

# Arizona CARTS FY2020 Report

## Basic State Information

### Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the [CARTS Help Desk](#).

1. State or territory name:

2.

Program type:

- Both Medicaid Expansion CHIP and Separate CHIP
- Medicaid Expansion CHIP only
- Separate CHIP only

3. CHIP program name(s):

Who should we contact if we have any questions about your report?

4. Contact name:

Mohamed Arif

5. Job title:

Federal Relations Administrator

6. Email:

mohamed.arif@azahcccs.gov

7. Full mailing address:

Include city, state, and zip code.

801 E. Jefferson Street Phoenix, Arizona 85034

8. Phone number:

602-417-4573

## PRA Disclosure Statement.

This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## **Program Fees and Policy Changes**

### **Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems**

1.

Does your program charge an enrollment fee?

Yes

No

2.

Does your program charge premiums?

Yes

No

3.

Is the maximum premium a family would be charged each year tiered by FPL?

Yes

No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

No

5.

Which delivery system(s) do you use?

Select all that apply.

Managed Care

Primary Care Case Management

Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Arizona is a mandatory managed care state, and maintains an 1115 waiver for this authority for most populations. However, the state does maintain a small fee for service (FFS) program available to our AI/AN enrolled members called the American Indian Health Program (AIHP).

## **Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems**

1.

Does your program charge an enrollment fee?

Yes

No

2.

Does your program charge premiums?

Yes

No

3.

Is the maximum premium a family would be charged each year tiered by FPL?

Yes

No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

No

5.

Which delivery system(s) do you use?

Select all that apply.

Managed Care

Primary Care Case Management

Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Arizona is a mandatory managed care state, and maintains an 1115 waiver for this authority for most populations. However, the state does maintain a small fee for service (FFS) program available to our AI/AN enrolled members called the American Indian Health Program (AIHP).

## Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1.

Have you made any changes to the eligibility determination process?

Yes

No

N/A

2.

Have you made any changes to the eligibility redetermination process?

Yes

No

N/A

3.

Have you made any changes to the eligibility levels or target populations?

For example: increasing income eligibility levels.

Yes

No

N/A

4.

Have you made any changes to the benefits available to enrollees?

For example: adding benefits or removing benefit limits.

Yes

No

N/A

5.

Have you made any changes to the single streamlined application?

Yes

No

N/A



6.

Have you made any changes to your outreach efforts?

For example: allotting more or less funding for outreach, or changing your target population.

Yes

No

N/A

7.

Have you made any changes to the delivery system(s)?

For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

Yes

No

N/A

8.

Have you made any changes to your cost sharing requirements?

For example: changing amounts, populations, or the collection process.

Yes

No

N/A

9.

Have you made any changes to the substitution of coverage policies?

For example: removing a waiting period.

Yes

No

N/A

10.

Have you made any changes to the enrollment process for health plan selection?

Yes

No

N/A

11.

Have you made any changes to the protections for applicants and enrollees?

For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

Yes

No

N/A

12.

Have you made any changes to premium assistance?

For example: adding premium assistance or changing the population that receives premium assistance.

Yes

No

N/A

13.

Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

Yes

No

N/A

14.

Have you made any changes to eligibility for "lawfully residing" pregnant women?

Yes

No

N/A

15.

Have you made any changes to eligibility for "lawfully residing" children?

Yes

No

N/A

16.

Have you made changes to any other policy or program areas?

Yes

No

N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

Requirements related to timely processing of applications are temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area. The state temporarily provides continuous eligibility to CHIP enrollees who reside and/or work in a State or Federally declared disaster area. The state temporarily delays acting on certain changes in circumstances affecting CHIP eligibility for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area. However, the state will continue to act on changes in circumstance related to residency, death, voluntary termination of coverage, erroneous eligibility determinations, and becoming eligible for Medicaid. Premiums or enrollment fees and co-payments are temporarily waived for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or federally declared disaster area. Premiums are waived for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements and who reside and/or work in Governor or FEMA declared disaster areas for a specified period of time. The premium balance will be waived if the family is determined to have been living or working in FEMA or Governor declared disaster areas based on self-declared application information or other documentation provided by the family.

18.

Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- Yes
- No
- N/A

## **Part 4: Separate CHIP Program and Policy Changes**

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year. Many changes listed in this section require a State Plan

Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1.

Have you made any changes to the eligibility determination process?

Yes

No

N/A

2.

Have you made any changes to the eligibility redetermination process?

Yes

No

N/A

3.

Have you made any changes to the eligibility levels or target populations?

For example: increasing income eligibility levels.

Yes

No

N/A

4.

Have you made any changes to the benefits available to enrollees?

For example: adding benefits or removing benefit limits.

Yes

No

N/A

5.

