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

FEB 16 2018

Tom Betlach
State Medicaid Director
Arizona Health Care Cost Containment System
801 E. Jefferson St.
Phoenix, AZ 85034

Dear Mr. Betlach:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) AZ-17-0010 has been approved. AZ-17-0010 implements mental health parity requirements in section 2103(c)(6) of the Social Security Act (the Act) and regulations at 42 CFR 457.496 to ensure that treatment limitations and financial requirements applied to mental health and substance use disorder benefits are no more restrictive than those applied to medical/surgical benefits. This SPA has an effective date of October 1, 2017.

Section 2103(c)(6)(B) of the Act, as implemented through regulations at 42 CFR 457.496(b), provides that if CHIP coverage includes the Early, Periodic Screening, Diagnostic and Treatment (EPSDT) benefit as defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the state plan will be deemed to satisfy parity requirements. Arizona has provided the necessary assurances and supporting documentation that EPSDT is covered under Arizona's CHIP program and provided in accordance with sections 1905(r) and 1902(a)(43) of the Act. This approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

Your title XXI project officer is Jasmine Aplin. She is available to answer questions concerning these amendments. Ms. Aplin's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8102
E-mail: jasmine.aplin@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Jasmine Aplin and to Ms. Henrietta Sam-Louie, Associate Regional Administrator in our San Francisco Regional Office. Ms. Sam-Louie's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
90-7th Street, Suite 5-300
San Francisco, CA 94103

If you have additional questions or concerns, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs, at (410) 786-0721. We look forward to continuing to work with you and your staff.

Sincerely,

Anne Marie Costello
Director

Enclosures

cc: Ms. Henrietta Sam-Louie, ARA, CMS Region IV, 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) October 1 2017 (mental health parity)

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.

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:

6.1.4.1. X Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT).

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver.

6.1.4.3. ☐ Coverage that the State has extended to the entire Medicaid population.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage.

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done).

6.1.4.7. ☐ Other. (Describe)

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. X Disposable medical supplies (Section 2110(a)(13))
Medical supplies include consumable items that are disposable and are essential for the member's health.

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

6.2.15. X 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. X 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. X 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. X Vision screenings and services (Section 2110(a)(24))

6.2.19. X **Hearing screenings and services (Section 2110(a)(24))**

6.2.20. X **Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))**

Inpatient substance abuse treatment is limited to acute detoxification.

6.2.21. X **Outpatient substance abuse treatment services (Section 2110(a)(19))**

a. Refer to coverage under 6.2.11 - Outpatient mental health services, subject to the limitations prescribed in that section.

6.2.22. X **Case management services (Section 2110(a)(20))**

Case management for persons with developmental disabilities.

6.2.23. X **Care coordination services (Section 2110(a)(21))**

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

6.2.24. X **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.

6.2.25. X **Hospice care (Section 2110(a)(23))**

Hospice services for a terminally ill member.

6.2.26. X EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

6.2.27. X **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.
d. Immunizations, preventive health services, patient education, age and gender appropriate clinical screening test and periodic health exams.

6.2.28 **Premiums for private health care insurance coverage (Section 2110(a)(25))**

6.2.29. X Medical transportation (Section 2110(a)(26))

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

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

All printed materials are in English and Spanish. Outreach services will be available through AHCCCS, and others as specified in Section 4.4.5 and Section 5.

6.2.31.X 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, 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.

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

☒ International Classification of Disease (ICD)

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ Other (Describe:)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

☒ Yes

☐ No

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☒ Yes

☐ No

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☒ All children covered under the State child health plan.

☐ A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

☒ All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

☒ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

☒ All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

☒ Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

☒ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

☒ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

☒ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

☒ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

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

6.3.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*