DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

JUL 2 2 2016

Monica H. Coury
Assistant Director
Arizona Health Care Cost Containment System
Office of Intergovernmental Relations
801 East Jefferson
Phoenix, AZ 85034

Dear Ms. Coury:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your title XXI Children's Health Insurance Program (CHIP) state plan amendments (SPAs) AZ-16-0016 and AZ-16-0017.

Arizona's SPA AZ-16-0016, submitted on May 23, 2016 and effective on July 26, 2016, lifts the state's existing enrollment freeze enabling children ages birth through age 19 with income above 133 percent up to and including 200 percent of the federal poverty level (FPL) to enroll in the state's CHIP, known as "KidsCare." The state's enrollment into its separate CHIP was initially frozen on January 1, 2010. While enrollment was temporarily opened as part of a section 1115 demonstration, KidsCare II, from May 2012 to January 2014, KidsCare II was sunset on January 31, 2014. With this SPA, we support the state's efforts to ensure that low income uninsured children have access to affordable coverage and the protections that exist under CHIP.

CMS is also approving SPA AZ-16-0017, which was submitted on May 27, 2016 and has an effective date of July 26, 2016. This SPA reduces the state's existing premium lock-out period from 90 to 60 days. Consistent with 42 CFR 457.570, states may identify a state-specified period of time (referred to as a premium lock-out period) that a CHIP eligible child who has an unpaid premium may not reenroll in coverage in CHIP.

Your title XXI project officer is Ms. Tonia Brown. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Brown's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-8613
Facsimile: (410) 786-5943
E-mail: Tonia.Brown@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Brown and to Ms. Kristin Dillon, Associate Regional Administrator (ARA) in our San Francisco Regional Office. Ms. Dillon's address is:

Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (W)
San Francisco, California 94103-6706

If you have additional questions, please contact Mr. Manning Pellanda, Director, Division of State Coverage Programs, at (410) 786-5143. We look forward to continuing to work with you and your staff.

Sincerely,

Anne Marie Costello
Director

Enclosures
cc: Ms. Kristin Dillon, ARA, CMS Region IX, San Francisco

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)

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

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

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

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

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

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

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

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

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

A member is allowed to change contractors on an annual basis and when an individual moves into a new geographic area not served by the current contractor. A member can change PCPs at any time. The option to change contractors is based on the member's anniversary date, which is the first day of the month that the member is enrolled into KidsCare. Ten months following the anniversary date, the member will be sent an annual enrollment notice advising that a different contractor may be selected. A list of contractors, with toll-free numbers and the available services, is included. The member, or parent of the child, has 60 days to change contractors. If a change is requested, the effective date is a year from the anniversary date or the month after the change is requested, whichever is later. Enrollees must notify AHCCCS of a change in address or other circumstances that could affect continued eligibility or enrollment.

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

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

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

4.4. Describe the procedures that assure that:

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

AHCCCS administers both the Medicaid and KidsCare Program. Medicaid screening is part of the KidsCare eligibility determination process. Records of KidsCare eligibility are maintained in a database that is also used for Medicaid eligibility. The database is checked for current Medicaid eligibility before determining KidsCare eligibility. Medicaid eligibility always overrides KidsCare eligibility.

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

When conducting a renewal (periodic redetermination) of KidsCare eligibility, AHCCCS screens for potential Medicaid eligibility, group health plan, health insurance coverage, or other state health benefits. For review of potential group health plan coverage see section 4.4.4.1.

A Public Hearing was held in Phoenix on January 12, 2004 regarding the February 1, 2004 premium increase. No testimony was received either verbally or in writing.

One of the areas targeted by the Arizona legislature in various legislative hearings was an increase in the monthly premiums that would be paid by families who had children or adults enrolled in a SCHIP program. The February 2004 increase is the result of the legislative mandate to enhance cost sharing. Interested parties had an opportunity to testify in the several public hearings and during the public hearings on the changes to AHCCCS' rules. In addition, the attached notice was sent to all who had children enrolled with KidsCare who would be affected by the increase in monthly premiums.

Public notice for the July 1, 2004 premium implementation for families with income between 100% and 150% of the FPL is scheduled for May 7, 2004. The Public Hearing will be held on June 9, 2004 to hear testimony on this premium change.

9.10 Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

Planned use of funds, including --

Projected amount to be spent on health services;

Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and

Assumptions on which the budget is based, including cost per child and expected enrollment.

Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

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

CHIP Budget Plan

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

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

Budget Assumptions:

FFY:	**# of eligibles**	**$ PMPM**
Managed Care	30,490	$216.55
Fee for Service	759	$596.71
Total PMPM (Net Benefit)	31,249	$225.78

Source(s) of non-federal funding used for state match: No state match.

Other Assumptions:

Open enrollment effective September 1, 2016.
Phase-in enrollment over 9 months. September 2017: 34,621
Does not show total shortfall (incl. M-CHIP) of: $219,726,200
PMPMs decrease from FFY 2016 to FFY 2017 due to lower Health Insurer Fee and no prior year adjustments