Have you made any changes to the single streamlined application?

Yes

No

N/A



6.

Have you made any changes to your outreach efforts?

For example: allotting more or less funding for outreach, or changing your target population.

Yes

No

N/A

7.

Have you made any changes to the delivery system(s)?

For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

Yes

No

N/A

8.

Have you made any changes to your cost sharing requirements?

For example: changing amounts, populations, or the collection process.

Yes

No

N/A

9.

Have you made any changes to substitution of coverage policies?

For example: removing a waiting period.

Yes

No

N/A

10.

Have you made any changes to an enrollment freeze and/or enrollment cap?

Yes

No

N/A

11.

Have you made any changes to the enrollment process for health plan selection?

- Yes
- No
- N/A

12.

Have you made any changes to the protections for applicants and enrollees?

For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- Yes
- No
- N/A

13.

Have you made any changes to premium assistance?

For example: adding premium assistance or changing the population that receives premium assistance.

Yes

No

N/A

14.

Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

Yes

No

N/A

15.

Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?

For example: expanding eligibility or changing this population's benefit package.

Yes

No

N/A

16.

Have you made any changes to your Pregnant Women State Plan expansion?

For example: expanding eligibility or changing this population's benefit package.

Yes

No

N/A

17.

Have you made any changes to eligibility for "lawfully residing" pregnant women?

Yes

No

N/A

18.

Have you made any changes to eligibility for "lawfully residing" children?

Yes

No

N/A

19.

Have you made changes to any other policy or program areas?

Yes

No

N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

Requirements related to timely processing of applications are temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area. The state temporarily provides continuous eligibility to CHIP enrollees who reside and/or work in a State or Federally declared disaster area. The state temporarily delays acting on certain changes in circumstances affecting CHIP eligibility for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area. However, the state will continue to act on changes in circumstance related to residency, death, voluntary termination of coverage, erroneous eligibility determinations, and becoming eligible for Medicaid. Premiums or enrollment fees and co-payments are temporarily waived for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or federally declared disaster area. Premiums are waived for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements and who reside and/or work in Governor or FEMA declared disaster areas for a specified period of time. The premium balance will be waived if the family is determined to have been living or working in FEMA or Governor declared disaster areas based on self-declared application information or other documentation provided by the family.

21.

Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

Yes

No

# Enrollment and Uninsured Data

## Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

<b>Program</b>	<b>Number of children enrolled in FFY 2019</b>	<b>Number of children enrolled in FFY 2020</b>	<b>Percent change</b>
Medicaid Expansion CHIP	75,185	71,524	-4.869%
Separate CHIP	52,012	48,877	-6.027%



1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

Arizona received questions via email from CMS regarding our Q3 and Q4 SEDS data. We responded to both inquiries with the following: Arizona believes the following are impacting CHIP enrollment: Due to maintenance of effort (MOE) requirements, we are moving fewer children to CHIP from Medicaid. The population is also decreasing due to members aging out of the CHIP program. MOE requirements are resulting in fewer Medicaid discontinuances unless for very specific reasons (residency, deceased or a voluntary withdrawal). We are not discontinuing Medicaid for excessive income which leaves some of our child members in Medicaid as opposed to moving to the CHIP program. Prior, a child may have been found ineligible for Medicaid and moved to the CHIP program due to the countable income of their parent(s). After responding to the Q4 data question on December 29, 2020, we identified we likely have a data error. We are in the process of researching our data elements to determine if our data is accurate. We will provide an updated response and/or updated SEDS data as soon as possible.

## **Part 2: Number of Uninsured Children in Your State**

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2015	99,000	8,000	5.9%	0.5%
2016	81,000	7,000	4.8%	0.4%
2017	78,000	7,000	4.6%	0.4%
2018	79,000	7,000	4.6%	0.4%
2019	88,000	9,000	5.2%	0.5%

Percent change between 2018 and 2019
Not Available

2.

Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

Yes

No

3.

Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

Yes

No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

# Eligibility, Enrollment, and Operations

## Program Outreach

1.

Have you changed your outreach methods in the last federal fiscal year?

Yes

No

2.

Are you targeting specific populations in your outreach efforts?

For example: minorities, immigrants, or children living in rural areas.

Yes

No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

N/A. The state has not changed or redirected any outreach strategies over the past year. Arizona does not target outreach to specific populations.

4. Is there anything else you'd like to add about your outreach efforts?

5.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

## Eligibility, Enrollment, and Operations

### Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1.

Do you track the number of CHIP enrollees who have access to private insurance?

Yes

No

N/A

2.

Do you match prospective CHIP enrollees to a database that details private insurance status?

Yes

No

N/A

14

%

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting data?

