# Arizona CARTS FY2021 Report

## Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the mdct_help@cms.hhs.gov.

1. State or territory name:

Arizona

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

KidsCare

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

4. Contact name:

Alex Demyan

5. Job title:

Deputy Assistant Director

6. Email:

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7. Full mailing address:

Include city, state, and zip code.

801 E. Jefferson Street Phoenix, Arizona 85034

8. Phone number:

602-417-4130

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.

# 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

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

- (●) Yes
- ( ) No

2b. Indicate the range for premiums and corresponding FPL for one child.

## Premiums for one child, tiered by FPL

**FPL starts at** 100 → **FPL ends at** 150

**Premium starts at** $ 10 → **Premium ends at** $ 15

**FPL starts at** 150 → **FPL ends at** 175

**Premium starts at** $ 40 → **Premium ends at** $ 60

**FPL starts at** 175 → **FPL ends at** 200

**Premium starts at** $ 50 → **Premium ends at** $ 70

- ○ No

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

- ○ Yes
- ◉ No

3b. What's the maximum premium a family would be charged each year?

**$**

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

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

- (●) Yes
- ( ) No

2b. Indicate the range of premiums and corresponding FPL ranges for one child.

## Premiums for one child, tiered by FPL

**FPL starts at** 100 → **FPL ends at** 150

**Premium starts at** $ 10 → **Premium ends at** $ 15

**FPL starts at** 150 → **FPL ends at** 175

**Premium starts at** $ 40 → **Premium ends at** $ 60

**FPL starts at** 175 → **FPL ends at** 200

**Premium starts at** $ 50 → **Premium ends at** $ 70

○ No

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

○ Yes

◉ No

3b. What's the maximum premium fee a family would be charged each year?

**$**

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

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

- ○ Yes
- ◉ No

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

| |
|---|
| Part 4 - #1 & #2 - All eligibility changes made this year were in response to the PHE. |

# 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.

| Program | Number of children enrolled in FFY 2020 | Number of children enrolled in FFY 2021 | Percent change |
|---|---|---|---|
| **Medicaid Expansion CHIP** | 71,524 | 76,269 | 6.634% |
| **Separate CHIP** | 16,329 | 57,859 | 254.333% |

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

The significant increase in children enrolled in Arizona's Medicaid and CHIP programs can be attributed to two main factors - A significant increase in the enrolled population from 2020, and continued enrollment under FFCRA maintenance of effort requirements during the public health emergency.

# 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. Due to the impacts of the COVID-19 PHE on collection of ACS data, the 2020 children's uninsurance rates are currently unavailable. Please skip to Question 3.

| Year | Number of uninsured children | Margin of error | Percent of uninsured children (of total children in your state) | Margin of error |
|---|---|---|---|---|
| **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% |
| **2020** | Not Available | Not Available | Not Available | Not Available |

| Percent change between 2019 and 2020 |
|---|
| **Not Available** |

1. What are some reasons why the number and/or percent of uninsured children has changed?

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?

| |
|---|
| Note: We need SEDS data from CMS before Section 2, Part 2 can be completed. |

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).

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# 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?

No

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).

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# 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

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

[ ] %

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

◉ Yes

4a. How long is the waiting period?

Three months

4b. Which populations does the waiting period apply to? (Include the FPL for each group.)

The uninsurance period applies to all children eligible for CHIP.

4c. What exemptions apply to the waiting period?

The three month period does not apply when: •The creditable coverage was from another insurance affordability program. •The premium to cover the child was more than 5 percent of the household income. •The child's parent is eligible for advance payment of the premium tax credit to enroll in a QHP because the coverage the family had through an employer is determined unaffordable. •The cost of family coverage that includes the child is more than 9.5 percent of the household income. •The employer stopped offering coverage of dependents (or any coverage). •The child lost coverage because of a family member's job change. •The child has special health care needs. •The child lost coverage due to the death or divorce of a parent.

4d. What percent of individuals subject to the waiting period meet a state or federal exemption?

This data is not readily available.

- ○ No
- ○ N/A

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 over 5% 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).

Browse...

# 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?

N/A

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

N/A

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

N/A

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

The state continued to follow the rules for ex parte renewal. *Program retention has been higher than normal due to the MOE and is not representative of normal business operation.

# Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2021?
Don't include applicants being considered for redetermination - this data will be collected in Part 3.

25570

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.

11312

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.

14036

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?

222

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. #3a. Unable to provide this data.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

| | Percent |
|---|---|
| **Total denials** | 100% |
| **Denied for procedural reasons** | 44.24% |
| **Denied for eligibility reasons** | 54.89% |
| **Denials for other reasons** | 0.87% |

# 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 2021?

31458

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

31458

3. How many children were retained in CHIP after redetermination?

29425

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.

2033

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?

| |
|---|
| 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. #4a., 4b., & 4c. Unable to provide this data. |

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

| | **Percent** |
|---|---|
| **Children screened for redetermination** | 100% |
| **Children retained after redetermination** | 93.54% |
| **Children disenrolled after redetermination** | 6.46% |

Table: Disenrollment in CHIP after Redetermination

| | **Percent** |
|---|---|
| **Children disenrolled after redetermination** | 100% |
| **Children disenrolled for procedural reasons** | |
| **Children disenrolled for eligibility reasons** | |
| **Children disenrolled for other reasons** | |

# 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 2021?

568457

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

568457

3. How many children were retained in Medicaid after redetermination?

544889

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.

23568

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?

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. #4a, 4b & 4c Unable to provide this data.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

| | Percent |
|---|---|
| **Children screened for redetermination** | 100% |
| **Children retained after redetermination** | 95.85% |
| **Children disenrolled after redetermination** | 4.15% |

Table: Disenrollment in Medicaid after Redetermination

| | Percent |
|---|---|
| **Children disenrolled after redetermination** | 100% |
| **Children disenrolled for procedural reasons** | |
| **Children disenrolled for eligibility reasons** | |
| **Children disenrolled for other reasons** | |

# 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 last year you reported on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). This year you'll report on 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): included in 2020 report.
You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

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): included in 2020 report.

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 |
|---|---|---|---|
| <11 | 79 | 81 | 36 |

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:• Transferred to another health insurance program other than CHIP• Didn't meet eligibility criteria anymore• Didn't complete documentation• Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| <11 | 143 | 235 | 93 |

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 this data.

January - March 2021 (12 months later): to be completed this year.
This year, please report data about your cohort for this section

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 |
|---|---|---|---|
| 107 | 1065 | 3615 | 1613 |

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 |
|---|---|---|---|
| 36 | 642 | 1122 | 497 |

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 |
|---|---|---|---|
| <11 | 238 | 286 | 104 |

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:• Transferred to another health insurance program other than CHIP• Didn't meet eligibility criteria anymore• Didn't complete documentation• Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 11 | 321 | 516 | 190 |

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): to be completed this year
This year, please report data about your cohort for this section.

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 |
|---|---|---|---|
| 75 | 840 | 3016 | 1322 |

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 |
|---|---|---|---|
| 54 | 663 | 1268 | 613 |

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 |
|---|---|---|---|
| 13 | 390 | 569 | 214 |

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:• Transferred to another health insurance program other than CHIP• Didn't meet eligibility criteria anymore• Didn't complete documentation• Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 25 | 525 | 969 | 365 |

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?

#14 & 19. Unable to provide this 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 last year you reported the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). This 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 2021. 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 2021 must be born after January 2004. Similarly, children who are newly enrolled in February 2021 must be born after February 2004, and children newly enrolled in March 2021 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): included in 2020 report
You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

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): included in 2020 report
You completed this section in your 2020 CARTS report. Please refer to that report to assist in filling out this section if needed.

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:• Transferred to another health insurance program other than Medicaid• Didn't meet eligibility criteria anymore• Didn't complete documentation• 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): to be completed this year
This year, please report data about your cohort for this section.

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 |
|---|---|---|---|
| 11760 | 8312 | 7876 | 3753 |

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 |
|---|---|---|---|
| 534 | 1114 | 980 | 448 |

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 |
|---|---|---|---|
| 27 | 176 | 154 | 57 |

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:• Transferred to another health insurance program other than Medicaid• Didn't meet eligibility criteria anymore• Didn't complete documentation• Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 80 | 410 | 300 | 139 |

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): to be completed next year
This year, please report data about your cohort for this section.

