

Questions on Arizona's Compliance SCHIP State Plan Amendment

1. Section 4.1.8 – Duration of Eligibility

It is our understanding that the State disenrolls enrollees with income changes that make them ineligible for SCHIP and that enrollees are required to report income changes. If this is the case, please list the requirement to report income changes in this section and that changes in income interrupt the 12 months of continuous coverage.

Answer 1

4.1.8. X **Duration of eligibility:**

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

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

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

2. Section 4.3.1 – Enrollment Caps and Waiting Lists

Please assure that the State, if it decides to implement an enrollment cap, will submit a State plan amendment that requests approval to institute an enrollment cap as required by 42 CFR §457.65(b). The State also has the option to omit this language from the state plan, which might make sense given the terms and conditions of Arizona's HIFA demonstration. The terms and conditions require that the State end the demonstration if SCHIP enrollment is capped or if a waiting list is instituted.

Answer 2

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

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

3. Section 4.4.1 – Screen and Enroll, Redetermination

Please describe the screening procedures during *periodic redetermination* that assure that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR §457.310(b) (42 CFR §457.350(a)(1)) and §457.80(c)(3))

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Answer 3

- 4.4.1. **Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

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

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

When conducting a renewal (periodic redetermination) of KidsCare eligibility, AHCCCS screens for potential Medicaid eligibility. If a child appears to meet the Medicaid eligibility criteria, AHCCCS forwards a copy of the renewal application and all obtained verification to the department of Economic Security staff for an eligibility determination.

4. Section 4.4.4.1 – Monitoring Substitution

We note that Arizona uses a three-month period of uninsurance to prevent crowd out. Regardless of whether a state uses a method such as a waiting period to prevent crowd out, states must also monitor the extent to which substitution occurs. Please describe the methods that Arizona uses to monitor substitution of SCHIP coverage for private group health coverage, consistent with 42 CFR §457.805.

Answer 4

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

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

AHCCCS monitors substitution under its Quality Control and Quality Assurance process. Records are reviewed to ensure that the three month period of ineligibility policy is applied appropriately. Action is taken as needed. Trends are monitored to ensure that the policy is consistently applied throughout the program.

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5. Section 7.2.4 – Prior Authorization

Please clarify that the timeframe for prior authorization of decisions is the same in SCHIP as in Medicaid.

Answer 5

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

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

6. Section 8.4.3 – Out-of-Network Emergency Medical Costs

Please assure that no additional cost sharing applies to the costs of emergency medical services delivered outside the network, consistent with 42 CFR §457.515(f).

Answer 6

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

The AHCCCS Administration imposes a copayment on the non-emergency use of the emergency room. The state assures enrollees will not be held liable for cost-sharing amounts for emergency services that are provided at a facility that does not participate in the enrollee's managed care network beyond the copayment amounts specified in the State plan for emergency services.

7. Section 8.7.1 – Disenrollment Protections

Please assure that the Medicaid rules regarding opportunities for impartial reviews prior to disenrollment apply to SCHIP and that enrollees are ensured the opportunity to continue benefits pending the outcome of the hearing.

Answer 7

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

X State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

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

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8. Section 9.2 – Strategic Objectives

Please clarify if the period of uninsurance reflected in the strategic objective should be three months or six months given that the State plan was amended to change the period of uninsurance from six months to three months in 2001.

Answer 8

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

- Decrease the percentage of children in Arizona who are uninsured. (In the first year of the KidsCare Program, decrease the percentage of children with income under 150% of FPL who are uninsured and, in subsequent years, decrease the number of children with income under 200% of FPL who are uninsured.)
- Screen 100 percent of applications to determine if the child was covered by employer sponsored insurance within the last ~~six~~ three months. If however, a child has exceeded the lifetime limit to his or her employer sponsored insurance policy; the child will not be required to go bare for ~~six~~ three months.
- Improve the number of KidsCare eligible children who receive preventive and primary care by meeting goals according to Health People 2010:
 1. 90 percent of children under two will receive age appropriate immunizations;
 2. 90 percent of children under 15 months will receive the recommended number of well child visits;
 3. 90 percent of three, four, five, and six year olds will have at least one well-child visit during the year;
 4. 90 percent of children will have at least one dental visit during the year; and
- Ensure that KidsCare enrolled children receive access to a regular source of care:
 1. 100 percent of enrolled children will be assigned a PCP; and
 2. 90 percent of KidsCare children will see a PCP at least once during the first 12 months of enrollment.

9. Section 9.9 – Ongoing Public Involvement

The description in the state plan appears to mostly describe public involvement in the initial approval of Arizona's SCHIP state plan. Please describe the process used by the State to ensure ongoing public involvement, consistent with 42 CFR §457.135.

Answer 9

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

Arizona has developed a collaborative process with many interested parties in the design, implementation and evaluation of the KidsCare State Plan. The state has a process for conducting a statewide collaborative effort to provide the community with awareness, education and an opportunity to shape the KidsCare Program (see Attachment N). The Children's Action Alliance also held public forums to discuss the parameters of the KidsCare Program. Please see sections 9.9.1 and 9.9.2 for a description of ongoing public involvement opportunities.

In December 1997, the Governor convened a KidsCare Task Force consisting of state legislators, state agencies, representatives from the hospital and medical industry,

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advocacy organizations and tribal organization to develop recommendations about how targeted, low-income children could best be served by the funds available under Title XXI. The members of this task force are identified in Attachment O. The Governor's Office also convened a special meeting for the 21 Arizona tribes to discuss tribal issues.

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

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

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

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

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

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

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

10. Section 9.10 – Budget

Please revise the budget to incorporate the correct EFMAP rates, the recalculated Federal and State shares, and include additional information on planning assumptions (i.e., number of enrollees multiplied by the per member per month amount).

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Answer:10.

	FFY 2001	FFY 2002	FFY 2003
Enhanced FMAP rate	76.04%	75.49%	77.08%
BENEFIT COSTS			
Insurance payments			
Managed care	\$55,680,632	\$63,148,534	\$67,539,117
per member/per month rate X # of eligibles	\$105.42	\$106.23	\$109.39
Fee for Service	2,034,625	1,880,133	1,554,041
Total Benefit Costs	57,715,257	65,028,667	69,093,158
(Offsetting beneficiary cost sharing payments)	(1,337,710)	(1,994,478)	(2,119,291)
Net Benefit Costs	56,377,547	63,034,189	66,973,867
ADMINISTRATION COSTS			
Personnel	4,843,205	5,228,849	5,558,005
General administration			
Contractors/Brokers (e.g., enrollment contractors)	158,113		
Claims Processing			
Outreach/marketing costs	465,830	50,000	50,000
Other	1,597,730	1,724,950	1,833,536
Total Administration Costs	7,064,878	7,003,799	7,441,541
10% Administrative Cost Ceiling	6,730,002	7,003,799	7,441,541
Federal Share (multiplied by enhanced FMAP rate)	47,986,980	52,871,677	57,359,396
State Share	15,120,569	17,166,311	17,056,012
TOTAL PROGRAM COSTS	\$63,107,549	\$70,037,988	\$74,415,408