#3. There is no separate application for CHIP. Eligibility is determined using MAGI rules and cascades through a Medicaid determination prior to a CHIP determination. Just under 14% of the CHIP denial actions were due to creditable health insurance coverage.

6.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

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# Eligibility, Enrollment, and Operations

## Renewal, Denials, and Retention

### Part 1: Eligibility Renewal and Retention

1.

Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

This question should only be answered in respect to Separate CHIP.

Yes

No

N/A

2.

In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

Yes

No

3.

Do you send renewal reminder notices to families?

Yes

No

4. What else have you done to simplify the eligibility renewal process for families?

5. Which retention strategies have you found to be most effective?

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

7. Is there anything else you'd like to add that wasn't already covered?

We follow the rules for ex parte renewal. Approximately 80% of our total Medicaid/CHIP population was renewed without requiring information from the family. When information is needed, a pre-populated form is sent and the family is given 30 days to respond. If no response, a discontinuance notice is sent providing 10 days advance notice. \*data note- this includes 6 months of data where all renewals were completed without requiring data from the customer. However, prior to the PHE, an average of 68% of renewals were completed automatically.



## Part 2: CHIP Eligibility Denials (Not Redetermination)

1.

How many applicants were denied CHIP coverage in FFY 2020?

Don't include applicants being considered for redetermination - this data will be collected in Part 3.

35530

2.

How many applicants were denied CHIP coverage for procedural reasons?

For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

14426

3.

How many applicants were denied CHIP coverage for eligibility reasons?

For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

20775

3a.

How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

4.

How many applicants were denied CHIP coverage for other reasons?

329

5. Did you have any limitations in collecting this data?

There is no separate application for CHIP. Eligibility is determined using MAGI rules and cascades through a Medicaid determination prior to a CHIP determination. Therefore, there is no CHIP denial when the applicant is enrolled in Title XIX.

Table: CHIP Eligibility Denials (Not Redetermination)

This table is auto-populated with the data you entered above.

Type	Number	Percent
Total denials	35530	100%
Denied for procedural reasons	14426	40.6%
Denied for eligibility reasons	20775	58.47%
Denials for other reasons	329	0.93%

### Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1.

How many children were eligible for redetermination in CHIP in FFY 2020?

35510

2.

Of the eligible children, how many were then screened for redetermination?

35510

3.

How many children were retained in CHIP after redetermination?

4.

How many children were disenrolled in CHIP after the redetermination process?

This number should be equal to the total of 4a, 4b, and 4c below.

9059

**Computed:**

4a.

How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b.

How many children were disenrolled for eligibility reasons?

This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

4c.

How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting this data?

#4. a, b & c - Unable to provide this data. The MMIS system used to collect this information does not have a breakdown of disenrollment reasons. #4 reflects disenrolled actions after any point in the redetermination process.

Table: Redetermination in CHIP

These tables are auto-populated with the data you entered above.

Type	Number	Percent
Children screened for redetermination	35510	100%
Children retained after redetermination	Not Answered	Not Answered
Children disenrolled after redetermination	9059	25.51%

Table: Disenrollment in CHIP after Redetermination

Type	Number	Percent
Children disenrolled after redetermination	9059	100%
Children disenrolled for procedural reasons	Not Answered	Not Answered
Children disenrolled for eligibility reasons	Not Answered	Not Answered
Children disenrolled for other reasons	Not Answered	Not Answered

## Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1.

How many children were eligible for redetermination in Medicaid in FFY 2020?

582639

2.

Of the eligible children, how many were then screened for redetermination?

582639

3.

How many children were retained in Medicaid after redetermination?

533363



4.

How many children were disenrolled in Medicaid after the redetermination process?

This number should be equal to the total of 4a, 4b, and 4c below.

49276

**Computed:**

4a.

How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b.

How many children were disenrolled for eligibility reasons?

This could be due to an income that was too high and/or eligibility in CHIP instead.

4c.

How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting this data?

#4. a, b & c - Unable to provide this data. The MMIS system used to collect this information does not have a breakdown of disenrollment reasons. #4 reflects disenrolled actions after any point in the redetermination process.

Table: Redetermination in Medicaid

These tables are auto-populated with the data you entered above.

Type	Number	Percent
Children screened for redetermination	582639	100%
Children retained after redetermination	533363	91.54%
Children disenrolled after redetermination	49276	8.46%

Table: Disenrollment in Medicaid after Redetermination

Type	Number	Percent
Children disenrolled after redetermination	49276	100%
Children disenrolled for procedural reasons	Not Answered	Not Answered
Children disenrolled for eligibility reasons	Not Answered	Not Answered
Children disenrolled for other reasons	Not Answered	Not Answered

## Part 5: Tracking a CHIP cohort (Title XXI) over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

## Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1.

How does your state define "newly enrolled" for this cohort?

Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP in December 2019.

Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-16 years) instead.

Yes

No

January - March 2020 (start of the cohort)

3.

How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

154

2028

5253

2300

July - September 2020 (6 months later)

4.

How many children were continuously enrolled in CHIP six months later?

Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

123

1346

4187

1832

5.

How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

26

539

831

375

6.

Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

7.

How many children were no longer enrolled in CHIP six months later?

Possible reasons for no longer being enrolled:

b" Transferred to another health insurance program other than CHIP

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

8.

Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

9. Is there anything else you'd like to add about your data?

#8. Unable to provide the data.

January - March 2021 (12 months later)

Next year you'll report this data. Leave it blank in the meantime.

10.

How many children were continuously enrolled in CHIP 12 months later?

Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

11.

How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

12.

Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

13.

How many children were no longer enrolled in CHIP 12 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than CHIP

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

14.

Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16



July - September of 2021 (18 months later)

Next year you'll report this data. Leave it blank in the meantime.

15.

How many children were continuously enrolled in CHIP 18 months later?

Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

16.

How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

17.

Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

18.

How many children were no longer enrolled in CHIP 18 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than CHIP

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

19.

Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

20. Is there anything else you'd like to add about your data?

## **Part 6: Tracking a Medicaid (Title XIX) cohort over 18 months**

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This year you'll report the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

### Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1.

How does your state define "newly enrolled" for this cohort?

Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in Medicaid in December 2019.

Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-16 years) instead.

Yes

No

January - March 2020 (start of the cohort)

3.

How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

12376

9836

9156

4340

July - September 2020 (6 months later)

4.

How many children were continuously enrolled in Medicaid six months later?

Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

12091

9240

8680

4095

5.

How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

240

392

362

193

6.

Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

18

71

49

20

7.

How many children were no longer enrolled in Medicaid six months later?

Possible reasons for no longer being enrolled:

b" Transferred to another health insurance program other than Medicaid

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

45

204

114

52

8.

Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

9. Is there anything else you'd like to add about your data?

#8. Unable to provide the data.

January - March 2021 (12 months later)

Next year you'll report this data. Leave it blank in the meantime.

10.

How many children were continuously enrolled in Medicaid 12 months later?

Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

11.

How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

12.

Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

13.

How many children were no longer enrolled in Medicaid 12 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than Medicaid

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

14.

Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

July - September of 2021 (18 months later)

Next year you'll report this data. Leave it blank in the meantime.



15.

How many children were continuously enrolled in Medicaid 18 months later?

Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

16.

How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

17.

Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

18.

How many children were no longer enrolled in Medicaid 18 months later?

Possible reasons for not being enrolled:

b" Transferred to another health insurance program other than Medicaid

b" Didn't meet eligibility criteria anymore

b" Didn't complete documentation

b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

19.

Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

20. Is there anything else you'd like to add about your data?

## Eligibility, Enrollment, and Operations

### Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles,

coinsurance, and copayments.

1.

Does your state require cost sharing?

Yes

No

## **Eligibility, Enrollment, and Operations**

### **Employer Sponsored Insurance and Premium Assistance**

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1.

Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

Yes

No

# Eligibility, Enrollment, and Operations

## Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1.

Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

Yes

No

2.

Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

Yes

No

3.

Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

Yes

No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

Yes, the OIG monitors, guides, and trains the Managed Care Organizations' (MCO) Corporate Compliance Officers under the Corporate Compliance Section of the AHCCCS, MCO contracts; and the Arizona Contractors Operations Manual (ACOM) 103. The OIG has the authority and responsibility to conduct preliminary and full investigations relating to fraud, waste, and abuse involving the programs administered by AHCCCS. As the single State Medicaid Agency, AHCCCS OIG holds the authority for oversight, investigation, referrals to the State of Arizona's Medicaid Fraud Control Unit (MFCU), federal, state, and local Law Enforcement entities. The OIG has authority to determine whether fraud, waste, and abuse has occurred regarding all Medicaid programs, services, and monies. In accordance with A.R.S. B'B'36-2918.01, 36-2932, and ACOM, Policy 103, the Contractor, its subcontractors, and providers are required to immediately notify the AHCCCS OIG regarding any suspected fraud, waste, or abuse [42 CFR 455.17] as outlined in the agreed upon contract section D. Program Requirements, Corporate Compliance. The State Medicaid Agency, following the applicable Federal regulations, must conduct preliminary investigations to determine whether there is sufficient basis to warrant a full investigation [42 CFR 455.14]. In the state of Arizona, the authority to conduct preliminary and/or full investigations is only granted to the State Medicaid Agency, not to contractors, or other state agencies. Pursuant to 42 CFR Part 455, Subpart A, and an Intergovernmental Agreement with the Arizona Attorney General's Office, OIG refers case of suspected Medicaid fraud to the MFCU for appropriate legal action. In addition, the OIG has the authority to make independent referrals to other law enforcement entities.

