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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory ARIZONA

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Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: Arizona

Citation

42 CFR
430.10

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

System Cont 5/30/93

Arizona Health Care Cost Containment Administration (AHCCCSA)
(Single State Agency)

submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: ARIZONA

SECTION 1 - SINGLE STATE AGENCY ORGANIZATION

Citation

42 CFR 431.10
AT-79-29

1.1 Designation and Authority

(a) The Arizona Health Care Cost Containment System (AHCCCS) Administration is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation

Sec. 1902(a) of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

___ Yes. The State agency so designated is _____ _____.

This agency has a separate plan covering that portion of the State plan under Title XIX for which it is responsible.

X Not applicable. The entire plan under Title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

State/Territory: ARIZONA

Citation

Intergovernmental Cooperation Act of 1968

1.1(c) Waivers of the single State agency requirement that are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

___ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

_X_ Not applicable.

___ Waivers are no longer in effect.

_X_ No waivers have ever been granted.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation

42 CFR 431.10
AT-79-29

1.1(d) ___ The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.

_X_ Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation

42 CFR 431.10
AT-79-29

1.1 (e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.

Revisions: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Arizona

Citation

42 CFR 431.11
AT-79-29

1.2 Organization for Administration

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the Office of the Medical Director has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

/_/ Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.

State/Territory: ARIZONA

Citation

42 CFR 431.50(b)
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

_X_ The plan is State administered.

___ The plan is administered by the political subdivisions of the State and is mandatory on them.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Arizona

Citation		
42 CFR 431.12(b) AT-78-90	1.4	State Medical Care Advisory Committee There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.
42 CFR 438.104		_X_ The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials. *

*Members are enrolled with MCOs and receive most behavioral health services through the PIHPs

Citation

1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will be reimbursed more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

State/Territory: ARIZONA

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

___ State Medicaid Agency

_X_ State Public Health Agency

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation		
42 CFR 435.10 and Subpart J	2.1	Application, Determination of Eligibility and Furnishing Medicaid
	(a)	The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Revision: HCFA-PM- (MB)

State/Territory: Arizona

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47)		(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

State/Territory: Arizona

Citation

1902(a)(55) of the Act	2.1(d)	The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in $1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

☆ U.S. Government Printing Office : 1991 - 281-878/40326

State: Arizona

Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

/_/ Mandatory categorically needy and other required special groups only.

/_/ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

/X/ Mandatory categorically needy, other required special groups, and specified optional groups.

/_/ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

435.231
now 1e#
435.236

STATE OF ARIZONA

ADDENDUM
COVERAGE AND CONDITIONS OF ELIGIBILITY

CITATION: Page 12 and Attachment 2.2-A, Pages 11 & 17, of the State Plan

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In accordance with the terms of waivers granted to the State of Arizona, the State is waived from Federal requirements (42 CFR §§435.217 and 435.231) to enable Arizona to exclude hospitalized individuals and others not requiring long term care services from the optional institutionalized eligibility categories.

EFFECTIVE DATE: 12/19/88

Verified page placement
with online CMS version
4/30/03
BZ

State: Arizona

Citation	2.3 Residence
435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405)	Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

State: Arizona

Citation	2.4 Blindness
42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29	All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

State: ARIZONA

Citation		2.5	Disability
42 CFR 435.121,			A. All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability as the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.
435.540(b) 435.541	(WAIVER*)	*	B. In accordance with the waiver, approved June 27, 1995, disability of SSI eligible children under the age of 18 who apply for ALTCS shall be determined using the ALTCS Preadmission Screening instrument, to the extent that this would not result in an individual being denied eligibility who would otherwise be eligible.

C. Except for TWWIIA Basic Coverage Group and TWWIIA Medical Improvement Group the following provisions apply to an AHCCCS applicant who is determined seriously mentally ill (SMI) by the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS):

1. The determination of seriously mentally ill by ADHS/DBHS meets all requirements of subsection A, and;

2. Determinations by ADHS/DBHS that an otherwise eligible applicant is disabled and (a) unable to live in an independent or family setting without supervision, or (b) is at risk of serious harm to self or others will be reviewed on a sample basis by the Arizona Department of Economic Security/Disability Determination Services Administration (ADES/DDSA) to assure consistency with A.

3. Determinations by ADHS/DBHS that an otherwise eligible applicant is disabled and has (a) dysfunction in role performance or (b) is at risk of deterioration without treatment will be considered presumptive disability determinations that will be reviewed in all cases for consistency with A by ADES/DDSA following approval for Medicaid if otherwise eligible.

4. The date of the determination by ADHS/DBHS will be the date for compliance purposes under 42 CFR 435.911.

State: Arizona

Citation(s)	2.6 Financial Eligibility
42 CFR 435.10 and Subparts G & H 1902(a)(10)(A)(i)(III), (IV), (V), (VI), and (VII), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(C), 1902(f), 1902(l) and (m), 1905(p) and (s), 1902(r)(2), and 1920	(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

State/Territory: Arizona

Citation	2.7	Medicaid Furnished Out of State
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

State/Territory: ARIZONA

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation	
	3.1 Amount, Duration, and Scope of Services
42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act	(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.
	(1) Categorically needy.
	Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:
1902(a)(10)(A) and 1905(a) of the Act	(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.
	(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.
	__ Not applicable. Nurse-midwives are not authorized to practice in this State.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Arizona

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/X/ (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10)(F)(VII) ~~clause (VII) of the matter following (B) F of the Act~~

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: Arizona

Citation	3.1(a)(1)		Amount, Duration, and Scope of Services: Categorically Needy (Continued)
		(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act		(vii)	Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	X	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act		(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	___	(x)	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.** CW 3/30/93

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy. CW 3/30/93

** Note: Arizona has not elected this option.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Arizona

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440, Subpart B (a)(2) Medically needy.

N/A

/_/ This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act
42 CFR 440.220

(i) If services (42 CFR 440.140 AND 440.160) in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

/_/ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act

(ii) Prenatal care and delivery services for pregnant women.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Arizona

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

~~1902(a)(10)(C)~~

N/A

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/_/ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

/_/ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, 440.160 Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act

/_/ (vii) Services in an institution for mental diseases for individuals over age 65..

/_/ (viii) Services in an intermediate care facility for the mentally retarded.

1902(a)(10)(C) AD.

/_/ (ix) INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER AGE 21.

Revision: HCFA-PM-93- 5 (MB)
MAY 1993

State: Arizona

Citation

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of Act

N/A

___ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23) and 1929 of the Act

___ (xi) 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.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Revision: HCFA-PM-98-1 (CMSO)
April 1998

State: ARIZONA

Citation	3.1 Amount, Duration, and Scope of Services (continued)	
1902(a)(10)(E)(i) and clause (VII) of the matter following (F), and 1905(p)(3) of the Act	(a)(3)	Other Required Special Groups: Qualified Medicare Beneficiaries Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided as indicated in item 3.2 of this plan.
1902(a)(10 (a)(4)(i) (E)(ii) and 1905(s) of the Act	(a)(4)(i)	Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10) (E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10) (E)(iv)(I), 1905(p)(3) (A)(ii), and of the Act	(iii)	Other Required Special Groups: Qualifying Individuals - 1 Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

Revision: HCFA-PM-98-1 (CMSO)
April 1998

State: ARIZONA

Citation 3.1 Amount, Duration, and Scope of Services (Continued)

1925 of the Act (a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Arizona

Citation 3.1 Amount, Duration, and Scope of Services (Continued)

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Arizona

Citation	3.1(a)(6)	Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
1902(a) and 1903(v) of the Act	(iii)	Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act N/A	(a)(8)	PRESUMPTIVELY ELIGIBLE PREGNANT WOMEN Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State: Arizona

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60

The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.*

42 CFR 440.240 and 440.250

(a)(10) Comparability of Services

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), 1925(b)(4), and 1932 of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

/_/ (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

* Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.

Contracts with MCO's specify the compliance requirements for continuing care providers

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: ARIZONA

Citation
42 CFR Part 440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1 (b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or older.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

/X/ Yes

/_/ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

/_/ Yes, to all

/_/ Yes, to individuals age 21 or over; SNF services are provided

/_/ Yes, to individuals under age 21; SNF services are provided

/_/ No; SNF services are not provided

/X/ Not applicable; the medically needy are not included under this plan

Revision: HCFA-PM-93-8 (BPD)
December 1993

State/Territory: Arizona

Citation (continued) 3.1 Amount, Duration, and Scope of Services

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

State/Territory: ARIZONA

Citation

42 CFR 440.260
AT-78-90

3.1(d) Methods and Standards to Assure Quality of Services

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

Revision: HCFA-AT-80-38 (BPP) MB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation

42 CFR 441.20 3.1(e) Family Planning Services
AT-78-90 The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

Revision: HCFA-PM-87-5 (BERC)
APRIL 1987

OMB No.: 0938-0193

State/Territory: Arizona

Citation
42 CFR 441.30
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

/ / Yes.

/ / No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

/X/ Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

/ / No.

/X/ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987—181-270/60174

Citation
42 CFR
431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act,
P.L. 99-509
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who—

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of—

/XX/ 30 consecutive days;

/ / ___ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/XX/ Yes. The requirements of section 1920(e)(9) of the Act are met.

/ / Not applicable. These services are not included in the plan.

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

___ Part A X Part B

N/A The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: ARIZONA

Citation

1902(a)(10)(E)(ii) and 1905(s) of the Act

(ii) Qualified Disabled and Working Individual (QDWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act

(iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act

(iv) Qualifying Individual - 1 (QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

Revision: HCFA-PM-97-3 (MB)
December 1997

State: ARIZONA

Citation

1843(b) and 1905(a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

_X_ All individuals who are: a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).

____ Individuals receiving title II or Railroad Retirement benefits.

____ Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

____ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: Arizona

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a),and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

Q1,15

42 CFR 431.625

X For the entire range of services available under Medicare Part B.

___ Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

Revision: HCFA-PM-91-8 (MB) OMB No.:
October 1991

State/Territory: Arizona

Citation		Condition or Requirement
1906 of the Act	(c)	Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans. When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).
1902(a)(10)(F) of the Act	(d)	/__/ The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

X Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met. *

_ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

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

State/Territory: ARIZONA

Citation

42CFR 441.252
AT-78-99

3.4 Special Requirements Applicable to Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F are met.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: Arizona

Citation
1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

/X/ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

/_/ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

/_/ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/_/ Medical or remedial care provided by licensed practitioners.

/_/ Home health services.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: Arizona

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

/_/ Private duty nursing services.

/_/ Physical therapy and related services.

/_/ Other diagnostic, screening, preventive, and rehabilitation services.

N/A /_/ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.

/_/ Intermediate care facility services for the mentally retarded.

/_/ Inpatient psychiatric services for individuals under age 21.

/_/ Hospice services.

/_/ Respiratory care services.

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

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: Arizona

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

N/A ☐ 1st 6 months ☐ 2nd 6 months

☐ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

☐ 1st 6 mos. ☐ 2nd 6 mos.

(d) ☐ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

☐ Enrollment in the family option of an employer's health plan.

N/A ☐ Enrollment in the family option of a State employee health plan.

☐ Enrollment in the State health plan for the uninsured.

☐ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

N/A

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/_/ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

State/Territory: Arizona

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

State/Territory: ARIZONA

Citation		
42 CFR 431.202 AT-79-29 AT-80-34	4.2	Hearings for Applicants and Recipients The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

State/Territory: Arizona

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Arizona

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of the Act,
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

/_/ Yes.

/X/ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

Outdated page

Need waiver for 1902(a)(4) and 42 CFR 431, Subpart P.

Outdated Page

455.13 — .16

Revision: HCFA-PM-88-10 (BERC))38-0193
SEPTEMBER 1988

no 455.17 - .21 or .23

State/Territory: Arizona

Citation		
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	4.5	Medicaid Agency Fraud Program The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

New: HCFA-PM-9 (CMSO)
June 1999

State: Arizona

Citation
Section 1902(a)(64) of
the Social Security Act
P.L. 105-33

4.5a Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation

42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

State/Territory: ARIZONA

Citation

42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation

42 CFR 431.18(b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation

42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to the Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

New: HCFA-PM-99-3
JUNE 1999

State: Arizona

Citation		
42 CFR 431.51 AT 78-90 46 FR 48524 48 FR 23212 1902(a)(23) P.L. 100-93 (section 8(f)) P.L. 100-203 (Section 4113)	4.10	Free Choice of Providers (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. (b) Paragraph (a) does not apply to services furnished to an individual – (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,
Section 1902(a)(23) Of the Social Security Act P.L. 105-33		(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or
Section 1932(a)(1) Section 1905(t)		(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c). (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

ADDENDUM
FREE CHOICE OF PROVIDERS

STATE OF **ARIZONA**

CITATION: Page 41 of the State Plan

Under the terms of the waivers granted to the State of Arizona, provider freedom of choice is restricted. Administration means the Administration of the Arizona Health Care Cost Containment System (AHCCCS). Provider, as used in this addendum, refers to the prepaid capitated health plans with whom the AHCCCS Administration enters into agreements for the delivery of services. PCP, as used in this addendum, means primary care provider.

An eligible person is provided freedom of choice to select a provider when more than one is available and accessible in the geographic service area (GSA) in which the eligible persons resides. Eligible persons failing to make a health plan choice when a choice is available, or failing to enroll when no choice is available, will be enrolled by AHCCCS with a provider in their geographic service area.

Upon enrollment with a provider, the eligible person may choose a PCP from the provider's network. The PCP is responsible for supervising, coordinating and providing initial and primary care to the eligible person as well as initiating referrals for specialty care and authorizing hospital admissions and any other medically necessary services. There are provisions which allow the eligible person to change from one PCP to another. However, PCPs must use the provider's subcontracted service delivery network (hospitals, pharmacies, specialty providers, etc.).

Eligible persons are allowed to change providers on an annual basis if there is more than one provider available within their geographic service area. This annual period is determined by the eligible person's anniversary date. At least 60 days prior to the eligible person's anniversary date, a notice will be mailed to the eligible person which advises them about the available provider options in their GSA and the time period in which a choice must be made if a change is desired. The eligible person is also advised that failure to make a change within the specified time period will mean that the eligible person will continue enrollment with their current provider. During the remainder of the year, the Administration may approve the transfer of an eligible person from one provider to another for cause in accordance with policies established by the Administration.

Enrollment with a provider shall continue within a given contract year for a period of up to 12 months following the effective date of enrollment. Continuous enrollment is contingent upon the eligibility of the person. At the time of initial enrollment, an eligible person has a period of guaranteed enrollment which is five months, plus the remaining days of the month of enrollment.

Persons eligible for the Arizona Long Term Care System will be enrolled with the program contractor in their county of residence. Upon enrollment with the program contractor, the eligible person may choose a PCP from the program contractor's network.

State/Territory: ARIZONA

Citation

42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is Arizona Department of Health Services.

(b) The State authority(ies) responsible for establishing and maintaining standards,other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): Arizona Department of Health Services.

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation		
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The Arizona Department of Health Services (agency), which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

State/Territory: ARIZONA

Citation

42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

X Yes, as listed below:

1. Health Plans
2. County agencies including Health Departments

___ Not applicable. Similar services are not provided to other types of medical facilities.

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107	(a)	For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
42 CFR Part 483 1919 of the Act	(b)	For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
42 CFR Part 483, Subpart D	(c)	For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
1920 of the Act	(d)	For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

/X/ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: Arizona

Citation
1902 (a)(58)
1902(w) 4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans(as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law Or court decision exist regarding advance directives.

Revision: HCFA-PM-91-10 (MB)
DECEMBER 1991

State/Territory: Arizona

Citation
42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and
1902(d) of the
Act, P.L. 99-509
(Section 9431)

4.14 Utilization/Quality Control

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

_____ Directly

_____ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —

(1) Meets the requirements of §434.6(a):

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1932(c)(2)
and 1902(d) of the
ACT, P.L. 99-509
(section 9431)

__X__ A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E of each managed care organization, prepaid inpatient health plan, and health insuring organization under contract, except where exempted by the regulation

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

State: ARIZONA

OMB NO. 0938-0193

Citation		
42 CFR 456.2 50 FR 15312	4.14	(b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

/XX/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

/ / All hospitals (other than mental hospitals).

/ / Those specified in the waiver.

/ / No waivers have been granted.

State/Territory: ARIZONA

Citation

42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

____ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

____ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

____ All mental hospitals.

____ Those specified in the waiver.

____ No waivers have been granted.

____ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

_X_ The Medicaid agency assures that the requirements of 42 CFR 456,Subpart D, are met either directly or through an intergovernmental agreement with the Arizona Department of Health Services (ADHS) which oversees utilization review in mental hospitals for persons who receive behavioral health services through the ADHS.

Revision: HCFA-PM-85-3 (BERC) OMB No.: 0938-0193
MAY 1985

State/Territory: ARIZONA

Citation

42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

42, 456 Subpart E - no longer exists

X Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

___ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

___ All skilled nursing facilities.

___ Those specified in the waiver.

now Subchapter F Part 475

X No waivers have been granted.

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

State: ARIZONA

OMB No.: 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 /X/ (e) The Medicaid agency meets the requirements of CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/X/ Facility-based review

/_/ Direct review by personnel of the medical assistance unit of the State agency.

/_/ Personnel under contract to the medical assistance unit of the State agency.

/_/ Utilization and Quality Control Peer Review Organizations.

/_/ Another method as described in ATTACHMENT 4.14-A.

/_/ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/_/ Not applicable. Intermediate care facility services are not provided under this plan.

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: Arizona

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e) For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

42 CFR 438.354
42 CFR 438.356(b) and (d) The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

___ Not applicable.

Outdated
No Longer Used

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: Arizona

Citation 4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act

____ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

____ ICFs/MR;

____ Inpatient psychiatric facilities for recipients under age 21; and

____ Mental Hospitals.

42 CFR Part 456 Subpart A and 1902(a)(30) of the Act

_X_ All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

____ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

____ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan. (SEE NOTE BELOW)

____ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

NOTE: These services are provided subject to the limitations identified in Attachment 3.1-A.

State/Territory: ARIZONA

Citation

42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

STATE: ARIZONA

Citation	4.16 (a)	Coordination with WIC Operations
1902(a)(11)(C) of the Act Section 6406 of P.L. 101-239		The AHCCCS Administration has cooperative arrangements with other State agencies for the coordination of operations under the Special Supplemental Food Program for Women, Infants and Children (WIC) under Section 17 of the Child Nutrition Act of 1966. ATTACHMENT 4.16-B describes the cooperative arrangements with the other State agencies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

Citation
42 CFR 433.36(c)
1902(a) (18) and
1917 (a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

_X_ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.*

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

_X_ The State imposes liens on real property on account of benefits incorrectly paid.

_X_ The State imposes TEFRA liens 1917(a) (1) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.*

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

_X_ The State imposes liens on both real and personal property of an individual after the individual's death.

* TEFRA liens apply only to persons who are institutionalized and enrolled in ALTCS.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

____ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) ____ The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a) (1) (B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

_X_ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as below:

All services provided to ALTC members based on the total amount of reimbursement paid by AHCCCS for Medicaid covered services. The reimbursements include, but are not limited to, capitation payments, reinsurance, any FFS payments, Medicare Part A and B, and Medicare premiums, deductibles, coinsurance and copayments or any other forms of cost sharing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

1917(b)1(C) (4) X If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b) (2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at minimum, estate as defined under State probate law). Except for the grandfathered States listed in Section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
- individual's home
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines exemptions to placing a TEFRA lien and to the recovery of a TEFRA lien.

(6) Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(7) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved. Describes TEFRA lien procedures for: notification, the request for an exemption, the request for a State Fair Hearing and the release of a TEFRA lien. Describes the State Fair Hearing procedures for Estate Recovery.

STATE OF ARIZONA

ADDENDUM
COST SHARING

Citation: Pages 54 to 56a of the State Plan

Co-payments are as follows:

o Doctor's office or home visit and all diagnostic and rehabilitative, x-ray and laboratory services associated with such visits	$1.00 per visit
o Non-emergency use of the emergency room	$1.00 per visit
o All other services	No charge

The average payment for non-emergency use of the emergency room is over $10.00. Members shall not be denied services because of their inability to pay a co-payment.

Revision: HCFA-AT-91-4(BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Arizona

431.55(g) reserved

Citation 42 CFR 447.51 through 447.58

4.18 Recipient Cost Sharing and Similar Charges

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[ ] Age 19

[ ] Age 20

[ ] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Arizona

Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women. women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

[X] Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

[ ] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Arizona

Citation 4.18(b) (Continued)

42 CFR 447.51 through 447.48

Waiver *

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

/_/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

/_/ 18 or older

/_/ 19 or older

/_/ 20 or older

/_/ 21 or older

/_/ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

* See addendum for explanation of copayment

State/Territory: Arizona

Citation
42 CFR 447.51
through 447.58

4.18(b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

Waiver *

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

/X/ Not applicable. There is no maximum.

* See addendum for explanation of copayment.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Arizona

Citation		
1916(c) of the Act	4.18(b)(4) /_/ N/A	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5) /_/ N/A	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6) /_/ N/A	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Arizona

Citation		
42 CFR 447.51 through 447.58	4.18(c)	☐ Individuals are covered as medically needy under the plan.
	(1)	☐ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.
N/A		
447.51 through 447.58	(2)	No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:
	(i)	Services to individuals under age 18, or under--
		☐ Age 19
		☐ Age 20
N/A		☐ Age 21
		Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

Citation	4.18 (c)(2) (Continued)	
42 CFR 447.51 through 447.58	(ii)	Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.
	(iii)	All services furnished to pregnant women.
N/A		/_/ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
	(iv)	Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.
	(v)	Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
	(vi)	Family planning services and supplies furnished to individuals of childbearing age.
1916 of the Act, P.L. 99-272 (Section 9505)	(vii)	Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.
447.51 through 447.58	(viii)	Services provided by a health maintenance organization (HMO) to enrolled individuals.
		/_/ Not applicable. No such charges are imposed.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Arizona

Citation 4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

/_/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

/_/ 18 or older

/_/ 19 or older

/_/ 20 or older

N/A

/_/ 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Arizona

Citation 4.18(c)(3) (Continued)

447.51 through

447.58

Waiver *

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

☑ Not applicable. There is no maximum.

* See addendum for explanation of copayments.

Citation 4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

/XX/ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

/_/ Inappropriate level of care days are not covered.

State/Territory: Arizona

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements: (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

Revision: HCFA-AT-80-38 (BPP)
MAY 22, 1980

State: ARIZONA

Citation
42 CFR 447.40
AT-78-90

4.~~17~~19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

/XX/ Yes. The State's policy is described in ATTACHMENT 4.19-C.

/ / No.

42, Part 447
Subpart D
(reserved)

Revision: HCFA-PM-87-9 (BERC) OMD No.: 0938-0193
AUGUST 1987

State/Territory: ARIZONA

Citation 4.19 (d)
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

/XX/ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments (WAIVER) for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

/_/ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

/XX/ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/_/ Not applicable. The agency does not provide payment for SNF services to a swing-bed hosiptal.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

/_/ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

/XX/ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/_/ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

/_/ (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

State/Territory: ARIZONA

Citation		
42 CFR 447.45(c) AT-79-50	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Arizona

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing charge.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

State/Territory:

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Citation

42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: Arizona

Citation

1903(i)(14) of the Act	4.19(1)	The Medicaid agency meets the requirements of section 1903(i)(~~14~~) (12) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physican to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

State/Territory: ARIZONA

Citation

4.19 (m) Medicaid Reimbursement for Administration of Vaccines Under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of theAct

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

X sets a payment rate at the level of the regional maximum established by the DHHS Secretary.*

___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

___ sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

*The maximum rate for the administration of a vaccine is $15.43.

State/Territory: ARIZONA

Citation

42 CFR 447.25(b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians'or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

___ Yes, for ___ physicians' services

___ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

_X_ Not applicable. No direct payments are made to recipients.

State/Territory: ARIZONA

Citation

42 CFR 447.10(c)
AT-78-90
46 FR 42699

4.21 Prohibition Against Reassignment of Provider Claims

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: Arizona

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

(1) 42 CFR 433.138 and 433.139.
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433.151 through 433.154.
(4) Sections 1902(a)(25)(H) and (I) of the Act.

1902(a)(25)(H) and (I) of the Act

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A --

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii)

(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i) and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i) through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: Arizona

Citation

42 CFR 433.139(b)(3)(ii)(A) ___ (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3)(ii)(C) (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).

42 CFR 433.139(f)(2) (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: Arizona

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

X State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

___ Other appropriate State agency(s)--

___ Other appropriate agency(s) of another State--

___ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

X The Secretary's method as provided in the State Medicaid Manual, Section 3910.

___ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

Revision: HCFA-AT-84-2 (BERC)
01-84

State/Territory: Arizona

Citation	4.23	Use of Contracts
42 CFR 434.4 48 FR 54013		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434. /_/ Not applicable. The State has no such contracts.
42 CFR Part 438		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply): _X_ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2 _X_ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2 ___ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2. ___ Not applicable.

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: ARIZONA

Citation		
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L. 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ____ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

State/Territory: ARIZONA

Citation

42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Revision: HCFA-PM-93-3 (MB)
April 1993

State/Territory: Arizona

Citation

1927(g)
42 CFR 456.700

4.26 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

-Appropriate
-Medically necessary
-Are not likely to result in adverse medical results

1927(g)(1)(A)
42 CFR 456.705(b) and
456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

-Potential and actual adverse drug reactions
-Therapeutic appropriateness
-Overutilization and underutilization
-Appropriate use of generic products
-Therapeutic duplication
-Drug disease contraindications
-Drug-drug interactions
-Incorrect drug dosage or duration of drug treatment
-Drug-allergy interactions
-Clinical abuse/misuse

1927(g)(1)(B)
42 CFR 456.703
(d)and(f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

-American Hospital Formulary Service Drug Information
-United States Pharmacopeia-Drug Information
-American Medical Association Drug Evaluations

WAIVER FOR ENTIRE PAGE

Revision: HCFA-PM-93-3 (MB)
April 1993

State/Territory: Arizona

Citation

1927(g)(1)(D)
42 CFR 456.703(b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

___ Prospective DUR
___ Retrospective DUR.

1927(g)(2)(A)
42 CFR 456.705(b)

E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)
42 CFR 456.705(b), (1)-(7))

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

-Therapeutic duplication
-Drug-disease contraindications
-Drug-drug interactions
-Drug-interactions with non-prescription or over-the-counter drugs
-Incorrect drug dosage or duration of drug treatment
-Drug allergy interactions
-Clinical abuse/misuse

1927(g)(2)(A)(ii)
42 CFR 456.705 (c) and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)
42 CFR 456.709(a)

F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

-Patterns of fraud and abuse
-Gross overuse
-Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

WAIVER FOR ENTIRE PAGE

Revision: HCFA-PM-93-3 (MB)
April 1993

State/Territory: Arizona

Citation

1927(g)(2)(C)
42 CFR 456.709(b)

F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

-Therapeutic appropriateness
-Overutilization and underutilization
-Appropriate use of generic products
-Therapeutic duplication
-Drug-disease contraindications
-Drug-drug interactions
-Incorrect drug dosage/duration of drug treatment
-Clinical abuse/misuse

1927(g)(2)(D)
42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927(g)(3)(A)
42 CFR 456.716(a)

G.1. The DUR program has established a State DUR Board either:

___ Directly, or
___ Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) AND (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

1927(g)(3)(C)
42 CFR 456.716(d)

3. The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

WAIVER FOR ENTIRE PAGE

Revision: HCFA-PM-93-3 (MB) OMB No.
April 1993

State/Territory: Arizona

Citation		
1927(g)(3)(C) 42 CFR 456.711 (a)-(d)	G.4	The interventions include in appropriate instances: - Information dissemination - Written, oral, and electronic reminders - Face-to-Face discussions - Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (A) and (B)	H.	The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(1) 42 CFR 456.722	___ I.1.	The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: - real time eligibility verification - claims data capture - adjudication of claims - assistance to pharmacists, etc. applying for and receiving payment.
1927(g)(2)(A)(i) 42 CFR 456.705(b)	___ 2.	Prospective DUR is performed using an electronic point of sale drug claims processing system.
1927(j)(2) 42 CFR 456.703(c)	J.	Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

WAIVER FOR ENTIRE PAGE

State/Territory: ARIZONA

Citation

42 CFR 431.115(c)
AT-78-90
AT-79-74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

State/Territory: ARIZONA

Citation		
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)).	4.28	Appeals Process
	(a)	The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
	(b)	The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

New: HCFA-PM-99-3
JUNE 1999

State: Arizona

Citation		
1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29	Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58		The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

State/Territory: Arizona

Citation	
42 CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772	4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

/_/ The agency, under the authority of State law, imposes broader sanctions.

Revision: HCFA-AT-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Arizona

Citation		
	(b)	The Medicaid agency meets the requirements of –
1902(p) of the Act		(1) Section 1902(p) of the Act by excluding from participation—
		(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808		(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –
		(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
		(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610		(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c)

TN # 03-009
Supersedes TN # 88-1

Effective Date 10/1/03
Approval Date MAR 15 2004

Citation

1902(a)(39) of the Act, P.L. 100-93 (sec. 8(f))

(2) Section 1902(a)(39) of the Act by--

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

1902(a)(41) of the Act P.L. 96-272, (sec. 308(c)) and P.L. 101-508 (sec. 4754)

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA and, in the case of a physician, the State medical licensing board, whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act P.L. 100-93 (sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Citation	
455.103 44 FR 41644 1902(a)(38) of the Act P.L. 100-93 (sec. 8(f))	4.31 Disclosure of Information by Providers and Fiscal Agents The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.
435.940 through 435.960 52 FR 5967	4.32 Income and Eligibility Verification System (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Arizona

Citation
1902(a)(48)
of the Act,
P.L. 99-570
(Section 11005)
P.L 100-93
(sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987— 201-818/60437

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Arizona

Citation
1137 of
the Act

P.L. 99-603
(sec. 121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

/_/ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

/_/ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/_/ Total waiver

/_/ Alternative system

/_/ Partial implementation

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

Citation

4.35 Enforcement of Compliance for Nursing Facilities

(a) Notification of Enforcement Remedies

42CFR §488.402(f)

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR §488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR §488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcment remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance consititutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.~~488~~.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR §488.404(b)(1) & (2).

_____ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

Citation

(c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to removethethreat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR §488.414 §1919(h)(2)(D) of the Act

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422 ,when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 §1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR §488.412 (a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

(i) The State has established the remedies defined in 42 CFR §488.406(b).

X (1) Termination
X (2) Temporary Management
X (3) Denial of Payment for New Admissions
X (4) Civil Money Penalties
X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
X (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.
Arizona Revised Statute §36-2932 is the authority for remedies cited above.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

Citation

42 CFR
§488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) ____ The State uses alternative remedies.
The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR §488.406(b).

____ (1) Temporary Management
____ (2) Denial of Payment for New Admissions
____ (3) Civil Money Penalties
____ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
____ (5) State Monitoring

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR
§488.303(b)
~~§1910~~ §1919(h)(2)(F)
of the Act.

e. ____ State Incentive Programs

____ (1) Public Recognition
____ (2) Incentive Payments

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Arizona

Citation	4.36 Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act	The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

State/Territory: Arizona

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	4.38	Nurse Aide Training and Competency Evaluation for Nursing Facilities

(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

x (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

x (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

___ (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.

x (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

State/Territory: Arizona

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.

(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.

(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).

(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).

x (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.

(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

(t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.

(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

(v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.

(w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

___ (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

(y) The State has a standard for successful completion of competency evaluation programs.