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 |
|---|---|---|---|
| 9581 | 7444 | 7119 | 3275 |

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 |
|---|---|---|---|
| 2157 | 1577 | 1442 | 823 |

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 |
|---|---|---|---|
| 143 | 324 | 274 | 100 |

18. How many children were no longer enrolled in Medicaid 18 months later? Possible reasons for not being enrolled:• Transferred to another health insurance program other than Medicaid• Didn't meet eligibility criteria anymore• Didn't complete documentation• Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 638 | 815 | 595 | 242 |

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?

#14. & #19. Data is not available.

## 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

## 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

## 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?

The Arizona Health Care Cost Containment System (AHCCCS), Office of the Inspector General (OIG), does have safeguards and procedures in place to prevent Fraud, Waste, and Abuse (FWA). The OIG continuously monitors, guides, and trains the Managed Care Organizations' (MCO) Corporate Compliance Officers as set forth in the Corporate Compliance Section of the AHCCCS, MCO contracts; and the Arizona Contractors Operations Manual (ACOM) 103. The OIG holds quarterly Corporate Compliance Officers Network Group (CONG) meetings; and quarterly one on one meetings with each Corporate Compliance Officer. 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, and 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. §§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 cases 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 2021?

1392

7. How many cases have been found in favor of the beneficiary in FFY 2021?

<11

8. How many cases related to provider credentialing were investigated in FFY 2021?

0

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2021?

0

10. How many cases related to provider billing were investigated in FFY 2021?

1090

11. How many cases were referred to appropriate law enforcement officials in FFY 2021?

56

12. How many cases related to beneficiary eligibility were investigated in FFY 2021?

6050

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2021?

27

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

15a. How do you provide oversight of the contractors?

As noted above, AHCCCS, OIG, provides oversight to AHCCCS contractors pertaining to Program Integrity. The OIG provides communications and training to enhance the contractors' Corporate Compliance Officers understanding of their responsibilities regarding the detection, prevention and reporting of FWA. Arizona is almost the only state where the investigations are handled by the OIG; and coordination with MFCU and other Law Enforcement entities are only conducted by OIG. All contractors' referrals must be provided to the OIG, and not directly to Law Enforcement. AHCCCS Contractors are required to immediately refer any suspected FWA to the OIG. These requirements are outlined in contracts and policy. As noted previously, the Inspector General meets regularly with the plans to discuss referrals received, top trends, potential indicators, policy changes, contract changes, and other areas of program integrity. As stated above, the OIG also holds quarterly CONG meetings. CONG meetings feature various speakers, open forum discussions, coding trends, Policy Changes, Contract changes, and additional updates pertinent to new initiatives and focal areas. Other divisions in AHCCCS also monitor actions of the contractors, with the OIG, to ensure that the MCOs, per the contract, comply with Title 42, CFR Section 438.608. The MCOs as contractors must have a mandatory Corporate Compliance Program, supported by other administrative procedures including a Corporate Compliance Plan. The plan is written. The ACOM 103 provides guidance and direction to the MCOs' Corporate Compliance program.

( ) 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?

#8. & #9. Credentialing is not captured as a separate allegation in the OIG case management system. Please see numbers reflected in Provider Billing questions. #10. 49 evaluated and closed, 51 No fraud found, 112 no investigation, 67 combined into another case, 47 closed with civil recoveries. 764 active referrals - note if a case is submitted to law enforcement, it appears as two separate cases in our system.

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).

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# 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 2021?

| Ages 0-1 | Ages 1-2 | Ages 3-5 | Ages 6-9 | Ages 10-14 | Ages 15-18 |
|---|---|---|---|---|---|
| 195 | 3698 | 7940 | 11475 | 14622 | 10122 |

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 2021?

| Ages 0-1 | Ages 1-2 | Ages 3-5 | Ages 6-9 | Ages 10-14 | Ages 15-18 |
|---|---|---|---|---|---|
| | | 3900 | 6553 | 7582 | 4343 |

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 2021?

| Ages 0-1 | Ages 1-2 | Ages 3-5 | Ages 6-9 | Ages 10-14 | Ages 15-18 |
|---|---|---|---|---|---|
| | | 3680 | 6199 | 7225 | 3942 |

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 2021?
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 | 80 | 952 | 2743 | 2540 | 1670 |

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 2021?