5.

Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

Yes

No

N/A

6.

How many eligibility denials have been appealed in a fair hearing in FFY 2020?

82

7.

How many cases have been found in favor of the beneficiary in FFY 2020?

0

8.

How many cases related to provider credentialing were investigated in FFY 2020?

9.

How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2020?

10.

How many cases related to provider billing were investigated in FFY 2020?

11.

How many cases were referred to appropriate law enforcement officials in FFY 2020?

12.

How many cases related to beneficiary eligibility were investigated in FFY 2020?

622

13.

How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2020?

17

14.

Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- CHIP only
- Medicaid and CHIP combined

15.

Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- Yes
- No



16.

Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

Yes

No

17. Is there anything else you'd like to add that wasn't already covered?

AHCCCS, OIG, does not capture credentialing a separate allegation in our case management system. The number would be captured in the numbers reflected in the provider billing questions below. AHCCCS, OIG, handles a variety of cases that fall under the category of Provider Billing. The OIG's case management system captures multiple allegations for each referral under general descriptions. For example, the numbers below reflect cases captured include, but are not limited to: alteration of a claim; attendant care worker time card fraud; pharmacy fraud; false statements/false claims; unbundling; billing for services/supplies not provided; double billing/overbilling; excluded providers; and incorrect coding. AHCCCS, OIG, has investigated provider billing cases as follows: 844 referrals; 112 cases closed with no investigation or combined into another case; 106 cases closed with various findings; 37 cases referred to law enforcement and 686 cases pending and still active. AHCCCS, OIG, has identified a fraud ring this year that has highly inflated this number of billing allegations. Data is still being run to identify and consolidate the true and accurate number of providers involved. As OIG logs each case, the potential size of this fraud ring is still being determined. This is a joint operation involving federal, state, and local law enforcement. The OIG is working in concert with Law Enforcement to ensure the appropriate subjects are handled within the appropriate and necessary jurisdictions. This is a unique matter; and required the OIG's efforts to be strategic and thoughtful in both the civil and criminal arenas. AHCCCS, OIG, cannot separate this number from question number nine. Therefore, the answer is duplicative.

18.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

## **Eligibility, Enrollment, and Operations**

### **Dental Benefits**

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups

Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5" group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-18 years) instead.

Yes

No

2.

How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2020?

Ages 0-1

Ages 1-2

Ages 3-5

Ages 6-9

Ages  
10-14

Ages  
15-18

211

3469

7201

10400

13223

8988

3.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2020?

Ages 0-1

Ages 1-2

Ages 3-5

Ages 6-9

Ages  
10-14

Ages  
15-18

10

1431

4208

6768

7950

4413

## Dental care service codes and definitions

The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
7	1325	4003	6489	7631	4106

## Dental care service codes and definitions

The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim. All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2020?

This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	49	1041	2946	2796	1725

#### Dental treatment service codes and definitions

The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6.

How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2020?

1726

## Sealant codes and definitions

The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7.

Do you provide supplemental dental coverage?

Yes

No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

9.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

# Eligibility, Enrollment, and Operations

## CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction.

1.

Did you collect the CAHPS survey?

Yes

No

### **Part 2: You collected the CAHPS survey**

### **Part 3: You didn't collect the CAHPS survey**

Since you didn't collect the CAHPS survey, please complete Part 3.

1.

Why didn't you collect the CAHPS survey?

Check all that apply.

- Entire population wasn't included in the survey
- Part of the population wasn't included in the survey
- Data wasn't available due to budget constraints
- Data wasn't available due to staff constraints
- Data wasn't consistent or accurate
- Data source wasn't easily accessible
- Data source wasn't easily accessible: requires medical records
- Data source wasn't easily accessible: requires data linkage that doesn't currently exist
- Data wasn't collected by a provider
- Sample size was too small (fewer than 30)
- Other



2. Explain in more detail why you weren't able to collect the CAHPS survey.

The CAHPS survey was not collected due to the COVID-19 Public Health Emergency.

## Eligibility, Enrollment, and Operations

### Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section. States can use up to 10% of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1.

Does your state operate Health Service Initiatives using CHIP (Title XXI) funds?

Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

Yes

No

# **State Plan Goals and Objectives**

## **Part 1: Tell us about your goals and objectives**

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.

Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

Reduce the percent of children losing Medicaid or CHIP eligibility at renewal for procedural reasons.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Total children who lost eligibility at renewal for procedural reasons. NOTE - for this year, only using data from prior to COVID-19 PHE. After that date the MOE requirements skew the data significantly.

4.

