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

Children and Adults Health Programs Group

September 3, 2020

Jami Snyder
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034

Dear Ms. Snyder:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number AZ-20-0012, has been approved. Through this SPA, Arizona has demonstrated compliance with section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. Additionally, this SPA clarifies Arizona's policies regarding coverage of children aging out of CHIP during a public health emergency. This SPA has an effective date of July 1, 2019 and June 26, 2020, respectively.

Section 5022 of the SUPPORT Act added Section 2103(c)(5) to the Social Security Act (the Act) and requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders. Additionally, Section 2103(c)(5)(B) of the Act requires that these behavioral health services be delivered in a culturally and linguistically appropriate manner. Arizona demonstrated compliance by providing the necessary assurances and benefit descriptions that the state covers a range of behavioral health services in a culturally and linguistically appropriate manner.

Your Project Officer is Ms. Joyce Jordan. She is available to answer your questions concerning this amendment and other CHIP-related matters. Ms. Jordan's contact information is as follows:

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Center for Medicaid and CHIP Services
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If you have additional questions, please contact Meg Barry, Acting Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

Amy Lutzky
Acting Deputy Director

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) January 27, 2020 (COVID-19 Disaster Response) July 1, 2019 (SUPPORT Act BH Services)

Discontinuation of coverage of children aging out of CHIP during the COVID public health emergency became effective on June 26, 2020.

In the event of a disaster, the State will notify CMS of its intent to provide temporary adjustments to; flexibilities around delays in processing applications and renewals, the ability to waive the three month waiting period for applicants, the ability to waive existing premiums, and the ability to waive the premium lock-out period. In addition, the state is requesting to temporarily provide continuous eligibility to its CHIP population.

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.

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 for the duration of the declared emergency.

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 for the duration of the declared emergency.

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 for the duration of the declared emergency.

At State discretion, the State may temporarily delay acting on changes in circumstances for CHIP beneficiaries other than the required changes in circumstances described in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d),applicable to 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 for the duration of the declared emergency.

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.

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)

6.2. 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)) (42CFR 457.490)

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 pre-pregnancy 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. ☒ 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.

6.2.11. ☒ Disposable medical supplies (Section 2110(a)(13))

Medical supplies include consumable items that are disposable and are essential for the member's health.

6.2.12. ☐ Home and community-based health care services (Section 2110(a)(14))

6.2.13. ☒ Nursing care services (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.

6.2.14. ☒ 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.

6.2.15. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

a. Dental services, including routine, preventive, therapeutic and emergency services.
b. Dentures and dental devices are covered if authorized in consultation with a dentist.

6.2.16. ☒ Vision screenings and services (Section 2110(a)(24))

6.2.17. ☒ Hearing screenings and services (Section 2110(a)(24))

6.2.18. ☒ Case management services (Section 2110(a)(20))

Case management for persons with developmental disabilities.

6.2.19. ☒ Care coordination services (Section 2110(a)(21))

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

6.2.20. ☒ 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.

6.2.21. ☒ Hospice care (Section 2110(a)(23))

Hospice services for a terminally ill member.

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

6.2.22.1 ☒ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

6.2.23. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (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.

6.2.24. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

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

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

6.2.26. ☒ Enabling services (such as transportation, translation, and outreach services) (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.

6.2.27. ☒ 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-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for

behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

☐ State-developed schedule
☐ American Academy of Pediatrics/ Bright Futures
☐ Other Nationally recognized periodicity schedule (please specify:)
☒ Other: The AHCCCS EPSDT Periodicity Schedule is state developed to mirror the AAP/Bright Future EPSDT Periodicity Schedule. The one significant deviation alignment is that AHCCCS currently does not cover a thirty (30) month EPSDT Well Child Visit. To address this, the agency is undertaking an internal discussion and fiscal review to determine the feasibility of adding this visit to the schedule thus aligning with Bright Futures.

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.26 and 6.2.26.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

6.3.1.2- BH ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools:

AHCCCS has policies and procedures that outline use of standardized, age-appropriate, and validated behavioral health screening tools in both primary care settings as well as behavioral health care settings. These requirements are also outlined in Contract with MCOs. The MCOs are tasked with educating providers on the screening tool requirements as well as care coordination and service referrals if member needs cannot fully be met by the attending provider. The MCOs have provider relations teams that make contact with providers on at least a quarterly basis as well as make themselves available any time providers have questions regarding service delivery. MCOs also send out mass notifications as warranted as well as utilize their websites and/or provider newsletters to provide timely updates on programmatic requirements.

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

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.

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

6.3.2.3- BH ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

6.3.2.3.2- BH ☒ Alcohol Use Disorder

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.5- BH ☒ Caregiver Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.6- BH ☒ Respite Care
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.7- BH ☒ Intensive in-home services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.9- BH ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.3- BH ☒ Day Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned

structural services (Sections 2110(a)(10) and 2110(a)(18))

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.

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.4.1- BH ☒ Residential Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.4.2- BH ☒ Detoxification
Provided for: ☒ Substance Use Disorder

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.6- BH ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7- BH ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7.1- BH ☒ Intensive wraparound
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7.2- BH ☒ Care transition services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.9- BH ☐ Other
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☒ ASAM Criteria (American Society Addiction Medicine)

☐ Mental Health ☒ Substance Use Disorders

☒ InterQual
☒ Mental Health ☒ Substance Use Disorders

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☒ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☒ Mental Health ☐ Substance Use Disorders

☒ CASII (Child and Adolescent Service Intensity Instrument)
☒ Mental Health ☒ Substance Use Disorders

☐ CANS (Child and Adolescent Needs and Strengths)
☐ Mental Health ☐ Substance Use Disorders

☐ State-specific criteria (e.g. state law or policies) (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

AHCCCS contract requires validated assessment tools be utilized for EPSDT aged members, as well as for adult members. AHCCCS required tool is limited to CALOCUS (formerly CASII). MCG criteria is for both SUD and MH.

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

The state requires the use of the CALOCUS for all child members aged 6 through 18. The ECSII, is currently required for the 0-5 population only through the Targeted Investments Program. This is not an exhaustive list, and may differ by provider agency and population served by each.

The state requires contractors to implement validated behavioral health screening tools by Primary Care Providers (PCPs) to determine if further assessment for behavioral health services is necessary. The state requires that providers serving EPSDT-aged members utilize AHCCCS approved EPSDT tracking forms and standardized developmental screening tools and that these providers are trained in the use of these tools.

For the children's population, Contractors are required to ensure provision of Trauma Informed Care (TIC) services, including routine trauma screenings and development of a network of TIC-certified therapists, as well as to promote service delivery for children age birth through five, including screening and high need identification as directed by AHCCCS through the use of validated assessment tools. AHCCCS currently requires the use of the Child and Adolescent

Level Of Care Utilization System (CALOCUS) (Formerly Child and Adolescent Service Intensity Instrument (CASII) tool for children 6-18 years of age, and requires the use of the Early Childhood Service Intensity Instrument (ECSII) through the Targeted Investments Program for the 0-5 population.

Contractors are required to promote expansion of services for children age birth through five through training and monitoring of specialists as directed by AHCCCS and in alignment with Evidence Based Practices for this population (i.e. Infant Toddler Mental Health Coalition of Arizona (ITMHCA) standards) and to utilize Substance Use Disorders (SUD) screening tools to identify youth with substance use disorders and refer to SUD specialty services as appropriate.

The American Society of Adiction Medicine (ASAM) Criteria is required for adults receiving behavioral health services, who have been identified as having a substance use disorder.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions

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*