1530

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.

For questions 3 and 4 - Ages 0-1 and Ages 1-2 was left blank- Data suppressed due to an insufficient numerator.

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).

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# 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. For the 2021 CARTS report, we highly encourage states to report all raw CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database instead of reporting a summary of the data via CARTS. For 2022, the only option for reporting CAHPS results will be through the submission of raw data to ARHQ.

1. Did you collect the CAHPS survey?

- (●) Yes
  - 1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database?
    - ( ) Yes
    - (●) No
- ( ) No

# Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1. Upload a summary report of your CAHPS survey results.
This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

**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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2. Which CHIP population did you survey?

- ○ Medicaid Expansion CHIP
- ◉ Separate CHIP
- ○ Both Separate CHIP and Medicaid Expansion CHIP
- ○ Other

3. Which version of the CAHPS survey did you use?

- ○ CAHPS 5.0
- ○ CAHPS 5.0H
- ◉ Other

3a. Which CAHPS survey did you use?

CAHPS 5.1H

4. Which supplemental item sets did you include in your survey?
Select all that apply.

- [ ] None
- [x] Children with Chronic Conditions
- [ ] Other

5. Which administrative protocol did you use to administer the survey?
Select all that apply.

- [ ] NCQA HEDIS CAHPS 5.0H
- [ ] HRQ CAHPS
- [x] Other

5a. Which administrative protocol did you use?

NCQA HEDIS CAHPS 5.1H

6. Is there anything else you'd like to add about your CAHPS survey results?

While AHCCCS conducted a CAHPS Survey during FFY 2021 specific to the CHIP (Title XXI) population; final CAHPS reporting was not available at the time of submitting this report.

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

# 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

# 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.

Not available.

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.

Not available

6. Denominator (total number)

**Computed:**

7. What is the date range of your data?

## Start

mm/yyyy

01 / 2021

## End

mm/yyyy

12 / 2021

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?

No

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

The FFCRA MOE has been in place for the entire reporting period. No Medicaid or CHIP children lost eligibility at renewal for procedural reasons.

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

Yes. We plan to maintain it in future years. #s 4, 6, 7 & 8. Not available.

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).

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## Do you have another Goal 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 Annual Dental Visits

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%.

The goal is for the percent of members having Annual Dental Visits to meet or exceed the associated NCQA Medicaid Mean for the associated reporting period.

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.

Numerator calculated in accordance with NCQA HEDIS® specifications and inclusive of children enrolled in Medicaid and CHIP. Draft numerator reported (rates currently undergoing validation).

4. Numerator (total number)

350956

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 calculated in accordance with NCQA HEDIS® specifications and inclusive of children enrolled in Medicaid and CHIP. Draft denominator reported (rates currently undergoing validation).

6. Denominator (total number)

701528

**Computed:** 50.03%

7. What is the date range of your data?

## Start

mm/yyyy

01 / 2020

## End

mm/yyyy

12 / 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?

No, as FFY 2021 reported rates reflect performance during the COVID-19 Public Health Emergency with a decline in performance noted.

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. Maintained an internal Quality Steering Committee comprised of subject matter experts from various divisions c. Established a workgroup with the Managed Care Organizations (MCOs) specific to quality improvement d. Maintained a Performance Improvement Project (PIP) inclusive of the Annual Dental Visit measure.

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

Numerator and Denominator increase from previous year reporting is the result of including both the Medicaid and CHIP population within the current FFY 2021 reporting. FFY 2021 reported rates are reflective of performance during the COVID-19 Public Health Emergency with a decline in performance noted. Arizona intends to maintain this goal which was established prior to the COVID-19 Public Health Emergency.

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).

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## Do you have another Goal 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.

Maintain or increase Child and Adolescent Well-Care Visits

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%.

The goal is for the percent of members having a Child and Adolescent Well Visit to meet or exceed the associated NCQA Medicaid Mean for the associated reporting period.

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

4. Numerator (total number)

295680

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

6. Denominator (total number)

687228

**Computed:** 43.03%

7. What is the date range of your data?

## Start

mm/yyyy

01 / 2020

## End

mm/yyyy

12 / 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?