State/Territory: Arizona

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	X	(aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	___	(cc) The State includes home health aides on the registry.
	___	(dd) The State contracts the operation of the registry to a non State entity.
	___	(ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	X	(ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: ARIZONA

Citation
Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

___ (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

State/Territory: ARIZONA

4.39 (Continued)

____ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

Revision: HCFA-PM-92-3 (HSQB) OMB No.:
APRIL 1992

State/Territory: Arizona

Citation		
	4.40 Survey & Certification Process	
Sections 1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
1919(g)(1)(B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). **Attachment 4.40-A** describes the survey and certification educational program.
1919(g)(1)(C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. **Attachment 4.40-B** describes the State's process.
1919(g)(1)(C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1)(C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1)(C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. **Attachment 4.40-C** describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

1919(g)(2)(D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
1919(g)(2)(E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2)(E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

Revision: HCFA-PM-92- 2 (HSQB)
MARCH 1992

State/Territory: Arizona

Citation	4.41 Resident Assessment for Nursing Facilities
Sections 1919(b)(3) and 1919 (e)(5) of the Act	(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b) The State is using:
	X the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or
1919(e)(5) (B) of the Act	___ a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

4.42 EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

1902(a)(68) 4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

4.42 EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

4.42 EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OMB No.: 0938-0193

State/Territory: ARIZONA

SECTION 5 - PERSONNEL ADMINISTRATION

Citation

42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

___ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

State/Territory: ARIZONA

5.2 [RESERVED]

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State/Territory: ARIZONA

Citation

42 CFR Part 432, Subpart B
AT-78-90

5.3 Training Programs; Subprofessional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

State/Territory: ARIZONA

SECTION 6 - FINANCIAL ADMINISTRATION

Citation

42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

Revision: HCFA-AZ-81- (EPP)

State Arizona

Citation		
42 CFR 433.34 47 FR 17490	6.2	Cost Allocation There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARIZONA

Citation
42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

☐ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☒ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

SECTION 7 - GENERAL PROVISIONS

Citation	7.1 Plan Amendments
42 CFR 430.12(c)	The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

State/Territory: Arizona

Citation	7.2 Nondiscrimination
45 CFR Parts 80 and 84	In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap. The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Financing Administration

Refer to: MCD-O-RFG

Region IX
75 Hawthorne Street
San Francisco, CA 94105

JUN 19 1992

JUN 26 1992
DIRECTOR'S OFF

Leonard J. Kirschner, M.D., M.P.H., Director
Arizona Health Care Cost Containment System
801 East Jefferson
Phoenix, Arizona 85034

Dear Dr. Kirschner:

Enclosed is Arizona's Medicaid State Plan Amendment Transmittal #92-06 which I have approved effective January 1, 1992 as you requested. Please note the pen and ink changes made on the transmittal sheet as a result of the removal of page 88 from your original submission. Your staff should contact Rosada Gonzales at (415) 744-3597 if they have any questions.

Sincerely,

Lawrence L. McDonough
Associate Regional Administrator
Division of Medicaid

Enclosure

cc: Lynn Dunton, AHCCCS
Mildred Reed, HCFA

KC, M.K
M. Chen
Original - L. Redman

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: Arizona

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

/_/ Not applicable. The Governor--

/_/ Does not wish to review any plan material.

/_/ Wishes to review only the plan materials specified in the enclosed document.

/X/ Wishes to review only the Plan Materials as necessary.

I hereby certify that I am authorized to submit this plan on behalf of

Arizona Health Care Cost Containment System
(Designated Single State Agency)

Date: March 25, 1992

Gradel Chen for Leonard J. Kaschinski M.D.
(Signature)

Director
(Title)

TN No. 92-6
Supersedes Approval Date 6/18/92 Effective Date January 1, 1992
TN No. None

HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 1.1-A

State of ARIZONA

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

the ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

is the single State agency responsible for:

x administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is

ARIZONA REVISED STATUTE 36-2902 through 36-2903
(statutory citation)

___ supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

_____
(statutory citation)

The agency's legal authority to make rules and regulations that are binding ~~XXXX

State of ARIZONA

WAIVER(S) OF THE SINGLE STATE AGENCY REQUIREMENT GRANTED UNDER THE INTERGOVERMENTAL COOPERATION ACT OF 1968

Waiver #1.[1/] NOT APPLICABLE

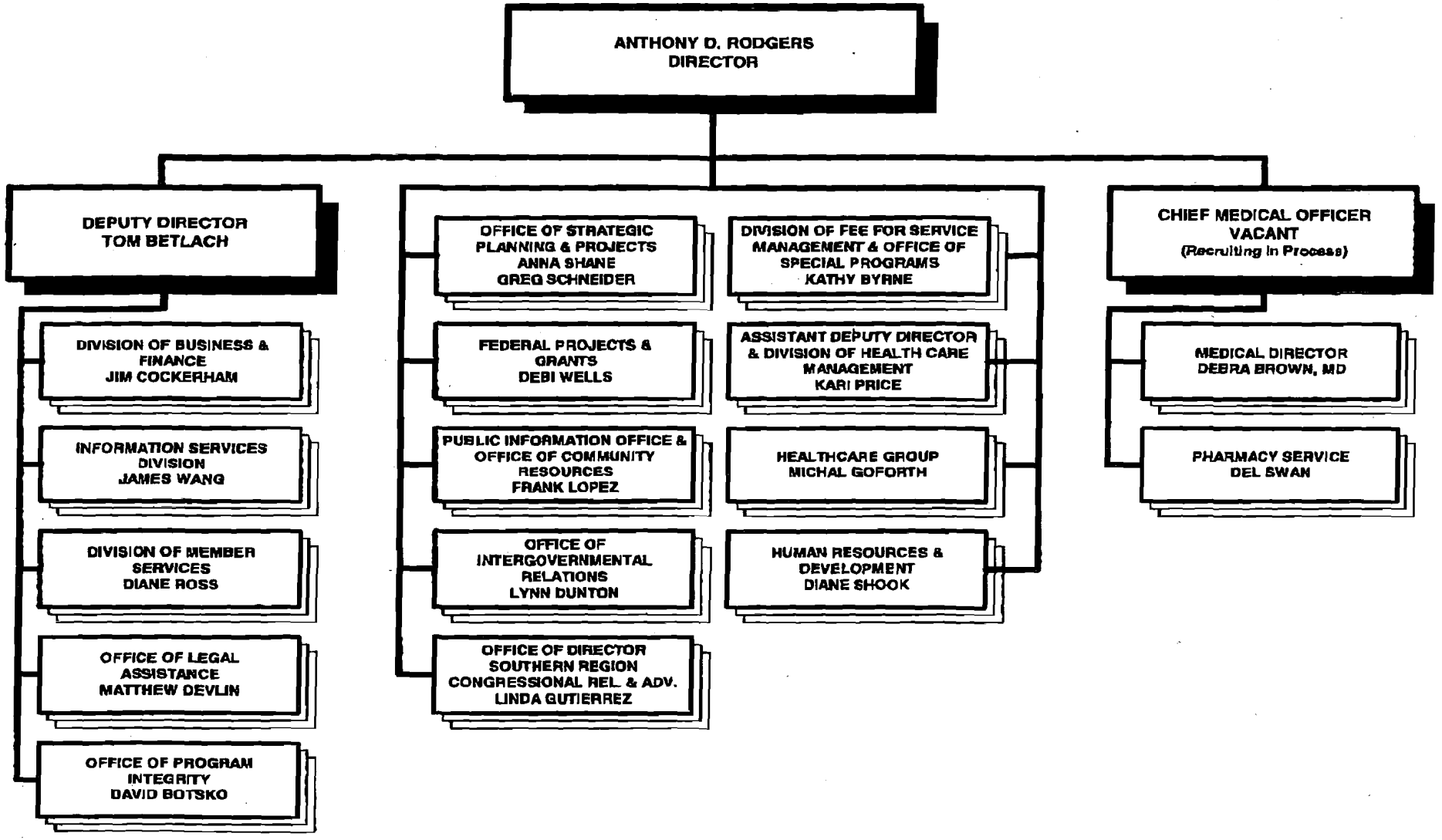
a. Waiver was granted on _____
(date)

b. The organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to _____, and
(name of agency)
the resources and/or services of such agency to be utilized in administration of the plan are described below:

[1/] (Information on any additional waivers which have been granted is contained in attached sheets.)

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Agency Organization

Attachment 1.2-A



APR-19-2004 10:23 CENTERS FOR MEDICARE 415 744 2933 P.02
TOTAL P.02

Description of the Functions of the Medical Assistance Unit

Within AHCCCS, the responsibilities and functions for medical assistance report to the Deputy Director/Chief Medical Officer and are performed by the:

- Division of Health Care Management: Responsible for the programs and services related to all populations served through managed care contracts. These programs include Acute, Long Term Care, Behavioral Health and Children's Rehabilitative Services (CRS).
- Division of Fee-for-Service Management: Responsible for the administrations of programs and services related to the Fee-for-Service population.
- Medical Director: Responsible for medical direction and medical oversight of all programs.
- Pharmacy Program Administrator: Responsible for management of the pharmacy benefit for the Fee-for-Service population and other pharmacy related policies and programs of the agency.
- Office of Special Programs: Responsible for a variety of programs including research on new technology and oversight of the AHCCCS Medical Policy Manual.

The key functions are:

- Identifying, developing, monitoring and evaluating quality of care and services;
- Formulating and implementing medical policy;
- Exercising medical interpretation; and
- Assessing new technology.

An organization chart of Medical Assistance functions is included as part of this attachment.

Description of the Functions of the Medical Assistance Unit

1. Division of Fee-for-Service Management

(a) Medical management, including prior authorization, concurrent and retrospective reviews, for the Indian Health Service members and the Federal Emergency Services Program.

(b) Grievances and appeals specific to Fee-for-Service denials

(c) Quality of care issue identification and referral for evaluation and investigation to the Clinical Quality Management Unit within the Division of Health Care Management.

(d) Authorizations for special services such as environmental modifications and out-of-state placement requests.

(e) Medical review of Fee-for-Service claims.

(f) Review and revise, as needed the qualifications and standards for the registration of AHCCCS provider types.

(g) Review and make recommendations to Executive Management regarding the addition or deletion of provider types.

2. Division of Health Care Management

(a) **ALTCS Unit**

i. Development, maintenance and oversight of comprehensive Case Management Program for ALTCS Program.

ii. Oversight of Traumatic Brain Injury/Behavioral Health Reinsurance Program.

iii. Technical assistance to ALTCS Contractors and Tribal case managers.

iv. Oversight of federal and state compliance for ALTCS Program, PASARR, and Nurse Aide Training and Competency Evaluation Program.

v. Coordination with the Arizona Department of Health Services on the status of licensure and certification of nursing facilities and Intermediate Care Facilities for the Mentally Retarded and distribution of information to AHCCCS Contractors.

vi. Coordination and oversight of Department of Economic Security/Division of Developmental Disabilities ALTCS program.

Description of the Functions of the Medical Assistance Unit

(b) **Clinical Quality Management Unit**

i. Program and operational reviews to assess each Contractor's management of medical issues, including quality management, utilization management, as well as medical policy and contractual compliance.

ii. Oversight of federal and state compliance related to quality management, EPSDT and maternal health and review of annual quality management plans. Continuous training, technical assistance and interface with Contractors regarding refining and developing these annual plans.

iii. Program monitoring, including for Maternal Child Health, Family Planning, EPSDT, dental utilization, immunization, ALTCS, and adult health care.

iv. Problem resolution, including individual quality of care issues for members, access to care, level of coverage, quality of coverage provided.

v. Quality management development and analysis (e.g., utilization reports and performance indicators).

vi. Monitoring implementation of corrective action plans and quality interventions related to quality management oversight.

vii. Coordinate and conduct focused medical audits

(c) **Data Analysis and Research Unit**

i. Data handling, analysis and reporting for utilization monitoring, performance measures, quality indicators, clinical studies, and medical audits.

ii. Coordination of data handling and analysis for medical audits, clinical studies, performance measures, and related projects.

3. **Office of Special Programs**

(a) Medical policy development, distribution, interpretation and evaluation.

(b) Chair and coordination of the AHCCCS Clinical Technology/Steering Committee.

(c) Coordination and oversight of school-based claiming of Medicaid reimbursable services.

Description of the Functions of the Medical Assistance Unit

4. **Medical Director**

   (a) Medical oversight of acute, ALTCS, Behavioral Health and Fee-for-Service Programs

   (b) Medical review for Fee-for-Service out-of-state placement requests, prior authorization and claim denials

   (c) Medical policy interpretation.

   (d) Chairman of Peer Review Committee, which reports and discusses results of investigations on quality of care issues, with emphasis on Fee-for-Service members.

   (e) Technical assistance and interface with providers for both Fee-for-Service and Medicaid Programs.

   (f) Medical resource for the grievance and appeals process.

5. **Pharmacy Program Administration**

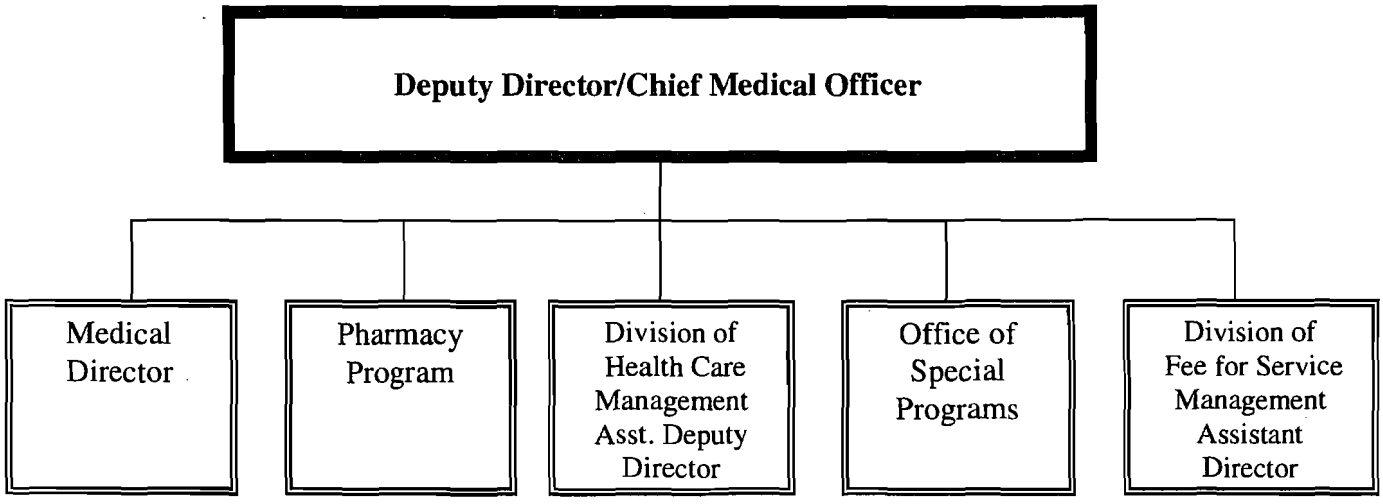
   (a) Oversight and coordination of the Fee For Service contract with a pharmacy administrator, including formulary review, provider network and any quality of care issues related to pharmacy.

   (b) Utilization data analysis and recommendations for appropriateness as well as potential cost savings.

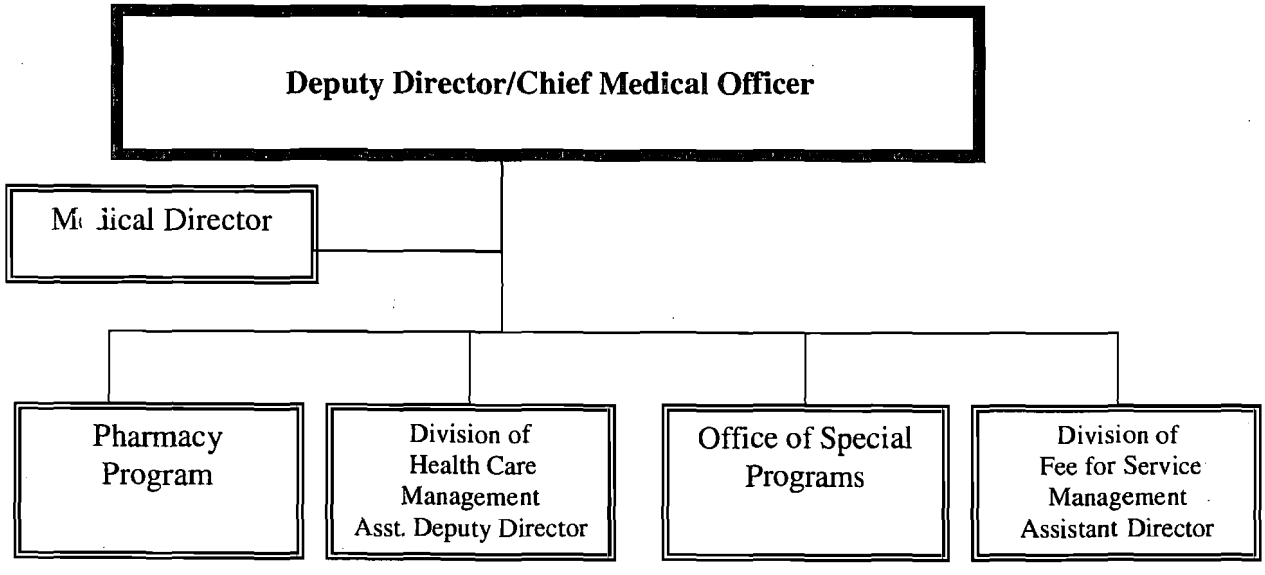
   (c) Resource of pharmacy expertise for policy development.

Description of the Functions of the Medical Assistance Unit

Administrative Units



Functional Units



- Pharmacy Benefits Management (FFS Population)

- Clinical Quality Management
- Clinical Service Management for Managed Care Population

- Clinical Technology

- Clinical Services Management (FFS Population)
- Medical Review of Claims (FFS)

Professional Medical Personnel and Support Staff

Medical Director/Office of the Director

POSITION	QUANTITY
Chief Medical Officer	1
Medical Director	1
Total	**2**

Pharmacy Program Administration

POSITION	QUANTITY
Pharmacy Program Administrator	1
Total	**1**

Division of Fee for Service Management

POSITION	QUANTITY
Health Program Manager III (LPN)	1
Health Program Manager II (RN)	1
Medical Service Program Review Specialist (RN)	8
Total	**10**

Office of Special Programs

POSITION	QUANTITY
Health Program Manager I	3
Health Program Manager III	2
Medical Service Program Review Specialist (RN)	1
Administrative Assistant III	1
Total	**7**

Professional Medical Personnel and Support Staff

Division of Health Care Management

POSITION	QUANTITY
Assistant. Deputy Director	1
Senior Administrator	1
Executive. Staff Assistant	3
Administrative Assistant II	2
Administrative Assistant III	1
Administrative Secretary III	4
Administrative Assistant I	1
Financial Consultant	5
Program Compliance Auditor III	6
Executive Consultant	2
Administrative Services Officer III	9
Economist III	3
Research & Statistical Analyst	1
Medical Services Program Review Specialist	9
Health Program Manager III	5
Health Program Manager I	5
Program and Project Specialist II	6
Management Analyst IV	1
Management Analyst III	1
Management Analyst II	3
Management Analyst I	3
Health Planning Consultant	1
Claims Specialist II	1
Finance Manager	1
Research Manager	2
Reimbursement & Special Project Administrator	1
Clinical Quality Management Administrator	1
Health Plan Manager	1
Mental Health Manager	1
ALTCS Manager	1
Total	**82**

Responsibility for Title XIX Eligibility Determinations

INTRODUCTION

In Arizona, all Title XIX eligibility determinations are made by the Arizona Department of Economic Security (DES), the Social Security Administration (SSA) or AHCCCS. Title XIX determinations are consistent with federal laws and regulations, state statutes and rules, Title XIX State Plan, Arizona 1115 Waiver, the intergovernmental agreement (IGA) between AHCCCS and DES and the 1634 agreement between AHCCCS and SSA.

ELIGIBILITY AGENCIES

Arizona Department of Economic Security (DES)

DES staff in two divisions, the Division of Benefits and Medical Eligibility (DBME) and the Division of Children, Youth and Families (DCYF), performs the acute care eligibility determinations for children, families, and single adults who are not aged, blind or disabled.

With the exception of foster care and adoption subsidy children, Title XIX DBME staff in 106 statewide local offices process Title XIX applications. In addition, Title XIX applications are accepted in community sites throughout Arizona. Sites include hospitals, FQHC's and certain Department of Health locations. Applications are also accepted by mail at both DES and AHCCCS.

DCYF staff conduct Title XIX eligibility determinations for children in the foster care and adoption subsidy programs.

Social Security Administration (SSA)

SSA provides AHCCCS with information on individuals who are eligible or ineligible for SSI cash via the File Transfer Protocol. The agreement between AHCCCS and SSA provides for the transfer of eligibility information.

AHCCCS - Division of Member Services (DMS)

DMS is responsible for determining TXIX eligibility for ALTCS (Arizona Long Term Care System), Medicare Cost Sharing, and SSI non-cash persons. ALTCS and Medicare Cost Sharing applications are processed in 16 statewide local offices. If a client who applies in an ALTCS office is approved for SSI non-cash or Medicare Cost Sharing, the case is transferred to the AHCCCS SSI non-cash office.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Arizona Attachment 2.1-A

AHCCCS PREPAID HEALTH PLANS

The following organizations or persons may submit competitive bids to contract with the AHCCCS Administration as a prepaid health plan (PHP):

- A group disability insurer
- A hospital and medical service corporation
- A health care services organization
- Any other appropriate public or private person, including county owned and operated health care facilities, authorized by Arizona Revised Statutes to provide health and medical care services

An AHCCCS contracting prepaid health plan must meet at least the following requirements:

(1) Be organized primarily for the purpose of providing health care services.

(2) Make the services it provides to its AHCCCS enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to nonenrolled AHCCCS recipients within the area served by the PHP.

(3) Make provision, satisfactory to the AHCCCS Administration, against the risk of insolvency, and assure that AHCCCS enrollees will not be liable for the PHP's debts if it does become insolvent.

(4) Comply with the terms and conditions set forth by contract with the AHCCCS Administration.

(5) Comply with all applicable Federal, State and local laws, rules, regulations, standards and executive orders, without limitation to those designated within the contract with the AHCCCS Administration.

(6) Comply with provisions of Federal laws and regulations governing the Title XIX program, except for those requirements waived for Arizona by the Health Care Financing Administration.

(7) Comply with the provisions of Title 36, Chapter 29, Arizona Revised Statutes, governing the Arizona Health Care Cost Containment System, and with all applicable rules promulgated by the AHCCCS Administration.

TRANSMITTAL # _____ EFFECTIVE _____
REC'D RO _____ SUPERSEDED BY TRANSM # 86-10
APPROVED 2/19/87 EFFECTIVE 10/1/86

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered

The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

42 CFR 435.110 1. Recipients of AFDC

The approved State AFDC plan includes:

/X/ Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months.

/X/ Pregnant women with no other eligible children.

/X/ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

42 CFR 435.115 2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.

*Agency that determines eligibility for coverage. Please see Attachment 1.2-D regarding agencies that determine eligibility.

see Supplement 12 to attachment 2.6-A for 1931 additions

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
		2. Deemed Recipients of AFDC.
	1902(a)(10)(A)(i)(I) of the Act	b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
	402(a)(22)(A) of the Act	c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
	406(h) and 1902(a)(10)(A)(i)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
	1902(a) of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act	3. Qualified Family Members Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.
	N/A	/_/ Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.
	1902(a)(52) and 1925 of the Act	4. Families terminated from AFDC ~~solely~~ because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.113	5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:
		a. Families denied AFDC solely because of income and resources deemed to be available from--
		(1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;
		(2) Grandparents;
		(3) Legal guardians; and
		(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);
		b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.
		c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.114

6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

___ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

___ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

X Not applicable with respect to intermediate care facilities; State did or does not cover this service.

1902(a)(10)(A)(i)(III) and 1905(n) of the Act

7. Qualified Pregnant Women and Children.

a. A pregnant woman whose pregnancy has been medically verified who--

(1) Would be eligible for an AFDC cash payment ~~(or who would be eligible if the State had an AFDC-unemployed parents program)~~ if the child had been born and was living with her;

deleted per 91-10 #13.

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or
	(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
1902(a)(10)(A)(i)(III) and 1905(n) of the Act	b. Children born after September 30,1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
	X Children born after See schedule below* (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

Effective*	10/01/95	born after	10/31/81
	11/01/95	born after	11/30/81
	12/01/95	born after	12/31/81
	01/01/96	born after	01/31/82
	02/01/96	born after	02/28/82
	03/01/96	born after	03/31/82
	04/01/96	born after	04/30/82
	05/01/96	born after	05/31/82
	06/01/96	born after	06/30/82
	07/01/96	born after	07/31/82
	08/01/96	born after	08/31/82
	09/01/96	born after	09/30/82

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act	8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A. ___ The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.
	9. Children:
1902(a)(10)(A)(i)(VI) and 1902(l)(1)(C) of the Act	a. who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.
1902(a)(10)(A)(i)(VII) and 1902(l)(1)(D) of the Act	b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels. X Children born after June 30, 1982 (specify optional earlier date) who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.
	Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.6A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(i)(V) and 1905(m) of the Act See MRM 91-10 item 14	10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC. Reserved.
1902(e)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(e)(4) of the Act	12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
42 CFR 435.120	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance
	X a. Individuals receiving SSI.
	This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.
	X Aged X Blind X Disabled

State: Arizona

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
435.121	13. /7	b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)
1619(b)(1) of the Act	N/A	
		___ Aged ___ Blind ___ Disabled
		The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(A)(i)(II) and 1905(q) of the Act	14. Qualified severely impaired blind and disabled individuals under age 65, who--
		a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or
		b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--
		(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
		(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;
		(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

/X/ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1619(b)(3) of the Act	/_/ N/A	The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1634(c) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--
		a. Are at least 18 years of age;
		b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.
	N/A	/_/ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.
	N/A	/_/ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.
	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

State: Arizona

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

/_/ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

___ Aged ___ Blind ___ Disabled

/X/ Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.132	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
	42 CFR 435.133	20. Blind and disabled individuals who-- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
N/A	42 CFR 435.134	21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. /_/ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). /_/ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan). /_/ Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

State: Arizona

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135 22. Individuals who --

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

/X/ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

N/A /_/ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

N/A /_/ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

State: Arizona

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1634 of the Act	23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.
		/X/ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.
		N/A /_/ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

State/Territory: Arizona

Agency*	Citation(s)	Groups Covered
1634(d) of the Act		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
		24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.
		____ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.
	N/A	____ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.
		____ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.
		____ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual.

*Agency that determines eligibility for coverage.

State: Arizona

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10(E)(i) and 1905(p) of the Act	25. Qualified Medicare beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
	1902(a)(10)(E)(ii), 1905(s) and 1905(p)(3)(A)(i) of the Act	26. Qualified disabled and working individuals-- a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

*Agency that determines eligibility for coverage.

State: Arizona

Agency*	Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
1902(a)(10(E)(iii) and 1905(p)(3)(A)(ii) of the Act	27. Specified low-income Medicare beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income for calendar years 1993 and 1994 exceeds the income level in 25. b., but is less than 110 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 120 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)	

*Agency that determines eligibility for coverage.

State: ARIZONA

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634(e) of the Act

28. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

___b. The State applies more restrictive eligibility standards than those under SSI.

Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611(e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State Plan, are eligible for Medicaid as categorically needy.

* Agency that determines eligibility for coverage.

State: Arizona

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy

42 CFR 435.210
1902(a)
(10)(A)(ii)(I) and
1905(a) of the Act

☒ 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

☐ The plan covers all individuals as described above.

☒ The plan covers only the following group or groups of individuals:

X Aged
X Blind
X Disabled
X Caretaker relatives
X Pregnant women

42 CFR
435.211

☒ 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, i they were not in a medical institution.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L.

[ ] 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

___ The State elects not to guarantee eligibility.

_X_ The State elects to guarantee eligibility. The minimum enrollment period is ** months (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[X] The date beginning the initial period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

** The single period of guaranteed eligibility is five months plus the remaining days of the first month that the member is enrolled.

State: Arizona

Agency*	Citation(s)	Groups Covered
	B.	Optional Groups Other Than Medically Needy (continued)
1932(a)(4) of Act		The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56.
		This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.
		_X_ Disenrollment rights are restricted for a period of _12_ months (not to exceed 12 months).
		During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.
		___ No restrictions upon disenrollment rights.
1903(m)(2)(H), 1902(a)(52) of the Act P.L. 101-508 42 CFR 438.56(g)		In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with a
		MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.
		_X_ The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.
		___ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

State/Territory: Arizona

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.217 (Waiver)	4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

*Agency that determines eligibility for coverage.

State: Arizona

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(VII) of the Act

/_/ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

/_/ The State covers all individuals as described above.

/_/ The State covers only the following group or groups of individuals:

N/A

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
  ___ 21
  ___ 20
  ___ 19
  ___ 18
___ Caretaker relatives
___ Pregnant women

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.220 — /_/ 6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

N/A — /_/ The State covers all individuals as described above.

1902(a)(10)(A)(ii) and 1905(a) of the Act — /_/ The State covers only the following group or groups of individuals:

___ Individuals under the age of--
___ 21
___ 20
___ 19
___ 18
___ Caretaker relatives
___ Pregnant women

42 CFR 435.222
1902(a)(10)(A)(ii) and 1905(a)(i) of the Act

7. /X/ a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are ~~at years of~~ under the age ~~or younger as~~ indicated below:

___ 21
___ 20
___ 19
X 18

State: Arizona

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.222	/_/ b. Reasonable classifications of individuals described in (a) above, as follows:
		___ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:
		___ (a) In foster homes (and are under the age of _____).
	N/A	___ (b) In private institutions (and are under the age of _____).
		___ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of _____).
		___ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).
		___ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.
		___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____ _).

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

___ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of _____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

N/A

___ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

State: ARIZONA

Citation(s)	Groups Covered
1902(a)(10)(A)(ii)(VIII) of the Act	B. Optional Groups Other Than the Medically Needy (Continued)

X 8. A child for whom there is in effect a State adoption assistance agreement (other than under Title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement--

a. Was eligible for Medicaid under the State's approved Medicaid plan; or

b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of--

X 21
___ 20
___ 19
___ 18

In addition to a child identified in B 8, the State also covers a child who resides in Arizona and is receiving state adoption subsidy from a state other than Arizona provided:

The state is a member of the Interstate Compact on Adoption and Medical Assistance (ICAMA) as provided under 42 CFR 435.403 and

The state covers children under the Medicaid optional group listed under Section 1902(a)(10)(A)(ii)(VIII).

States that are not a member of ICAMA or do not cover children under 1902(a)(10)(A)(ii)(VIII) are listed in Attachment 2.6-A, Page 3.

Agency*	Citation (s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.223 /_/	9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:
1902(a)(10)(A)(ii) and 1905(a) of the Act	N/A	___ Individuals under the age of--
		___21
		___20
		___19
		___18
		___ Caretaker relatives
		___ Pregnant women

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230 /_/ 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

N/A

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
		___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	42 CFR 435.230	___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	N/A	___ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		___ (9) Individuals in additional classifications approved by the Secretary as follows:

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued) The supplement varies in income standard by political subdivisions according to cost-of-living differences.
	N/A	___ Yes. ___ No.
		The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.~~120~~ 230
435.121
1902(a)(10)(A)(ii)(XI) of the Act

/7 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

N/A

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
		___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
N/A		___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		___ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		___ (9) Individuals in additional classifications approved by the Secretary as follows:

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

N/A

___ Yes

___ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.231 /X/
1902(a)(10)(A)(ii)(V) of the Act
(Waiver)

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

/X/ The State covers all individuals as described above.

/ / The State covers only the following group or groups of individuals:

1902(a)(10)(A)(ii) and 1905(a) of the Act

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
  ___ 21
  ___ 20
  ___ 19
  ___ 18
___ Caretaker relatives
___ Pregnant women

Agency*	Citation(s)		Groups Covered
			B. Optional Groups Other Than the Medically Needy (Continued)
1902(e)(3) of the Act	/_/ N/A	13.	Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in an medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
1902(a)(10)(A)(ii)(IX) and 1902(l) of the Act	/X/	14.	The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A: a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and b. Infants under one year of age.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(D) of the Act. /X/

15. The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of ATTACHMENT 2.6-A for a family of the same size.

Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained--

/ / 7 years of age; or

/X/ 8 years of age.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	1902(a)(ii)(X) and 1902(m)(1) and (3) of the Act	16. Individuals--
		a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.
	N/A	b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
		c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(47) and 1920 of the Act	N/A 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.

