- c. Partial care services are included as part of the inpatient benefit.

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

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

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

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

6.2.13. 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))**
- Case management for persons with developmental disabilities.
- 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 and non-emergency transportation are covered services when the transportation is medically necessary.

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

All printed materials 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 in a nursing facility or in an alternative residential setting for a maximum of 90 days when the medical condition of the person indicates that these services are necessary to prevent hospitalization.
2. Total parenteral nutrition services.
3. Podiatry services and optometrist services if furnished by a licensed podiatrist or optometrist, respectively.
4. Other practitioner's services are covered and include services provided by:
 - a. Respiratory Therapists
 - b. Certified Nurse Practitioners
 - c. Certified Nurse Anesthetists
 - d. Physician Assistants
 - e. Nonphysician behavioral health professionals if the services are provided by social workers, physician assistants, psychologists, counselors, registered nurses, certified nurse practitioners, behavioral health technicians and other approved therapists who meet all applicable state standards. Except for behavioral health services provided by psychologists, ~~or~~ psychiatric nurse practitioners, physician assistants, certified independent social workers, certified marriage/family therapists, and certified professional counselors, all nonphysician behavioral health professional services shall be provided by professionals affiliated with an approved behavioral health setting in accordance with rules and AHCCCS policies and procedures.
5. Home health services
 - a. Home health services when necessary to prevent re-hospitalization or institutionalization, and may include home health nursing services, therapies, personal care, medical supplies, equipment and appliances and home health aide services.
 - b. Nursing service and home health aide if provided on an intermittent or part time basis by a home health agency. When no home health agency exists, nursing services may be provided by a registered nurse.
 - c. Therapy services.

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

6.3. 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))

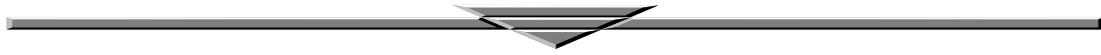
6.3.1.3. The coverage shall be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments 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 8



Cost Sharing and Payment

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

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

8.1 Is cost sharing imposed on any of the children covered under the plan?

- 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:

On October 1, 1999, AHCCCS began imposing monthly premiums on families whose income exceeded 150 percent of the FPL. In addition, on this date AHCCCS raised the income eligibility level to 200 percent of the FPL.

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

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

The following is the premium billing and collection process:

- Payments will be accepted on a monthly basis.
- The cost sharing methodology will not favor children from families with higher incomes over families with lower incomes.
- AHCCCS will ensure that premiums are not assessed on Native American or Alaska Native populations.
- AHCCCS will monitor the number of persons who are disenrolled due to nonpayment of premiums and notify KidsCare members about their premium rights and responsibilities.
- The first monthly premium is not required prior to initial enrollment in the program.
- All premium payments are due by the 15th day of each month of enrollment.
- If the payment is not made by the due date, a past due notice will be sent with a request for payment no later than the last day of the month.
- If the payment is not received by the 15th day of the second month, a ten-day discontinuance letter will be mailed. Services will be terminated if the delinquent payment is not received the end of the second month. If AHCCCS receives the delinquent

payment prior to the end of the second month, there will be no break in coverage.

- Persons will be re-enrolled if all outstanding balances are paid and an updated application is submitted.

The following is the hardship exemption to disenrollment process:

- The following definitions apply to this Section:
 - "Major expense" means the expense is more than 10 percent of the household's countable income
 - "Medically necessary" means as defined in A.A.C. R9-22-101.
- The Administration shall grant a hardship exemption to the disenrollment requirements under A.R.S. § 36-2982 for a household who:
 - Is no longer able to pay the premium due to one of the hardship criteria listed below, and
 - Requests and provides all necessary written verification at the time of request.
- The Administration shall consider the following hardship criteria:
 - Medically necessary expenses or health insurance premiums that:
 - Are not covered under Medicaid or other insurance and
 - Exceed 10 percent of the household's countable income;
 - Unanticipated major expense, related to the maintenance of shelter or transportation for work;
 - A combination of medically necessary and unanticipated major expenses in this section that exceed 10% of the household's countable income; or
 - Death of a household member.
- The Administration must receive the written request and verification of exemption eligible criteria by the 10th day of the month in which the household receives the billing statement containing the current and past due premium notice.
- The Administration shall notify the head of household concerning the approval or denial of the request for exemption and discontinuance 10 days prior to the end of the month in which the request was received.
- The head of household may request a hearing concerning the termination and denial of exemption.

The premium amounts are:

PREMIUM AMOUNTS

Federal Poverty Levels (FPL)	1 st Child	More than 1 Child
Above 150% - 175.00%	\$10.00	\$15.00 Total
Above 175% - 200.00%	\$15.00	\$20.00 Total

8.2.2 Deductibles: Not applicable

8.2.3 Coinsurance: Not applicable

8.2.4 Other: Copayments

The AHCCCS Administration will only impose a \$5.00 copayment on the non-emergency use of the emergency room. Native Americans and Alaskan Natives will not be assessed any copayments.

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

Information about cost sharing will be included in the following:

- Outreach and application materials.
- Member handbooks provided by KidsCare contractors.
- *Arizona Administrative Register* and other rulemaking activities conducted by the AHCCCS Administration.
- Native American newsletters and meetings will make clear that the Native American and Alaska Native populations are exempt from paying any cost sharing.

8.4 The state assures that it has made the following findings with respect to the cost sharing 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).

The AHCCCS Administration imposes a copayment on the non-emergency use of the emergency room.