This is a newly implemented goal; progress anticipated to be reported within future year reporting

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. Maintained an internal Quality Steering Committee comprised of subject matter experts from various divisions c. Established a workgroup with the Managed Care Organizations (MCOs) specific to quality improvement d. Maintained a Performance Improvement Project (PIP) inclusive of the Child and Adolescent Well-Care Visits measure. (Note: PIP methodology updated from that previously indicated within FFY 2020 reporting specific to Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure and Adolescent Well-Care Visits measure due to performance measure specification changes).

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

Objectives and goals included in the previous year's reporting were modified/ discontinued, as necessary to align with changes made to the FFY 2021 CMS Child Core Set list, with new goals established. FFY 2021 reported rates are reflective of performance during the COVID-19 Public Health Emergency. Arizona intends to maintain this goal with FFY 2021 performance serving as the baseline measurement year.

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.**
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## Do you have another Goal in this list?

Optional

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

Maintain or increase Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose and Cholesterol Testing)

1. Briefly describe your goal for this objective.

The goal is for the percent of members having Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose and Cholesterol Testing) to meet or exceed the associated NCQA Medicaid Mean for the associated reporting period.

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 specifications and inclusive of children enrolled in Medicaid and CHIP. Draft numerator reported (rates currently undergoing validation).

4. Numerator (total number)

3078

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

6. Denominator (total number)

9134

**Computed:** 33.7%

7. What is the date range of your data?

## Start

mm/yyyy

01 / 2020

## End

mm/yyyy

12 / 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?

This is a newly implemented goal; progress anticipated to be reported with future year reporting.

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. Maintained an internal Quality Steering Committee comprised of subject matter experts from various divisions c. Established a workgroup with the Managed Care Organizations (MCOs) specific to quality improvement

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

Objectives and goals included in the previous year's reporting were modified/ discontinued, as necessary to align with changes made to the FFY 2021 CMS Child Core Set list, with new goals established. FFY 2021 reported rates are reflective of performance during the COVID-19 Public Health Emergency. Arizona intends to maintain this goal with FFY 2021 performance serving as the baseline measurement year.

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.**
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## Do you have another Goal 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 2021 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 Medicaid and CHIP population utilizing a selection of standardized CMS Child Core and NCQA HEDIS® 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 updated the associated Performance Measure Monitoring Report 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. Additionally, the Agency established and implemented a MCO required Health Disparity Summary & Evaluation Report that focuses on the identification of health disparities and associated efforts meant to ameliorate identified disparities.

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 FFY 2021, 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. 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 MCO performance. In addition, the Agency transitioned to the use of national benchmark data (CMS Medicaid Median, NCQA HEDIS® 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 Child and Adolescent Well-Care Visits 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.**
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Tell us how much you spent on your CHIP program in FFY 2021, and how much you anticipate spending in FFY 2022 and 2023.

# Part 1: Benefit Costs

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

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 324,643,400 | **$** 347,307,300 | **$** 318,078,400 |

2. How much did you spend on Fee for Service in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 18,608,600 | **$** 19,843,900 | **$** 16,752,600 |

3. How much did you spend on anything else related to benefit costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 0 | **$** 0 | **$** 0 |

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 60,600 | **$** 160,000 | **$** 10,000,000 |

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

| | FFY 2021 | FFY 2022 | FFY 2023 |
|---|---|---|---|
| **Managed Care** | 324643400 | 347307300 | 318078400 |
| **Fee for Service** | 18608600 | 19843900 | 16752600 |
| **Other benefit costs** | 0 | 0 | 0 |
| **Cost sharing payments from beneficiaries** | 60600 | 160000 | 10000000 |
| **Total benefit costs** | 343312600 | 367311200 | 344831000 |

# 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 2021? How much do you anticipate spending in FFY 2022 and 2023?
This includes wages, salaries, and other employee costs.

| 2021 | 2022 | 2023 |
|---|---|---|
| **$** 3,159,100 | **$** 3,392,000 | **$** 3,073,100 |

2. How much did you spend on general administration in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 8,775,200 | **$** 9,422,300 | **$** 8,536,500 |