State/Territory: Arizona

Citation	Groups Covered
B.	Optional Groups Other Than the Medically Needy (Continued)
1906 of the Act	18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of -0- months.
1902(a)(10)(F) and 1902(u)(1) of the Act	19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid extenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

State: ARIZONA

Citation	Groups Covered
1902(a)(10)(A)(ii)[redacted] of the Act (XVII)	20. Individuals age 18-20 who were under the jurisdiction of the Arizona Department of Economic Security/Division of Children, Youth and Families/Administration for Children, Youth and Families (DES/DCYF/ACYF) on the individual's 18th birthday. "Under the jurisdiction" means that the individual was adjudicated dependent by the Juvenile Court or was under a voluntary agreement. The fact that the individual was residing in a foster care setting on the individual's 18th birthday does not necessarily indicate that the individual was under the jurisdiction of the DES/DCYF/ACYF. Eligible individuals could have been Title IVE or non-IVE eligible. Medicaid coverage for these individuals may be applied for at any time prior to age 21. No resource or income test is required.

"YATI"

STATE: Arizona

Citation	Groups Covered
	B. Optional Groups Other than Medically Needy (continued)
1902 (a) (10) (A)(ii) (XVIII) of the Act	_X_ 21. Women who: a. Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer; b. Are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act; c. Are not eligible for Medicaid under any mandatory categorically needy eligibility group; and d. Have not attained age 65.
	___ 22. Women who are determined by a "qualified entity" (as defined in 1920(b)) based on preliminary information, to be a woman described in 1902(aa) the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

Citation			Groups Covered
B.	Optional Groups Other Than the Medically Needy (Continued)		
1902(a)(10)(A) (ii)(XIII) of the Act	[ ]	23.	BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A
1902(a)(10)(A) (ii)(XV) of the Act	[X]	24.	TWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XVI) of the Act	[X]	25.	TWWIIA Medical Improvement Group - Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A. NOTE: If the State elects to cover this group, it MUST also cover the Basic Coverage Group described in no. 24 above.

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 435.301 — This plan includes the medically needy.

☒ No.

☐ Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)(C)(ii)(I) of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

Agency*	Citation(s)	Groups Covered
		C. Optional Coverage of Medically Needy (Continued)
	1902(e)(4) of the Act	4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.
	42 CFR 435.308	5. /_/ a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--
N/A		___ 21 ___ 20 ___ 19 ___ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training
		/_/ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:
N/A		___ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:
		___ (a) In foster homes (and are under the age of _____).
		___ (b) In private institutions (and are under the age of _____).

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

___ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___ ___).

N/A ___ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

___ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

___ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

___ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

State: Arizona

Agency*	Citation(s)	Groups Covered
		C. Optional Coverage of Medically Needy (Continued)
	42 CFR 435.310	/_/ 6. Caretaker relatives.
	42 CFR 435.320 and 435.330	/_/ 7. Aged individuals.
	42 CFR 435.322 and 435.330	/_/ 8. Blind individuals.
	42 CFR 435.324 and 435.330	/_/ 9. Disabled individuals.
	42 CFR 435.326	/_/ 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
	435.340	N/A 11. Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

Citation(s)	Groups Covered
	C. Optional Coverage of Medically Needy (Continued)
1906 of the Act	12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered
1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER
THE AGE OF 21, 20, 19, AND 18

(Not Applicable)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

(Not Applicable)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

Citation	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.402	3. Is residing in the United States and--
	a. Is a citizen;
Sec. 245A of the Immigration and Nationality Act	b. Is an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, as defined in 42 CFR 435.408;
1902(a) and 1903(v) of the Act and 245A(h)(3)(B) of the Immigration & Nationality Act	c. Is an alien granted lawful temporary resident status under section 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of P.L. 96-422;

Citation	Condition or Requirement
	d. Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of c. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted such status); or
	e. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services).
42 CFR 435.403 1902(b) of the Act	4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.
	_X_ For a child receiving state adoption subsidy from another state (Attachment 2.2A, B8), Arizona has an interstate residency agreement through the Interstate Compact on Adoption and Medical Assistance (ICAMA) with all the states except: Connecticut, Florida, Illinois, Michigan, New Mexico, New York, Pennsylvania, Tennessee, Vermont, and Wyoming.
	___ State has open agreement(s).
	___ Not applicable; no residency requirement.

State/Territory: Arizona

Citation	Condition or Requirement
42 CFR 435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded ~~intermediate care facilities~~, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. ☒ * Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 433.145 1912 of the Act	6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court of administrative order.)

* Except as provided to EPSDT children under the age of 21 years as specified in Attachment 3.1-A. LMR.

State Arizona

Citation(s)		Condition or Requirement
		An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in 1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.
		An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.
		/X/ Assignment of rights is automatic because of State law.
42 CFR 435.910	7.	Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number). Exception, aliens seeking medical assistance for the treatment of an emergency medical condition under Section 1903(v)(2) of the Social Security Act (Section 1137(f)).

State: ARIZONA

Citation	Condition or Requirement
1902(c)(2) of the Act	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirments under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

State/Territory: Arizona

Citation	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

delete

STATE: ARIZONA

Citation		Condition or Requirement
	B.	Posteligibility Treatment of Institutionalized Individuals' Incomes
	1.	The following items are not considered in the posteligibility process:
1902(o) of the Act	a.	SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v Sullivan (SSI)	b.	Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c.	German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P.L. 100-383	d.	Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e.	Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f.	Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g.	Radiation Exposure Compensation.
12005 of P.L. 103-66	h.	VA pensions limited to $90 per month under 38 U.S.C. 5503.

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA): a. 15% of the Federal Benefit Rate For the following persons with greater need: Supplement 12a to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b AFDC related: Children: 15% of the Federal Benefit Rate Adults: 15% of the Federal Benefit Rate For the following persons with greater need: Supplement 12a to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2 –A: 15% of the Federal Benefit Rate

* In Arizona, all applicants are treated as individuals. If two individuals are married, each would receive a Personal Needs Allowance of15% of the Federal Benefit Rate .

State: ARIZONA

Citation		Condition or Requirement
		For the following persons with greater need:
		Supplement 12a to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.
1924 of the Act	3.	In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:
		a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.
		__X__ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.
		_____ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to
		____%, of the official poverty level (still subject to maximum maintenance needs standard).
		_____ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).
		Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

Citation | Condition or Requirement

In determining any excess shelter allowance, utility expenses are calculated using:

__X__ the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or

_____ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

__X__ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income.

_____a greater amount calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A).

State: ARIZONA

Citation	Condition or Requirement
435.725 435.733 435.832	4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple. a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the: • AFDC level; or • Medically needy level: as selected below: (Check one) __X__ AFDC levels in Supplement 1 * ____ Medically needy level in Supplement 1 ____ Other: $_____ b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party: (I) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)
435.725 435.733 435.832	5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple: A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period: _____ No. __X__ Yes (the applicable amount is shown on page 5a.)

* The AFDC Need Standard corresponding to the family size.

State: ARIZONA

Citation	Condition or Requirement
	X Amount for maintenance of home is: $ 210.00.
	____ Amount for maintenance of home is the actual maintenance costs not to exceed $_____.
	____ Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
	____ Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	C. Financial Eligibility For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below. For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply. Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level—pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.

State: ARIZONA

Citation	Condition or Requirement
___	Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
___	Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
___	Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
___	Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
X	Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
X	Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
___	Supplement 14 to Attachment 2.6-A specifies income levels used by States for determining eligibility Tuberculosis-infected individuals whose eligibility is determined under §1902(z)(1)of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children). (1) In determining countable income for AFDC-related individuals, the following methods are used: ___ (a) The methods under the State's approved AFDC plan only; or X (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. (2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) the Act	(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ELIGIBILTY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: ☐ The methods of the SSI program only. ☒ The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. See Supplement 14 to ATTACHMENT 2.6-A

Citation	Condition or Requirement
N/A	☐ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ☐ For institutional couples, the methods specified under section 1611(e)(5) of the Act. ☐ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. ☐ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-- ___ SSI methods only. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

State: Arizona

Citation	Condition or Requirement
42CFR 435.721 and 435.831 1902(m)(1)(B),(m)(4), and 1902(r)(2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: ___ The methods of the SSI program only. __X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. See Supplement 14 to ATTACHMENT 2.6-A. ___ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under section 1611(e)(5) of the Act. ___ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. ___ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements – ____ SSI methods only. ____ SSI methods and/or any more liberal methods then SSI described in Supplement 8a to ATTACHMENT 2.6-A. ____ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A

State: Arizona

Citation	Condition or Requirement
	In determining relative responsibility, the agency considers only the income of spouse living in the same household as available to spouses and the income of parents as available to children living with parents until the a child reaches the age of 21.
42 CFR 435.721, and 435.831, 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d. Disabled individuals. In determining countable income of disabled individuals, including individuals with income up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:
	___ The methods of the SSI program only.
	X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. (see Supplement 14 to ATTACHMENT 2.6-A)
	___ For institutional couples: the methods specified under section 1611(e)(5) of the Act.
	___ For optional State supplement recipients under § 435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.
	___ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provision of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

State: Arizona

Citation	Condition or Requirement
	___ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements –
	___ SSI methods only.
	___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
	___ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until a child reaches the age of 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3)(E) and 1902(r)(2) of the Act	e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act--
	(1) The following methods are used in determining countable income:
	X The methods of the State's approved AFDC plan.
	X The methods of the approved title IV-E plan.
	N/A The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	N/A The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) of the Act	(3) The agency continues to treat women eligible under the provisions of section 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: ___ The methods of the SSI program only. X SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

Citation	Condition or Requirement
	If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g. (1) <u>Qualified disabled and working individuals</u>. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act	(2) <u>Specified low-income Medicare beneficiaries</u>. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

* U.S. G.P.O.:1993-342-239:80032

Citation	Condition or Requirement
1902(u) of the Act	(h) COBRA Continuation Beneficiaries In determining countable income for COBRA continuation beneficiaries, the following disregards are applied: _____ The disregards of the SSI program; _____ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

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Citation		Condition or Requirement
1902(a)(10)(A) (ii)(XIII) of the Act	(i)	Working Individuals with Disabilities - BBA
		In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied:
	____	The methodologies of the SSI program.
	____	The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A.
	____	The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

Citation		Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act	(ii)	Working Individuals with Disabilities - Basic Coverage Group - TWWIIA In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied: ____ The agency does not apply any income or resource standard. NOTE: If the above option is chosen, no further eligibility-related options should be elected. _X_ The agency applies the following income and/or resource standard(s): Income limit is at or below 250% of FPL and there is no resource limit.

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	Income Methodologies In determining whether an individual meets the income standard described above, the agency uses the following methodologies. ___ The income methodologies of the SSI program. ___ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. _X_ The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	Resource Methodologies

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.

Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.

____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.

____ The agency disregards funds in retirement accounts in a manner other than those decribed above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

Citation	Condition or Requirement
1902(a)(10)(A) ____ (ii)(XV) of the Act (cont.)	
	____ The agency does not disregard funds in retirement accounts.
	____ The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.
	____ The agency uses the resource methodologies of the SSI program. The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.
	X No resource test is imposed.

State/Territory: Arizona

Citation		Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act	(iii)	Working Individuals with Disabilities - Employed Medically Improved Individuals - TWWIIA In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied: ____ The agency does not apply any income or resource standard. NOTE: If the above option is chosen, no further eligibility-related options should be elected. _X_ The agency applies the following income and/or resource standard(s): Income limit is at or below 250% of FPL and there is no resource limit.

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	Income Methodologies In determining whether an individual meets the income standard described above, the agency uses the following methodologies. ____ The income methodologies of the SSI program. ____ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. X The agency uses more liberal income methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A.

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	Resource Methodologies

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.

Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.

____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.

____ The agency disregards funds in retirement accounts in a manner other than those listed above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

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Citation	Condition or Requirement
1902(a)(10)(A) ____ (ii)(XVI) of the Act (cont.)	
	____ The agency does not disregard funds in retirement accounts.
	____ The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.
	____ The agency uses the resource methodologies of the SSI program.
	____ The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.
	X No resource test is imposed.

State/Territory: Arizona

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XVI) and 1905(v)(2) of the Act	Definition of Employed - Employed Medically Improved Individuals - TWWIIA

___ The agency uses the statutory definition of "employed", i.e., earning at least the minimum wage, and working at least 40 hours per month.

_X_ The agency uses an alternative definition of "employed" that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency's threshold criteria are described below:

1. Earns at least the minimum wage and works at least 40 hours per month, or
2. Has gross monthly earnings at least equal to those earned by an individual who is earning the minimum wage and working 40 hours per month.

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Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act	Payment of Premiums or Other Cost Sharing Charges For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A: ____ The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other costsharing charges, and how they are applied, are described below:

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act (cont.)	For individuals eligible under the Basic Coverage Group described in No. 24 on page 23d of Attachment 2.2-A, and the Medical Improvement Group described in No. 25 on page 23d of Attachment 2.2-A: NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds $75,000 pay 100 percent of premiums. X The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income. The premiums or other cost-sharing charges, and how they are applied, are described on page 12o.

Citation	Condition or Requirement
Sections 1902(a)(10)(A)(ii)(XV), (XVI), and 1916(g) of the Act (cont.)	<u>Premiums and Other Cost-Sharing Charges</u> For the Basic Coverage Group and the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described below. 1. For a member living in a community setting and with countable income: a. Under $500, the monthly premium payment shall be $0. b. Over $500 but not greater than $750, the monthly premium payment shall be $10. 2. The premium for a member living in a community setting shall be increased by $5 for each $250 increase in countable income above $750. 3. For a member living in an institution, the monthly premium payment shall be $0.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

Citation	Condition or Requirement

2. Medicaid Qualifying Trusts Established on or before August 10, 1993

   a. A "Medicaid qualifying trust" is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual (trustor) may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual. This provision shall apply without regard to whether or not the Medicaid qualifying trust is irrevocable or is established for purposes other than to enable a trustor to qualify for medical assistance under the State Plan or 1115 Waiver and whether or not the trustee's discretion is actually exercised.

   b. For the purposes of Title XIX eligibility, the amounts from a Medicaid qualifying trust deemed available to the trustor is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the trustor, assuming that the trustee has full exercise of discretion for the distribution of the maximum amount to the trustor.

   c. This provision does not apply to any trust established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

Citation	Condition or Requirement
	X The Agency does not count the funds in a trust as described above in any instance where the State determines that an undue hardship exists. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
	2A. Trusts established on or after August 11, 1993, other than by will. In determining eligibility for, or the amount of benefits, trusts shall be treated in accordance with Section 1917(d) of the Social Security Act. The term "trust" includes any legal instrument or device that is similar to a trust; an annuity shall be included to the extent that the Secretary of HHS specifies. X The agency does not count the funds in a trust as described above in any instance where the State determines that an undue hardship exists. Supplement 10 of Attachment 2.6-A specifies what constitutes an undue hardship.
1902(a)(10) of the Act	3. Medically needy income levels (MNILs) are based on family size.
(Not Applicable)	Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

State: Arizona

Citation	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only
	a. Medically Needy
	(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either ____ or ___ month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.
N/A	(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:
	(a) Health insurance premiums, deductibles and coinsurance charges.
	(b) Expenses for necessary medical and remedial care not included in the plan.
	(c) Expenses for necessary medical and remedial care included in the plan.
	___ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.
1902(a)(17) of the Act	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
	a. Medically Needy (Continued)
1903(f)(2) of the Act	___ (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

State/Territory ARIZONA

Citation	Condition or Requirement
	Medically Needy (continued)
1902(a)(17) 435.831(g)(2) 436.831(g)(2)	States are permitted to exclude from incurred medical expenses those bills for services furnished more than three months before a Medicaid Application.
NOT APPLICABLE	____ Yes, the State elects to exclude such expenses. ____ No, the State does not elect to exclude such expenses.

Citation		Condition or Requirement
		b. Categorically Needy - Section 1902 (f) States
42 CFR 435.732	N/A	The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203		Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
	4.b. Categorically Needy - Section 1902(f) States Continued
1903(f)(2) of the Act	___ (6) Spenddown payments made to the State by the individual. NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

Citation	Condition or Requirement
	5. Methods for Determining Resources
	a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).
	(1) In determining countable resources for AFDC-related individuals, the following methods are used:
	(a) The methods under the State's approved AFDC plan; and
N/A	/_/ (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
	(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Arizona

Citation	Condition or Requirement
	5. Methods for Determining Resources
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act	b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:
	___ The methods of the SSI program.
	X SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.
	___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

State: Arizona

Citation	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902 (r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. _X_ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with their parents until a child reaches the age of 21.

State: Arizona

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902 (r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: ___ The methods of the SSI program only. _X_ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until a child reaches the age of 21.
1902(l)(3) and 1902(r)(2) of the Act	e. Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act. The agency uses the following methods in the treatment of resources. ___ The methods of the SSI program only. ___ The methods of the SSI programs and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

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Citation	Condition or Requirement
	N/A Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	X Not applicable. The agency does not consider resources in determining eligibility.
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	f. Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.
	The agency uses the following methods for the treatment of resources:
	N/A The methods of the State's approved AFDC plan.
1902(l)(3)(C) of the Act	N/A Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(r)(2) of the Act	N/A Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	X Not applicable. The agency does not consider resources in determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g. 1. Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act.
	The agency uses the following methods for the treatment of resources:
	N/A The methods of the State's approved AFDC plan.
1902(l)(3)(C) of the Act	N/A Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(r)(2) of the Act	N/A Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A.
	X Not applicable. The agency does not consider resources in determining eligibility.
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	g. 2. Poverty level children under section 1902(a)(10)(A)(i)(VII) The agency uses the following methods for the treatment of resources: N/A The methods of the State's approved AFDC plan.
1902(1)(3)(C) the Act	N/A Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(r)(2) of the Act	N/A Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A. X Not applicable. The agency does not consider resources in determining eligibility. In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State/Territory: Arizona

Citation	Condition or Requirement
1905(p)(1)(C) and (D) and 1902(r)(2) of the Act	5. h. For Qualified Medicare beneficiaries and SLMBs, QI-Is and QI-IIs, covered under section 1902(a)(10)(E)(i), (iii) and (iv) of the Act the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. _X_ The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. ___ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to ATTACHMENT 2.6-A.

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Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act-- The agency uses the same method as in 5.h. of Attachment 2.6-A.
	6. Resource Standard - Categorically Needy
N/A	a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals: ___ Same as SSI resource standards. ___ More restrictive. The resource standards for other individuals are the same as those in the related cash assistance program.
	b. Non-1902(f) States (except as specified under items 6.c. and d. below) The resource standards are the same as those in the related cash assistance program. Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard. N/A Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan. X No. The agency does not apply a resource standard to these individuals.
1902(1)(3)(A) and (C) of the Act	d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard. N/A Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan. X No. The agency does not apply a resource standard to these individuals.

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is:
	___ Same as SSI resource standards.
N/A	___ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).
	Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

State: Arizona

Citation		Condition or Requirement
		7. Resource Standard - Medically Needy
		a. Resource standards are based on family size.
1902(a)(10)(C)(i) of the Act		b. A single standard is employed in determining resource eligibility for all groups.
	N/A ___	c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for-- ___ Aged ___ Blind ___ Disabled Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 so indicates.
1905(p)(1)(D) and (p)(2)(B) of the Act		8. Resource Standard - Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act and specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, the resource standard is twice the SSI standard.
1905(s) of the Act		9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

Citation		Condition or Requirement
1902(u) of the Act	9.1	For COBRA continuation beneficiaries, the resource standard is:
	__	Twice the SSI resource standard for an individual.
Not Applicable	__	More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

Citation	Condition or Requirement
1902(u) of the Act	10. Excess Resources a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries Any excess resources make the individual ineligible. b. Categorically Needy Only _X_ This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources. c. Medically Needy (N/A) Any excess resources make the individual ineligible.

State: Arizona

Citation	Condition or Requirement
42 CFR 435.914	11. Effective Date of Eligibility
	a. Groups Other Than Qualified Medicare Beneficiaries
	(1) For the prospective period.
	Coverage is available for the full month if the following individuals are eligible at any time during the month. _X_ Aged, blind, disabled. _X_ AFDC-related.
	Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements. __ Aged, blind, disabled. __ AFDC-related.
	(2) For the retroactive period
(WAIVER)	Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied. __ Aged, blind, disabled. __ AFDC-related.
	Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied. __ Aged, blind, disabled. __ AFDC-related.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1920(b)(1) of the Act	N/A (3) For a presumptive eligibility for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.
1902(e)(8) and 1905(a) of the Act	X b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for-- X 12 months ___ 6 months ___ ___ months (no less than 6 months and no more than 12 months)

State: ARIZONA

Citation	Condition or Requirement
1902 (a) (18) and 1902 (f) of the Act	12. Pre-OBRA 93 Transfer or Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working individuals The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources. Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.
1917(c)	13. Transfer of Assets - All eligibility groups The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets. Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.
1917(d)	14. Treatment of Trusts - All eligibility groups The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA, with regard to trusts. ____ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts; _X_ The agency meets the requirements in section 1917(d)(~~2~~)(4)(B) of the Act for use of Miller trusts. The agency does not count the funds in a trust in any instance where the agency determines that ~~the transfer~~ application of the trust rules would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
1924 of the Act	15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: _____ the maximum standard permitted by law; __X__ the minimum standard permitted by law; or * $_____ a standard that is an amount between the minimum and the maximum.

* One-half of the combined resources of the institutionalized spouse and the community spouse, not to exceed the maximum standard permitted by law.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

Family Size	Need Standard	Payment Standard	Maximum Payment Amounts

The income level is 100% FPL based on household size. Please see Supplement 12 to Attachment 2.6-A, pages 2 & 3 for the income methodology.

2. Pregnant Women and Infants under Section 1902(a)(10)(A)(i)(IV) of the Act: based on the following percent of the official Federal income poverty level--

X 133 percent

State Plan under Title XIX of the Social Security Act
STATE: Arizona

Income Maximum; Need and Payment Standards

A-1 STANDARD

Number of Persons	185% AFDC Income Maximum	Need Standard	Payment Standard
1	$1048	$ 567	$ 204
2	1415	765	275
3	1783	964	347
4	2149	1162	418
5	2516	1360	489
6	2884	1559	561
7	3250	1757	632
8	3616	1955	703
9	3983	2153	775
10	4349	2351	846
11	4715	2549	917
12	5081	2747	988
13	5448	2945	1060
14	5814	3143	1131
		Extra + 198	

A-2 STANDARD

Number of Persons	185% AFDC Income Maximum	Need Standard	Payment Standard
1	$ 660	$ 357	$128
2	889	481	173
3	1122	607	218
4	1354	732	263
5	1583	856	308
6	1816	982	353
7	2046	1106	398
8	2277	1231	443
9	2508	1356	488
10	2739	1481	533
11	2971	1606	578
12	3202	1731	623
13	3433	1856	668
14	3664	1981	713
		Extra +125	

These Payment Standards are based on 36% of the 1992 federal poverty level adjusted for family size and a shelter cost factor.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

3. Supplemental Security Income:

Individual Federal Benefit Rate

Couple Federal Benefit Rate

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(1)(A)(ii)(IX) and 1902(l)(2) of the Act are based on the following percent of the Federal poverty levels:

140 percent for pregnant women

AND

140 percent for infants under one year of age

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. Children Between Ages 6 and 8

The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained 6 years of age but are under 8 years of age under the provisions of section 1902(l)(2) of the Act are as follows:

Based on 100 percent (no more than 100 percent) of the official Federal income poverty line. *

Family Size	Income Level
1	$
2	$
3	$
4	$
5	$
6	$
7	$
8	$
9	$
10	$

* As revised annually in the Federal Register for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

Not Applicable

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m) ~~(4)~~ (1) of the Act are as follows:

Based on _____ percent of the official Federal income poverty line.

Family Size	Income Level
1	$_____
2	$_____
3	$_____
4	$_____
5	$_____

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

Pages 6 & 7

were superceded

See old State Plan

book (OPAC)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

(Not Applicable)

_____ Applicable to all groups.

_____ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____months	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1/]	Net income level for persons living in rural areas for _____months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1/]
/_/ urban only				
/_/ urban & rural				
1	$	$	$	$
2	$	$	$	$
3	$	$	$	$
4	$	$	$	$
For each additional person, add:	$	$	$	$

[1/] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY (Not Applicable)

(1) Family Size	(2) Net income level protected for maintenance for _____ months /_/ urban only /_/ urban & rural	(3) Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1/]	(4) Net income level for persons living in rural areas for _____ months	(5) Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1/]
5	$	$	$	$
6	$	$	$	$
7	$	$	$	$
8	$	$	$	$
9	$	$	$	$
10	$	$	$	$
For each additional person, add:	$	$	$	$

[1/] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

/_/ Same as SSI resources levels.

/_/ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	
2	

b. Optional Groups

/_/ Same as SSI resources levels.

/_/ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	
2	

NO RESOURCE LIMITS APPLY; N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

N/A

2. Infants

a. Mandatory Group of Infants

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

b. Optional Group of Infants

N/A

/_/ Same as resource levels in the State's approved AFDC plan.

/_/ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

3. Children

a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

___ Same as resource levels in the State's approved AFDC plan.

___ Less restrictive than the AFDC levels and are as follows:

N/A

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

NO RESOURCE LIMITS APPLY

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

b. Mandatory Group of Children under Section 1902(a)(10)(i)(VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

___ Same as resource levels in the State's approved AFDC plan.

___ Less restrictive than the AFDC levels and are as follows:

N/A

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

NO RESOURCE LIMITS APPLY

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

4. Aged and Disabled Individuals

N/A

/_/ Same as SSI resource levels.

/_/ More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	

/_/ Same as medically needy resource levels (applicable only if State has a medically needy program).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

RESOURCE LEVELS (Continued) N/A

B. MEDICALLY NEEDY

Applicable to all groups -

[/] Except those specified below under the provisions of section 1902(f) of the Act.

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

For each additional person _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

To be considered as a deduction from the share of cost income, the expense must be for a type of care which is recognized under State law but not covered under the Title XIX State Plan.

The expense must be for a medically necessary service or remedial care service prescribed by a physician and incurred solely by the applicant or recipient. The applicant or recipient must have a legal obligation to pay the medical or remedial expense and there must be no liable third party. Such services and care do not include covered services and care which were not authorized by the applicant's or recipient's AHCCCS health plan or ALTCS program contractor.

The expense is allowed only when one of the following conditions are met:

1. The expense represents a current payment, by the individual, of an allowed non-covered medical or remedial expense, and the expense has not previously been allowed as a share of cost deduction. A current payment is a payment made and reported to AHCCCS during the application period or a payment reported to AHCCCS no later than the end of the month following the month in which the payment occurred.

2. The expense represents the unpaid balance of an allowed non-covered medical or remedial expense and the expense has not previously been allowed as a share of cost deduction.

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

(Not Applicable)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

(NOT APPLICABLE)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

(Not Applicable)

Revision: HCFA-AT-85-1
FEBRUARY 1985

SUPPLEMENT 6 TO
Attachment 2.6-A

State ARIZONA

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by		Income Level				Income Disregards Employed
			Gross		Net		
	Federal	State	1 person	Couple	1 person	Couple	
(1)	(2)		(3)		(4)		(5)
1. Private Nursing Home	State		SAME	AS FOR	CURRENT	SSI ELIG	BILITY
2. County Nursing Home	"		"	"	"	"	"
3. Housekeeping Svcs.	"		"	"	"	"	"
4. Licensed Supervisory Care Home	"		"	"	"	"	"
5. Visiting Nurse Svc.	"		"	"	"	"	"
6. Home Health Aide.	"		"	"	"	"	"
7. Adult Foster Care.	"		"	"	"	"	"

TN # 85-5
Supersedes
TN # 82-1

Approval Date AUG 30 1985

Effective Date APR 1 1985

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

(Not Applicable)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

(Not Applicable)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT*

__ Section 1902(f) State _X_ Non-Section 1902(f)State

I. The following income method applies to individuals covered in Section 1905(p) of the Act (QMB, SLMB, and QI-1) and in Section 1902(a)(10)(A)(ii)(I) of the Act (SSI Non Cash).

The State shall follow SSI computation rules with following exceptions:

- For an applicant or recipient living with a spouse, the computation rules for an eligible couple shall be followed, even when the spouse is not eligible for or applying for SSI or Medicaid benefits.

- For a couple living with a child** (or children), a deduction from the combined net income of the couple shall be allowed as an allocation for each child using the methodology described in 20 CFR 416.1163(b)(1) and (2) regardless of whether the child is ineligible or eligible. The child's allocation is reduced by that child's income [20CFR 416.1161(c)], including public income-maintenance payments.

- For an applicant/recipient not living with a spouse but living with his or her child** (or children), a deduction from the individual's net income shall be allowed as an allocation for each child using the methodology described in 20 CFR 416.1163(b)(1) and (2), regardless of whether the child is ineligible or eligible. The child's allocation is reduced by that child's income [20 CFR 416.1161(c)], including public income-maintenance payments.

- For an applicant/recipient who is a child, the deemed income from an ineligible parent shall allow an allocation for both eligible and ineligible children of the parent(s) using the methodology described in 20 CFR 416.1165(b). The child's allocation is reduced by that child's income [20 CFR 416.1161(c)], including public income-maintenance payments.

- Interest and dividend income from resources excluded under Section 1613(a) of the Social Security Act shall be disregarded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

II. Except for ALTCS eligibility, including individuals approved for ALTCS acute care services under 1902(a)(10)(A)(ii)(I) of the Act, the following income method applies to aged, blind or disabled individuals covered under 1902(a)(10)(A)(ii)(I) of the Act.

The State shall disregard the amount equal to the difference between 100% of the Federal poverty guidelines (as revised annually in the Federal Register) for an individual or a couple and the corresponding Federal Benefit Rate. (The disregard shall be applied by using 100% of the FPL for an individual or a couple as the income standard.)

When applying this disregard, if the individual or the individual's spouse has earned income, the $20 and $65 disregards shall apply according to SSI methodology, but not one-half of the remainder. If ineligible because the one-half of the remainder disregard is not allowed, eligibility shall also be determined using the FBR as the income standard for the individual or couple, allowing the $20, $65, and one-half of the remainder disregard according to SSI methodology.

In determining the income of an individual who is receiving Title II (Social Security) income, the State shall disregard the amount attributable to the cost of living increase in the level of monthly income payable pursuant to section 215(i) of the Act, from January until the State implements the Federal Poverty Guideline for the current year.

III. The following income method applies to TWWIIA individuals covered in Sections #24 and #25 on ATTACHMENT 2.2-A, page 23d under 1902(a)(10)(A)(ii)(XV) and (XVI) of the Act. The State shall follow SSI computation rules with the following exceptions:

- The State shall disregard the unearned income of the applicant/recipient.
- The State shall disregard the earned and unearned income of the spouse and/or any other family members including a deduction for a minor child.

IV. The following income method applies to pregnant individuals covered under 1902(a)(10)(A)(i)(IV) of the Act:

- The State shall disregard the amount equal to the difference between 140% and 150% of the Federal Poverty Level. (The disregard shall be applied by using 150% of the FPL as the income standard.)

* More liberal methods may not result in exceeding income limitations under section 1903(f)
** A child is a person, as defined in 20 CFR 416.1856, who is a natural child or adopted child of the applicant/recipient or his or her spouse

V. All wages paid by the Census Bureau for Temporary employment related to Census activities are excluded for the eligibility groups listed below:

- 1902(a)(10)(A)(i)(III) - Qualified children and pregnant women
- 1902(a)(10)(A)(i)(IV) – Poverty level pregnant women and children (133 – 185% FPL).
- 1902(a)(10)(A)(i)(VI) – Poverty level children under age 6 (133% FPL).
- 1902(a)(10)(A)(i)(VII) – Poverty level children under age 19 (100% FPL).
- 1905(p) – QMBs.
- 1902(a)(10)(E)(iii) – SLMBs.
- 1902(a)(10)(E)(iv)(I) – QIs.

MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902 (r)(2) OF THE ACT*

__ Section 1902(f) State X__ Non-Section 1902(f) State

1. The following resource methodology applies to individuals covered in Section 1905(p) (QMB, SLMB, and QI-1) and, except for ALTCS eligibility, including individuals approved for ALTCS acute care services under 1902(a)(10)(A)(ii)(I) of the Act, aged, blind or disabled individuals covered in Section 1902(a)(10)(A)(ii)(I) of the Act:

   All resources shall be excluded.