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 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 is 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 21039(e)(3)(B))

Families will be advised that the total cost sharing under KidsCare can not exceed five percent of the families' income. Families will be advised to contact AHCCCS if the total cost sharing will exceed the five percent limit. Upon notification, AHCCCS will make changes to the system to stop the imposition of monthly premiums and advise the family that they do not have to pay a \$5.00 copayment if they use the emergency room for a non-emergency condition. Although AHCCCS will have safeguards in place to ensure that the families do not pay more than the five percent limit, the agency believes that this will not be an issue. For example, a family of four with income between 150% and 175% of FPL, with two children enrolled in the program, would have to make 156 visits to the emergency room while paying the family premium of \$15 a month. Families with higher income levels are even less likely to exceed the five percent limit.

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 contacts 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:

Attachment K

RESERVED

Contents no longer applicable as KidsCare benefits now mirror the acute care Medicaid plan.

Section 6



Coverage Requirements for Children's Health Insurance

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

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

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

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

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

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

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

**6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2))
Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.**

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

6.1.4 Secretary-Approved Coverage. (Section 2103(a)(4))

Arizona will use the same benefits as are provided under the Medicaid State plan. Any limitations on the covered services are discussed in this section and will be delineated in the AHCCCS Medical Policy Manual. The cost sharing requirements are specified in Section 8 of the State Plan.

Members who enroll in the KidsCare Program who select an AHCCCS health plan or the state employee HMO, if the HMO elects to participate in the program, will receive the following KidsCare services, subject to the limitations described below:

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))

- d. 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.
- e. Services in an Institution for Mental Diseases (IMD) when the member requires services in an inpatient psychiatric hospital. IMD are available to members who are determined to require these services after enrollment in KidsCare. However, applicants in an IMD at the time of application are excluded from enrollment in KidsCare.
- f. Medically necessary transplant services, which are not experimental, if provided to correct or ameliorate disabilities, physical illnesses or conditions. Transplantation services will be authorized in accordance with AHCCCS transplantation policies.

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

Outpatient hospital services ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient hospital services include services provided by or under the direction of a PCP or primary care practitioner or licensed or certified behavioral health professional according to federal and state law. Certified behavioral health professionals include certified independent social workers, certified marriage/family therapists, and certified professional counselors.

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

Physician services if provided by or under the direction of a PCP, psychiatrist, or under the direction of a primary care

practitioner according to federal and state law. Services are covered whether furnished in the office, the member's home, a hospital, a nursing home or other setting.

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

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

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

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

- d. Outpatient services (Section 6.2.2).
- e. Ambulatory services offered by a health center receiving funds under section 330 of the Public Health Services Act.
- f. Rural health clinic services and federally qualified health center services and other ambulatory services.

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

- d. Pharmaceutical services provided to a member if prescribed by the attending physician, practitioner, or dentist.
- e. Prescription drugs for covered transplantation services provided according to AHCCCS transplantation policies.
- f. 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))

- d. The following family planning services:

- Contraceptive counseling, medication, supplies and associated medical and laboratory exams
 - Natural family planning education or referral
- e. Infertility services and reversal of surgically induced infertility are not covered services.
- f. 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))

- c. 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.
- d. Services in a state operated mental hospital (e.g., Institution for Mental Diseases). IMD services are only available to members who are determined to require these services after enrollment. Applicants who are receiving IMD services at the time of application are excluded from enrollment in KidsCare.
- c. Partial care services are included as part of the inpatient benefit.

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

- c. 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.
- d. Outpatient behavioral health services includes individual and/or group counseling/therapy, rehabilitation services, including basic and intensive partial care, emergency/crisis services, behavior management, psychosocial rehabilitation, evaluation and behavioral health related services.

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

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

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

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))

- c. Private duty nursing care, respiratory care services, and services provided by certified nurse practitioners in a home or other setting.
- d. 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))

- c. Dental services, including routine, preventive, therapeutic and emergency services.
- d. 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))
- c. Refer to coverage under 6.2.11 - Outpatient mental health services, subject to the limitations prescribed in that section.
 - d. Rehabilitation services provided by a substance abuse rehabilitation agency that do not exceed 30 outpatient visits for each 12-month period of eligibility.
- 6.2.20. Case management services** (Section 2110(a)(20))
- Case management for persons with developmental disabilities.
- 6.2.21. Care coordination services** (Section 2110(a)(21))
- Care coordination 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))
- e. Services provided in a facility, home, or other setting if recognized by state law.
 - f. Respiratory therapy
 - g. Eye examinations for prescriptive lenses.
 - h. Immunizations, preventive health services, patient education, age and gender appropriate clinical screening test and periodic health exams.
- 6.2.25. Premiums for private health care insurance coverage** (Section 2110(a)(25))

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

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

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

All printed materials 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))

5. Nursing facility services in a nursing facility or in an alternative residential setting for a maximum of 90 days when the medical condition of the person indicates that these services are necessary to prevent hospitalization.
6. Total parenteral nutrition services.
7. Podiatry services and optometrist services if furnished by a licensed podiatrist or optometrist, respectively.
8. Other practitioner's services are covered and include services provided by:
 - f. Respiratory Therapists
 - g. Certified Nurse Practitioners
 - h. Certified Nurse Anesthetists
 - i. Physician Assistants
 - j. 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, physician assistants, certified independent social workers, certified marriage/family therapists, and certified professional counselors, all nonphysician behavioral health professional services shall be provided by professionals affiliated with an approved behavioral health setting in accordance with rules and AHCCCS policies and procedures.

5. Home health services

- b. 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))