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 0 | **$** 0 | **$** 0 |

4. How much did you spend on claims processing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 1,755,000 | **$** 1,884,500 | **$** 1,707,300 |

5. How much did you spend on outreach and marketing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 0 | **$** 0 | **$** 0 |

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 0 | **$** 0 | **$** 0 |

7. How much did you spend on anything else related to administrative costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 0 | **$** 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.

| | FFY 2021 | FFY 2022 | FFY 2023 |
|---|---|---|---|
| **Personnel** | 3159100 | 3392000 | 3073100 |
| **General administration** | 8775200 | 9422300 | 8536500 |
| **Contractors and brokers** | 0 | 0 | 0 |
| **Claims processing** | 1755000 | 1884500 | 1707300 |
| **Outreach and marketing** | 0 | 0 | 0 |
| **Health Services Initiatives (HSI)** | 0 | 0 | 0 |
| **Other administrative costs** | 0 | 0 | 0 |
| **Total administrative costs** | 13689300 | 14698800 | 13316900 |
| **10% administrative cap** | 38132377.78 | 40776800 | 36092333.33 |

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 2023 will be calculated once the eFMAP rate for 2023 becomes available. In the meantime, these values will be blank.

| FMAP Table | FFY 2021 | FFY 2022 | FFY 2023 |
|---|---|---|---|
| **Total program costs** | 357001900 | 382010000 | 358147900 |
| **eFMAP** | 79.01 | 79.01 | 78.69 |
| **Federal share** | 282067201.19 | 301826101 | 281826582.51 |
| **State share** | 74934698.81 | 80183899 | 76321317.49 |

8. What were your state funding sources in FFY 2021?
Select all that apply.

- [x] 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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
|---|---|---|
| 1431414 | 1547401 | 1344157 |

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?
Round to the nearest whole number.

| 2021 | 2022 | 2023 |
|---|---|---|
| **$** 227 | **$** 225 | **$** 235 |

| | **FFY 2021** | **FFY 2022** | **FFY 2023** |
|---|---|---|---|
| **PMPM cost** | 227 | 225 | 235 |

# 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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
|---|---|---|
| 54282 | 58480 | 52796 |

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?
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.

| 2021 | 2022 | 2023 |
|---|---|---|
| **$** 343 | **$** 339 | **$** 349 |

| | **FFY 2021** | **FFY 2022** | **FFY 2023** |
|---|---|---|---|
| **PMPM cost** | 343 | 339 | 349 |

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

Premium collections for the KidsCare program were halted at the start of the Public Health Emergency in early 2020. Given uncertainty over when the PHE will expire and premiums will resume, question 4 in part 1 has been left blank.

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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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. With CHIP PHE flexibilities in-place, the impact to members has been mitigated but, at the macro-level, our CHIP budget and operations have been impacted by provisions such as continuous eligibility and the suspension of member cost-sharing. The shift in presidential administrations and its corresponding policy objectives has also influenced our program. The agency continues to place an emphasis on collecting data on member social determinants of health and expanding relevant programs, such as housing.

2. What's the greatest challenge your CHIP program has faced in FFY 2021?

The COVID-19 pandemic has been the greatest challenge facing our CHIP program in FFY 2021. The state has implemented several operational policies to ensure that members maintain coverage during the pandemic. Over the course of 2021 one of the biggest challenges the agency faced was trying to plan for how to effectively "unwind" many of the flexibilities that were initially implemented without a clear picture of when the PHE is going to end.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2021?

The greatest accomplishment for the KidsCare program in 2021 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. In 2021, an internal COVID-19 response committee met regularly to discuss policy options and evaluate the PHE-related policies that were implemented. That committee has evolved to include planning for the eventual resumption of normal operations, which includes areas such as member communication and stakeholder engagement.

4. What changes have you made to your CHIP program in FFY 2021 or plan to make in FFY 2022? Why have you decided to make these changes?

In response to the COVID-19 pandemic, AHCCCS implemented several flexibilities around application processing timeframes, timeframes, member changes in circumstances, and premium assessment and enforcement. With the anticipated end of the PHE in FFY 2022, the resumption of normal operations will be a significant change with large implications for our members and the wider community. These changes will be made in compliance with federal regulations for unwinding PHE-related operational flexibilities.

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

No

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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