

State/Territory: ARIZONA

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided:  No limitations  With limitations\*

2. a. Outpatient hospital services.

Provided:  No limitations  With limitations\*

- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).

Provided:  No limitations  With limitations\*\*  
 Not Provided

- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided:  No limitations  With limitations\*\*

3. Other laboratory and x-ray services.

Provided:  No limitations  With limitations\*

\* Description provided in Limitations section of this Attachment.

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- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.  
Provided:  No limitations  With limitations\*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.\*
- 4.c. Family planning services and supplies for individuals of child-bearing age.  
Provided:  No limitations  With limitations\*
- 4.d. Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women  
Provided:  No limitations  With limitations\*
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.  
Provided:  No limitations  With limitations\*\*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).  
Provided:  No limitations  With limitations\*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' services.  
Provided:  No limitations  With limitations\*

\* Description provided in Limitations section of this Attachment.

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TN No. 16-004  
Supersedes  
TN No. 13-001

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b. Optometrists' services.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Chiropractors' services.

Provided:  No limitations  With limitations\*  
 Not provided.

d. Other practitioners' services.

Provided: Identified in Limitations section of Attachment.  
 Not provided.

7. Home health services.

a. Intermittent or parttime nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided:  No limitations  With limitations\*

b. Home health aide services provided by a home health agency.

Provided:  No Limitation  With limitations\*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided:  No Limitations  With limitations\*\*

\* Description provided in Limitations section of this Attachment.

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- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided:  No limitations  With limitations\*  
 Not provided

8. Private duty nursing services.

Provided:  No limitations  With limitations\*  
 Not provided

\*Description provided in Limitations section of this Attachment..

TN No. 99-04  
Supersedes  
TN No. 91-27

Approval Date SEP 7 1999

Effective Date July 1, 1999

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9. Clinic services.

Provided:  No limitations  With limitations\*  
 Not provided

10. Dental services.

Provided:  No limitations  With limitations\*  
 Not provided

11. Physical therapy and related services.

a. Physical therapy.

Provided:  No limitations  With limitations\*\*  
 Not provided

b. Occupational therapy.

Provided:  No limitations  With limitations\*  
 Not provided

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

Provided:  No limitations  With limitations\*  
 Not provided

\* Description provided in Limitations section of this Attachment.

\*\*Sole limitation is authorization by appropriate entity as defined in the Limitations section of this Attachment.

TN No. 99-04  
Supersedes  
TN No. 88-10

Approval Date SEP 7 1999

Effective Date July 1, 1999

State/Territory: ARIZONA

AMOUNT, DURATION AND SCOPE OF MEDICAL  
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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Dentures.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Prosthetic devices.

Provided:  No limitations  With limitations\*  
 Not provided.

d. Eyeglasses.

Provided:  No limitations  With limitations\*  
 Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided in Limitations section of this Attachment.

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Revision: HCFA-PM-85-3 (BERC)  
MAY 1985

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b. Screening services.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Preventive services.

Provided:  No limitations  With limitations\*  
 Not provided

d. Rehabilitative services.

Provided:  No limitations  With limitations\*  
 Not provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

Provided:  No limitations  With limitations\*\*, \*\*\*  
 Not provided

b. Nursing facility services.

Provided:  No limitations  With limitations\*\*  
 Not provided

\* Description provided in Limitations section of this Attachment.

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\*\*\*Pursuant to the 1115 Waiver, Medicaid reimbursement is available for Medicaid-eligible persons ages 21 through 64.

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15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Provided:  No limitations  With limitations\*\*  
 Not provided

- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided:  No limitations  With limitations\*  
 Not provided

16. Inpatient psychiatric facility services for individuals under 21 years of age.

Provided:  No limitations  With limitations\*\*  
 Not provided

17. Nurse-midwife services.

Provided:  No limitations  With limitations\*  
 Not provided

18. Hospice care (in accordance with section 1905(o) of the Act).

Provided:  No limitations  With limitations in accordance with §2302 of the Affordable Care Act \*  
 Not Provided.

\* Description provided in Limitations section of this Attachment.

\*\*Sole limitation is authorization by appropriate entity as defined in the Limitations section of this Attachment.

TN No. 11-014  
Supersedes  
TN No. 10-002

Approval Date OCT 12 2011 Effective Date July 20, 2011



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19. Case management services and tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Provided:  With limitations\*  
 Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

Provided:  With limitations\*  
 Not provided.

20. Extended services for pregnant women

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.\*

Additional coverage ++

- b. Services for any other medical conditions that may complicate pregnancy.

Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

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21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

Provided:  No limitations  With limitations\*  
 Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Provided:  No limitations  With limitations\*\*  
 Not provided

23. Certified pediatric or family nurse practitioners' services.

Provided:  No limitations  With limitations\*\*  
 Not provided

\* Description provided in Limitations section of this Attachment.

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TN No. 99-04  
Supersedes  
TN No. 91-27

Approval Date SEP 7 1999 Effective Date July 1, 1999

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24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

Provided:  No Limitations  With limitations\*  
 Not provided

b. Services provided in Religious Non-Medical Health Care Institutions

Provided:  No limitations  With limitations\*\*  
 Not provided

c. Reserved

d. Nursing facility services for patients under 21 years of age.

Provided:  No limitations  With limitations\*  
 Not provided.

e. Emergency hospital services.

Provided:  No limitations  With limitations\*  
 Not provided

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25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A .

Provided  Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

Provided:  State Approved (Not Physician) Service Plan Allowed

Services Outside the Home Also Allowed

Limitations Described on Attachment

Not Provided. Not a covered service except under EPSDT and for ALTCS through 1115 waiver authority.

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**Freestanding Birth Center Services**

**27. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers**

Provided:     No limitations     With limitations     None licensed or approved

Please describe any limitations:

**27. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center**

Provided:     No limitations     With limitations (please describe below)

Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

(a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

(b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). \*

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).\*

\*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

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**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED**  
**CATEGORICALLY NEEDY GROUP(S)**

**28. Coverage of Routine Patient Cost in Qualifying Clinical Trials**

\*The state needs to check each assurance below.

Provided:   X  

I. General Assurances:

**Routine Patient Cost – Section 1905(gg)(1)**

  X   Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

**Qualifying Clinical Trial – Section 1905(gg)(2)**

  X   A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

**Coverage Determination – Section 1905(gg)(3)**

  X   A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. 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.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency ARIZONA

## MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEED

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	<p>1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.</p> <p>The following excluded drugs are covered:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)</li> <li><input type="checkbox"/> (b) agents when used to promote fertility (see specific drug categories below)</li> <li><input type="checkbox"/> (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)</li> <li><input type="checkbox"/> (d) agents when used for symptomatic relief of cough and colds (see specific drug categories below)</li> <li><input type="checkbox"/> (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)</li> <li><input checked="" type="checkbox"/> (f) nonprescription drugs (see specific drug categories below)</li> </ul>

TN No. 14-007  
 Supercedes  
 TN No. 05-003

Approval Date: April 15, 2014Effective Date: January 1, 2014

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency ARIZONA

## MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEED

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	<input type="checkbox"/> (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

(The Medicaid agency lists specific category of drugs below)

Medicaid continues to cover non-prescription medications in accordance with AHCCCS medical policy: an over-the-counter medication in place of a covered prescription medication, that is clinically appropriate, equally safe and effective, and less costly than the covered prescription medication.

 No excluded drugs are covered

TN No. 14-007  
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