2. The following resource methodology applies to individuals covered in Section 1902(a)(1 0)(A)(ii)(V):

a. Rather than the disregards described at section 1613(d) of the Social Security Act, the following disregards are used:

- Term insurance;
- Burial insurance;
- Assets that an individual has irrevocably assigned to fund the expenses of a burial;
- The value of all life insurance when the face value does not exceed $1,500 (total per insured individual) and the policy has not been assigned to fund a pre-need burial plan or declaratively designated as a burial fund;
- Burial plot items as defined in 1613(a)(2)(B) of the Social Security Act;
- At the time of the eligibility determination, $1,500 of the equity value of an asset declaratively designated as a burial fund or a revocable burial arrangement when there is no irrevocable burial arrangement, and
- If an individual remains continuously eligible, all appreciation in value of his assets will also be disregarded.

b. Disregard up to $4,500 of the equity value of one automobile that is not excluded under 1613(a)(2)(A) in the resource eligibility determination.

c. Disregard the value of oil, mineral and timber rights in the resource eligibility determination.

3. The following resource methodology applies to individuals covered in Section 1902(a)(10)(A)(ii)(IV) and (V).

   Rather than performing resource determinations as of the first moment of the month, resource determinations may be made at any time during the month. If the individual's resources are within the resource limit at any time during the month, the individual will be eligible for the entire calendar month.

4. The following resource methodology applies to individuals covered in Section 1902(a)(10)(A)(ii)(IV) and (V).

   Disregard the value of payments refunded by a nursing facility as required by Section 1919(c)(5) of the Social Security Act for a period of six months beginning the month the refund is received. However, transfer penalties will apply if a refund is transferred without receipt of adequate compensation.

5. The following resource methodology applies to individuals covered in Section 1902(a)(10)(ii)(IV) and (V):

   Disregard the value of payments refunded by a provider of home and community based services for a period of six months beginning the month the refund is received. However, transfer penalties will apply if a refund is transferred without receipt of adequate compensation.

6. Except for ALTCS eligibility, including individuals approved for ALTCS acute care services under 1902(a)(10)(A)(ii)(I) of the Act, the following resource methodology applies to individuals described in 1902(a)(i) and (ii) who are covered under 1902(a)(10)(A)(ii)(1) i.e. Ribicoff children, 18 year old students and caretaker relatives.

   All resources shall be excluded.

7. The following resource methodology applies to TWWIIA individuals covered in Sections #23 and #25 on ATTACHMENT 2.2-A, Page 23d under 1902(a)(10)(A)(ii)(XV) and (XVI) of the Act:

   All resources shall be excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2) 1917(b)(1)(C) The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

- Individuals covered in Section 1902(a)(10)(A)(ii)(IV) and (V).

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

X The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State's Insurance Department.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.

- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

- The policy was issued no earlier than the effective date of this State plan amendment.

- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.

- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.

- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.

- The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

TRANSFER OF RESOURCES

1902(f) and 1917 of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

a. /_7 The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds $12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

b. ___ The period of ineligibility is less than 24 months, as specified below:

c. X The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

2. Transfer of the home of an individual who is an inpatient in a medical institution.

/_/ A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

b. /_/ Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

No individual is ineligible by reason of item A.2 if—

i. A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;

ii. Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;

iii. A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or

iv. The agency determines that denial of eligibility would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

3. 1902(f) States

/_/ Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is $12,000 or less:

2. If the uncompensated value of the transfer is more than $12,000:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ARIZONA

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

See Addendum to Supplement 9 to Attachment 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ARIZONA

TRANSFER OF RESOURCES (PRIOR TO AUGUST 11, 1993)

Section 1917 (c) of the Act

(1) The agency provides for a period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under Section 1915(c) of the Act in the case of an institutionalized individual (as defined in item (4), on page 3 of this Addendum to Supplement 9 to Attachment 2.6-A) who, or whose spouse, transfers resources (as defined in item (5), on page 3 of this Addendum to Supplement 9 to Attachment 2.6-A) for less than fair market value at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual or, if later, the date the institutionalized individual applies for medical assistance.

Except as provided in item (2) on page 2 of this Addendum to Supplement 9 to Attachment 2.6-A, the period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of:

A) 30 months; or

B) the total uncompensated value of the resources so transferred, divided by (check one of the following):

_____ $_____, which is the average cost, to a private patient at the time of application, of nursing facility services in the State; or

__X__ the average cost, to a private patient at the time of application, of nursing facility services in the community in which the individual is institutionalized. The average monthly costs for nursing facility services in the various communities in the State are listed below:

Developmentally Disabled	$ 2,475.90	(entire state)
Non-Developmentally Disabled	$ 2,406.30	(Maricopa County)
	$ 2,406.30	(Pima County)
	$ 2,406.30	(Pinal County)
	$ 2,321.10	(balance of State)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

(2) An individual shall not be ineligible for medical assistance by reason of a transfer (as provided on page 1 of this Addendum to Supplement 9 to Attachment 2.6-A) to the extent that-

(A) the resources transferred were a home and title to the home was transferred to-

(i) the spouse of such individual;

(ii) a child of such individual who is under age 21 or is blind or disabled as defined in Section 1614 of the Act;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in item (2)(A)(ii) above) who was residing in such individual's home for a period of at least 2 years immediately before the date the individual becomes an institutionalized individual, and who (as determined by State instructions) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the resources were transferred-

(i) to or from (or to another for the sole benefit of) the individual's spouse, or

(ii) to the individual's child described in item (2)(A)(ii), above;

(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that-

(i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration; or

(ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

(3) An institutionalized individual who (or beginning December 20, 1989 whose spouse) transferred resources for less than fair market value shall not be found ineligible for nursing facility services, for a level of care in a medical institution equivalent to that of nursing facility services, or for home and community-based services where the State determines that denial of eligibility would work an undue hardship under the provision of Section 1917(c)(2)(D) of the Social Security Act.

(4) For purposes of Section 1917(c) of the Act, the term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in Section 1902(a)(10)(A)(ii)(VI) of the Act.

(5) For purposes of Section 1917(c) of the Act, the term "resources" has the meaning given such term in Section 1613 of the Act, without regard to the exclusion described in subsection (a)(1) thereof.

(6) For transfers occurring prior to April 1, 1990, but on or after July 1, 1988 only when the initial application for long-term care is made prior to April 1, 1990, the policies described in Supplement 9 to Attachment 2.6-A which were effective prior to April 1, 1990 remain in effect.

(7) For those transfers occuring on or after July 1, 1988, when the initial application for long-term care is made on or after April 1, 1990, the policies described in the ~~July 1, 1991~~ addendum to Supplement 9 of Attachment 2.6-A apply.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

TRANSFERS OF ASSETS (ON OR AFTER AUGUST 11, 1993)

Section 1917(c) of the Act

For transfers of assets on or after August 11, 1993, the State complies with 1917(c) of the Social Security Act, as amended by Section 13611 of the Omnibus Budget Reconciliation Act of 1993. Page 2 of Supplement 9 to Attachment 2.6-A specifies what constitutes undue hardship.

For transfers that occurred before February 8, 2006, the period of ineligibility shall begin with the month in which such assets were transferred and the number of months in such period shall be equal to the total uncompensated value of the assets so transferred, divided by (check one of the following):

_____ $_____, which is the average cost to, a private patient at the time of application, of nursing facility services in the State; or

__X__ the average cost, to a private patient at the time of application, of nursing facility services in the community in which the individual is institutionalized.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency withholds payment to institutionalized individuals for the following services:

   Payments based on a level of care in a nursing facility;

   Payments based on a nursing facility level of care in a medical institution;

   Home and community-based services under a 1915 waiver.*

2. Non-institutionalized individuals:

   ____ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

   The agency withholds payment to non-institutionalized individuals for the following services:

   Home health services (section 1905(a)(7));

   Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

   Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

   ____ The following other long-term care services for which medical assistance is otherwise under the agency plan:

* AHCCCS has an 1115 waiver for home and community based services.

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State: ARIZONA

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

X* the first day of the month in which the asset was transferred;

____ the first day of the month following the month of transfer.

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

____ the average monthly cost to a private patient of nursing facility services in the agency;

X the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

____ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

* Except when multiple transfers occur and a period of ineligibility already exists. (see #7 on Page 3)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

_X_ does not impose a penalty;

____ imposes a penalty for less than a full month, based on the portion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

_X*_ does not impose a penalty;

____ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap--
The agency:

____ totals the value of all assets transferred to produce a single penalty period;

_X **_ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap--
The agency:

_X_ assigns each transfer its own penalty period;

____ uses the method outlined below:

* Unless the total amount transferred in the month exceeds the private nursing facility rate.

** Any carry-over uncompensated value from the first transfer is added to the uncompensated value of the next transfer.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual-

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

1. When both spouses are eligible, the penalty period is equally divided between the two members, regardless of which spouse made the transfer.

2. If one member of the couple is eligible and assessed a penalty period, and the other member subsequently becomes eligible, the remaining penalty is divided equally between the two members.

3. When a penalty has been divided between two eligible spouses and one spouse subsequently dies or becomes ineligible, the remainder of the penalty period is assessed to the remaining eligible spouse.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

____ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

____ For transfers of individual income payments, the agency will impose partial month penalty periods.

__X_ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

____ The agency uses an alternate method to calculate penalty periods, as described below:

If the monthly amount of the income transferred is less than the private nursing facility monthly rate, no penalty is imposed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship--
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations.

1. Provide a notice to the applicant/recipient that explains the hardship criteria, and offer an opportunity to claim undue hardship.

2. Request evidence.

3. Submit evidence to the Policy Unit for review.

4. The Administration will review the case to determine if all the criteria for an undue hardship (listed below) are met. If all criteria are met, the period of ineligibility for long term care services resulting from the transfer will be waived.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

1. The individual is otherwise eligible for medical benefits.

2. The individual is unable to obtain medical care without receipt of assistance.

3. The individual is experiencing an emergent, life threatening episode and without medical care is in imminent danger of death, as determined by the Director.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

TRANSFER OF ASSETS

1917(c) **FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006**, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   Nursing facility services;

   Nursing facility level of care provided in a medical institution;

   Home and community-based services under Arizona's 1115 waiver.

2. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

   - the first day of a month during or after which assets have been transferred for less than fair market value;

   _X_ The State uses the first day of the month in which the assets were transferred

   ___ The State uses the first day of the month after the month in which the assets were transferred

   or

   the first day of the month the individual is otherwise eligible for long term care services, but for the transfer, based on an approved application.

   AND

   which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

TRANSFER OF ASSETS

3. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

___ the average monthly cost to a private patient of nursing facility services in the State at the time of application;

__X_ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

4. Penalty period for amounts of transfer less than cost of nursing facility care--

__X_ Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

__X_ The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

5. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains. The method of apportioning the existing penalty period between spouses is as follows:

When both spouses are otherwise eligible (except for the transfer penalty), the period of ineligibility is equally divided between the two spouses

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

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State: Arizona

TRANSFER OF ASSETS

6. Treatment of a transfer of income--

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

_X_ For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

_X_ For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

7. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

8. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's

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State: Arizona

TRANSFER OF ASSETS

personal representative.

9. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

____ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed_____ days (may not be greater than 30).

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State: ARIZONA

CONSIDERATION OF TRUSTS--UNDUE HARDSHIP

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship under the following criteria:

> A determination by the agency that the applicant/recipient would be forced to go without life-sustaining services if the trust funds were not available to pay for these needed services.

State/Territory: Arizona

Citation	Condition or Requirement
	COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES
1902(u) of the Act	Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods: ___ The methodology as described in SMM section 3598. ___ Another cost-effective methodology as described below.

(NOT APPLICABLE)

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State: ARIZONA

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State plan effective July 16, 1996:

_X_ Pregnant women with no other eligible children.

_X_ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

_X_ Families with unemployed parents.

The State wants to continue providing Medicaid to all cash assistance recipients. All Medicaid eligibility provisions apply.

_X_ In determining ALTCS eligibility, including individuals approved for ALTCS acute care services under 1902(a)(10)(ii)(I) of the Act, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 except that the agency excludes an additional $1,000 in resources, effectively increasing the resource standard to $2,000.

_X_ In determining eligibility for Medicaid,other than ALTCS, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications.

____ The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

____ The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

____ The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

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X The agency uses the following less restrictive income and/or resource methodologies. These methodologies are less restrictive than those in effect on July 16, 1996.

1. The $90 cost of employment and $30 and 1/3 earned income disregard will be allowed, with no time limit.
2. Dependent child's earned income will be totally disregarded provided the child is enrolled at least half the time in any recognized elementary, secondary, or post secondary school.
3. Dependent care deductions will be allowed as billed not to exceed the Title IV-A standard that was in place as of July 1996.
4. Exclude all resources.
5. The Fair Labor Standard Act "FLSA Supplement Income" payment by the State's TANF agency to Temporary Assistance to Needy Families (TANF) recipients engaging in uncompensated work activity, is disregarded as income.
6. The one time lump sum TANF grant diversion payment is disregarded as income and as resources.
7. Eliminate the shelter cost factor when applying the income standard for the family size, thereby using the highest standard.
8. For applicants who meet the needs test and for all recipients, apply the existing $30 and 1/3 earned income disregards or for all applicants and recipients, an income disregard equal to the difference between the income standard and 100% of the Federal Poverty Level for the family size, adjusted annually, plus one dollar, whichever is greater. Income eligibility will be calculated as follows:
   a. Starting with the family's countable unearned and earned income, subtract from the earned income, the earned income disregards of $90 cost of employment, $30 and 1/3 of the remainder and appropriate dependent care expenses and compare the family's total net amount to 36% of the 1992 FPL income standard. If the net amount is less than the standard, the family is eligible under Section 1931 of the Social Security Act. If the net amount equals or exceeds the standard, complete a second step.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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b. Use the same methodology except for the $30 and 1/3 earned income disregard, apply the 100% FPL income disregard to the family's net unearned and earned income and compare the net income amount to the income standard. If the net amount is less than the standard, the family is eligible under Section 1931 of the Social Security Act.

9. All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

The state does not use the income and/or resource methodologies listed below. These were the methodologies used on July 16, 1996. This list is for historical purposes. The current list of income and/or resource methodologies used by the state begins on page 2 of this supplement.

1. The time limited $30 and 1/3 earned income disregard.
2. Part-time students are eligible for disregard only if working part-time.
3. Dependent care deductions are allowed as paid not to exceed the Title IV-A standard that was in place as of July 1996.
4. $2,000 resource standard.
5. None. This supplement payment was first implemented by the State's TANF agency in July 1999.
6. None. The TANF Grant Diversion program was first implemented by the state in October 1999.
7. In effect as of July 16, 1996, the income standard was adjusted for a shelter cost factor.
8. In effect as of July 16, 1996, there was no additional income disregard if the family's net income, after applying all appropriate income disregards, met or exceeded the income standard.
9. Census income is countable earned income.

___ The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

X The agency continues to apply the following waivers of provisions of Part A of Title *IV* in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

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Waiver of §402(a)(41) and §407 of the Act and 45 CFR 233.100(a)(1) and (c)(1)(iii) and 233.101(a)(1) and (c)(1)(iii). A child will be considered deprived if the family income is below the applicable income payment standard, regardless of the number of hours the principal wage earner is employed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Individuals who have received institutional services less than 30 days:
300% of the Federal Benefit Rate (allowed by waiver)

Individuals receiving HCBS:
300% of the Federal Benefit Rate (as allowed by 42 CFR 435.726 and the 1115 waiver which allows the State to provide HCBS to individuals whose income does not exceed 300% of SSI.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

SECTION 1924 PROVISIONS

A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924, except for those provisions set forth in Supplement 14 to Attachment 2.6A.

B. In the determination of resource eligibility the State minimum resource deduction is equal to the minimum community spouse resource standard, updated annually by the Centers for Medicare and Medicaid Services, based on the Consumer Price Index.

C. An institutionalized spouse who (or whose community spouse) has excess resources shall not be found ineligible under Title XIX of the Social Security Act, per Section 1924(c)(3)(C), where the State determines that denial of eligibility on the basis of having excess resources would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB) INFECTED INDIVIDUALS

For TB infected individuals under §1902(z)(1) of the Act, the income and resource eligibility levels are as follows:

NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

~~THODOLOGIES FOR TREATMENT OF INCOME THAT ARE LESS RESTRICTIVE THAN THOSE OF THE I PROGRAM PER SECTION 1902(r)(2) OF THE SOCIAL SECURITY ACT.~~

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In cases where there is an institutionalized spouse and a community spouse, income eligibility is to be calculated using community property rules, by which the income of both spouses is combined and divided into half. The result may be no more than three times the SSI Federal Benefit Rate for an individual.

If the result is more than three times the SSI Federal Benefit Rate for an individual, the institutionalized spouse's own income may be no more than three times the SSI Federal Benefit Rate for an individual.

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State: Arizona

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

__X__ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

_____ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is _____.

_____ This higher standard applies statewide.

_____ This higher standard does not apply statewide. It only applies in the following areas of the State:

_____ This higher standard applies to all eligibility groups.

_____ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

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 _X_ With limitations*

2. a. Outpatient hospital services.

   Provided: ___ No limitations _X_ 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).

   _X_ Provided: ___ No limitations _X_ 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 _X_ With limitations**

3. Other laboratory and x-ray services.

   Provided: ___ No limitations _X_ With limitations*

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

State/Territory: ARIZONA

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

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 _X_ 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 _X_ 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 _X_ 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 _X_ 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.

_X_ Provided: ___ No limitations _X_ With limitations*
___ Not provided

* Description provided in Limitations section of this Attachment.
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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

_X_ Provided: ___ No limitations _X_ With limitations*
___ Not provided.

c. Chiropractors' services.

___ Provided: ___ No limitations ___ With limitations*
_X_ Not provided. Not a covered service except when provided under EPSDT

d. Other practitioners' services.

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

7. Home health services.

a. Intermittent or part-time 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 _X_ With limitations*

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

Provided: ___ No Limitation _X_ With limitations*

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

Provided: ___ No Limitations _X_ With limitations**

* Description provided in Limitations section of this Attachment.
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AMOUNT, DURATION, AND SCOPE OF MEDICAL
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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.

_X_ Provided: ___ No limitations _X_ With limitations*
___ Not provided

8. Private duty nursing services.

_X_ Provided: ___ No limitations _X_ With limitations*
___ Not provided

*Description provided in Limitations section of this Attachment..

State/Territory: ARIZONA

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

9. Clinic services.

_X_ Provided: ___ No limitations _X_ With limitations*
___ Not provided

10. Dental services.

_X_ Provided: ___ No limitations _X_ With limitations*
___ Not provided

11. Physical therapy and related services.

a. Physical therapy.

_X_ Provided: ____ No limitations _X_ With limitations**
___ Not provided

b. Occupational therapy.

_X_ Provided: ____ No limitations _X_ 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).

_X_ Provided: ____ No limitations _X_ 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.

State/Territory: ARIZONA

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

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.

_X_ Provided: ____ No limitations _X_ With limitations*
___ Not provided

b. Dentures.

_X_ Provided: ____ No limitations _X_ With limitations*
___ Not provided

c. Prosthetic devices.

_X_ Provided: ____ No limitations _X_ With limitations*
___ Not provided

d. Eyeglasses.

_X_ Provided: ____ No limitations _X_ 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.

_X_ Provided: ____ No limitations _X_ With limitations**
___ Not provided

*Description provided in Limitations section of this Attachment.
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AMOUNT, DURATION, AND SCOPE OF MEDICAL
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b. Screening services.

_X_ Provided: ____ No limitations _X_ With limitations*
___ Not provided.

c. Preventive services.

_X_ Provided: ____ No limitations _X_ With limitations*
___ Not provided

d. Rehabilitative services.

_X_ Provided: ____ No limitations _X_ With limitations*
___ Not provided

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

a. Inpatient hospital services.

_X_ Provided: ____ No limitations _X_ With limitations**, ***
___ Not provided

b. Nursing facility services.

_X_ Provided: ____ No limitations _X_ 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.
***Pursuant to the 1115 Waiver, Medicaid reimbursement is available for Medicaid-eligible persons ages 21 through 64.

State/Territory: ARIZONA

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

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.

_X_ Provided: ____ No limitations _X_ 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.

_X_ Provided: ____ No limitations _X_ With limitations*
___ Not provided

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

_X_ Provided: ____ No limitations _X_ With limitations**
___ Not provided

17. Nurse-midwife services.

_X_ Provided: ____ No limitations _X_ With limitations*
___ Not provided

18. Hospice care (in accordance with section 1905(o) of the Act) available to all acute care Medicaid beneficiaries who elect the service and are determined medically eligible for it. Additionally, hospice services are available to members in the Arizona Long Term Care Services program as authorized under Arizona's Section 1115 waiver.

_X_ Provided: _X___ No limitations ___ With limitations*

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

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

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).

_X_ Provided: _X_ With limitations*
___ Not provided.

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

____ Provided: ____ With limitations*
_X_ 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.

*Description provided in Limitations section of this Attachment.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
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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*
_X_ Not provided.

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

_X_ Provided: ____ No limitations _X_ With limitations**
___ Not provided

23. Certified pediatric or family nurse practitioners' services.

_X_ Provided: ____ No limitations _X_ 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.

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

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

a. Transportation.

_X_ Provided: ____ No Limitations _X_ With limitations*
___ Not provided

b. Services of nurses in Religious Non-Medical Health Care Institutions (in accordance with section 1861(ss)(1) of the Act)

_X_ Provided: ____ No limitations _X_ With limitations**
___ Not provided

c. Care and services provided in Religious Non-Medical Health Care Institutions (in accordance with section 1861(ss) (1) of the Act)

_X_ Provided: ____ No limitations _X_ With limitations**
___ Not provided

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

_X_ Provided: ____ No limitations _X_ With limitations*
___ Not provided.

e. Emergency hospital services.

_X_ Provided: ____ No limitations _X_ 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.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
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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 __X__ 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 individaul 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

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

All covered services shall be authorized by an appropriate entity or entities except in the case of emergency hospital services and emergency transportation. As provided in AHCCCS' policies and procedures, authorization for medical services shall be obtained from at least one of the following entities: a primary care provider (a licensed physician, physician assistant or certified nurse practitioner) or a physician specialist or dentist, a health plan, a program contractor, a Regional Behavioral Health Authority, an ALTCS case manager affiliated with a program contractor, or the AHCCCS Administration. The appropriate entity shall only authorize medically necessary services subject to the limitations specified below and in compliance with applicable federal and state law and regulations and AHCCCS policies and procedures or other applicable guidelines.

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

Inpatient hospital services furnished by a licensed and certified hospital.

Inpatient hospital services include services in inpatient psychiatric facilities, when provided to EPSDT eligible persons under the age of 21 years and, pursuant to the 1115 Waiver, to eligible persons ages 21 through 64.

Inpatient hospital services for medically necessary abortions only when the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Medically necessary transplant services, as specified in AHCCCS rule and policy and Attachment 3.1-E of the State Plan.

2a. **Outpatient hospital services.**

Outpatient hospital services are services ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers.

Outpatient hospital services for medically necessary abortions only when the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

3. Other laboratory and x-ray services.

Laboratory, x-ray, and medical imaging services. All laboratory providers must obtain appropriate CLIA certification based on the complexity of testing performed. Providers with a CLIA Certificate of Waiver are limited in procedures which can be performed.

4a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Nursing facility services for individuals 21 years of age or older when they are provided in a facility that is licensed and certified as a nursing facility.

Nursing facility services are provided under acute care and the ALTCS Transitional program for up to 90 days per contract year when hospitalization would be necessary if nursing facility services are not provided.

There is no limit on nursing facility services under the regular ALTCS program approved through the 1115 waiver authority.

See section 24d for limitations on nursing facility services for individuals under 21 years of age.

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

Early and periodic screening, diagnostic, and treatment (EPSDT) services furnished to individuals under 21 years of age to detect and correct or ameliorate defects and physical and mental illnesses and conditions identified through EPSDT services. Section 1905(a) services not otherwise covered under the State Plan but which are available to EPSDT recipients are:

i. Chiropractors' services to correct or ameliorate defects, physical illnesses and conditions when provided by a licensed chiropractor.

ii. Case-management to coordinate services necessary to correct or ameliorate defects and physical illnesses and conditions and behavioral health problems and conditions.

iii. Personal care services to assist in performing daily living tasks for members with physical illnesses and conditions and/or behavioral health problems and conditions.

iv. Medically necessary transplant services, as specified in AHCCCS rule and policy and Attachment 3.1-E of the State Plan if provided to correct or ameliorate defects, physical illnesses and conditions.

v. Routine, preventive, therapeutic and emergency dental services.

vi. Eye exams and prescriptive lenses.

vii. Outpatient occupational and speech therapy. The duration, scope and frequency of each therapeutic modality shall be authorized as part of a treatment plan.

viii. The AHCCCS Administration, in accordance with the signed Intergovernmental Agreement between AHCCCS and the Arizona Department of Education, shall provide direct Medicaid reimbursement for certain Medicaid services provided by a participating Local Education Agency (LEA). A LEA is a public school district, a charter school not sponsored by a school district and the Arizona School for the Deaf and Blind. Beginning in January 2001, AHCCCS will reimburse LEAs on a fee-for-service basis for a defined set of Medicaid covered services with dates of service on or after July 1, 2000. The medically necessary Medicaid services must be provided by a qualified school-based provider to students who are Title XIX eligible and eligible for school health and school-based services pursuant to the Individuals with Disabilities Education Act (IDEA), Part B. AHCCCS health plans and ALTCS program contractors will continue to provide medically necessary services to all Title XIX members enrolled with AHCCCS and a health plan or program contractor.

Reimbursable Services

Medicaid covered services will only be reimbursable for persons who are at least three years of age and less than 21 years of age and who have been determined eligible for Title XIX and IDEA, Part B services. The following Medicaid services will be eligible for reimbursement:

Assessment, Diagnosis and Evaluation services. Assessment, diagnosis and evaluation services, including testing, are services used to determine IDEA eligibility or to obtain information on the individual for purposes of identifying or modifying the health related services on the IEP. These services are covered in accordance with the requirements in 42 CFR § 440.130. These services are not covered if they are performed for educational purposes (e.g. academic testing or are provided to an individual who as the result of the assessment and evaluation is determined not to be eligible under IDEA). Services must be performed by qualified and registered AHCCCS providers as set forth in this State plan amendment and who provide these

services as part of their respective area of practice (e.g., psychologists providing a behavioral health evaluation).

Outpatient Speech, Occupational and Physical Therapy Services. Outpatient speech, occupational and physical therapy services include individual and group therapy (e.g., neuromuscular re-education, wheel chair management, aural rehabilitation). These services are covered in accordance with the requirements in 42 CFR § 440.110. Providers of therapy services must be registered with AHCCCS and be state-licensed occupational therapists, physical therapist or speech-language pathologists. In addition, persons who have a Provisional Speech and Language Impaired Certificate must be supervised by an American Speech and Language Hearing Association-certified pathologist.

Nursing Services. Nursing services include direct nursing care services as identified in the IEP such as catheterization, suctioning and medication management, individual student health training and counseling, and training and oversight of school-based attendants. These services are covered in accordance with the requirements in 42 CFR § 440.130. School nursing personnel must follow the guidelines for care produced by the Rehabilitation Act of 1973, Section 504. Providers of nursing services must be registered with AHCCCS and be state-licensed as a registered nurse or a licensed practical nurse.

Transportation Services. Transportation services will be provided in compliance with HCFA policy and will be paid for when an eligible member's need for special transportation is specified in the IEP. These services are covered in accordance with the requirements in 42 CFR § 441.62.. These services will only be reimbursed on the same day in which the member obtains another Medicaid covered reimbursable service through the LEA. Transportation services are not covered if the eligible member is transported on a school bus with other non-IDEA eligible students who are attending school. The LEA must be registered with AHCCCS as a transportation provider and must meet the same provider qualifications as all AHCCCS Medicaid transportation providers (e.g., proof of insurance and licensure of school bus drivers).

Behavioral Health Services. Behavioral health services include individual/group therapy, counseling and training, behavioral management, psychosocial rehabilitation and emergency and crisis stabilization. These services are covered in accordance with the requirements in 42 CFR § 440.130. Behavioral health providers must be registered with AHCCCS and be AHCCCS recognized independent practitioners, i.e., state licensed psychiatrists, state licensed Ph.D. psychologists and Arizona Board of Behavioral Health Examiners licensed marriage and family therapists, professional counselors and independent social workers. In addition, school-based school psychologists or school-based guidance counselors who are certified by the Arizona

Department of Education will also be allowed to provide behavioral health services in the public school system.

Personal Care Services. Personal care services include assistance to eligible members in meeting essential personal physical needs, e.g., skin care, oral hygiene, toileting, ambulation, use of assistive device, feeding, training in activities of daily living. These services are covered in accordance with the requirements in 42 CFR § 440.167. Providers of personal care services will be the same providers as those described under nursing services, e.g., state-licensed registered nurses or licensed practical nurses or LEA certified school-based health attendants. In addition, school-based health attendants, who are specially trained and certified by the LEA in general care, such as first aid and CPR and the specific needs of the students they assist, will be allowed to provide certain delegated tasks under the supervision of the licensed nurses.

Audiological Services. Audiology services include testing and evaluating hearing-impaired children that may or may not be improved by medication or surgical treatment. These services are covered in accordance with the requirements in the AHCCCS Medical Policy Manual (AMPM) Chapter 700. Annual audiological assessments will be provided as Arizona Administrative Code, R9-22-213, requires for students with disabilities and are separate from the screenings offered to the general student population. Providers of audiological services must be registered with AHCCCS, meet the licensing requirements of 42 CFR § 440.110 (c)(3), and be licensed as an Audiologist through the Arizona Department of Health Services (ADHS).

4.c. Family planning services and supplies for individuals of child-bearing age.

Family planning services include:

i. contraceptive counseling, medication, supplies and associated medical and laboratory exams;

ii. sterilizations; and,

iii. natural family planning education or referral.

Family planning services do not include abortion or abortion counseling.

5 b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Dental care and extractions for persons 21 years or older when provided by a licensed dentist are limited to:

i. The relief or treatment of the sudden onset of an emergency dental condition.

ii. Pre-transplantation dental evaluation and treatment for oral infections.

iii. Medically necessary dentures.

See section 10 for limitations on dental services

6. Medical care and any other types of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

6a. Podiatrists' services.

Podiatry services when provided by a licensed podiatrist.

In order for a member to receive routine foot care, the member must be receiving medical treatment from a primary care provider for a systemic disease which is of such severity that performance of foot care services by a non-professional would be hazardous to the member.

6b. Optometrists' services.

Optometrists' services when they are provided by a licensed optometrist. See section 12d for limitations on eyeglasses and contact lenses.

6d. Other practitioners' services.

Other practitioners' services provided by:

i. Respiratory Therapists

ii. Certified Nurse Practitioners

iii. Certified Registered Nurse Anesthetists

iv. Non-physician First Surgical Assistants and Physician Assistants

v. Licensed midwives within the limitations provided in the AHCCCS policy and procedures

vi. Licensed affiliated practice dental hygienists practicing within the scope of Arizona's state practice act.

vii. Nonphysician behavioral health professionals, as defined in rule, when the services are provided by social workers, physician assistants, psychologists, counselors, registered nurses, certified psychiatric nurse practitioners, behavioral health technicians and other approved therapists who meet all applicable state standards. Except for behavioral health services provided by psychologists, certified psychiatric nurse practitioners and physician's assistants supervised by AHCCCS registered psychiatrists, certified independent social workers, certified marriage/family therapists, and certified professional counselors, all non-physician behavioral health professional services shall be provided by professionals affiliated with an approved behavioral health setting in accordance with AHCCCS policies and procedures.

7. Home health services.

7a. Intermittent or part-time nursing services provided by a licensed and/or certified home health agency, or by a registered nurse when no home health agency exists in the area.

Intermittent or part-time nursing services provided by a licensed and/or certified home health agency, or by a registered nurse when no home health agency exists in the area, when the services are necessary to prevent re-hospitalization or institutionalization.

7b. Home health aide services provided by a home health agency.

Home health aide services when provided on an intermittent basis by a licensed and/or certified home health agency.

7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Therapy services provided to an individual who is 21 years of age or older when a rehabilitation plan demonstrating rehabilitation potential is documented. The duration, scope, and frequency of each therapeutic modality shall be authorized by the appropriate entity as part of a rehabilitation plan.

8. Private duty nursing services.

Private duty nursing services when they are provided in a setting approved by the AHCCCS Administration.

9. Clinic services.

Medical services provided in an ambulatory clinic including physician services, dental services, dialysis, laboratory, x-ray and imaging services, health assessment services, immunizations, medications and medical supplies, therapies, family planning services and EPSDT services.