Numerator (total number)

2723

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

Total children who lost Medicaid or CHIP eligibility at renewal. NOTE - for this year, only using data from prior to COVID-19 PHE. After that date the MOE requirements skew the data significantly.

6.

Denominator (total number)

7158

**Computed:** 38.04%

7.

What is the date range of your data?

**Start**

mm/yyyy

10 / 2019

**End**

mm/yyyy

09 / 2020

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Yes, the previous year's data indicated that ~51.5% of discontinuances at renewal were due to procedural reasons. For the first 5.5 months of FFY 2020, ~38.04% of discontinuances at renewal were due to procedural reasons.

10. What are you doing to continually make progress towards your goal?

The state continues to focus on improvement efforts to reduce administrative burden on customers, clarify policy and procedures, and simplify processes. Efforts include improving automation to allow eligibility to be renewed administratively, clarifying customer letters, and revising policies and procedures.

11. Anything else you'd like to tell us about this goal?

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

**Do you have another in this list?**

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Maintain or increase access to PCPs for members 25 months - 6 years of age



1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Ensure that a minimum of 87% of members had a visit with a PCP.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

4.

Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

6.

Denominator (total number)

**Computed:**

7.

What is the date range of your data?

**Start**

mm/yyyy

 , 

**End**

mm/yyyy

 ,

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

**Do you have another in this list?**

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Ensure that a minimum of 41% of members had an adolescent well care visit.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Numerator to be calculated in accordance with CMS Child Core 2020 specifications and inclusive of children enrolled in CHIP. Draft numerator reported (rates currently undergoing validation).

4.

Numerator (total number)

3351

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Denominator to be calculated in accordance with CMS Child Core 2020 specifications and inclusive of children enrolled in CHIP. Draft denominator reported (rates currently undergoing validation).

6.

Denominator (total number)

5426

**Computed:** 61.76%

7.

What is the date range of your data?

**Start**

mm/yyyy

10 / 2018

**End**

mm/yyyy

09 / 2019

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source



9. How did your progress towards your goal last year compare to your previous year's progress?

The reported draft rate of 61.8% exceeds the established goal and reflects a statistically significant improvement from prior year reporting (59.3%).

10. What are you doing to continually make progress towards your goal?

The following quality improvement activities involving the CHIP program have been implemented: a. Agency initiative to align the Quality Strategy with the Agency's Strategic Plan which outlines overarching goals that guide the Agency's direction b. Established an internal Quality Steering Committee comprised of subject matter experts from various divisions c. Implemented a Performance Improvement Project (PIP) inclusive of the Well-Child Visits in the First 15 Months of Life measure, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure, Adolescent Well-Care Visits measure, and Annual Dental Visits measure

11. Anything else you'd like to tell us about this goal?

This goal will be discontinued as this performance measure was retired by the measure steward. While this goal will be discontinued, it is anticipated that a new goal based on the Child and Adolescent Well-Care Visit (WCV) measure will be established in future year reporting.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

**Do you have another in this list?**

Optional

1. What is the next objective listed in your CHIP State Plan?

Maintain or increase Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

1. Briefly describe your goal for this objective.

Ensure that a minimum of 66% of members had a well-child visit

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

Numerator calculated in accordance with CMS Child Core 2020 specifications and inclusive of children enrolled in CHIP. Draft numerator reported (rates currently undergoing validation).

4.

Numerator (total number)

2001

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator calculated in accordance with CMS Child Core 2020 specifications and inclusive of children enrolled in CHIP. Draft denominator reported (rates currently undergoing validation).

6.

Denominator (total number)

2566

**Computed:** 77.98%

7.

What is the date range of your data?

**Start**

mm/yyyy

10 / 2018

**End**

mm/yyyy

09 / 2019

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The reported draft rate of 78.0% exceeds the established goal and reflects an increase in performance from previous year reporting (75.7%).

10. What are you doing to continually make progress towards your goal?

The following quality improvement activities involving the CHIP program have been implemented: a. Agency initiative to align the Quality Strategy with the Agency's Strategic Plan which outlines overarching goals that guide the Agency's direction b. Established an internal Quality Steering Committee comprised of subject matter experts from various divisions c. Implemented a Performance Improvement Project (PIP) inclusive of the Well-Child Visits in the First 15 Months of Life measure, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure, Adolescent Well-Care Visits measure, and Annual Dental Visits measure

11. Anything else you'd like to tell us about this goal?

This goal will be discontinued as this performance measure was retired by the measure steward. While this goal will be discontinued, it is anticipated that a new goal based on the Child and Adolescent Well-Care Visit (WCV) measure will be established in future year reporting.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

**Do you have another in this list?**

Optional

1. What is the next objective listed in your CHIP State Plan?

Maintain or increase Annual Dental Visits

1. Briefly describe your goal for this objective.

Ensure that a minimum of 60% of members had an annual dental visit.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

Numerator calculated in accordance with CMS Child Core 2020 specifications and inclusive of children enrolled in CHIP. Draft numerator reported (rates currently undergoing validation).

