March 24, 2020

Joyce Jordan
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid & Chip Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Arizona SPA #20-002, CHIP Disaster Relief SPA

Dear Ms. Jordan:

Enclosed is State Plan Amendment (SPA) #20-002, CHIP Disaster Relief SPA, which revises the CHIP State Plan to allow the State additional flexibility regarding cost-sharing and enrollment/renewal processes.

If you have any questions about the enclosed SPA, please contact Alex Demyan at (602) 417-4130.

Sincerely,

Dana Flannery
Assistant Director
Arizona Health Care Cost Containment System (AHCCCS)

cc:
Mohamed Arif, AHCCCS
Alex Demyan, AHCCCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 0 — 0 0 2

2. STATE: Arizona

3. PROGRAM IDENTIFICATION: ~~TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)~~ Title XXI of the Socual Security Act (CHIP)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 457

7. FEDERAL BUDGET IMPACT
a. FFY 2020 $ 0
b. FFY 2021 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Section 1, Page 3
Section 4, Pages 3, 4, 5
Section 8, Pages 1, 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Section 1, Page 3
Section 4, Pages 3, 4, 5
Section 8, Pages 1, 3

10. SUBJECT OF AMENDMENT

Updates the CHIP State Plan to provide the state flexability to waive cost sharing requirements and to provide additional flexabilties around enrollment and renewal timeframes in response to COVID-19.

11. GOVERNOR'S REVIEW *(Check One)*

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: Dana Flannery

14. TITLE: Assistant Director

15. DATE SUBMITTED: 3/24/20

16. RETURN TO

Dana Flannery
801 E. Jefferson, MD#4200
Phoenix, Arizona 85034

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Instructions on Back

Original Implementation date: November 1, 1998

Amendment Effective date:

February 1, 2004 (premiums >150% FPL)
July 1, 2004 (premiums 100%-150% FPL)
May 1, 2009 (premiums >150% FPL)
January 1, 2010 (enrollment cap)
October 10, 2013 (remove wait list)
July 26, 2016 (remove enrollment cap)
August 6, 2016 (premium lock out period)
October 1, 2017 (mental health parity)
July 1, 2018 (Managed Care Regulations)
July 1, 2019 (COVID-19 Disaster Response)

In the event of a disaster, the State will notify CMS of its intent to provide temporary adjustments to the following policies (insert summary of State specific requested flexibilities)

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

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

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

To address the COVID-19 public health emergency, the State seeks a waiver under section 1135 of the Act to modify the tribal consultation process by shortening the number of days before submission of the SPA and/or conducting consultation after submission of the SPA.

- Is a patient in an institution for mental diseases; or
- Voluntarily withdraws from the program.

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

4.1.9. X Other standards (identify and describe):

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

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

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

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

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

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

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

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

The child, a family member or legal guardian, fills out a simple application form which is submitted to AHCCCS. If assistance with the application is needed, appropriate personnel assist the applicant. The form also serves as an application for Medicaid.

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

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

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

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

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

The KidsCare providers are:

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

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

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

AHCCCS approves a newborn of a mother who is eligible for KidsCare on the date the child is born. The newborn's KidsCare eligibility begins with the newborn's date of birth. Once approved for KidsCare, AHCCCS enrolls the newborn with the mother's health plan. AHCCCS notifies the mother by mail of the newborn's enrollment into KidsCare and is given an opportunity to change health plans at that time.

A member is allowed to change contractors on an annual basis and when an individual moves into a new geographic area not served by the current contractor. A member can change PCPs at any time. The option to change contractors is based on the member's anniversary date, which is the first day of the month that the member is enrolled into KidsCare. Ten months following the anniversary date, the member will be sent an annual enrollment notice advising that a different contractor may be selected. A list of contractors, with toll-free numbers and the available services, is included. The member, or parent of the child, has 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.

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

At State discretion, requirements related to timely processing of applications may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area.

At State discretion, it may temporarily provide continuous eligibility to CHIP enrollees who reside and/or work in a State or Federally declared disaster area. Additionally, the State is permitted to extend eligibility beyond the CHIP eligible individual's 19th birthday through the end of the month in which the emergency period ends.

At State discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area.

At State discretion, the requirement that a child is ineligible for CHIP for a period of three months from the date of the voluntary discontinuance of employer-sponsored group health insurance or individual insurance coverage may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area.

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

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

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

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

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

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

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

At State discretion, premiums or enrollment fees and co-payments may be temporarily waived for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or Federally declared disaster area.

8.2.1. Premiums:

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

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

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

The following is the premium billing and collection process:

- Payments are accepted on a monthly basis.

- The cost sharing methodology does not favor children from families with higher incomes over families with lower incomes.
- AHCCCS ensures that premiums are not assessed on Native American or Alaska Native populations.
- AHCCCS monitors the number of persons who are disenrolled due to nonpayment of premiums and notifies KidsCare members about their premium rights and responsibilities.
- The first monthly premium is not required prior to initial enrollment in the program.
- All premium payments are due by the 15th day of each month of enrollment.
- If the payment is not made by the due date, a past due notice will be sent with a request for payment no later than the last day of the month.

At State discretion, premiums may be waived for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements and who reside and/or work in Governor or FEMA declared disaster areas for a specified period of time.

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

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

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

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

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

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

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

Exception to Disenrollment for Failure to Pay Premiums—At State discretion, premiums may be waived for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements and who reside and/or work in Governor or FEMA declared disaster areas for a specified period of time. The premium balance will be waived if the family is determined to have been living or working in FEMA or Governor declared disaster areas based on self-declared application information or other documentation provided by the family.

A. The consequences for non payment of premium are as follows:
   1. If the payment is not made by the due date, AHCCCS sends a past due notice with a request for payment no later than the last day of the month.
   2. If the payment is not received by the 15th day of the second month, AHCCCS mails a ten-day discontinuance letter. Services are terminated if the delinquent payment is not received the end of the second month. If AHCCCS receives the delinquent payment prior to the end of the second month, there is no break in coverage.
   3. Persons may be re-enrolled if all outstanding balances are paid and an updated application is submitted.

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