Behavioral health services provided in a clinic include individual, group and/or family counseling/therapy, psychotropic medications, psychotropic medication adjustment and monitoring, emergency/crisis services, behavior management, psychosocial rehabilitation, screening, evaluation and diagnosis, case management services, laboratory and radiology services. The duration, scope and frequency of each therapeutic modality shall be part of a treatment plan.

Screening services are limited to no more than one service during each six-month period of continuous behavioral health enrollment.

10. Dental services.

Routine, preventive, therapeutic and emergency dental services under EPSDT services. See section 5b for limitations on medical and surgical services furnished by a dentist.

Dental services for adults are limited to emergency dental care and extractions, pre-transplant evaluation and treatment for oral infections and medically necessary dentures. See section 12b for limitations on dentures.

11. Physical therapy and related services.

Therapies and related services for persons 21 years of age and older when a rehabilitation plan demonstrating rehabilitation potential is documented. The duration, scope and frequency of each therapeutic modality must be prescribed by the rehabilitation plan.

Therapies and related services for persons under the age of 21 are covered whether or not there is a demonstrated potential for rehabilitation.

11b. Occupational therapy.

Outpatient occupational therapy is not covered for persons 21 years of age or older unless the person is enrolled in ALTCS.

11c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

Outpatient speech therapy is not covered for persons 21 years of age or older unless the person is enrolled in ALTCS.

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

12a. Prescribed drugs.

Prescription drugs for covered transplantation services shall be provided in accordance with AHCCCS transplantation policies.

Over-the-counter or non-prescription medications are not covered unless an appropriate, alternative over-the-counter medication is available and less costly than a prescription medication.

12b. Dentures.

Medically necessary dentures when authorized in consultation with a provider dentist.

12c. Prosthetic devices.

Orthotic and prosthetic devices which are essential to the rehabilitation of the member.

Covered prosthetic devices do not include hearing aids for persons 21 years of age or older or penile implants or vacuum devices.

12d. Eyeglasses.

Eye examinations for prescriptive lenses and the provision of prescriptive lenses under EPSDT services.

Adult services are limited to eyeglasses and contact lenses as the sole prosthetic device after a cataract extraction.

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

13b. Screening services.

Age and sex appropriate clinical screening tests.

13c. Preventive services.

Preventive services, including health education and immunizations.

13d. Rehabilitative services.

Rehabilitation services include physical therapy, occupational therapy, speech and hearing services provided by licensed professionals in order to reduce physical disability and/or restore functional level. Services shall be provided on an inpatient or outpatient basis within the limitations outlined under section 11.

Rehabilitative services provided by a behavioral health and/or substance abuse rehabilitation agency.

15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

The public institution shall meet all federally approved standards and only include the Arizona Training Program facilities, a state-owned or operated service center, a state-owned or operated community residential setting, or an existing licensed facility operated by this state or under contract with the Department of Economic Security on or before July 1, 1988.

17. Nurse-midwife services.

Certified nurse-midwife services when provided by a certified nurse-midwife in collaboration with a licensed physician.

19. Case management services and Tuberculosis related services

19a. 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).

Targeted case management services as defined in Supplement 1 to Attachment 3.1-A.

20. Extended services for pregnant women.

Extended services to pregnant women include all covered services if they are determined to be medically necessary and related to the pregnancy.

20a. 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.

Prenatal care shall not be provided to women eligible for the Federal Emergency Services Program

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

24a. Transportation.

Emergency ambulance transportation for emergency medical situations, and non-emergency transportation for non-emergency medical situations.

Emergency ambulance transportation does not require prior authorization from an appropriate entity.

24d Nursing facility services for patients under 21 years of age.

Nursing facility services for individuals under 21 years of age when the services are provided in a facility that is licensed and certified as a nursing facility. See section 4a for limitations on nursing facility services for individuals 21 years of age or older.

Nursing facility services are provided under acute care and the ALTCS transitional program for up to 90 days per contract year when hospitalization would be necessary if nursing facility services are not provided.

There is no limit on nursing facility services under ALTCS that are approved through the 1115 waiver authority.

24e. Emergency hospital services.

Emergency hospital services do not require prior authorization from an appropriate entity. However, the provider must notify the member's contractor within 12 hours of the member presenting for the services.

If the medical condition is non-emergent, either the AHCCCS Administration or the member's health plan or program contractor shall be notified prior to treatment. Neither AHCCCS or any AHCCCS provider shall be responsible for the costs of hospitalization and medical care delivered by a hospital which does not have a contract to provide care after the eligible person has been determined to be transferable, and/or an attempt is made by AHCCCS or the provider to transfer the person and the person receiving care has refused to consent to the transfer.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

CASE MANAGEMENT SERVICES

A. TARGET GROUP:

The target population is comprised of persons who meet the following definition of developmental disability.

"Developmental Disability" is defined in State law and means a severe and chronic disability which originates before an individual attains age 18, continues or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. This term shall include mental retardation, cerebral palsy, epilepsy, and autism as defined by the State. This disability results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.

A child under the age of six years of age may be considered eligible if there is a strong demonstrated potential that the child is or will become developmentally disabled. Children must have an identified delay in one or more areas of development as measured by a culturally appropriate and recognized developmental assessment tool.

Persons for whom federal financial participation is requested are those who are financially eligible for the Title XIX acute care program but who do not meet the functional eligibility requirements of the Arizona Long Term Care System program (ALTCS). These individuals are typically eligible for Supplemental Security Income (SSI) and may reside in a variety of settings (e.g., nursing facilities, group homes, foster homes or their own homes).

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED:

_X_ Entire State

___ Only in the following geographic areas (authority of section 1915 (g) (1) of the Act is invoked to provide services less than statewide).

C. COMPARABILITY OF SERVICES:

___ Services are provided in accordance with section 1902 (a) (10) (B) of the Act.

_X_ Services are not comparable in amount, duration and scope. Authority of section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

D. DEFINITION OF SERVICES:

For the purposes of Targeted Case Management, services will be limited to case management services provided to individuals who are financially eligible for the Title XIX acute care program but who are not eligible for the ALTCS program.

Case management is the process of needs assessment, setting objectives related to needs, service scheduling, program planning, and evaluating program effectiveness. The Department of Economic Security/Division of Developmental Disabilities (DES/DDD) provides services which ensure that the changing needs of the person and the family are recognized on an ongoing basis and the widest array of appropriate options are provided for meeting those needs.

Case management will assist individuals in gaining access to needed medical, social, educational and other support services and will consist of the following:

- Informing members of options including medical services available from AHCCCS health plans, based on assessed needs.
- Developing a Plan of Care.
- Locating, coordinating, arranging social, educational and other resources to meet member needs.
- Providing necessary information to providers about the member's functioning level to enable the provider to plan, deliver and monitor services.
- Monitoring the member's progress and compliance with the Plan of Care.
- Informing providers of changes in the member's condition.
- Coordinating and participating in Individual Service Program Plan meetings.
- Informing the family of members or other caregivers of the support needed to obtain optimal benefits from available services.
- Revising the Plan of Care.
- Recording the delivery of case management services.
- Case management, in the context of Family Support, consists of activities designed to:

  1) Strengthen the role of the family as primary care-giver, thereby reducing dependency upon government support;
  2) Prevent costly, inappropriate and unwanted out-of-home placement and maintain family unity;
  3) Reunite families with children with disabilities who have been placed in government funded out-of-home placement, whenever possible; and
  4) Identify services provided by different agencies to eliminate costly duplication.

Members are not required to accept case management services. Should a member refuse to accept case management services, this refusal shall not be used as a basis to restrict the member's access to other Medicaid services. The provision of case management services shall not restrict the member's choice of the available health plans and primary care providers in the AHCCCS system. If a member is dissatisfied with their assigned case manager, he/she will be provided the opportunity to choose another case manager from those available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

E. QUALIFICATIONS OF PROVIDERS:

Qualified providers of case management services are case managers employed by the DES/DDD who meet the following criteria:

- Human Service Specialist I - Bachelors' degree with a major in child development, social work, rehabilitation, counseling, education, sociology, psychology or other closely related field focusing on assisting individuals in accessing services and identifying social or behavioral problems of individuals in the community; or two years of work experience equivalent to a Human Service Worker II.

- Human Service Specialist II - Two years of work experience equivalent to a Human Services Specialist I; OR a Bachelor's degree in social work, rehabilitation, counseling, education, sociology, psychology or other closely related field focusing on the provision of helping services in the community and one year of required experience; OR a Master's degree.

- Human Service Specialist III - Two years of work experience equivalent to a Human Service Specialist II.

- Human Services Unit Supervisor - Two years of work experience equivalent to a Human Services Specialist II or Human Services Specialist III.

- Registered Nurse - Licensed by the State of Arizona to practice professional nursing case management services.

- Qualified case managers must have considerable knowledge of the DES/DDD policies, procedures and practices. They have extensive knowledge of the common human needs, growth, personality and behavior of the individuals they case manage. Case managers have knowledge of the developmental and behavioral problems of children, their causes, symptoms and treatment and the effects and problems of foster care placements. They have knowledge of developmental disabilities and their effects on adults and children. They have knowledge of cultural, environmental and community influences on the behavior and development of individuals in specific member groups. Qualified case managers have an understanding of the laws governing placement, custody and treatment of children and adults. They are knowledgeable about the resources available in the community that can be utilized on behalf of applicants or members.

  All case managers hired since July 1, 1990 are required to completed a competency based training curriculum prior to completing their original probation. This curriculum consists of the following seven training modules:

  1. Introduction to Case Management
  2. Intake and Eligibility
  3. Assessment
  4. Plan Development
  5. Facilitation Skills
  6. Plan Coordination
  7. Monitoring and Reassessment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services available from DES/DDD.
- Eligible recipients will have free choice of the providers of other medical care under the plan.*

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Payment will not be made for services for which another payer is liable or for services for which no payment liability is incurred.

Payments will not be made under this State Plan for targeted case management services for persons enrolled in the ALTCS program since Arizona currently provides ALTCS case management under an 1115 Research and Demonstration Waiver.

Arizona is proposing the same reimbursement arrangement as is used for ALTCS case management. As required, the targeted case management reimbursement methodology is described in Attachment 4.19-B. The reimbursement proposal is based on the following facts regarding the targeted group:

- Individuals in the targeted case management group meet the financial requirements of Title XIX and require the same case management supports as those in the ALTCS program (i.e., planning, coordination and brokering of support and services).
- Case management for this group of developmentally disabled members is frequently more difficult than for ALTCS participants due to the lack of government resources to meet their needs. As a result, case managers must often provide more direct support to a family or individual.

* AHCCCS is waived from this requirement under 1115 waiver authority. Recipients shall have a choice of available health plans and primary care providers in the AHCCCS system.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

(NOT COVERED)

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

1. The State of _____ provides home and community care to functionally disabled elderly individuals to the extent described and defined in this Supplement (and Appendices) in accordance with section 1929 of the Social Security Act.

2. Home and community care services are available Statewide.

   _____ Yes _____ No

   If no, these services will be available to individuals only in the following geographic areas or political subdivisions of the State (specify): _____

3. The home and community care services specified in this Supplement will be limited to the following target groups of recipients (specify all restrictions that will apply):

   a. _____ aged (age 65 and older, or greater than age 65 as limited in Appendix B)

   b. _____ In accordance with §1929(b)(2)(A) of the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

   c. _____ In accordance with §1929(b)(2)(A) of the Act, individuals who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

   d. _____ In accordance with §1929(b)(2)(B) of the Act, individuals who meet the test of disability under the State's §1115 waiver which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. Financial eligibility standards for these individuals are specified in Appendix A. Functional disability standards for these individuals are specified in Appendix B.

4. Additional targeting restrictions (specify):

   a. _____ Eligibility is limited to the following age groups (specify): _____

State: Arizona

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

b. _____ Eligibility is limited by the severity of disease or condition, as specified in Appendix B.

c. _____ Eligibility is limited to individuals who have been shown to have a need for one or more of the services elected by the State under this benefit.

5. Standards for financial eligibility are set forth in Appendix A. Each individual served shall meet applicable standards for financial eligibility.

6. Each individual served will meet the test of functional disability set forth in Appendix B.

7. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 of this Supplement. This assessment will be provided at the request of the individual or another person acting on such individual's behalf. The individual will not be charged a fee for this assessment.

8. The comprehensive functional assessment will be used to determine whether the individual is functionally disabled, as defined in Appendix B. Procedures to ensure the performance of this assessment are specified in Appendix D.

9. The comprehensive functional assessment is based on the uniform minimum data set specified by the Secretary. Check one:

a. _____ The State will use the assessment instrument designed by HCFA.

b. _____ The State will use an assessment instrument of its own designation. The assessment instrument to be used is consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. A copy of the assessment instrument can be found at Appendix D.

10. The comprehensive functional assessment will be reviewed and revised not less often than every 12 months. Procedures to ensure this review and revision are specified in Appendix D.

11. The comprehensive functional assessment and review will be conducted by an interdisciplinary team designated by the State. Qualifications of the interdisciplinary team are specified in Appendix D.

12. Based on the comprehensive functional assessment or review, the interdisciplinary team will:

a. identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

State: Arizona

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

b. based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

13. The results of the comprehensive functional assessment or review will be used in establishing, reviewing and revising the person's individual community care plan (ICCP).

14. An ICCP will be developed by a qualified community care case manager for each individual who has been determined, on the basis of a comprehensive functional assessment, to be a functionally disabled elderly individual.

15. All services will be furnished in accordance with a written ICCP which:

a. is established, and periodically reviewed and revised, by a qualified community care case manager after a face-to-face interview with the individual or primary care giver;

b. is based upon the most recent comprehensive functional assessment of the individual;

c. specifies, within the amount, duration and scope of service limitations specified in Appendix C, the home and community care to be provided under the plan. The ICCP will specify the community care services to be provided, their frequency, and the type of provider to furnish each service;

d. indicates the individual's preferences for the types and providers of services and documents the individual's free choice of providers and services to be furnished; and

e. may specify other services required by the individual.

A copy of the ICCP format to be used in implementing this benefit is included in Appendix E.

16. Each individual's ICCP will be established and periodically reviewed and revised by a qualified community care case manager, as provided in Appendix E.

17. A qualified community care case manager is a nonprofit or public agency or organization which meets the conditions and performs the duties specified in Appendix E.

18. The State will provide the following home and community care services, as defined, described and limited in Appendix C to the groups specified in items 3, 4, 5 and 6 of this Supplement.

a. _____ Homemaker services

b. _____ Home health aide services

c. _____ Chore services

State: Arizona

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

d. _____ Personal care services

e. _____ Nursing care services provided by, or under the supervision of, a registered nurse

f. _____ Respite care

g. _____ Training for family members in managing the individual

h. _____ Adult day care

i. _____ The following services will be provided to individuals with chronic mental illness:

1. _____ Day treatment/Partial hospitalization

2. _____ Psychosocial rehabilitation services

3. _____ Clinic services (whether or not furnished in a facility)

j. _____ Other home and community-based services (other than room and board) as the Secretary may approve. The following other services will be provided:

1. _____ Habilitation

A. _____ Residential Habilitation

B. _____ Day Habilitation

2. _____ Environmental modifications

3. _____ Transportation

4. _____ Specialized medical equipment and supplies

5. _____ Personal Emergency Response Systems

6. _____ Adult companion services

7. _____ Attendant Care Services

8. _____ Private Duty Nursing Services

9. _____ Extended State plan services (check all that apply):

A. _____ Physician Services

B. _____ Home health care services

State: Arizona

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

C. _____ Physical therapy services

D. _____ Occupational therapy services

E. _____ Speech, hearing and language services

F. _____ Prescribed drugs

G. _____ Other State plan services (specify): _____

10. _____ Other home and community based services (specify): _____

19. The State assures that adequate standards for each provider of services exist and will be met. These provider standards are found at Appendix C-2.

20. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are adversely affected by the determinations of the interdisciplinary team, or who are denied the service(s) of their choice, or the provider(s) of their choice, or who disagree with the ICCP which has been established.

21. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement prior to the development of the ICCP. FFP will not be claimed for home and community care services which are not included in the ICCP.

22. The State provides the following assurances to HCFA:

a. Home and community care services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.

b. FFP will not be claimed in expenditures for the cost of room and board, except when provided as part of respite care furnished in a facility which is (1) approved by the State, and (2) not a private residence. Meals furnished under any community care service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).

c. FFP will not be claimed in expenditures for the cost of room and board furnished to a provider of services.

d. The agency will provide HCFA annually with information on the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year. These reports will begin with information relative to FFY 1990 and will be provided in the manner prescribed by HCFA. The State assures that it will provide data on its maintenance of effort, as required by section 1929(e) of the Social Security Act, in such format and at such times as are specified by HCFA.

State: Arizona

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

e. The home and community care provided in accordance with this Supplement and Appendices will meet all requirements for individual's rights and quality of care as are published or developed by HCFA.

1. All individuals providing care are competent to provide such care; and

2. Each provider of services under this benefit will meet the requirements applicable to the provision of home and community care as set forth in Appendix C.

3. Each individual receiving home and community care will be accorded the rights specified in Appendix F.

4. Case managers will comply with all standards and procedures set forth in Appendix E.

23. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement in any quarter to the extent that cost of such care in the quarter exceeds 50 percent of the product of:

a. the average number of individuals in the quarter receiving home and community care;

b. the average per diem rate of Medicare payment for extended care services (without regard to coinsurance) furnished in the State during such quarter; and

c. the number of days in such quarter.

24. Community care settings in which home and community care is provided will meet the requirements set forth in section 1929(g) and (h) of the Act, as applicable to the specific setting. The State assures that the requirements of Appendix G will be met for each setting in which home and community care is provided under this section.

25. The State will refuse to provide home and community care in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

26. The State will comply with the requirements of section 1929(i), of the Act, regarding survey and certification of community care settings, as set forth in Appendix G.

27. The State will comply with the requirements of section 1929(i) of the Act, regarding the compliance of providers of home and community care and reviews of this compliance, as set forth in Appendix C.

28. The State will provide for an enforcement process for providers of community care, as required by section 1929(j) of the Act. This process is described in Appendix C.

State: Arizona

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

29. The State assures that payment for home and community care services will be made through rates which are reasonable and adequate to meet the costs of providing care efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

30. Payment will not be made for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under title XIX or title XI of the Social Security Act or for legal expenses in defense of an exclusion or civil money penalty under title XIX or title XI of the Social Security Act if there is no reasonable legal ground for the provider's case.

31. The State will begin provision of services under section 1905(a)(23) of the Social Security Act effective (specify date):

_____

These services will be provided to eligible individuals for a minimum of four calendar quarters, beginning on this date.

32. Services will be provided to eligible recipients for the duration of the period specified in item 31, above, without regard to the amount of Federal financial participation available to the State.

33. The State assures that it will monitor the appropriateness and accuracy of the assessments and reviews. Through its monitoring, the State assures the appropriateness and accuracy of the assessments and periodic reviews. The State assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

State: Arizona

MEDICAID ELIGIBILITY GROUPS SERVED

a. Home and community care services will be made available to individuals age 65 or older, when the individuals have been determined to be functionally disabled as specified in Appendix B.

b. Individuals served under this provision must meet the following Medicaid eligibility criteria (check all that apply):

1. _____ Age 65 or older who have been determined to be functionally disabled (as determined under the SSI program) as specified in Appendix B.

A. _____ The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate). Individuals must be receiving SSI/SSP benefits to be eligible under this provision.

B. _____ The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to Attachment 2.6-A. Individuals must be eligible for Medicaid under the State's plan to be eligible under this provision.

2. _____ Medically needy, age 65 or older who have been determined to be functionally disabled as specified in Appendix B. In determining the individual's eligibility, the State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income). (Check one):

A. _____ The State does not consider anticipated medical expenses.

B. _____ The State considers anticipated medical expenses over a period of _____ months (not to exceed 6 months).

State: Arizona

INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER

a. _____ The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. In accordance with §1929(b)(2)(B) of the Act, the following individuals will be eligible to receive home and community care services. (Check all that apply):

1. _____ Age 65 or older.

2. _____ Disabled, receiving SSI.

These individuals meet the resource requirement and income standards that apply in the State to individuals described in §1902(a)(10)(A)(ii)(V) of the Act.

b. _____ In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

c. _____ In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older, who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

State: Arizona

FUNCTIONAL DISABILITY

Home and community care services, as defined in this Supplement, are provided to the following classifications of individuals who have been found on the basis of an assessment to be functionally disabled. Services will be limited to individuals who meet the following targeting criteria.

Check all that apply:

a. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with at least two of the following activities of daily living: toileting, transferring, eating.

b. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with each of the following activities of daily living: toileting, transferring, eating.

c. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

d. _____ Services are provided to individuals, who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, (check one):

1. _____ at least 3 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

2. _____ at least 4 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

3. _____ all of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

e. _____ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are sufficiently cognitively impaired so as to require substantial supervision from another individual because they engage in inappropriate behaviors that pose serious health or safety hazards to themselves or others.

State: Arizona

AGE

Check all that apply:

a. _____ Services are provided to individuals age 65 and older.

b. _____ Services are provided to individuals who have reached at least the following age, greater than 65 (specify): _____

c. _____ Services are provided to individuals who meet the criteria set forth in item 3.b. of Supplement 2, as set forth in Appendix B-3, who were 65 years of age or older on the date of the waiver's discontinuance.

d. _____ Services are provided to individuals who meet the criteria set forth in item 3.c. of Supplement 2, as set forth in Appendix B-3, who were served under the waiver on the date of its discontinuance.

e. _____ Services are provided to individuals who meet the criteria in item 3.d. of Supplement 2, who fall within the following age categories (check all that apply):

1. _____ Age 65 and older

2. _____ Age greater than 65. Services are limited to those who have attained at least the age of (specify): _____

3. _____ Age less than 65. Services will be provided to those in the following age category (specify): _____

4. _____ The State will impose no age limit.

State: Arizona

INDIVIDUALS PREVIOUSLY SERVED UNDER WAIVER AUTHORITY

a. _____ In accordance with §1929(b)(2)(A) of the Act, the State will discontinue the following home and community-based services waiver(s), approved under the authority of §1915(c) or §1915(d) of the Act. (Specify the waiver numbers):

Waiver Number	Last date of waiver operation

b. For each waiver specified in Appendix B-3-a, above, the State will furnish at least 30 days notice of service discontinuance to those individuals under 65 years of age, and to those individuals age 65 or older who do not meet the test of functional disability specified in Appendix B-1 (except those individuals who will continue to receive home and community-based services under a different waiver program).

c. Individuals age 65 years of age or older, who were eligible for benefits under a waiver specified in Appendix B-3-a on the last date of waiver operation, who would, but for income or resources, be eligible for home and community care under the State plan, shall be deemed functionally disabled elderly individuals for so long as they would have remained eligible for services under the waiver.

d. The financial eligibility standards which were in effect on the last date of waiver operation are attached to this Appendix.

e. The following are the schedules, in effect on the last date of waiver operation, under which individuals served under a waiver identified in Appendix B-3-a were reevaluated for financial eligibility (specify):

Waiver Number	Reevaluation schedule

State: Arizona

DEFINITION OF SERVICES

The State requests that the following services, as described and defined herein, be provided as home and community care services to functionally disabled elderly individuals under this program:

a. _____ Homemaker Services. (Check one.)

_____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities. This service does not include medical care of the client. Hands-on care is limited to such activities as assistance with dressing, uncomplicated feeding, and pushing a wheelchair from one room to another. Direct care furnished to the client is incidental to care of the home. These standards are included in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

b. _____ Home Health Aide Services. (Check one.)

_____ Services defined in 42 CFR 440.70 with the exception that limitations on the amount, duration and scope of such services shall instead be governed by the limitations imposed below.

_____ Other Service Definition: _____

State: Arizona

DEFINITION OF SERVICES (con't)

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

c. _____ Chore Services. (Check one.)

_____ Services identified in the ICCP which are needed to maintain the individual's home in a clean, sanitary and safe environment. For purposes of this section, the term "home" means the abode of the individual, whether owned or rented by the client, and does not include the residence of a paid caregiver with whom the client resides (such as a foster care provider), or a small or large community care facility.

Covered elements of this service include heavy household chores such as washing floors, windows and walls, removal of trash, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access inside the home for the recipient, and shoveling snow to provide access and egress.

Chore services will be provided only in cases where neither the client, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

State: Arizona

DEFINITION OF SERVICES (con't)

Provider qualifications are specified in Appendix C-2.

d. _____ Personal Care Services. (Check one.)

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service includes meal preparation, when required by the individual community care plan (ICCP), but does not include the cost of the meals. When specified in the ICCP, this service also includes such housekeeping chores as bedmaking, cleaning, shopping, or escort services which are appropriate to maintain the health and welfare of the recipient. Providers of personal care services must meet State standards for this service. These standards are included in Appendix C-2.

_____ Other Service Definition: _____

1. Services provided by family members. Check one:

_____ Payment will not be made for personal care services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

_____ Personal care providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

_____ Family members who provide personal care services must meet the same standards as other personal care providers who are unrelated to the recipient. These standards are found in Appendix C-2.

_____ Standards for family members who provide personal care services differ from those for other providers of this service. The standards for personal care services provided by family members are found in Appendix C-2.

2. Personal care providers will be supervised by:

_____ a registered nurse, licensed to practice nursing in the State

_____ case managers

_____ other (specify): _____

State: Arizona

DEFINITION OF SERVICES (con't)

3. Minimum frequency or intensity of supervision:

_____ as indicated in the client's ICCP

_____ other (specify): _____

4. Personal care services are limited to those furnished in a recipient's home.

_____ Yes _____ No

5. Limitations (check one):

_____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

_____ The State will impose the following limitations on the provision of this service (specify): _____

e. _____ Nursing Care Services Provided By or Under The Supervision of a Registered Nurse.

_____ Nursing services listed in the ICCP which are within the scope of State law, and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Standards for the provision of this service are included in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

State: Arizona

DEFINITION OF SERVICES (con't)

f. _____ Respite care. (Check one.)

_____ Services given to individuals unable to care for themselves; provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

_____ Other Service Definition: _____

1. Respite care will be provided in the following location(s):

_____ Recipient's home or place of residence

_____ Foster home

_____ Facility approved by the State which is not a private residence

2. The State will apply the following limits to respite care provided in a facility.

_____ Hours per recipient per year

_____ Days per recipient per year

_____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of facility-based respite care which may be utilized by a recipient.

_____ Not applicable. The State does not provide facility-based respite care.

3. Respite care will be provided in the following type(s) of facilities.

_____ Hospital

_____ NF

_____ ICF/MR

_____ Group home

_____ Licensed respite care facility

State: Arizona

DEFINITION OF SERVICES (con't)

_____ Other (specify): _____

_____ Not applicable. The State does not provide facility-based respite care.

4. The State will apply the following limits to respite care provided in a community setting which is not a facility (including respite care provided in the recipient's home).

_____ Hours per recipient per year
_____ Days per recipient per year

_____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of community-based respite care which may be utilized by a recipient.

_____ Not applicable. The State does not provide respite care outside a facility-based setting.

Qualifications of the providers of respite care services are included in Appendix C-2. Applicable Keys amendment (section 1616(e) of the Social Security Act) standards are cited in Appendix F-2.

g. _____ Training for Family Members in Managing the Individual. (Check one.)

_____ Training and counseling services for the families of functionally disabled elderly individuals. For purposes of this service, "family" is defined as the persons who live with or provide care to a disabled individual, and may include a spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the functionally disabled individual. Training includes instruction about treatment regimens and use of equipment specified in the ICCP and shall include updates as may be necessary to safely maintain the individual at home. This service is provided for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the individual at home. All training for family members must be included in the client's ICCP.

_____ Other Service Definition: _____

State: Arizona

DEFINITION OF SERVICES (con't)

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

h. _____ Adult Day Care. (Check one.)

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the client. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

_____ Other Service Definition: _____

Check all that apply:

1. _____ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of adult day care services.

2. _____ Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of adult day care services.

3. _____ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of adult day care services.

State: Arizona

DEFINITION OF SERVICES (con't)

4. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.

5. _____ Transportation between the recipient's place of residence and the adult day care center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of adult day care services.

6. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify): _____

Limitations. Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

i. _____ Services for individuals with chronic mental illness, consisting of (Check all that apply):

1. _____ Day Treatment or other Partial Hospitalization Services. (Check one.)

_____ Services that are necessary for the diagnosis or active treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

State: Arizona

DEFINITION OF SERVICES (con't)

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. patient training and education (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this benefit. The purpose of this benefit is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other Service Definition: _____

Limitations. Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

2. _____ Psychosocial Rehabilitation Services. (Check one.)

State: Arizona

DEFINITION OF SERVICES (con't)

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- o Restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- o Social skills training in appropriate use of community services;
- o Development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- o Telephone monitoring and counseling services.

The following services are specifically excluded from Medicaid payment:

Vocational services,
Prevocational services,
Supported employment services,
Educational services, and
Room and board.

_____ Other Service Definition: _____

Psychosocial rehabilitation services are furnished in the following locations (check all that apply):

a. _____ Individual's home or place of residence

b. _____ Facility in which the individual does not reside

c. _____ Other (Specify): _____

State: Arizona

DEFINITION OF SERVICES (con't)

Limitations. Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

3. _____ Clinic Services (Whether or Not Furnished in a Facility) are services defined in 42 CFR 440.90.

Check one:

a. _____ This benefit is limited to those services furnished on the premises of a clinic.

b. _____ Clinic services may be furnished outside the clinic facility. Services may be furnished in the following locations (specify): _____

Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

State: Arizona

DEFINITION OF SERVICES (con't)

Qualifications of the providers of this service are found in Appendix C-2.

j. _____ Habilitation. (Check one.)

_____ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully at home or in the community. This service includes:

1. _____ Residential habilitation: assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a home or community setting. Payments for residential habilitation are not made for room and board, or the costs of facility maintenance, upkeep, and improvement. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the recipient's immediate family. Payments will not be made for routine care and supervision, or for activities or supervision for which a payment is available from a source other than Medicaid. The methodology by which payments are calculated and made is described in Attachment 4.19-B.

2. _____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides. Services shall normally be furnished 4 or more hours per day, on a regularly scheduled basis, for 1 or more days per week, unless provided as an adjunct to other day activities included in the recipient's ICCP. Day habilitation services shall focus on enabling the individual to attain or retain his or her maximum functional level.

_____ Other Service Definition: _____

State: Arizona

DEFINITION OF SERVICES (con't)

Check all that apply:

A. _____ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of habilitation services.

B. _____ Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of habilitation services.

C. _____ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of habilitation services.

D. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.

E. _____ Transportation between the recipient's place of residence and the habilitation center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of habilitation services.

F. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify): _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: Arizona

DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Payment will not be made for the following:

Vocational Services;
Prevocational services;
Educational services; or
Supported employment services.

Qualifications of the providers of this service are specified in Appendix C-2.

k. _____ Environmental Modifications. (Check one.)

_____ Those physical adaptations to the home, required by the individual's ICCP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies the need for which is identified in the client's ICCP.

Adaptations or improvements to the home which are of general utility, or which are not of direct medical or remedial benefit to the client, such as carpeting, roof repair, central air conditioning, etc., are specifically excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: Arizona

DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

l. _____ Transportation. (Check one.)

_____ Service offered in order to enable individuals receiving home and community care under this section to gain access to services identified in the ICCP. Transportation services under this section shall be offered in accordance with the recipient's ICCP, and shall be used only when the service is not available without charge from family members, neighbors, friends, or community agencies, and when the appropriate type of transportation is not otherwise provided under the State plan. In no case will family members be reimbursed for the provision of transportation services under this section.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

m. _____ Specialized Medical Equipment and Supplies. (Check one.)

_____ Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the ICCP, which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This

State: Arizona

DEFINITION OF SERVICES (con't)

service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not otherwise available under the State plan. Items which are not of direct medical or remedial benefit to the recipient are excluded from this service. All specialized medical equipment and supplies provided under this benefit shall meet applicable standards of manufacture, design and installation.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

n. _____ Personal Emergency Response Systems (PERS). (Check one.)

_____ PERS is an electronic device which enables certain high-risk clients to secure help in the event of an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to signal a response center once the "help" button is activated. The response center is staffed by individuals with the qualifications specified in Appendix C-2.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: Arizona

DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

o. _____ Adult Companion Services. (Check one.)