4.

Numerator (total number)

9615

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator to be calculated in accordance with CMS Child Core 2020 specifications and inclusive of children enrolled in CHIP. Draft denominator reported (rates currently undergoing validation).

6.

Denominator (total number)

12627

**Computed:** 76.15%

7.

What is the date range of your data?

**Start**

mm/yyyy

10 / 2018

**End**

mm/yyyy

09 / 2019



8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The reported draft rate of 76.1% exceeds the established goal and reflects a statistically significant improvement from prior year reporting (74.1%).

10. What are you doing to continually make progress towards your goal?

The following quality improvement activities involving the CHIP program have been implemented: a. Agency initiative to align the Quality Strategy with the Agency's Strategic Plan which outlines overarching goals that guide the Agency's direction b. Established an internal Quality Steering Committee comprised of subject matter experts from various divisions c. Implemented a Performance Improvement Project (PIP) inclusive of the Well-Child Visits in the First 15 Months of Life measure, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure, Adolescent Well-Care Visits measure, and Annual Dental Visits measure

11. Anything else you'd like to tell us about this goal?

This goal is anticipated to be maintained in future year reporting; however, the target rate is expected to be adjusted based on current performance. This goal will be reported within Objective 2: Access to Care for future year reporting.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

  

**Do you have another in this list?**

Optional

1. What is the next objective listed in your CHIP State Plan?

1. Briefly describe your goal for this objective.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

4.

Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

6.

Denominator (total number)

**Computed:**

7.

What is the date range of your data?

**Start**

mm/yyyy

 , 

**End**

mm/yyyy

 ,

8.

Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

12.

Do you have any supporting documentation?

Optional

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**Do you have another in this list?**

Optional

**Do you have another objective in your State Plan?**

Optional

## Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

Once the FFY 2020 Performance Measure reported rates are finalized, the Agency will evaluate performance with historical performance and national benchmark data. It is the Agency's intent to continue measuring and monitoring access to, quality of, and outcomes of care received by the CHIP population utilizing a selection of standardized CMS Child Core and NCQA HEDISB. measures. The Agency underwent transition in its Data Quality Strategy in efforts to align with the CMS Child and Adult Core Quality Measure Sets. As part of these efforts, the Agency updated its Contract language and has updated the associated CYE 2021 Performance Measure Reporting templates. The Agency utilizes the MCO submitted Performance Measure Reporting data to monitor trends in performance and provides feedback to MCOs to assist in identifying improvement opportunities and focus areas.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will this data become available?

During CYE 2020, the Agency further advanced its Quality Steering Committee and established an Agency and MCO Quality Performance Measure Workgroup aimed at operationalizing the Agency Performance Measure Transitions. These efforts included the transition from the Agency's current process of utilizing performance measure rates calculated by the Agency's External Quality Review Organization (EQRO) as well as transition from a Contract Year Ending (October 1 - September 30) measurement period to a Calendar Year (January 1 - December 31) measurement period. Beginning with the Calendar Year 2020 performance measure calculations, MCOs will calculate performance measure rates internally which shall be validated by the Agency's EQRO, in alignment with CMS EQRO Protocol 2. The Agency will be utilizing MCO calculated rates that have been validated by the Agency's EQRO as the basis for monitoring and evaluating performance. In addition, the Agency transitioned from its use of internally established Minimum Performance Standards (MPS) to the use of national benchmark data (CMS Medicaid Median, NCQA HEDISB. Medicaid Mean) and Line of Business specific historical performance for evaluating MCO, Line of Business, and Agency performance starting with its CYE 2021 Contract Amendments. The Agency intends to continue to prioritize its focus on meaningful measures specific to the population(s) served and high priority Agency initiatives.



3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, special healthcare needs, or other emerging healthcare needs.) What have you discovered through this research?

A Performance Improvement Project (PIP) with a focus on access to and quality of care was implemented with a baseline measurement period of October 1, 2018 to September 30, 2019. This PIP focuses on improving the rates of Well-Child Visits in the First 15 Months of Life (W15); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); and Annual Dental Visits (ADV). Increasing the rates for these measures also impacts other measures and focus areas, including, but not limited to, childhood and adolescent immunizations, dental sealants for children at elevated caries risk, and developmental screenings. Data will be reported, as it becomes available with technical assistance provided to the MCOs, as required or requested.

4.

Optional: Attach any additional documents here.

For example: studies, analyses, or any other documents that address your performance goals.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

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## Program Financing

Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

### Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

1.

