ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

150 N. 18th Avenue
Phoenix, AZ 85007
602.417.4000

KATIE HOBBS
GOVERNOR

KRISTEN CHALLACOMBE
INTERIM DIRECTOR

August 28, 2025

Joyce Jordan
Division of Medicaid and Children's Health Operations
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RE: Arizona SPA # AZ-25-0009, CHIP Removal of Premium Lock-Out Period

Dear Ms. Jordan:

Enclosed is State Plan Amendment (SPA) # AZ-25-0009, Removal of Premium Lock-Out Period. This SPA updates the state plan language around the non-payment of premiums or enrollment fees and how that does not result in the loss of CHIP eligibility and Section 8, Cost Sharing and Payment, Section 8.7 and Section 8.7.1. The Removal of Premium Lock-Out Period SPA will reserve a July 1, 2025 effective date.

Tribal Consultation occurred for this SPA on August 7, 2025:
https://www.azahcccs.gov/AmericanIndians/TribalConsultation/

Public Notice for this SPA was posted on the following webpage: https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/25-0007_RemovalofPremiumLock-OutPeriod.pdf

The **Federal Fiscal Impact** of this SPA has been calculated as:

- FFY 2025: $0
- FFY 2026: $0

If there are any questions about the enclosed SPA, please contact Ryan Melson at Ryan.Melson@azahcccs.gov or 602-417-7309.

Sincerely,

Kyle Sawyer
Assistant Director, Public Policy and Strategic Planning
Arizona Health Care Cost Containment System (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: 25-0009

2. STATE: AZ

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: ○ XIX ◉ XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 457.50

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Section 8, Cost Sharing and Payment, Section 8.7 and 8.7.1., pg. 98-101 overall.

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Section 8, Cost Sharing and Payment, Section 8.7 and 8.7.1., pg. 98-101 overall.

9. SUBJECT OF AMENDMENT
This SPA updates the state plan language around the non-payment of premiums or enrollment fees and how that does not result in the loss of CHIP eligibility.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
Kyle Sawyer

12. TYPED NAME
Kyle Sawyer

13. TITLE
Assistant Director, Public Policy and Strategic Planning

14. DATE SUBMITTED
August 28, 2025

15. RETURN TO
Kyle Sawyer
150 N. 18th Avenue
Phoenix, AZ 85007

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

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)
March 11, 2021 (ARP Coverage of COVID-19 Vaccines, Testing and Treatment) October 1,
2023 (CHIP Vaccine Coverage)
January 1, 2024 (CHIP Continuous Eligibility)
August 6, 2024 (CHIP Substitution of Coverage)
August 6, 2024 (CHIP Substitution of Coverage, CS-20)
August 23, 2024 (Removal of Premium Lock-Out Period, CS-21)
January 1, 2025 (Section 5121 of the CAA 2023)
July 1, 2025 (Removal of Premium Lock-Out Period)

The CHIP Vaccine Coverage SPA attests to the State's coverage of age-appropriate vaccines and their administration without cost sharing.

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.

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.

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 the duration of the declared emergency. 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 premium 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.

~~1.~~2. There are currently no consequences for an enrollee or applicant who does not pay a charge.

~~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.~~

~~C. The Administration grants a hardship exemption to the disenrollment requirements under A.R.S. § 36-2982 for a household who:~~

~~1. Is no longer able to pay the premium due to one of the hardship criteria listed below, and~~

~~2. Requests and provides all necessary written verification at the time of request.~~

~~D. The Administration considers the following hardship criteria:~~

~~1. Medically necessary expenses or health insurance premiums that:~~

~~a. Are not covered under Medicaid or other insurance and~~

~~b. Exceed 10 percent of the household's countable income;~~

~~2. Unanticipated major expense, related to the maintenance of shelter or transportation for work;~~

~~3. A combination of medically necessary and unanticipated major expenses in this section that exceed 10% of the household's countable income; or~~

~~4. Death of a household member.~~

~~E.~~B. The Administration must receive the written request and verification of exemption eligible criteria by the 10th day of the month in which the household receives the billing statement containing the current and past due premium notice.

~~F.~~C. The Administration notifies the head of household concerning the approval or denial of the request for exemption and discontinuance 10 days prior to the end of the month in which the request was received.

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

~~X~~

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

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

~~X~~

The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. (42CFR 457.570(b))

~~KidsCare members may report a change at any time. If a change in income is reported, AHCCCS reevaluates KidsCare and Medicaid eligibility and the premium amount.~~

In the instance mentioned above, that the state will facilitate

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enrolling the child in Medicaid or adjust the childs cost-sharing category as appropriate. (42CFR 457.570(b))

~~If a change in income results in a lower premium amount AHCCCS adjusts the premium amount the next prospective month after the change is reported. If the child appears to be Medicaid eligible, AHCCCS refers the application and documentation to the Department of Economic Security for a Medicaid determination.~~

~~X~~ **The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))**

~~AHCCCS sends a notice to the household at least 10 days before benefits are discontinued due to non payment. The notice includes information about the right to request a hearing and how to request a hearing. If AHCCCS receives the hearing request prior to the discontinuance effective date, AHCCCS may continue benefits pending the outcome of the hearing. Prior to the hearing date, AHCCCS discusses all information with the household to determine if the premium was calculated correctly. If the premium amount is correct, AHCCCS informs the household that the premium amount is correct and that the household has the right to request a hearing. If the premium amount is not correct, AHCCCS corrects the premium amount and the hearing is not necessary.~~

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. X No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. X No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (*Previously 8.4.5*)

8.8.3. X No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. X Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. X No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. X **No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)**