_____ Non-medical care, supervision and socialization provided to a functionally disabled adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Companion services may include non-medical care of the client, such as assistance with bathing, dressing and uncomplicated feeding. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the client. This service is provided in accordance with a therapeutic goal in the ICCP, and is not merely diversionary in nature.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

3. Services provided by family members. Check one:

A. _____ Payment will not be made for adult companion services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

State: Arizona

DEFINITION OF SERVICES (con't)

B. _____ Adult companion service providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

1. _____ Family members who provide adult companion services must meet the same standards as other adult companion providers who re unrelated to the recipient. These standards are found in Appendix C-2.

2. _____ Standards for family members who provide adult companion services differ from those for other providers of this service. The standards for adult companion services provided by family members are found in Appendix C-2.

p. _____ Attendant Care. (Check one.)

_____ Hands-on care, of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. This service may include skilled medical care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of the client-based care may also be furnished as part of this activity.

_____ Other Service Definition: _____

Check all that apply:

1. _____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the ICCP.

State: Arizona

DEFINITION OF SERVICES (con't)

2. _____ Supervision may be furnished directly by the client, when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on observation of the client and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained with the client's ICCP.

3. _____ Other supervisory arrangements: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

q. _____ Private Duty Nursing. (Check one.)

_____ Private Duty Nursing services consist of individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within their scope of practice under State law.

_____ Other Service Definition: _____

Check one:

1. _____ Private duty nursing services are limited to services provided in the individual's home or place of residence.

State: Arizona

DEFINITION OF SERVICES (con't)

2. _____ Private duty nursing services are not limited to services provided in the individual's home or place of residence.

Check one:

A. _____ Services may also be provided in the following locations (Specify):

_____

_____

_____

B. _____ The State will not place limits on the site of private duty nursing services.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

_____

_____

_____

_____

_____

_____

r. _____ Extended State Plan Services. The following services are available under the State plan, but with limitations. Under this benefit, these services will be provided in excess of the limitations otherwise specified in the plan. Provider standards will remain unchanged from those otherwise indicated in the State plan. When these services are provided as home and community care, the limitations on each service will be as specified in this section.

1. _____ Physician services.

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

_____

_____

_____

State: Arizona

DEFINITION OF SERVICES (con't)

2. _____ Home Health Care Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

3. _____ Physical Therapy Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

4. _____ Occupational Therapy Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

5. _____ Speech, Hearing and Language Services

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

State: Arizona

DEFINITION OF SERVICES (con't)

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

6. _____ Prescribed Drugs

Check one:

A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _____ The State will impose the following limitations on the provision of this service (specify): _____

s. _____ Other services (specify): _____

Provider standards for each "other" services identified are found in Appendix C-2.

State: Arizona

PROVIDER QUALIFICATIONS

a. The following are the minimum qualifications for the provision of each home and community care service under the plan.

LICENSURE AND CERTIFICATION CHART

Cite relevant portions of State licensure and certification rules as they apply to each service to be provided.

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION
HOMEMAKER			
HOME HEALTH AIDE			
CHORE SERVICES			
PERSONAL CARE			
NURSING CARE			
RESPITE CARE			
IN HOME			
FACILITY BASED			
FAMILY TRAINING			
ADULT DAY CARE			
DAY TREATMENT/ PARTIAL HOSPITALIZATION			
PSYCHOSOCIAL REHABILITATION			
CLINIC SERVICES			

State: Arizona

PROVIDER QUALIFICATIONS (con't)

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION
HABILITATION			
RESIDENTIAL			
DAY			
ENVIRONMENTAL MODIFICATIONS			
TRANSPORTATION			
MEDICAL EQUIPMENT AND SUPPLIES			
PERSONAL EMERGENCY RESPONSE SYSTEMS			
ADULT COMPANION			
ATTENDANT CARE			
PVT DUTY NURSING			

Identify any licensure and certification standards applicable to the providers of "other" services defined in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

Identify any additional standards applicable to each service on a separate sheet of paper. Attach the paper to this Appendix.

b. ASSURANCE THAT REQUIREMENTS ARE MET

1. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under this section.

2. The State will require each provider furnishing services under this section to furnish proof that all applicable requirements for service provision, specified in this Appendix, are met prior to the provision of services for which FFP is claimed.

3. The State assures that it will review each provider at least once a year, to ensure that provider requirements continue to be met.

c. PROVIDER REQUIREMENTS APPLICABLE TO ALL SERVICES

In addition to standards of licensure and certification, each individual furnishing services under this section must demonstrate the following to the satisfaction of the State:

1. Familiarity with the needs of elderly individuals. The degree of familiarity must be commensurate with the type of service to be provided.

State: Arizona

PROVIDER QUALIFICATIONS (con't)

2. If the provider is to furnish services to individuals with Alzheimer's Disease or to recipients with other mental impairments, familiarity with the course and management of this disease, commensurate with the type of service to be provided.

3. The provider must furnish proof of sufficient ability to communicate with the client or primary caregiver. To be considered sufficient, this ability must be commensurate with the type of service to be provided.

4. Each provider must have received training, appropriate to the demands of the service to be provided, in proper response to emergency situations. This training must include instruction in how to contact the client's case manager.

5. Each provider must be qualified by education, training, experience and/or examination in the skills necessary for the performance of the service.

6. Providers may meet these standards by the following methods:

   A. Education, including formal degree requirements specified in the provider qualifications for the service to be furnished.

   B. Specific course(s), identified in the provider qualifications for the service to be furnished.

   C. Documentation that the provider has completed the equivalent of the course(s) identified in item c.6.B, above.

   D. Training provided by the Medicaid agency or its designee.

      The Medicaid agency or its designee will also make this training available to unpaid providers of service.

      _____ Yes _____ No

   E. Appropriate experience (specified in the provider qualifications for the applicable service) which may substitute for the education and training requirements otherwise applicable.

   F. The provider may demonstrate competence through satisfactory performance of the duties attendant upon the specified service. With regard to particular providers, and particular services, the State may also choose to require satisfactory completion of a written or oral test. Test requirements are included in the provider requirements applicable to the specific service.

Specific standards of education, training, experience, and/or demonstration of competence applicable to each service provided are attached to this Appendix.

d. PROVIDER REQUIREMENTS SPECIFIC TO EACH SERVICE

State: Arizona

PROVIDER QUALIFICATIONS (con't)

In addition to the licensure and certification standards cited in Appendix, the State will impose the following qualifications for the providers of each service.

SERVICE	MINIMUM QUALIFICATIONS OF PROVIDERS
HOMEMAKER	
HOME HEALTH AIDE	Providers of Home Health Aide services meet the qualifications set forth at 42 CFR Part 484 for the provision of this service under the Medicare program. Additional qualifications:
CHORE SERVICES	
PERSONAL CARE	
NURSING CARE	
RESPITE CARE IN HOME	
FACILITY BASED	
FAMILY TRAINING	
ADULT DAY CARE	
DAY TREATMENT/PARTIAL HOSPITALIZATION	Day treatment/partial hospitalization services are furnished by a hospital to its outpatients, or by a community mental health center. They are furnished by a distinct and organized ambulatory treatment center which offers care less than 24 hours a day.
PSYCHOSOCIAL REHABILITATION	
CLINIC SERVICES	
HABILITATION GENERAL STANDARDS	
RESIDENTIAL HABILITATION	
DAY HABILITATION	

State: Arizona

PROVIDER QUALIFICATIONS (con't)

SERVICE	MINIMUM QUALIFICATIONS OF PROVIDERS
ENVIRONMENTAL MODIFICATIONS	
TRANSPORTATION	
MEDICAL EQUIPMENT AND SUPPLIES	
PERSONAL EMERGENCY RESPONSE SYSTEMS	
ADULT COMPANION	
ATTENDANT CARE	
PVT DUTY NURSING	

Identify the provider requirements applicable to the providers of each "other" service specified in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

State: Arizona

ASSESSMENT

a. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in items 3 and 4 of Supplement 2.

b. This assessment will be provided at the request of the individual, or another person acting on the individual's behalf.

c. The individual will not be charged a fee for this assessment.

d. Attached to this Appendix is an explanation of the procedures by which the State will ensure the performance of the assessment.

e. The assessment will be reviewed and revised not less often than (check one):

1. _____ Every 12 months

2. _____ Every 6 months

3. _____ Other period not to exceed 12 months (Specify): _____

f. Check one:

1. _____ The State will use an assessment instrument specified by HCFA.

2. _____ The State will use an assessment instrument of its own specification. A copy of this instrument is attached to this Appendix. The State certifies that this instrument will measure functional disability as specified in section 1929(b) and (c) of the Act. The State requests that HCFA approve the use of this instrument, and certifies that at such time as HCFA may publish a minimum data set (consistent with section 1929(c)(2) of the Act), the assessment instrument will be revised, as determined necessary by HCFA, to conform to the core elements, common definitions, and uniform guidelines which are contained in the minimum data set.

g. In conducting the assessment (or the periodic review of the assessment), the interdisciplinary team must:

1. Identify in each such assessment or review each individual's functional disabilities; and

2. Identify in each such assessment or review each individual's need for home and community care. This identification shall include:

A. Information about the individual's health status;

B. Information about the individual's home and community environment; and

C. Information about the individual's informal support system.

State: Arizona

ASSESSMENT (con't)

3. Determine whether the individual is, or continues to be, functionally disabled. This determination will be made on the basis of the assessment or review.

h. The interdisciplinary team conducting the assessment shall furnish the results to the Medicaid agency and to the qualified community care case manager designated by the Medicaid agency (as specified in Appendix E) to establish, review and revise the individual's ICCP.

i. The Medicaid agency will monitor the appropriateness and accuracy of the assessments and periodic reviews on an ongoing basis, and whenever it is informed by a qualified community care case manager that inaccuracies appear to exist in the assessment of an individual. All problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

State: Arizona

INTERDISCIPLINARY TEAM

a. Initial assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting comprehensive functional assessments.

When assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the assessments without the prior written approval of the Medicaid agency.

b. Periodic reviews of assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

State: Arizona

INTERDISCIPLINARY TEAM (con't)

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting periodic reviews of the individuals' comprehensive functional assessments.

When periodic reviews of assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the periodic reviews without the prior written approval of the Medicaid agency.

c. The interdisciplinary teams conducting initial assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____

d. The interdisciplinary teams conducting periodic reviews of assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. _____ Registered nurse, licensed to practice in the State
2. _____ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. _____ Physician (M.D. or D.O.), licensed to practice in the State
4. _____ Social Worker (qualifications attached to this Appendix)
5. _____ Case manager
6. _____ Other (specify): _____

State: Arizona

INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

a. A written individual community care plan (ICCP) will be developed for each individual who has been determined, on the basis of a comprehensive functional assessment performed in accordance with Appendix D, to be a functionally disabled elderly individual, according to the criteria set forth in Appendices A and B.

b. The ICCP will be established, and periodically reviewed and revised, by a Qualified Community Care Case Manager after a face to face interview with the individual or primary caregiver.

c. The ICCP will be based on the most recent comprehensive functional assessment of the individual conducted according to Appendix D.

d. The ICCP will specify, within the amount, duration and scope of service limitations set forth in Appendix C, the home and community care to be provided to such individual under the plan.

e. The ICCP will indicate the individual's preferences for the types and providers of services.

f. The ICCP will specify home and community care and other services required by such individual. (Check one):

1. _____ Yes 2. _____ No

g. The ICCP will designate the specific providers (who meet the qualifications specified in Appendix C-2) which will provide the home and community care. (Check one):

1. _____ Yes 2. _____ No

h. Neither the ICCP, nor the State, shall restrict the specific persons or individuals (who meet the requirements of Appendix C-2) who will provide the home and community care specified in the ICCP.

State: Arizona

QUALIFIED COMMUNITY CARE CASE MANAGERS

a. A "Qualified Community Care Case Manager" will meet each of the following qualifications for the provision of community care case management.

1. Be a nonprofit or public agency or organization;

2. Have experience or have been trained in:

A. Establishing and periodically reviewing and revising ICCPs; and

B. The provision of case management services to the elderly.

The minimum standards of experience and training which will be employed by the State are attached to this Appendix;

3. Have procedures for assuring the quality of case management services. These procedures will include a peer review process.

4. The State will assure that community care case managers are competent to perform case management functions, by requiring the following educational or professional qualifications be met. (Check all that apply):

A. _____ Registered nurse, licensed to practice in the State

B. _____ Physician (M.D. or D.O.), licensed to practice in the State

C. _____ Social Worker (qualifications attached to this Appendix)

D. _____ Other (specify): _____

b. When community care case management is provided by a nonprofit, nonpublic agency, the agency providing the community case management will not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides home and community care or nursing facility services and will not furnish home and community care or nursing facility services itself. (Check one):

1. _____ Yes

2. _____ Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

c. The State will employ procedures to assure that individuals whose home and community care is managed by qualified community care case managers are not at risk of financial exploitation due to such managers. An explanation of these procedures is attached to this Appendix.

State: Arizona

QUALIFIED COMMUNITY CARE CASE MANAGERS (con't)

d. The State requests that the requirements of item E-2-b be waived in the case of a nonprofit agency located in a rural area. The State's definition of "rural area" is attached to this Appendix. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

State: Arizona

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS

a. A qualified community care case manager is responsible for:

1. Assuring that home and community care covered under the State plan and specified in the ICCP is being provided;

2. Visiting each individual's home or community care setting where care is being provided not less often than once every 90 days;

3. Informing the elderly individual or primary caregiver how to contact the case manager if service providers fail to properly provide services or other similar problems occur. This information will be provided verbally and in writing.

4. Completes the ICCP in a timely manner; and

5. Reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers.

b. Whenever a qualified community care case manager has reason to believe that an individual's assessment or periodic review (conducted under Appendix D) appears to contain inaccuracies, the community care case manager will bring these apparent discrepancies to the attention of the agency which has performed the assessment or review. If the assessors and the community care case manager are unable to resolve the apparent conflict, the case manager shall report the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

c. Whenever a qualified community care case manager is informed by an elderly individual or primary caregiver that provider(s) have failed to provide services, or that other similar problems have occurred, the community care case manager shall take whatever steps are necessary to verify or disprove the complaint. If a problem is confirmed by this monitoring, the community care case manager shall address the problem in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted. This may include reporting the situation to the component of the Medicaid agency which is responsible for monitoring the program.

1. _____ Yes 2. _____ No

d. Whenever a qualified community care case manager is informed by a provider of service (whether paid or unpaid) that there has been a change in the individual's condition, or that a problem may have arisen which is not currently being addressed, the community care case manager shall take whatever steps are necessary to verify or disprove the information. If a problem is confirmed by this monitoring, the community care case manager shall address it in an appropriate and timely manner, consistent with the nature and severity of the situation.

1. _____ Yes 2. _____ No

State: Arizona

COMMUNITY CARE CASE MANAGEMENT FUNCTIONS (con't)

e. Community care case managers shall verify the qualifications of each individual or agency providing home and community care services prior to the initiation of services, and at such intervals as are specified in Appendix C, thereafter. (Check one):

1. _____ Yes 2. _____ No

f. Where the provision of services in an individual's ICCP is not governed by State licensure or certification requirements, the community care case manager shall verify the qualifications of the individual or entity furnishing the services, and as necessary, provide or arrange for the training specified in Appendix C-2. (Check one):

1. _____ Yes 2. _____ No

3. _____ Not applicable. All services are governed by State licensure or certification requirements.

g. Community care case managers shall inform each elderly individual for whom an ICCP is established of the person's right to a fair hearing should the individual disagree with the contents of the ICCP.

State: Arizona

RIGHTS SPECIFIED IN THE STATUTE

The State assures that home and community care provided under the State plan will meet the following requirements:

a. Individuals providing care are competent to provide such care. The State will maintain documentation to show that each provider of care meets or exceeds the applicable minimum qualifications specified in Appendix C-2.

b. Individuals receiving home and community care shall be assured the following rights:

1. The right to be fully informed in advance, orally and in writing, of the following:

   a. the care to be provided,

   b. any changes in the care to be provided; and

   c. except with respect to an individual determined incompetent, the right to participate in planning care or changes in care.

2. The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities. A description of the procedures which the State will utilize to ensure this right is attached to this Appendix.

3. The right to confidentiality of personal and clinical records.

4. The right to privacy and to have one's property treated with respect.

5. The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

6. The right to education or training for oneself and for members of one's family or household on the management of care.

7. The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in the individual's ICCP.

8. The right to be fully informed orally and in writing of the individual's rights.

State: Arizona

ADDITIONAL RIGHTS

The State assures that home and community care provided under the State plan will meet the following additional requirements:

a. The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community care services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities. Copies of these standards are maintained at the Medicaid agency.

b. In the case of an individual who has been adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the individual are exercised by the person appointed under State law to act on the individual's behalf.

c. In the case of an individual who resides in his or her own home, or in the home of a relative, when the individual has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law. In addition, all rights to be informed of the care to be provided, and to have input into the development of the ICCP specified in Appendix F-1-b shall be extended to the principal caregiver.

d. In the case of an individual who resides in a community care setting, and who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law.

State: Arizona

GUIDELINES FOR PROVIDER COMPENSATION

a. The following advisory guidelines are provided for such minimum compensation for individuals providing home and community care. These guidelines will be used to assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

1. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under the approved Medicaid State plan, the State will compensate the providers on the same basis as that which is approved as part of the plan.

A. _____ Yes B. _____ No

2. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under another program funded and operated by the State, the State will compensate the providers on a basis which is equivalent to that used by the other publicly funded program.

A. _____ Yes B. _____ No

3. For services which are dissimilar to those provided under the plan or another program funded and operated by the State, the State will develop methods of compensation which are sufficient to enlist an adequate number of providers, taking into account the number of individuals receiving the service and their geographic location.

A. _____ Yes B. _____ No

b. The State assures that it will comply with these guidelines.

1. _____ Yes 2. _____ No

c. The methods by which the State will reimburse providers are described in attachment 4.19-B.

State: Arizona

COMMUNITY CARE SETTINGS-GENERAL

a. Definitions.

1. Small residential community care setting. A small residential community care setting is defined as a facility in which between 3 and 8 unrelated adults reside, and in which personal services (other than merely board) are provided in conjunction with residing in the setting. To qualify as a small residential community care setting, at least one resident must receive home and community care under this benefit.

2. Small nonresidential community care setting. A small nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves between 3 and 8 individuals, at least one of which receives home and community care under this benefit at the setting.

3. Large residential community care setting. A large residential community care setting is a facility in which more than 8 unrelated adults reside, and in which personal services are provided in conjunction with residing in the setting. To qualify as a large residential community care setting, at least one resident must receive home and community care under this benefit.

4. Large nonresidential community care setting. A large nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves more than 8 individuals, at least one of which receives home and community care under this benefit at the setting.

5. Unrelated adults. Unless defined differently under State law, for purposes of this benefit, unrelated adults are individuals who are 18 years of age or older, and who do not have any of the following relationships to other adults resident in the facility: spouses, parent (including stepparent) or child (including stepchild), or siblings.

6. Personal services. Personal services are those services provided to the individual by the setting, which are intended to compensate for the absence, loss, or diminution of a physical or cognitive function. Personal services, as defined here, are not equated with personal care services available under either 42 CFR 440.170, or personal care services provided under the home and community care benefit.

b. The State will provide home and community care to individuals in the following settings:

1. _____ Nonresidential settings that serve 3 to 8 people.

2. _____ Residential settings that serve 3 to 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

3. _____ Nonresidential settings that serve more than 8 people.

State: Arizona

COMMUNITY CARE SETTINGS-GENERAL

4. _____ Residential settings that serve more than 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

5. _____ Not applicable. The State will not provide services in these types of community care settings.

c. The State assures that the requirements of sections 1929(g) and (h) of the Act (as applicable to the specific setting) will be met for each setting in which home and community care is provided under this section.

d. FFP will not be claimed for home and community care which is provided in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

State: Arizona

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the client's individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

State: Arizona

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small nonresidential community care setting must meet any applicable State and local certification or license, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small nonresidential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients.

j. Nothing in this section shall be construed to require a small nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

k. Except to the extent dictated otherwise by State law, a small nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A small residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

g. Each small residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each small residential community care setting must meet any applicable State and local, certification, licensure, zoning, building and housing codes, and State and local fire and safety regulations.

i. Each small residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of residents.

j. Nothing in this section shall be construed to require a small residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

k. Except to the extent dictated otherwise by State law, a small residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large nonresidential community care settings.

The State will require that large nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

health or safety of the individual or other clients would be endangered.

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plans of remedial action in effect with respect to the facility.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large nonresidential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

c. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

d. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

State: Arizona

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

e. Each large nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

f. Each large nonresidential community care setting must be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

g. Nothing in this section shall be construed to require a large nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.

h. Except to the extent dictated otherwise by State law, a large nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

i. A large nonresidential community care setting must be licensed or certified under applicable State and local law.

j. A large nonresidential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.

_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of nonresidential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association for those particular settings.

_____ Yes _____ No

k. Each large nonresidential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.

State: Arizona

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

1. A large nonresidential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

State: Arizona

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large residential community care settings.

The State will require that large residential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.

2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.

3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.

4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.

5. Restraints may only be imposed -

A. to ensure the physical safety of the individual or other clients served in the setting, and

B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients) until such an order can reasonably be obtained.

6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.

7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.

10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.

11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.

12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.

13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting.

b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.

c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.

d. A large residential community care setting must extend to each individual served the following access and visitation rights.

1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.

2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.

3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(ii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.

1. The setting may not require clients to deposit their personal funds with the setting, and

2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.

3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.

4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:

1. The setting must deposit any amount of personal funds in excess of $50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.

2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

State: Arizona

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.

g. Each large residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.

h. Each large residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.

i. Nothing in this section shall be construed to require a large residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.

j. Except to the extent dictated otherwise by State law, a large residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

k. A large residential community care setting must be licensed or certified under applicable State and local law.

l. A large residential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.

1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.

_____ Yes _____ No

2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of residential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association.

_____ Yes _____ No

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

m. Each large residential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.

n. A large residential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

State/Territory: ARIZONA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.*

Medically Needy Not Covered

*Description provided on attachment

State/Territory: Arizona

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____ (NOT COVERED)

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.

/_/Provided: /_/No limitations /_/With limitations*

3. Other laboratory and X-ray services.

/_/ Provided: /_/ No limitations /_/With limitations*

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*

b.Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

c.Family planning services and supplies for individuals of childbearing age.

/_/Provided: /_/No limitations /_/With limitations*

*Description provided on attachment.

State/Territory: ARIZONA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(s): _____

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:

*Description provided on attachment.

State/Territory: ARIZONA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

Medically Needy
Not Covered

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*

b. Optometrists' Services

__ Provided: __ No limitations __ With limitations*

c. Chiropractors' Services

__ Provided: __ No limitations __ With limitations*

d. Other Practitioners' Services

__ Provided: __ No limitations __ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service 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 limitations __ With limitations*

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

__ Provided: __ No limitations __ With limitations*

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*

*Description provided on attachment.

State/Territory: ARIZONA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

Medically Needy
Not Covered

---

8. Private duty nursing services.

__ Provided: __ No limitations __ With limitations*

9. Clinic services.

__ Provided: __ No limitations __ With limitations*

10. Dental services.

__ Provided: __ No limitations __ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

__ Provided: __ No limitations __ With limitations*

b. Occupational therapy.

__ Provided: __ No limitations __ With limitations*

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

__ Provided: __ No limitations __ With limitations*

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*

b. Dentures.

__ Provided: __ No limitations __ With limitations*

*Description provided on attachment.

State/Territory: ARIZONA

Medically Needy

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED

Not Covered

MEDICALLY NEEDY GROUP(S): _____

c. Prosthetic devices.

__ Provided: __ No limitations __ With limitations*

d. Eyeglasses.

__ Provided: __ No limitations __ With limitations*

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

a. Diagnostic services.

__ Provided: __ No limitations __ With limitations*

b. Screening services.

__ Provided: __ No limitations __ With limitations*

c. Preventive services.

__ Provided: __ No limitations __ With limitations*

d. Rehabilitative services.

__ Provided: __ No limitations __ With limitations*

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

a. Inpatient hospital services.

__ Provided: __ No limitations __ With limitations*

b. Skilled nursing facility services.

__ Provided: __ No limitations __ With limitations*

*Description provided on attachment.

State/Territory: ARIZONA

Medically Needy

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____ Not Covered

c. Intermediate care facility services.

__ Provided: __ No limitations __ With limitations*

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*

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*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

__ Provided: __ No limitations __ With limitations*

17. Nurse-midwife services.

__ Provided: __ No limitations __ With limitations*

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

__ Provided: __ No limitations __ With limitations*

*Description provided on attachment.

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(Medically Needy Not Covered)

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

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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)(F) 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 for any remaining days in the month in which the 60th day falls.

___ Provided +: ___ Additional coverage + +

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

___ Provided +: ___ Additional coverage + + ___ Not provided.

21. Certified pediatric or family nurse practitioners' services.

___ Provided: ___ No limitations ___ With limitations*

___ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

\+ + 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.

Description provided on attachment

State/Territory: ARIZONA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

NOT COVERED

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. 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*

b. Services of Christian Science nurses.

/_/ Provided: /_/ No limitations /_/ With limitations*

c. Care and services provided in Christian Science sanitoria.

/_/ Provided: /_/ No limitations /_/ With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

/_/ Provided: /_/ No limitations /_/ With limitations*

e. Emergency hospital services.

/_/ Provided: /_/ No limitations /_/ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

/_/ Provided: /_/ No limitations /_/ With limitations*

NOT APPLICABLE

State/Territory: ARIZONA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

24. 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

25. Personal care services furnished to an individual who is not an inpatient or residnet 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 accorance 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 at home.

_____ Provided: _____ State Approved (Not Physician) Service Plan Allowed

_____ Services Outside the Home Also Allowed

_____ Limitations Described on Attachment

_____ Not Provided.

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STATE: ARIZONA

STANDARDS ESTABLISHED AND METHODS USED
TO ASSURE HIGH QUALITY CARE

The AHCCCS mission is to administer an innovative managed care program effectively and efficiently, and continually improve accessibility and delivery of quality health care to eligible members through integrated health systems. Below are the standards and methods used to assure high quality care:

1. AHCCCS has established a comprehensive system for assuring the delivery of high quality care. The Office of the Medical Director (OMD) in AHCCCS is responsible for facilitating quality health care delivery to members through identification, development and evaluation of quality indicators, formulation and interpretation of medical policy and by establishing health care service parameters.

2. Health Plans (HP) and Program Contractors (PC) are required, through contracts with AHCCCS, to provide quality medical care regardless of eligibility category or payer source. Each HP and PC must establish and implement processes to initiate, plan, assess, and evaluate quality improvement activities. The HP and PC must maintain a written QM/UM plan which provides detailed plans for compliance with requirements set forth in federal and State rules and the AHCCCS Medical Policy Manual, including the Manual requirement to report all standardized clinical outcome indicators. AHCCCS conducts annual on-site reviews to verify contract requirements are met.

   a. The OMD reviews are conducted to assess each HP's and PC's management of medical issues, quality management (QM), utilization management (UM) including both over and under utilization, compliance with AHCCCS medical policy, maternal child health services, family planning, EPSDT, dental services, immunization, case manager services and ALTCS Fee-For-Service (institutional and home and community based services). Quality management analysis (e.g., utilization reports and performance indicators) is a part of this process

   b. AHCCCS provides continuous training, technical assistance and interface to the HPs and PCs to develop and refine their QM plan, including performance indicators.

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STANDARDS ESTABLISHED AND METHODS USED
TO ASSURE HIGH QUALITY CARE

c. Problem resolution, including individual quality of care issues for members, access to care, level of coverage, quality of coverage provided and technology assessment takes place on an "as needed" basis.

3. All service providers must be registered with AHCCCS and assigned a provider type prior to furnishing services to members. Providers are required to meet the established provider profile and sign a provider agreement. The provider agreement language and format is consistent with Medicaid regulations and is mandatory for participation as an AHCCCS provider. Any provider who violates the terms of the provider agreement is subject to penalties, sanctions or termination.

   a. Any facility where care is provided to AHCCCS members must be appropriately licensed and/or certified as required by Arizona State law. OMD coordinates with regulatory agencies on the status of licensure/ certification of facilities and on the distribution of information to PCs and HPs when necessary.

   b. All providers must meet licensure and/or certification requirements appropriate to the provider type and as required by the professional licensing and certification boards or entities, and State statutes and rules. Each provider must submit documentation of required licenses and/or certifications prior to registration as an AHCCCS provider.

4. OMD provides prior authorization, concurrent and retrospective reviews for members receiving services through the ALTCS Fee-For-Service (FFS) program and the Emergency Services Program, and eligible members who are not yet enrolled in a HP or with a PC. OMD is responsible for resolution of FFS quality of care issues and utilization management/monitoring, including reinsurance review and utilization profiling. They also coordinate care for high risk member populations and tracking /trending of numbers and costs.

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METHODS OF PROVIDING TRANSPORTATION

Emergency Ambulance Services

Emergency ambulance transportation for eligible persons is a covered service if medically necessary based on an assessment of the eligible person's medical condition at the time of transport. Payment is limited to the cost of transporting eligible persons in a ground or air ambulance to the nearest appropriate provider or medical facility, when there is no other appropriate transportation available.

If the eligible person is enrolled with a Health Plan or Program Contractor, the ground or air ambulance provider shall notify Health Plan or Program Contractor within 10 (ten) working days from the date the emergency transportation is provided. Failure to notify the contractor shall be cause for denial or non-payment of the claim.

Medically Necessary Transportation

Whenever free transportation services are unavailable and an eligible person is unable to arrange or pay for transportation to a service site or location, the attending physician or practitioner shall order the fee-for-service transportation service in writing and obtain prior authorization. If the person is enrolled with a Health Plan or Program Contractor, these entities shall arrange or provide medically necessary transportation services, according to prior authorization guidelines.

Air Ambulance Services

Air ambulance services are covered for eligible persons only if the request is initiated by an emergency response unit, a law enforcement official, a hospital, a physician or clinic medical staff; and

(1) the point of pickup is inaccessible by ground ambulance; or

(2) great distances or other obstacles are involved in getting emergency services to the eligible person and transporting that person to the nearest appropriate hospital or other provider; or

(3) the medical condition of the eligible person requires ambulance service by a method faster than a ground ambulance service is able to provide.

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METHODS OF PROVIDING TRANSPORTATION

Meals, Lodging and Attendant Services

Expenses for meals, lodging and transportation for an eligible person are covered while en route to, or returning from, a health care service site which is outside of the eligible person's service area or county of residence, when the visit has been prior authorized.

Meals, lodging and transportation expenses of an attendant accompanying an eligible person out of the service area are covered services if the services of the attendant are ordered, in writing, by the primary care physician. The attendant may be a member of the eligible person's family household. The salary of an attendant is covered only when the attendant is not a member of the eligible person's family household.

Payment for meals, lodging, transportation and salary of an attendant (not to exceed federal minimum wage) is allowed only when the eligible person requires services which are not available in the service area. If the eligible person is admitted to an inpatient facility, the attendant's meals, lodging and salary are covered only when accompanying the eligible member en route to and returning from the facility.

Limitations

Family household members, friends and neighbors may be reimbursed for providing transportation services for the eligible person only if the services are ordered, in writing, by the primary care physician and free transportation or public transportation is unavailable.

A charitable organization, which routinely provides free transportation services to ambulatory or wheelchair-bound persons shall not charge or seek reimbursement from the Administration or contractors for the provision of transportation services to eligible persons, but may enter into subcontracting agreements with AHCCCS contractors for medically necessary transportation services.

Prior Authorization

Prior authorization, for transportation services which are provided or ordered by a capped fee-for-service provider is required for all non-emergent, medically necessary transportation services and all meals, lodging and services of an attendant.

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Standards for the Coverage of Organ Transplant Services

Medically necessary transplant services are available to AHCCCS members who meet nationally recognized criteria for non-experimental, non-investigational organ or tissue transplants.

AHCCCS members are eligible to receive all medically necessary transplant related services with the following exceptions:

- Title XIX SOBRA Family Planning Program members; and
- Federal Emergency Services Program (FESP) members.