How much did you spend on Managed Care in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 241,385,551

\$ 287,525,400

\$ 315,788,500

2.

How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 241,385,551

\$ 287,525,400

\$ 315,788,500

3.

How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 18,515,364

\$ 22,495,600

\$ 25,107,900

4.

How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 0

\$ 0

\$ 0

Table 1: Benefits Costs

This table is auto-populated with the data you entered above.

Type	FFY 2020	FFY 2021	FFY 2022
Managed Care	241385551	287525400	315788500
Fee for Service	18515364	22495600	25107900
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	-5051831	-5415700	-11372000
Total benefit costs	254849084	304605300	329524400

## Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1.

How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

This includes wages, salaries, and other employee costs.

2020

2021

2022

\$ 2,770,132

\$ 2,700,000

\$ 2,700,000

2.

How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 7,536,149

\$ 7,500,000

\$ 7,500,000

3.

How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 0

\$ 0

\$ 0

4.

How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 1,558,981

\$ 1,500,000

\$ 1,500,000

5.

How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 0

\$ 0

\$ 0

6.

How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 0

\$ 0

\$ 0

7.

How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 0

\$ 0

\$ 0

Table 2: Administrative Costs

This table is auto-populated with the data you entered above.

Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

Type	FFY 2020	FFY 2021	FFY 2022
Personnel	2770132	2700000	2700000
General administration	7536149	7500000	7500000
Contractors and brokers	0	0	0
Claims processing	1558981	1500000	1500000
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	0	0	0
Other administrative costs	0	0	0
Total administrative costs	11865262	11700000	11700000
10% administrative cap	28877879.44	34446777.78	37877377.78

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

<b>Type</b>	<b>FFY 2020</b>	<b>FFY 2021</b>	<b>FFY 2022</b>
Total program costs	271766177	321721000	352596400
eFMAP	90.51	79.01	79.01
Federal share	245975566.8	254191762.1	278586415.64
State share	25790610.2	67529237.9	74009984.36



8.

What were your state funding sources in FFY 2020?

Select all that apply.

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants
- Private donations
- Tobacco settlement
- Other

9.

Did you experience a shortfall in federal CHIP funds this year?

- Yes
- No

### **Part 3: Managed Care Costs**

Complete this section only if you have a Managed Care delivery system.

1.

How many children were eligible for Managed Care in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020

2021

2022

1176653

1261413

1324366

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?

Round to the nearest whole number.

2020

2021

2022

\$ 205

\$ 228

\$ 238

Type	FFY 2020	FFY 2021	FFY 2022
Eligible children	1176653	1261413	1324366
PMPM cost	205	228	238

## Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1.

How many children were eligible for Fee for Service in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020

2021

2022

50618

53914

54827

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?

The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2020

2021

2022

\$ 366

\$ 417

\$ 458

Type	FFY 2020	FFY 2021	FFY 2022
Eligible children	50618	53914	54827
PMPM cost	366	417	458

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

b" In March 2020, Premiums for the KidsCare program were suspended due to the COVID pandemic. o FFY20 represents approximately half a year of premiums. o For the purposes of this report, it is assumed that premium collections will resume in April 2021, therefore, FFY21 represents a half year as well, and FFY22 represents a full year. Both projections include small increases based on population growth. o The actual resumption of premiums date has not been determined.

2.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

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## Challenges and Accomplishments

1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

As in many states, the COVID-19 pandemic has impacted all facets of the healthcare system and the economy in Arizona. Historically, during an economic downturn the Arizona legislature has turned to enrollment freezes and rate cuts to curb state spending when experiencing revenue shortfalls. Given the nature of an economic downturn as a result of COVID-19, these options have not yet been discussed as a cost saving measure; however the state will continue to monitor the landscape as the pandemic progresses.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

The COVID-19 pandemic has caused a myriad of challenges across the healthcare system in Arizona, and has by far been the largest issue this year. This has impelled the state to find solutions to ensure members maintain coverage during the pandemic, as well as ensuring providers remain financially viable.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

The greatest accomplishment for the KidsCare program in 2020 has been the state's response to the COVID-19 pandemic. Through stakeholder engagement and a unified goal of maintaining member coverage and ensuring access to care by maintaining the financial viability of our provider network, Arizona has been able to maintain enrollment for all KidsCare recipients, reduce premium burden, and ensure members receive the care they need throughout the public health emergency.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

In response to the COVID-19 pandemic, AHCCCS has implemented flexibilities around application processing timeframes, timeframes around acting on changes in circumstances, and premium assessment and enforcement. AHCCCS will continue to monitor the PHE throughout 2021 to ensure these flexibilities remain in place as long as needed to ensure KidsCare members receive appropriate coverage.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

6.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

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