Table of Contents

State/Territory Name: Arizona

State Plan Amendment (SPA) #: AZ-25-0005 and AZ-25-0006

This file contains the following documents in the order listed:

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

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

Children and Adults Health Programs Group

September 4, 2025

Kristen Challacombe
Interim Director
Arizona Health Care Cost Containment System
150 N. 18th Avenue
Phoenix, AZ 85007

Dear Interim Director Challacombe:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendments (SPAs), AZ-25-0005 and AZ-25-0006, submitted on June 24, 2025, have been approved. The effective date for these SPAs is August 6, 2024.

Through SPA AZ-25-0006, Arizona removes the state's waiting period and describes the state's substitution of coverage monitoring strategy. Through SPA AZ-25-0005, Arizona makes corresponding technical edits to its CHIP state plan to remove references to the waiting period.

Your Project Officer is Joyce Jordan. She is available to answer your questions concerning this amendment and other CHIP-related matters and can be reached at Joyce.Jordan@cms.hhs.gov.

If you have additional questions, please contact Mary Beth Hance, Acting Director, Division of State Coverage Programs, at (410) 786-4299. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Alice Weiss/

Alice Weiss
Acting Director
on Behalf of
Sarah deLone, Director

Original Implementation Date: November 1, 1998

Amendment Effective Date: February 1, 2004 (premiums >150% FPL)
July 1, 2004 (premiums 100%-150% FPL)
May 1, 2009 (premiums >150% FPL) January 1, 2010 (enrollment cap)
October 10, 2013 (remove wait list)
July 26, 2016 (remove enrollment cap) August 6,
2016 (premium lock out period) October 1, 2017
(mental health parity)
July 1, 2018 (Managed Care Regulations)
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, CS20)

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.

4.1.7. X Access to or coverage under other health coverage:

See CS20. ~~A child is not eligible for KidsCare if the child is:~~
~~Eligible for Medicaid.~~
~~Covered under an employer's group health insurance plan.~~
~~Covered through family or individual health care coverage.~~
~~Eligible for health benefits coverage under a state health benefits plan on the basis of a family member's employment with a public agency (see Attachment H).~~
~~Covered under an employer's group health insurance plan or by private insurance within the last~~ three ~~months and the health insurance coverage was terminated for a reason other than involuntary loss of employment. This exclusion does not apply to persons with group health insurance who resigned from employment to avoid termination of employment. This exclusion also does not apply to children who:~~
~~Reached their lifetime insurance limit;~~
~~Are newborns;~~
~~Are transitioning Title XIX members;~~
~~Are applicants who are seriously or chronically ill:~~
~~Are Title XXI members who lose insurance coverage;~~
~~Are enrolledwith Children's Rehabilitative Services; or~~
~~Are Native American members receiving services from IHS or a 638 Tribal Facility.~~

4.1.8. X Duration of eligibility:

A child who is determined eligible for KidsCare is guaranteed an initial 12 months of continuous coverage unless the child (or parent or legal guardian if appropriate):

- Fails to cooperate in meeting the requirements of the program;
- Cannot be located;
- Attains the age of 1 9.
- Is no longer a resident of the state;
- Is an inmate of a public institution;
- Is enrolled in Medicaid;
- Is determined to have been ineligible at the time of approval;
- Obtains private or group health insurance;
- Is adopted and no longer qualifies for KidsCare;

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

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

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

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

At State discretion, requirements related to timely processing of applications may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area for the duration of the declared emergency.

At State discretion, it may temporarily provide continuous eligibility to CHIP enrollees who reside and/or work in a State or Federally declared disaster area for the duration of the declared emergency.

At State discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area for the duration of the declared emergency.

At State discretion, the State may temporarily delay acting on changes in circumstances for CHIP beneficiaries other than the required changes in circumstances described in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d),applicable to beneficiaries who reside and/or work in a State or Federally declared disaster area.

~~At State discretion, the requirement that a child is ineligible for CHIP for a period of three months from the date of the voluntary discontinuance of employer-sponsored group health insurance or individual insurance coverage may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area for the duration of the declared emergency.~~

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

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

4.4 Describe the procedures that assure that:

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

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

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

~~When conducting a renewal (periodic redetermination) of KidsCare eligibility, AHCCCS screens for potential Medicaid eligibility, group health plan, health insurance coverage, or other state health benefits. For review of potential group health plan coverage see section 4.4.4.1.~~
See CS20.

If the KidsCare staff screen a child both Medicaid and KidsCare ineligible, they forward the application to the AHCCCS Central Screening Unit (CSU). The CSU reviews the application and makes a full Medicaid eligibility determination. If the child is ineligible for Medicaid due to income, the CSU sends notification of the decision to the family.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 21 02(a)(1) and (2) and 21 02(c)(2)) (42CFR 431 .636(b)(4))

In addition to the process described in subsection 4. 4. 1 . the Department of Economic Security sends information daily to AHCCCS on children who lose their Medicaid coverage due to increased income. If eligible, AHCCCS approves the children for KidsCare.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.81 0(a)-(c))

4.4.4.1. X Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

See CS20.

~~The application requests information about group health plan coverage within the past three months. If a child is covered by group health insurance or was covered and the coverage was voluntarily discontinued, the child is not eligible for KidsCare for a period of three months unless the child has exceeded the lifetime limit to his or her insurance policy. AHCCCS grants exceptions to the three month period of ineligibility as discussed in 4.1.7.~~

~~AHCCCS monitors substitution under its Quality Control and Quality Assurance process to analyze the extent to which an applicant drops other health plan coverage. Records are reviewed to ensure that the three month period of ineligibility policy is applied appropriately. Action is taken as needed. Trends are monitored to ensure that the policy is consistantly applied throughout the program.~~

4.4.4.2. Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

CHIP Eligibility

State Name: Arizona

OMB Control Number: 0938-1148

Transmittal Number: AZ - 25 - 0006

Separate Child Health Insurance Program
Non-Financial Eligibility - Substitution of Coverage **CS20**

Section 2102(b)(3)(C) of the SSA and 42 CFR 457.340(d)(3), 457.350(i), and 457.805

Substitution of Coverage

☑ The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

■ Substitution of coverage prevention strategy:

Add	Name of policy	Description	Remove
Add	MA 515 Insurance Coverage (No Creditable Coverage) and MA 1502.T Medical Insurance and Premiums	The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. Substitution of coverage prevention strategy: The application asks the customer to report any health insurance coverage. If the family reports creditable coverage, the child will be found ineligible for CHIP. A family member, legal representative, or the child is required to report changes in employer sponsored insurance or eligibility for group health insurance or other creditable coverage. When conducting a periodic redetermination of eligibility, the State screens for potential Medicaid eligibility, group health coverage, or other commercial health insurance. The State requires its MCO's to make any commercial third-party payor information available to the State and to report to the State any third-party liability discovered for their enrolled members. Arizona also performs private insurance database checks. Arizona also performs data matches with private insurance carriers. If substitution exceeds 15%, the agency will collaborate with CMS to identify a strategy to reduce substitution.	**Remove**

A waiting period during which an individual is ineligible due to having dropped group health coverage. No

If the state elects to offer dental only supplemental coverage, the following assurances apply:

☐ The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.

☐ The waiting period does not apply to children eligible for dental only supplemental coverage.

CHIP Eligibility

PRA Disclosure Statement

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. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119