AHCCCS members must meet specific prior authorization medical criteria to receive transplant services as specified in the AHCCCS Medical Policy Manual, or in a supplemental part of the AHCCCS Medical Policy Manual.

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STATE ARIZONA

STANDARD SETTING AND SURVEY AGENCY
FOR INSTITUTIONS AND SUPPLIERS OF SERVICES

A. The Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Health Services (ADHS) have entered into an Intergovernmental Agreement (IGA) whereby ADHS is responsible for Title XIX licensure and certification activities. This IGA is on file with AHCCCS.

B. To establish its standard setting and survey agency objectives, ADHS is responsible for:

1. Establishing, maintaining or monitoring, as appropriate, health, safety and other standards for the facilities and service suppliers listed in the IGA.

2. Developing and maintaining health, safety and other standards which shall also encompass, but not be limited to, Medicare and other standards enumerated in 42 CFR, Parts 442, 405 and 483 where applicable.

3. Developing and maintaining certification and licensure survey mechanisms and survey documents which shall also encompass Medicare and other standards enumerated in 42 CFR Parts 442, 405 and 483 where applicable.

   Survey mechanisms shall include site visit; development of findings report; corrective action requirements and monitoring; penalties and sanctions; and a decertification, license revocation and suspension process. Monitoring and follow-up procedures for adult foster care facilities that are not certified by the Contractor shall be conducted.

4. Providing the AHCCCS Administration with notification of any proposed rule or statute changes and hearings for the facilities and service suppliers listed in the IGA. Prior to finalization of any rule or statute change, providing the AHCCCS Administration with the opportunity for review and comment.

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STANDARD SETTING AND SURVEY AGENCY
FOR INSTITUTIONS AND SUPPLIERS OF SERVICES

5. Upon request, providing the AHCCCS Administration with copies of standards, including rules and interpretive guidelines, survey mechanisms and documents used in certification and licensure activities.

6. Conducting a periodic review of standards and rules.

7. Making all information related to standards readily accessible to HCFA and the AHCCCS Administration and to the public, as required by federal law (42 CFR 431.610(f)(4) and 45 CFR 1397.10).

Cooperative Arrangements with Health and Vocational Rehabilitation Agencies and Title V Grantees

In Arizona, the Arizona Department of Health Services (ADHS) is the health agency and the Title V grantee as defined by 42 CFR 431.615. The agency responsible for providing vocational rehabilitation services is the Department of Economic Security (DES), specifically the Division of Employment and Rehabilitation Services.

AHCCCSA meets the requirements of 42 C.F.R. 431.615 through the Intergovernmental Agreements (IGAs) identified in this Attachment. These IGAs are available for review in the AHCCCSA Contracts office.

ADHS-CRS IGA

Children's Rehabilitative Services (CRS) is a program within ADHS' Division of Family Health Services which provides medical care to eligible persons under 21 years of age who have specific handicapping or potentially handicapping conditions which have the potential for functional improvement through medical, surgical or therapy modalities.

This agreement enables AHCCCSA Health Plans and Program Contractors access to CRS' network of specialized providers by referring members with covered conditions to that program for evaluation and treatment.

ADHS Mental Health IGA

This agreement enables AHCCCSA to capitate ADHS' Division of Behavioral Health for providing mental health care services to select population groups specified in the agreement. AHCCCSA Health Plans and Program Contractors may refer members to the ADHS system for mental health care. ADHS subcontracts with Regional Behavioral Health Authorities which are responsible for maintaining a network of providers within their designated geographic area.

Cooperative Arrangements with
Health and Vocational Rehabilitation Agencies and Title V Grantees

ADHS Dental IGA

This agreement obtains dental consultation services from ADHS on an as needed basis. The types of services that could be provided include: providing technical assistance regarding utilization review for dental services and delivering dental care efficiently; periodically reviewing AHCCCSA dental policy and standards; consulting on individual case reviews or fee-for-service prior authorization requests.

DES Eligibility IGA

The primary purpose of this agreement is to specify DES' requirements for providing eligibility determination services for AHCCCSA. It also contains a provision which requires DES to coordinate medically necessary care with AHCCCSA providers for any Title XIX eligible person to whom DES is providing vocational rehabilitation services since individuals who will require this type of coordination can often be identified when during the application process.

DES CMDP IGA

This agreement enables AHCCCSA to capitate DES for Title XIX eligible foster children receiving care through the Comprehensive Medical and Dental Program (CMDP). CMDP is treated similar to an AHCCCSA Health Plan.

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COORDINATION WITH SPECIAL SUPPLEMENTAL FOOD
PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

The AHCCCS Administration has cooperative arrangements with other State agencies for the coordination of operations under the Special Supplemental Food Program for Women, Infants and Children (WIC) under Section 17 of the Child Nutrition Act of 1966. The following is a description of cooperative arrangements between the State agencies.

1. The AHCCCS Administration and the Arizona Department of Economic Security (DES) have revised policy and training for medical assistance to reflect the provision of WIC services through the Arizona Department of Health Services (DHS).

2. Written instructions covering the implementation of WIC notification to all eligible households including women and children are provided.

3. WIC brochures are available for distribution and a verbal explanation of these benefits is given to everyone at the time of initial application interviews and recertification. Additional brochures are placed in DES and AHCCCS local office reception areas so they can be available to persons in other programs who may qualify for these benefits. Women enrolled in AHCCCS health plans, who at some time after certification become pregnant, are notified by their health plan coordinator of the WIC benefits.

4. Finally, the State assures that timely notification of WIC benefits will be provided. For ongoing monitoring purposes, review procedures are being established to ensure that notification of these benefits are provided in a timely manner to pregnant women, breastfeeding women, women in their postpartum period and children under the age of five.

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LIENS AND ADJUSTMENTS OR RECOVERIES

1. **The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:**

   The State tracks ALTCS Medicaid members who are institutionalized. If the member is institutionalized in a nursing facility, ICF/MR, or other medical institution defined in 42 CFR 435.1009 for 90 consecutive days, there is a rebuttable presumption that she/he is not reasonably expected to be discharged and return home.

   After the 90th day, the member or member's representative is sent a Notice of Intent advising that the State intends to place a TEFRA lien on the real property. The Notice of Intent advises the member of the exceptions and exemptions to TEFRA liens, as well as the member's right to request a state fair hearing. Additional information is included with the Notice of Intent describing the Estate Recovery Program and TEFRA liens.

   A member may rebut the above presumption by providing a written opinion from a treating physician that she/he is reasonably expected to be discharged and return home. The physician's opinion must state that the member's condition is likely to improve to the point that the member will be discharged from the medical institution and will be capable of returning home by a certain date.

   Transfers from one medical institution to another do not interrupt the 90-day period.

   A discharge to a community setting will terminate the 90-day period. If the member is re-admitted to a medical institution, a new 90-day period will begin. However, discharge to a community setting which is not the member's home will not constitute a basis for removal of a lien which had previously been placed.

2. **The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR § 433.36(f):**

   A son or daughter of the member must have lived with the member for the two years prior to the date of admission and provided care that enabled the member to reside at home. The following documentation must be provided:

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- Physician's statement describing the member's physical condition and service needs for the previous two years;
- Verification that the son or daughter lived in the home;
- Statement from the son or daughter providing services that describes and attests to the services provided;
- Any statement from the member regarding the services received, if available; and
- Statement from a physician, friend or relative as witness to the care provided.

3. **The State defines the terms below as follows:**

Estate: "The property of the decedent, trust or other person whose affairs are subject to this title as originally constituted and as it exists from time to time during administration. As it relates to a spouse, the estate includes only the separate property and the share of the community property belonging to the decedent or person whose affairs are subject to this title." Property "includes both real and personal property or any interest in real and personal property and means anything that may be the subject of ownership." (A.R.S. 14-1201.16 and 1412.01.41)

Individual's home: The property in which a member has an ownership interest and which serves as the member's primary residence. This property includes the shelter, the land on which the shelter is located and any related outbuildings.

Equity interest in the home: The county assessor's full cash value or market value of the home minus any valid liens, encumbrances or both.

Residing in the home for at least one or two years on a continuous basis: Occupancy of a member's home by a sibling or son or daughter of the member as a primary place of residence. During the one or two year period, the member's home address was used by the sibling or son or daughter as their permanent address and the address remained unchanged.

Lawfully residing: To live in a residence with the authorization of the owner and within the bounds of the law.

On a continuous basis: Without interruption.

Discharge from the medical institution and return home: To be officially discharged from the medical institution with the intent to return to the primary

residence. Discharge does not include release from the medical institution for medical leave days or visitation days.

4. **The State defines undue hardship as follows:**
AHCCCS' undue hardship criteria for a waiver of the estate claim follows federally suggested guidelines. AHCCCS waives its claim against the member's estate when any one of the heirs to the estate meets AHCCCS' undue hardship criteria. AHCCCS' undue hardship criteria apply when the estate contains either real or personal property, or both. Real property in the estate is listed as residential property by the Arizona Department of Revenue or County Assessor's Office.

   Undue Hardship exists if an heir to the estate meets either of the criteria below:
   - Owns a business that is located at the residential property which has been in operation at the residential property for at least 12 months preceding the AHCCCS member's death and provides more than 50% of the heir(s) livelihood and recovery of the property would result in the heir(s) to the estate losing their means of livelihood; or
   - Currently resides in the member's residence, resided there at the time of the AHCCCS member's death, has made the residence his or her primary residence for the 12 months immediately preceding the AHCCCS member's death and owns no other residence.

5. **The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:**
AHCCCS will waive its claim against the estate when the estate contains personal property assets only and an heir to the estate meets the criteria listed in both (1) and (2) below:
   (1) The heir(s) annual gross income for their household size is less than the federal income poverty guidelines. New sources of income (for example, employment, Social Security, etc.) will be included in determining the household's annual gross income; and
   (2) The heir does not own a home, land or other real property. If there is no heir to the estate that meets AHCCCS' undue hardship criteria as described in number 4 above, the State will not waive its claim against the estate. The State, however, will consider a Partial Recovery (reduction) of the estate claim if one of the heirs to the estate submits a completed application and supporting documentation to substantiate a qualifying

condition for a Partial Recovery. The Partial Recovery process is discussed in number 7.

If an estate consists of both personal and real property that meet the criteria for undue hardship waiver, AHCCCS may either grant an undue hardship waiver, or adjust its claim to the value of the personal property.

AHCCCS shall exempt the following income, resources and property of Native Americans (NA) from estate recovery:

- Income and resources from tribal land and other resources currently held in trust and judgment funds from the Indian Claims Commission or U.S. Claims Court;
- Ownership interest in trust or non-trust property;
- Ownership interests left as remainder in an estate in rents, leases, royalties or usage rights related to natural resources;
- Any other ownership interests in property rights that have unique religious, spiritual, traditional or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom; and
- Income left as a remainder in an estate derived from any property that was either collected by a NA or by a Tribe or Tribal organization and distributed to a NA.

A TEFRA lien shall not be placed against a member's home if one of the following individuals is lawfully residing in the member's home:

- Member's spouse;
- Member's son or daughter under the age of 21 years;
- Member's son or daughter who is blind or disabled under 42 U.S.C. 1382c; or
- Member's sibling who has an equity interest in the home and who was residing in the home for at least one year immediately prior to the date of admission to a medical institution as defined under 42 CFR 435.1009.

AHCCCS shall not attempt to recover a lien if the member is survived by any of the following:

- a spouse;
- a son or daughter under the age of 21;
- a son or daughter who receives benefits under either Title II or Title XVI of the Social Security Act as blind or disabled as defined under 42 U.S.C. 1382c;

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- a sibling currently residing in the deceased member's home and who was residing in the member's home for at least one year immediately prior to the member's admission to a medical institution; or
- a son or daughter currently residing in the deceased member's home who was residing in the member's home for at least two years immediately prior to the member's admission to a medical institution and who provided care to the member which allowed the member to reside in their home.

6. **The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):**
No initial cost threshold is applied and all potential cases are worked for recovery. However, should an estate enter into litigation, a $5,700 litigation cost threshold has been established which is applied at the point of litigation to determine whether it is cost effective to pursue recovery. Cases are worked in the order of priority using the amount of the AHCCCS' claim and the amount of estate assets as guidelines.

The following factors are taken into consideration in determining whether it is cost effective to pursue recovery:
- The claim amount;
- The priority of the claim;
- Other creditors and the amounts of their claims;
- Total estate assets;
- The number of surviving heir(s) to the estate;
- Legal and administrative costs necessary to obtain recovery; and
- Consequences of an unfavorable judicial decision.

The litigation threshold of $5,700 is based on the following methodology:
- $2,000 allowance for claim litigation threshold;
- $3,200 for attorney fees; and
- $500 for miscellaneous expenses (for example, preparing the case for attorneys, briefing attorneys, or negotiations with estate executor).

7. **The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):**

The TPL Contractor identifies potential cases using referrals provided by AHCCCS and other sources. Referral sources include, but are not limited to:

- AHCCCS' automated eligibility systems;
- Authorized representative;
- Estate representative;
- Personal representative;
- Public fiduciary;
- Probate court; or
- Newspaper clipping service.

Once a referral is received by the TPL Contractor from AHCCCS or another referral source, the TPL Contractor files a Demand for Notice with the Superior (Probate) Court in the county of residence, county of death, and county of property ownership. The Notice requires the court to notify AHCCCS about all orders and filings regarding the AHCCCS member's estate and assist in the protection of the state's interest in any future estate proceeding.

The TPL Contractor also mails the personal representative a Notice of Intent to File a Claim Against the Estate, an Estate Questionnaire and a copy of the Demand for Notice that was filed with the Superior Court(s).

The Notice of Intent to File a Claim Against the Estate cites federal and state Laws authorizing AHCCCS to seek reimbursement for AHCCCS' expenditures for the member and explains that a Demand for Notice has been filed with the Superior (Probate) Court.

The Estate Questionnaire provides information about exemptions and lists documents to provide if there is a surviving spouse of the member, surviving son or daughter of the member who is under age 21 or a surviving son or daughter of the member who is blind or disabled.

In addition, the questionnaire requests information about:

- property transfers since AHCCCS eligibility was determined;
- real and personal property owned by the AHCCCS member;
- the name and address of attorney or personal representative; and
- any petition filed for probate of the estate, and if so, the date filed and county court in which filed.

The party is given information on where to send the completed form, timeframes for submitting and whom to contact with any questions.

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The TPL Contractor closes the estate case if documentation is provided that verifies that the estate qualifies for an Estate Claim Statutory Exemption. If requested to do so by the personal representative or heir, the TPL Contractor files a withdrawal of the Demand for Notice with the Superior (Probate) Court. AHCCCS Demands for Notice that are left on file at the Superior (Probate) Court do not have any legal impact to heirs.

Upon identification that an AHCCCS member has an estate that will be filed by affidavit (small estate) or probated, and no qualifying Estate Claim Statutory Exemption has been identified, the TPL Contractor files a Superior Court Claim Against the Estate to provide information to the Court and interested parties that the estate is indebted to AHCCCS and the amount to which the estate is indebted. The TPL Contractor mails a copy of the Superior Court Claim Against the Estate and a Notification of the AHCCCS Claim Against the Estate to the personal representative with the following enclosures:

- Application form for Estate Claim Statutory Exemption, Undue Hardship Waiver or Partial Recovery of the AHCCCS Claim against the estate;
- Chronology of AHCCCS Medical Payment History; and
- Copy of the Superior Court Claim against the estate that was filed with the Superior (Probate) Court.

Notification of the AHCCCS claim includes the following information:

- AHCCCS claim amount and an itemization of AHCCCS expenditures to be recovered;
- Authority for the AHCCCS estate claim;
- Estate Claim Statutory Exemption criteria for a waiver of the estate claim and documentation required to support the criteria;
- Undue Hardship Waiver of Estate Claim criteria and documentation required to support the criteria;
- Partial Recovery criteria and documentation required to support the criteria;
- Explanation of the enclosed application form and the application process for applying for one or more of the three processes: Estate Claim Statutory Exemption, Undue hardship Waiver of Estate Claim and/or Partial Recovery;
- Timeframes for filing a completed application;
- To whom and where to file the application and supporting documentation;
- Whom to contact if there are any questions; and
- The heir's right to file a grievance and request a hearing.

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The personal representative is responsible for notifying the heirs and, if the heirs so choose, filing a request for an Estate Claim Statutory Exemption, Undue Hardship Waiver of Estate Claim and/or a Partial Recovery. Heirs are responsible for providing any supporting documentation. Applications must be submitted in writing with supporting documentation within 30 days from the date on the Notification of the AHCCCS Claim Against the Estate.

An heir may apply to receive a waiver under the Estate Claim Statutory Exemption or Undue Hardship Waiver of Estate Claim processes or a reduction of the claim under the Partial Recovery process based on his or her circumstances. Application and supporting documentation are reviewed first for an Estate Claim Statutory Exemption, followed by an Undue Hardship Waiver of Estate Claim, and lastly, for Partial Recovery dependent on the process(es) applied for and the decision(s) rendered.

If supporting documentation for an Estate Claim Statutory Exemption is provided to establish a qualifying exemption, the TPL Contractor reviews the supporting documentation and renders a decision. If the TPL Contractor determines that there is a qualifying condition for an Estate Claim Statutory Exemption, the TPL Contractor files a withdrawal of the Superior Court Claim Against the Estate with the Superior (Probate) Court, sends a Decision Notice regarding the AHCCCS Estate Claim and a copy of the withdrawal of the Superior Court Claim Against the Estate to the personal representative or heir and closes the case. No further action is taken.

If there is no qualifying Estate Claim Statutory Exemption and the application section of the application form has been completed for consideration of an Undue Hardship Waiver of Estate Claim, the application and supporting documentation are reviewed for a qualifying Undue Hardship Waiver of Estate Claim. The TPL Contractor reviews the application and supporting documentation and makes a recommendation to AHCCCS. If AHCCCS determines that there is a qualifying Undue Hardship Waiver of Estate Claim, AHCCCS will waive the prorata share of the probate assets attributable to the heir qualifying for the waiver. The TPL Contractor files a withdrawal of the Superior Court Claim Against the Estate with the Superior (Probate) Court, sends a Decision Notice Regarding the AHCCCS Estate Claim and a copy of the withdrawal of the Superior Court Claim Against the Estate to the personal representative or heir and closes the case. No further action is taken.

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A withdrawal of the Superior Court Claim Against the Estate releases both an AHCCCS claim against an estate filed by affidavit (small estate) or probated.
If there is no qualifying Estate Claim Statutory Exemption or Undue Hardship Waiver of Estate Claim and the personal representative or heir has completed the application section of the application form for consideration of Partial Recovery, the TPL Contractor reviews the application and supporting documentation and makes a recommendation to AHCCCS. AHCCCS may undertake partial recovery to avoid an undue hardship situation.

The factors that AHCCCS considers on a case-by-case basis when reviewing application requests and supporting documentation for a Partial Recovery include:

- Financial and medical hardship to the heir(s);
- Income of the heir(s) and whether the household income is within 100% of the Federal Poverty Guidelines;
- Resources of the heir(s);
- Value and type of assets in the estate (real and personal);
- Amount of the AHCCCS claim against the estate;
- Whether other creditors have filed claims against the estate or have foreclosed on the property; or
- Any other factors relevant for a fair and equitable determination under the circumstances of a particular case.

If AHCCCS determines there is a qualifying condition for a Partial Recovery, the TPL Contractor sends a Decision Notice Regarding the AHCCCS Estate Claim to the personal representative or heir and advises them of the approval for a reduction of the estate claim and that the new claim amount represents the amount due. The TPL Contractor closes the case when payment of the reduced claim is paid in full.

AHCCCS will not grant a Partial Recovery of the estate claim when there are sufficient assets in the estate to pay the claim and provide for the heir. AHCCCS' decision to grant a Partial Recovery does not waive or release its remaining claim against the estate of the AHCCCS member.

AHCCCS may initiate probate if the estate contains enough assets to pay a portion of or the full amount of AHCCCS' claim, if the case is legally uncontested with no other issues.

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If AHCCCS denies an application for an Estate Claim Statutory Exemption, Undue Hardship Waiver of Estate Claim and/or Partial Recovery, the TPL Contractor mails a Decision Notice Regarding the AHCCCS Estate Claim to the personal representative and sends a copy of the Decision Notice to the heir. The Decision Notice regarding the AHCCCS Estate Claim informs the personal representative and heir that AHCCCS has denied the application(s) and the full amount of AHCCCS' claim remains in force. The estate will be released when all available funds have been collected.

The Decision Notice regarding the AHCCCS Estate Claim includes the following information:

- Decision regarding application for Estate Claim Statutory Exemption, Undue Hardship Waiver of Estate Claim and/or Partial Recovery as applicable to the specific case;
- Reasons why the application was approved/denied;
- The amount due and payable to AHCCCS, if any;
- Instructions where to send the payment;
- Whom to contact to answer any questions; and
- The heir's right to file a grievance and request a hearing.

If the representative and/or heir(s) disagree with AHCCCS' Decision, they may file a grievance with the AHCCCS Administration. The grievance must be submitted in writing and must be received by the AHCCCS Administration, Office of Legal Assistance, Mail Drop 6200, PO Box 25520, Phoenix, Arizona 85002, no later than 60 days of the Decision Notice regarding the AHCCCS Estate Claim.

When a grievance is received, the Office of Legal Assistance (OLA) will either:

- Review the agency action and issue a final agency decision within 30 days (which final decision can then be appealed to a fair hearing); or
- Schedule the matter directly to hearing before an Administrative Law Judge (ALJ) at the Office of Administrative Hearings (OAH).

If OLA reviews the grievance and renders a decision, OLA sends the grievance decision, which contains information regarding the right to request a hearing at OAH, to the Complainant. Requests for hearing of OLA's decision must be submitted in writing and mailed or hand delivered to OLA so that it is received by OLA not later than 35 days from the date of the OLA grievance decision notice.

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If an administrative hearing is held concerning an estate matter, the ALJ issues a Recommendation Decision to the Director of AHCCCS within 20 days of the conclusion of the hearing.

Within 30 days of receipt of the Recommended Decision, the AHCCCS Director issues a Director's Decision, which will adopt, modify or reject the ALJ's Recommended Decision. A copy of the Director's Decision is mailed to all parties with information regarding filing a Motion for Rehearing or Review of the Director's Decision and appealing the Director's Decision to court. Additional information about the grievance process is found in Arizona Administrative code, Chapter R9-28-801 et seq.

If the assets of the AHCCCS member's estate are insufficient to pay all claims in full, the creditors of the estate are paid according to the priority of payment of claims as set forth by the Arizona Probate Code, A.R.S. § 14-3805. Statute provides that the personal representative of the estate shall pay expenses and creditors of the estate in the following order:

- Costs and expenses of administration, which includes:
  - Attorney's fees;
  - Probate Court fees;
  - Reasonable compensation of the personal representative or administrator;
  - Reasonable costs associated with the maintenance and repair of the real property of the estate; and
  - Other expenses reasonably related to the administration of the estate as determined by AHCCCS.
- Reasonable funeral expenses.
- Debts and taxes with preference under federal law.
- Reasonable and necessary medical and hospital expenses of the last illness of the decedent, including compensation of persons attending the decedent.
- Debts and taxes with preference under the laws of this state.
- All other claims.

Requests for refunds:
If an heir or personal representative disagrees with the estate claim amount that was paid to AHCCCS, a Request for Refund form must be completed by the heir or personal representative and submitted to AHCCCS with any supporting documentation. AHCCCS will review the request for refund and render a

decision within 30 days of receipt of the request. The decision notice will contain the following information:

- Reason why the refund was approved or denied;
- Who the heir or personal representative can contact with questions; and
- Explanation of the right of the heir or personal representative to file a grievance or request a hearing.

If an heir or personal representative disagrees with the estate claim amount stated on the Notification of the AHCCCS Claim Against the Estate prior to payment, a request must be made for review within 30 days of receipt of the Notification of the AHCCCS Claim Against the Estate along with any supporting documentation. The TPL contractor will review for an Estate Claim Statutory Exemption, Undue Hardship Waiver of Estate Claim and/ or a Partial Recovery. If any of these conditions are approved, the heir and personal representative will be notified of a withdrawal of the lien or the reduced estate claim amount.

TEFRA Lien notice procedures:
AHCCCS shall send the member, or the member's representative, a Notice of Intent at least 30 days prior to filing a TEFRA lien. The Notice of Intent shall include:

- A description of a TEFRA lien and what action AHCCCS intends to take;
- How a TEFRA lien affects the member's property;
- The legal authority for filing a TEFRA lien;
- The time frames and procedures involved in filing a TEFRA lien;
- The member's right to request a State Fair Hearing; and
- The process and time frames for requesting a State Fair Hearing.

Exemption of a TEFRA lien:
A request for exemption of a TEFRA lien must be in writing and received within 30 days of the member's receipt of a Notice of Intent. The request must describe the factual basis for a claim that the property should be exempt from placement of a TEFRA lien or recovery of a TEFRA lien.

State Fair Hearing procedures for TEFRA liens and Estate Recovery:
The request for a State Fair Hearing must be made in writing and within 30 days of notification of AHCCCS' intended action, including:

- A Notice of Intent to place a TEFRA line against a member's property;
- The denial of a request for exemption from a TEFRA lien;
- Notification of an AHCCCS claim made against the estate; or

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- The denial of a request to waive estate recovery because of an undue hardship.

AHCCCS shall mail the member a Notice of Hearing if the request for hearing is made timely. AHCCCS shall mail the member a Director's Decision no later than 30 days after the date of the Administrative Law Judge's recommended decision and within 90 days of the request for hearing.

Release of a TEFRA lien:
AHCCCS shall issue a release of a TEFRA lien within 30 days of:

- Satisfaction of the lien; or
- Notice that the member has been discharged from the medical institution and has returned home with the intent to remain in the home.

AHCCCS views "satisfaction of the lien" as a written document from AHCCCS indicating that the lien amount has been satisfied and/or paid.

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State Arizona

1. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge			Amount or Percentage and Basis for Determination
	D	Coins	Copay	
(1)	(2)	(3)	(4)	(5)
N/A				N/A

State ARIZONA

The following enrollment fee, premium or similar charge is imposed on the medically needy:

Gross Family Income (per mo.)	Charge Family Size 1 or 2	3 or 4	5 or more	Liability Period	Frequency of Charges
(1)	(2)	(3)	(4)	(5)	(6)
$150 or less					
151 - 200					
201 - 250					
251 - 300	NOT APPLICABLE				
301 - 350					
351 - 400					
401 - 450					
451 - 500					
501 - 550					
551 - 600					
601 - 650					
651 - 700					
701 - 750					
751 - 800					
801 - 850					
851 - 900					
901 - 950					
951 - 1000					
More than $1000					

State ARIZONA

Effect on recipient of non-payment of enrollment fee, premium or similar charge:

___ Non-payment does not affect eligibility

___ Effect is as described below:

NOT APPLICABLE

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State: ARIZONA

A. The following charges are imposed on the medically needy for services:

Service and Basis for Determination	Type of Charge			
	Deduct.	Coins.	Copay.	Amount

NOT APPLICABLE

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B. The method used to collect cost sharing charges for medically needy individuals:

___ Providers are responsible for collecting the cost sharing charges from individuals.

___ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

NOT APPLICABLE

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

NOT APPLICABLE

E. Cumulative maximums on charges:

___ State policy does not provide for cumulative maximums.

___ Cumulative maximums have been established as described below:

NOT APPLICABLE

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Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

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State/Territory: Arizona

C. State or local funds under other programs are used to pay for premiums:

/_/ Yes /X/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

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Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

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State/Territory: Arizona

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

N/A

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

STATE OF ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE

INTRODUCTION

Attachment 4.19-A describes the inpatient hospital reimbursement methodology for fee-for-service (FFS) payments made by the Arizona Health Care Cost Containment System Administration (AHCCCSA) to hospitals under both the AHCCCS acute care and the Arizona Long Term Care System (ALTCS) programs. Because the AHCCCS and the ALTCS programs operate on a prepaid capitation basis, the majority of inpatient hospital services received by AHCCCS and ALTCS members are provided through and paid directly by contracting health plans or program contractors. However, inpatient hospital services provided to certain off-reservation Indian Health Services members, Emergency Services Only populations, and special cases are paid on a FFS basis.

Beginning with admission dates of October 1, 1999 and thereafter, FFS payments to hospitals will be made in accordance with a prospective, tiered per diem reimbursement system. For each day of care which meets medical necessity and other applicable authorization requirements, hospitals will receive one of seven per diem rates appropriate to the type of service rendered. The tiered per diem payment methodology does not apply to: organ transplants (with the exception of cornea transplants which are reimbursed under the tiered per diem methodology) and bone marrow transplants, other specialty services, out-of-state hospitals, and freestanding psychiatric hospitals. This submittal is organized into seven sections:

- Definitions
- General Description of the Tiered Per Diem Rate Structure
- Rate Setting Methodology
- Payment to New and Out-of-State Hospitals, and for New Programs
- Payment to Freestanding Psychiatric Hospitals
- Appeals Procedures
- Public Notice

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE

I. DEFINITIONS

A. AHCCCS Days of Care

Inpatient hospital days of care that are eligible for payment under this plan are defined as the admission day and each day of stay except the day of discharge, provided that all medical necessity and authorization requirements have been met. If a member who is an inpatient dies, the date of death (date of discharge) is paid provided all medical necessity and authorization requirements have been met. Except in the case of death, hospital stays where the day of admission and discharge are the same are called same day admit and discharge claims, and are paid as an outpatient hospital claim (including same day transfers). Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid the lesser of the maternity/nursery tier rate or the outpatient cost-to-charge ratio multiplied by covered ancillary and accommodation charges. A claim must be legible, error free, and have an accommodation revenue code and an allowable charge greater than zero to receive payment as an inpatient hospital day.

B. New Hospital

A new hospital is any hospital for which Medicare Cost Report data and AHCCCS claims and encounter data are not available from any owner or operator of the hospital for hospital rate development, during the rate-setting year.

C. Operating Costs

Operating costs are defined as allowable accommodation and ancillary department hospital costs, excluding capital and direct medical education.

D. Outlier

Outliers are hospital claims in which the operating costs per day are extraordinary. AHCCCS shall set the statewide outlier cost threshold for each tier at the greater of:

1) Three standard deviations from the statewide mean operating cost per day within the tier; or

2) Two standard deviations from the statewide mean operating costs per day across all tiers.

The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers by multiplying the covered charges on a claim by the Medicare urban or rural cost-to-charge ratio. The Medicare urban or rural cost-to-charge ratio is defined as the sum of Medicare's urban or rural statewide average operating cost-to-charge ratio and Medicare's statewide average capital cost-to-charge ratio. If covered costs per day on a claim exceed the urban or rural cost threshold for a tier, the claim shall be considered an outlier. If there are two tiers on a claim or encounter, AHCCCS shall determine whether the claim or encounter is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying the threshold for each tier by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.

Routine maternity stays shall be excluded from outlier reimbursement. A routine maternity is any one-day stay with a delivery of one or two babies. A routine maternity stay will be paid at tier.

The Medicare urban cost-to-charge ratio will be used for hospitals located in an Arizona county of 500,000 residents or more, and for out-of-state hospitals. The Medicare rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.

E. Peer Group

A peer group consists of hospitals which share a common and stable characteristic which significantly influences the cost of providing hospital services when measured statistically.

F. Prospective Rates

Prospective rates are inpatient hospital rates defined in advance of a payment period and represent payment in full for covered services excluding any quick-pay discounts, slow pay penalties, and third party payments regardless of billed charges or individual hospital costs.

G. Prospective Rate Year

The prospective rate year is the period from October 1 of each year to September 30 of the following year.

II. GENERAL DESCRIPTION OF THE TIERED PER DIEM RATE STRUCTURE FOR INPATIENT SERVICES

For admissions on and after October 1, 1999 AHCCCS will reimburse in-state acute care hospitals for each AHCCCS day of care with a prospective per diem rate representing payment for both ancillary and accommodation services. Each AHCCCS day of care is classified into one

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE

of seven service categories (tiers) and is paid the per diem rate corresponding to that category unless the claim is identified as an outlier claim, or is for a covered organ (with the exception of cornea transplants which are reimbursed under the tiered per diem methodology) or bone marrow transplant or other specialty services which may be paid under separate contract arrangements. This section describes the structure of the tiered per diem payment system.

A. Tiered Rate Structure

Medically necessary AHCCCS days of care that meet all medical review and authorization requirements are assigned to tiers based on information submitted on the claim. The classification logic examines revenue codes, diagnostic and procedure code information, and peer groups as applicable. Assignment to a tier follows the ordered, hierarchical processing described below. It is possible for some AHCCCS days of care on a claim to be classified into one tier and the remaining AHCCCS days of care on the claim to be classified to a different tier for payment purposes. A claim can never have AHCCCS days of care paid on the basis of more than two tiers. If a claim has no charges associated with an accommodation revenue code it is not considered an inpatient day for payment.

The following are the seven tiers:

1) **Maternity:** The maternity tier is identified by a primary diagnosis code within the range of 640.XX - 643.XX, 644.2X - 676.XX, V22.XX - V24.XX or V27.XX. If a claim has a primary diagnosis within one of these ranges, all the days on the claim are paid at the maternity tier rate.

2) **NICU:** The neonatal intensive care tier is identified by a revenue code of 174. For a hospital to qualify for the NICU per diem, the hospital must be classified as either a level II or level III perinatal center by the Arizona Perinatal Trust. All of the days on the claim with the NICU revenue code that meet the criteria for the NICU tier will be paid at the NICU per diem. Any remaining days on the claim are paid at the nursery tier rate.

3) **ICU:** The intensive care tier is identified by a revenue code in the range of 200-204, 207-212 or 219. All of the days on the claim with an ICU revenue code that meet the criteria for the ICU tier will be paid at the ICU rate. If there are days on the claim without an ICU revenue code, they may be paid at the surgery, psychiatric or routine tier rate.

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4) **Surgery:** The surgery tier is identified by a revenue code of 36X in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgery procedure list. This excluded procedure list identifies minor procedures such as sutures which do not require the same hospital resources as other procedures. If these conditions are met, and the surgery was performed on a date after the person was determined AHCCCS eligible, any day that is not associated with an ICU revenue code is paid at the surgery tier rate.

5) **Psychiatric:** The psychiatric tier is identified in either of the following ways:

   a. A psychiatric revenue code within the range of 114, 124, 134, 144 or 154 and any psychiatric diagnosis in the range of 290.XX - 316.XX; or

   b. Any routine revenue code if all diagnosis codes on the claim are within the range of 290.XX - 316.XX.

   A claim with day(s) paid at the psychiatric tier rate, may also have day(s) paid at the ICU tier rate.

6) **Nursery:** A revenue code of 17X (excluding 174) is required to classify a day into this tier for payment at the nursery tier rate. A claim with day(s) paid at the nursery tier rate may also have day(s) paid at the NICU tier rate.

7) **Routine:** Other days associated with revenue codes within the following ranges that are not classified into one of the tiers listed above are paid at the routine per diem rate: 100-101, 110-113, 116-123, 126-133, 136-143, 146-153, 156-159, 16X, 206, 213 or 214.

Any day which does not group into a tier is pended for examination and may require additional information to be submitted before tier classification can occur.

B. Payment of Outliers, Transplants and Other Specialty Services

This section describes certain exceptions to the tiered payment rates for special cases in acute care hospitals.

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INPATIENT HOSPITAL CARE

1) **Outliers**: Effective with dates of service on and after October 1, 2007, AHCCCS shall reimburse hospitals for outlier claims by multiplying covered charges by the sum of Medicare's urban or rural statewide average operating cost-to-charge ratio and Medicare's statewide average capital cost-to-charge ratio, updated annually and phased in as described below. For rates effective on and after October 1, 2007, outlier cost thresholds shall be updated annually by the increase or decrease in the index published by the Global Insight hospital market basket index for prospective hospital reimbursement.

For calculations using the Medicare urban or rural cost-to-charge ratios, including outlier determination and threshold calculation, AHCCCS shall phase in the use of the Medicare urban or rural cost-to-charge ratios as follows: For outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient cost-to-charge ratio and the sum of Medicare's urban or rural statewide average operating cost-to-charge ratio and Medicare's statewide average capital cost-to-charge ratio. For outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient cost-to charge ratio and the sum of Medicare urban or rural statewide average operating cost-to-charge ratio and Medicare's statewide average capital cost-to-charge ratio.

For payment of outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio. For payment of outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio.

For outlier claims with dates of service on or after October 1, 2009, the full Medicare urban or rural cost-to-charge ratios shall be utilized for all calculations. The three year phase-in does not apply to out of state or new hospitals.

2) **Transplants**: Organ transplants (excluding cornea transplants) and bone marrow transplants are not reimbursed under the tiered per diem system. AHCCCS shall reimburse hospitals for an acute care stay in which a covered organ (excluding cornea) or bone marrow transplant was performed either through the terms of any relevant contract agreement; or, in the absence of a contract, by multiplying covered charges by the statewide inpatient cost-to-charge ratio inclusive of capital.

3) **Specialty Services**: AHCCCS may negotiate special contracts for specialized hospital services, including but not limited to: subacute, neonatalogy, neurology, cardiology and burn care.

III. RATE-SETTING METHODOLOGY

The final payment for each tier is the sum of two separate components: operating and capital. This section describes each component and how it is calculated. Five of the seven tiers are statewide. The NICU tier is peer grouped for NICU Level II versus NICU Level III, as certified by the Arizona Perinatal Trust. The Routine tier is peer grouped for rehabilitation hospital versus general acute care hospital.

A. Base Operating Component

The operating component of the rate represents the weighted average operating cost per day for treating AHCCCS patients in that tier across all acute care hospitals in Arizona with two exceptions:

Exception 1: For the Routine tier, the component represents the weighted average operating cost per day by peer group. The peer groups for the Routine tier are rehabilitation hospitals, and general acute care hospitals.

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Exception 2: For the NICU tier, the component represents the weighted average operating cost per day by peer group. The peer groups for the NICU tier are NICU Level III hospitals, and NICU Level II hospitals, as certified by the Arizona Perinatal Trust.

The computation of the operating component, and the application of inflation factors to the operating component, are described in the following paragraphs.

1) **Computation of Operating Cost:** Operating costs were computed based on a claim costing process involving cost report data and claims/encounter data for each hospital:

a. Hospital cost reports for fiscal years ending in 1996 served as the cost report data base. The cost report data provided ancillary department cost-to-charge ratios and accommodation costs per day. Cost-to-charge ratios were calculated for each hospital department. Cost-to-charge ratios were capped at 1.00 for each department. Because hospital cost report years are not standard, prior to calculating rates cost per diems were inflated to a common point in time, December 31, 1996, using the DRI inflation factor. Capital and medical education costs were excluded for computation of the operating cost component.

b. Hospital claims and encounters were pulled that matched each hospital's Medicare FYE96 dates of service for the claims and encounters data base. Only claims and encounters that were accepted and processed by AHCCCS at the time the extract file was developed were included. Claims/encounter data were also subjected to a series of data quality, data reasonableness, and data integrity edits. Claims/encounters that failed edits were excluded from the data base. Duplicate claims, claims with missing information necessary to group into a tier, and Medicare crossover claims, among others were excluded in this process.

c. The claim and cost data bases were then combined. Because revenue codes on claims and encounters do not match cost centers or departments on cost reports, a cross walk was developed for matching.

d. Operating costs were derived from the combined cost/claim data bases by applying departmental cost-to-charge ratios for a hospital to allowed ancillary charges on each claim. Ancillary charges were inflated to December 31, 1996, using the DRI

inflation factor. Accommodation costs were derived by multiplying the covered days on the claim/encounter times the accommodation cost per diems from the cost report.

e. Costed claims/encounters were then assigned to tiers using the logic specified above. For claims assigned to more than one tier, ancillary costs were allocated to the tiers in the same proportion as the accommodation costs.

f. All costs were reduced by an audit adjustment factor equal to four percent since cost reports were not audited.

2) **Inflation Factor**: For rates effective on and after October 1, 1999, AHCCCS shall inflate the operating component of the tiered per diem rates to the mid-point of the prospective rate year, using the DRI inflation factor.

Length of Stay (LOS) Adjustment: For rates effective October 1, 1999 through September 30, 2000, the operating component of the Maternity and Nursery tiers shall be adjusted to reflect changes in LOS as required by the federal mandate that allows women at least 48 hours of inpatient care for a normal vaginal delivery, and at least 96 hours of inpatient care for a cesarean section delivery, effective for dates of service on and after January 1, 1998. There shall be no LOS updates for any tiers for rates effective on or after October 1, 2000.

B. Direct Medical Education Component

Direct medical education includes nursing school education, intern and resident salaries, fringes and program costs and paramedical education.

1) For dates of service on and after October 1, 1997 (FFY98), GME payment dollars will be separated from the tiered per diem rates to create an AHCCCS GME pool. For FFY98 and each year thereafter, the value of the GME pool will be based on the total GME payments made for claims and encounters in FFY96, inflated by the global insight hospital market basket index. Subject to State legislative appropriations, on an annual basis GME pool funds will be distributed to each hospital with an approved GME program based on the percentage of the total FFY96 GME pool that each hospital's FFY96 GME payment represented. In

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essence, the percentage of the total FFY96 GME pool that a hospital received in FFY96 will be the percentage of the total FFY98 GME pool that a hospital receives in FFY98. New GME programs approved on or before October 1, 1999, but that did not receive a GME payment in FFY96, will receive a FFY98 GME payment based on the percentage of the total FFY96 GME pool that their FFY97 payment represented.

2) For the service period of January 1, 2007 to June 30, 2007, the AHCCCS Administration shall distribute up to $6 million for GME above the amount prescribed above in the following order or priority:

a) For the direct costs to support the expansion of GME programs established before July 1, 2006 at hospitals that do not receive payments pursuant to paragraph B(1). These programs must be approved by the AHCCCS Administration.
b) For the direct costs to support the expansion of GME programs established on or before October 1, 1999. These programs must be approved by the AHCCCS Administration.
c) For the direct costs of GME programs established on or after July 1, 2006. These programs must be approved by the AHCCCS Administration.

The Administration will allocate funds to eligible GME programs based on the number of filled resident positions in each program, weighted by Medicaid utilization, and a statewide average per-resident cost. The amount allocated to each program will be distributed to the eligible hospitals participating in that program based on each hospital's level of program participation.

For example:
IF: Program X Total Residents = 10; and
Participating Hospital A Rotation Share = 50%; and
Participating Hospital B Rotation Share = 30%; and
Participating Hospital C Rotation Share = 20%; and
Participating Hospital A Medicaid Load = 30%; and
Participating Hospital B Medicaid Load = 35%; and
Participating Hospital C Medicaid Load = 40%; and
Statewide Average Per Resident Amount = $95,000

THEN: Program X Medicaid-Weighted Residents = (10 x .50 x .30) + (10 x .30 x .35) + (10 x .20 x .40) = 3.35; Program X Allocation = 3.35 x $95,000 = $318,250; and

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Participating Hospital A Distribution = [(10 x .50 x .30)/3.35] x $318,250 = $142,500
Participating Hospital B Distribution = [(10 x .30 x .35)/3.35] x $318,250 = $ 99,750
Participating Hospital C Distribution = [(10 x .20 x .40)/3.35] x $318,250 = $ 76,000

For the service period January 1, 2007 to June 30, 2007, the number of residents for a program will be divided by two.

Medicaid utilization for each hospital will be determined using the most recent as-filed Medicare Cost Report on file with the Administration and the Administration's inpatient hospital Fee-For-Service claims and managed care encounter data for the time period corresponding to the MCR for each hospital. The Medicaid utilization percent for each hospital will be calculated as its total Medicaid inpatient days divided by total MCR inpatient days, rounded up to the nearest 5%. Total MCR inpatient days will be taken from Form 2552, Worksheet S-3, Part 1, Line 12, Column 6. The Medicaid utilization from the most recent as-filed Medicare cost reporting period is a proxy for the Medicaid utilization for the service period.

The statewide average per-resident cost will be determined using the most recent as-filed MCR on file with the Administration and resident counts reported by hospitals and GME programs. The average will be calculated by totaling all Intern/Resident direct costs for all hospitals reporting such costs on the MCR and dividing by the total number of residents at those hospitals. The direct I/R costs will be taken from Form 2552, Worksheet B, Part 1, Lines 22 & 23, Column 0.

A filled resident position is a GME program position for which a resident is enrolled and receiving a salary. The number of filled resident positions in a program will be derived by program reporting to the Administration.

A hospital's level of participation is defined by the hospital's share of resident rotations within the program. For example, if residents in Program X spend nine months of the year on rotation at hospital A and three months at hospital B, then hospital A's level of participation in Program X is 75% and hospital B's level of participation is 25%. The program rotation schedules will be derived by program and hospital reporting to the Administration.

For the service period of January 1, 2007 to June 30, 2007, all hospitals will be distributed the full amount as computed by the prescribed distribution formula for its qualifying GME programs.

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3) Beginning July 1, 2007, the AHCCCS Administration shall distribute monies appropriated for graduate medical education above the amount prescribed in paragraph B(1) in the following order of priority:

a) For the direct costs to support the expansion of GME programs established before July 1, 2006, at hospitals that do not receive payments pursuant to paragraph B(1). These programs must be approved by the AHCCCS Administration.
b) For the direct costs to support the expansion of GME programs established before July 1, 2006, at hospitals that receive payments pursuant to paragraph B(1). These programs must be approved by the AHCCCS Administration.

The Administration will allocate funds to eligible GME programs based on the number of filled resident positions in each program, weighted by Medicaid utilization, and a statewide average per-resident cost. The amount allocated to each program will be distributed to the eligible hospitals participating in that program based on each hospital's level of program participation.

For example:

IF: Program X Total Residents =10; and
Participating Hospital A Rotation Share =50%; and
Participating Hospital B Rotation Share =30%; and
Participating Hospital C Rotation Share =20%; and
Participating Hospital A Medicaid Load =30%; and
Participating Hospital B Medicaid Load =35%; and
Participating Hospital C Medicaid Load =40%; and
Statewide Average Per Resident Amount =$95,000

THEN: Program X Medicaid-Weighted Residents =(10 x .50 x .30) +(10 x .30 x .35) +(10 x .20 x .40) =3.35; Program X Allocation =3.35 x $95,000 =$318,250; and

Participating Hospital A Distribution =[(10 x .50 x .30)/3.35] x $318,250 =$142,500
Participating Hospital B Distribution =[(10 x .30 x .35)/3.35] x $318,250 =$ 99,750
Participating Hospital C Distribution =[(10 x .20 x .40)/3.35] x $318,250 =$ 76,000

For purposes of the allocation described above, resident positions that are funded under paragraph B(1) will be excluded. For example, Program X existed on October 1, 1999 with 5 filled resident positions as of October 1, 1999. On July 1, 2006 (the effective date of the statutory authority for expansion funding), Program X had 7 filled resident positions. It follows that program X has 5 resident positions that are funded by existing GME payments, and 2

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resident positions that are eligible for expansion funding. The per-resident allocation to Program X will be based on the 2 resident positions.

Medicaid utilization for each hospital will be determined using the most recent as-filed Medicare Cost Report on file with the Administration and the Administration's inpatient hospital Fee-For-Service claims and managed care encounter data for the time period corresponding to the MCR for each hospital. The Medicaid utilization percent for each hospital will be calculated as its total Medicaid inpatient days divided by total MCR inpatient days, rounded up to the nearest 5%. Total MCR inpatient days will be taken from Form 2552, Worksheet S-3, Part 1, Lines 12 and 14, Column 6. The Medicaid utilization from the most recent as-filed Medicare cost reporting period is a proxy for the Medicaid utilization for the service period.

The statewide average per-resident cost will be determined using the most recent as-filed MCR on file with the Administration and resident counts reported by hospitals and GME programs. The average will be calculated by totaling all Intern/Resident direct costs for all hospitals reporting such costs on the MCR and dividing by the total number of residents at those hospitals. The direct I/R costs will be taken from Form 2552, Worksheet B, Part 1, Lines 22 & 23, Column 0.

A filled resident position is a GME program position for which a resident is enrolled and receiving a salary. The number of filled resident positions in a program will be derived by hospital and program reporting to the Administration.

A hospital's level of participation is defined by the hospital's share of resident rotations within the program. For example, if residents in Program X spend nine months of the year on rotation at hospital A and three months at hospital B, then hospital A's level of participation in Program X is 75% and hospital B's level of participation is 25%. The program rotation schedules will be derived by program and hospital reporting to the Administration.

For the service period of July 1, 2008, to June 30, 2009, the Administration shall distribute up to $14,394,200 under this paragraph. If funds are insufficient to cover all calculated distributions within any priority group described in paragraphs B(3)(a) and (b), the Administration shall adjust the distributions proportionally within that priority group.

4) Beginning July 1, 2007 the AHCCCS Administration shall distribute monies appropriated for graduate medical education above the amounts prescribed in paragraphs B(1) and B(3) for the direct costs of graduate medical education programs established or expanded on or after July 1, 2006. These programs must be approved by the Administration.

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The Administration will allocate funds to eligible GME programs based on the number of filled resident positions in each program, weighted by Medicaid utilization, and a statewide average per-resident cost according to the methodology described in paragraph B(3).

For the service period of July 1, 2008, to June 30, 2009, the Administration shall distribute up to $4,000,000 under this paragraph. If funds are insufficient to cover all calculated distributions, the Administration shall adjust the distributions proportionally.

C. New Hospitals

Payments made to new hospitals with GME programs will be calculated using a statewide average where necessary until hospital-specific data can be obtained.

D. Indirect Medical Education Component

Beginning July 1, 2007, the AHCCCS Administration shall distribute monies appropriated for graduate medical education above the amounts prescribed in paragraphs B(1), B(3), and B(4) for a portion of additional indirect medical education costs at hospitals with GME programs with residency positions

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that include rotations in any county other than Maricopa or Pima whose population was less than five hundred thousand persons at the time the residency rotation was added to the academic year rotation schedule. These programs must be approved by the Administration.

The Administration will allocate funds for indirect costs to eligible GME programs based on the number of filled resident positions in each program that include rotations in qualifying counties, the number of months that a program's residents rotate to facilities in those counties, and a Medicaid-specific statewide average per-resident-per-month cost. The program allocation will be calculated as follows:

Program Allocation =(Total filled resident positions that include rotations in qualifying counties) x (Number of months per academic year that each resident will spend on such rotations) x (Medicaid-specific statewide average per-resident-per-month cost).

A filled resident position is a GME program position for which a resident is enrolled and receiving a salary. The number of filled resident positions in a program and the number of months that program residents rotate to facilities in qualifying counties will be derived by hospital and program reporting to the Administration.

The Medicaid-specific statewide average per-resident-per-month cost will be determined using the most recent as-filed Medicare cost reports on file with the Administration, and will be based on a calculated Medicaid IME cost for all hospitals that calculate a Medicare IME payment on the Medicare cost report and the total number of residents at those hospitals. A hospital's Medicaid IME costs will be calculated as follows:

Medicaid IME costs =(Calculated Medicare IME payment) x [(Medicaid utilization percent) / (Medicare utilization percent)]

The calculated Medicare IME payment for each hospital will be taken from Form 2552, Worksheet E, Part A, Line 3.24, Column "Hospital". The Medicaid utilization percent for each hospital will be determined using the method and data sources described by paragraph B(3), except that the ratio will not be rounded up to the nearest 5%. The Medicare utilization percent for each hospital will be calculated as its total Medicare inpatient days divided by its total inpatient days. The total Medicare inpatient days will be taken from Form 2552, Worksheet S-3, Part 1, Lines 12 and 14, Column 4. The total inpatient days will be taken from Form 2552, Worksheet S-3, Part 1, Lines 12 and 14, Column 6. The Medicaid and Medicare utilization from the most recent as-filed Medicare cost reporting period is a proxy for the Medicaid and Medicare utilization for the service period.

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The Medicaid-specific statewide average per-resident-per-month cost will be calculated by totaling the Medicaid IME costs for all hospitals that have such costs, dividing the result by the total number of residents at those hospitals, and dividing that result by 12.

The amount allocated to each program will be distributed to the program's sponsoring hospital or the program's base hospital if the sponsoring institution is not a hospital. The total amount distributed to a hospital for all programs combined shall not exceed the hospital's Medicaid IME costs calculated by the Administration or the median of all such costs if the Administration has not calculated costs for the recipient hospital.

For the service period of July 1, 2008, to June 30, 2009, the Administration shall distribute up to $2,500,000 under this paragraph. If funds are insufficient to cover all calculated distributions, the Administration shall adjust the distributions proportionally.

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E. Medical Education Funding Transfer Authority

Any remaining unallocated authority from paragraphs B(3), B(4) or D, may be redistributed among those pools if necessary to address insufficient funding levels in any of them.

F. Indirect Medical Education - Intergovernmental Transfer

Beginning July 1, 2007, the Administration may enter into intergovernmental agreements with local, county, and tribal governments wherein local, county and tribal governments may transfer funds to the Administration. Such funds will be used to qualify for additional federal funds. Those funds will be used for the purposes of reimbursing hospitals specified by the local, county, or tribal government for indirect program costs other than those reimbursed under paragraph D. Funds available under this subsection shall be distributed in accordance with paragraph D except that reimbursement with such funds includes resident positions or rotations other than those in counties with populations of less than five hundred thousand persons. The total amount distributed to a hospital under paragraphs D and F combined shall not exceed the hospital's Medicaid IME costs calculated by the Administration or the median of all such costs if the Administration has not calculated costs for the recipient hospital.

For the service period of July 1, 2008 to June 30, 2009, the Administration shall distribute up to $27,141,000 in total funds under this paragraph. Of this amount, $18,000,000 will be distributed to Maricopa Medical Center, the only public teaching hospital in Maricopa County and $9,141,000 million to hospitals designated by Pima County (specifically, University Medical Center and University Physicians Healthcare Hospital at Kino Campus). Any unallocated authority remaining from paragraphs B(3), B(4) or D after any necessary redistribution under paragraph E may be distributed to the hospitals designated by Pima County under this paragraph.

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G. Capital Component

Hospitals shall receive payment to compensate for capital costs associated with treating AHCCCS members. The capital component is a blend of hospital-specific and statewide costs, as defined below.

1) **Calculation of Capital Costs**: Capital costs for each hospital are identified through a claim costing process using accommodation cost per diems and cost-to-charge ratios in a manner similar to that described for operating costs. Costs identified using ratios and per diems which include only operating are subtracted from costs identified using ratios and per diems which include capital as well as operating. The result is capital cost per claim which is summed across claims for each hospital and divided by covered days. The statewide average is calculated based on capital costs across all claims divided by covered days across claims.

2) **Blend** Capital reimbursement represents a blend of statewide and individual hospital costs. For rates effective on and after October 1, 1999, the capital component shall be frozen at the 40% hospital-specific/60% statewide blend in effect on January 1, 1999.

PROSPECTIVE RATE YEAR	HOSPITAL SPECIFIC	STATEWIDE
1 (3/1/93-9/30/94)	90%	10%
2 (10/1/94-9/30/95)	80%	20%
3 (10/1/95-9/30/96)	70%	30%
4 (10/1/96-9/30/97)	60%	40%

5 (10/1/97-9/30/98)	50%	50%
6 (10/1/98) and after	40%	60%

3) **Capital Payment by Tier**: Capital payments effective before September 30, 2000, shall be indexed to each tier by a relative weight factor, which is calculated by dividing each of the hospital's tiered operating rates by the weighted average of all the tiered operating rates for that hospital. For rates effective on and after October 1, 2000, this weighting of capital rates by tier will be frozen at the level in effect on September 30, 2000.

4) **Annual Update:** On an annual basis, AHCCCS shall adjust the capital component by the DRI inflation factor.

D. Discounts and Penalties

AHCCCS shall subject all inpatient hospital admissions on and after March 1, 1993 to quick-pay discounts and slow-pay penalties in accordance with Arizona Revised Statute (A.R.S.) Title 36, Chapter 29, Article 1.

For dates of service or admissions on or after October 1, 1999, a quick pay discount of 1% is applied to claims paid within 30 days of the clean claim date.

Effective with dates of service or admissions on or after March 1, 1993, if a hospital's bill is paid after 30 days but within 60 days of the clean claim date, AHCCCS shall pay 100% of the rate. If a hospital's bill is paid any time after 60 days of the clean claim date, AHCCCS shall pay 100% of the rate plus a fee of 1% per month for each month or portion of a month following the 60th day of receipt of the bill until the date of payment.

IV. PAYMENT TO NEW HOSPITALS AND OUT-OF-STATE HOSPITALS, AND FOR NEW PROGRAMS

A. New Hospitals

New hospitals are assigned the statewide (or peer group) average operating cost and the statewide average capital amount for each tier, as appropriate. Capital reimbursement for new hospitals is indexed according to statewide relative weights per tier. New hospitals may

be eligible to receive direct GME payments from AHCCCS once the hospital's cost and claim data are available.

A new hospital's statewide operating and capital components shall be updated annually by the DRI inflation factor.

B. Out-of-State Hospitals

Out-of-state hospitals providing covered services (excluding organ and transplantation services) to persons eligible for AHCCCS are paid based on the lower of negotiated discount rates, the statewide average inpatient cost-to-charge ratio multiplied by covered charges, or if reasonably and promptly available, the Medicaid rate in effect at the time the covered services are provided in the state in which the hospital is located.

Out-of-state hospitals providing covered organ and transplantation services to persons eligible for AHCCCS are paid negotiated rates, at the discretion of the Director.

C. New Programs

Hospitals with new programs that are not reflected on the Medicare Cost Reports used to establish the tiered per diem rates will not be included in the tiered per diem rates. However, at the discretion of the Director, new medical education programs may be recognized.

V. PAYMENT TO FREESTANDING PSYCHIATRIC HOSPITALS

Psychiatric hospitals are paid an all-inclusive per diem fee determined for urban and rural areas based on the contracted rates used by the mental health contractor, the Arizona Department of Health Services.

VI. APPEALS PROCEDURES

Facilities may appeal rates within the limits of Arizona statute through the AHCCCS grievance and appeals process. Facilities may also informally request a rate review.

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 TRIBAL FACILITIES

Effective January 1, 2000, AHCCCS will reimburse the Indian Health Service (IHS) and 638 tribal facilities for Medicaid inpatient hospital services in accordance with the OMB all-inclusive rate most recently published in the Federal Register. Additionally, AHCCCS reimburses the IHS and 638 tribal facilities for inpatient professional services based on the AHCCCS' capped fee-for-service schedule.

The Navajo Nation and the Gila River Indian Community operate a nursing facility on-reservation and are reimbursed based on the established fee-for-service rate for long term care facilities in Attachment 4.19-D. All inpatient professional services will be reimbursed based on the AHCCCS capped fee-for-service schedule.

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The following is a description of methods and standards for determining payment rates for specific services when payments are made directly to providers. Fee-for-services payments are made in accordance with the Arizona Health Care Cost Containment System Fee-For-Service Provider Manual and are subject to the limitations set forth in Attachment 3.1-A of the State Plan.

- **Outpatient Hospital Services**
  From July 1, 2004 through June 30, 2005, AHCCCS shall reimburse a hospital by applying a hospital-specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona Department of Health Services by more than 4.7 per cent for dates of service effective on or after July 7, 2004, the hospital-specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7 per cent, the effective date of the increased charges will be the effective date of the adjusted AHCCCS cost-to-charge ratio.

  Beginning with dates of service on and after July 1, 2005, AHCCCS shall reimburse hospitals for outpatient acute care hospital services from a prospective fee schedule, by procedure code, established by AHCCCS. Hospitals with similar characteristics (peer groups) such as: rural/CAH designation, bed size, special needs hospitals, public ownership, GME programs or Level I Trauma Centers, may be paid percentage adjustments above the fee schedule amount not to exceed the total payments received under comparable circumstances pursuant to Medicare upper limits. Rural hospitals, defined as hospitals in Arizona, but outside Maricopa and Pima counties, may be paid an adjustment above the fee schedule amount not to exceed the total payments received under comparable circumstances pursuant to Medicare upper limits.

  Beginning with dates of service on and after July 1, 2005, services that do not have an established fee specified by the AHCCCS' outpatient hospital prospective fee schedule will be paid by multiplying the charges for the service by a statewide outpatient cost-to-charge ratio. The statewide outpatient cost-to-charge ratio is computed from hospitals' 2002 Medicare Cost Reports.

  Hospitals shall not be reimbursed for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation or other outpatient department. The emergency room, observation, and other outpatient hospital services provided before the admission are included in the inpatient reimbursement.

  Outpatient hospital payments shall be subject to the quick pay discounts and the slow pay penalties described in Attachment 4.19-A.

  Rebase
  AHCCCS will rebase the outpatient hospital fee schedule every five years.

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Annual Update
Beginning October 1, 2006, AHCCCS will update the outpatient hospital fee schedule on an annual basis by either: multiplying the rates effective during the prior year by the Global Insights Prospective Hospital Market Basket Inflation Index or, in any given year the director may update the rates by calculating the dollar amount associated with the Global Insights inflationary increase and applying that dollar value to adjust rates at various levels.

New Hospitals
New hospitals, as defined in Attachment 4.19-A, will be assigned the statewide average outpatient hospital cost-to-charge ratio.

Out-of-State Hospitals
Out-of-state hospitals will be paid the lesser of: a negotiated discount rate, the Arizona outpatient hospital statewide average cost-to-charge ratio, or if reasonably and promptly available, the Medicaid rate in effect on the date of service in the state in which the hospital is located.

Specialty Rates
The Administration may negotiate special contracted rates for outpatient hospital services provided in specialty facilities.

- **Laboratory Services and X-Ray**

AHCCCS' capped fee amounts will not exceed the reimbursement amounts authorized for clinical laboratory services under Medicare as set forth in 42 CFR 447.342.

- **Pharmacy Services**

Reimbursement is subject to the limitations set forth in 42 CFR 447.331 through 447.332.

- **EPSDT Services Not Otherwise Covered in the State Plan**

AHCCCS reimburses for chiropractor services and personal care services using a capped fee schedule. Payment is the lesser of the provider's charge for the service or the capped fee amount established by AHCCCS.

State-developed fee schedule rates are the same for both governmental and private providers of personal care services and chiropractor services. The fee schedule and any annual/periodic adjustments to the fee schedule are published on the AHCCCS website.

- **Hospice**

AHCCCS reimburses for the hospice benefit, including routine home care, continuous home care, inpatient respite care and general inpatient care. The Medicaid hospice payment base rates are calculated based on the annual hospice rate established under Medicare, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. These rates are authorized by section 1814(i)(c)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services. These rates will be adjusted by applying the hospice wage index for the geographic locale in which the hospice services are provided.

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- **Organ Transplantation**

As authorized in Attachment 3.1-E, AHCCCS reimburses for organ transplant services which are medically necessary and not experimental based on a competitive bid and/or negotiated flat rate process in accordance with State law. The rates are inclusive of hospital and professional services. If the service is provided in another state, AHCCCS will pay that state's approved Medicaid rate for the service or the negotiated rate, whichever is lower.

- **Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)**

AHCCCS will utilize the following payment methodology from January 1, 2001, forward.

1) AHCCCS will establish a baseline Prospective Payment System effective January 1, 2001. The calculation will conform to section 1902(a)(15)(c) of the Social Security Act. AHCCCS will use the center/clinic's fiscal year that ends during calendar year 1999 and 2000 for the base rate calculations. Each FQHC/RHC may elect to have rates adjusted by either the BIPA 2000 methodology, or the Alternative Payment Methodology. If the FQHC/RHC elects the BIPA methodology, the Medicare Economic Index (MEI) at the beginning of each federal fiscal year (October 1st) will be used to update rates on a prospective basis. If the FQHC/RHC elects the Alternative Payment Methodology, the Physician Service Index (PSI) subcomponent of the Medical Care component of the Consumer Price Index at the beginning of each federal fiscal year (October 1st) will be used to update rates on a prospective basis. Under either methodology, the baseline rates for 1999 and 2000 will be calculated based on the provider's cost data for the center/clinic's fiscal year that end during calendar year 1999 or 2000. Costs included in the base rate calculation will include all Medicaid covered services provided by the center/clinic. The calculated 1999 and 2000 base rates will be averaged by calculating a simple average of the costs per encounter for 1999 and 2000. The calculation is as follows:

$$\frac{\text{Total Medicaid costs 1999} + \text{Total Medicaid costs 2000}}{\text{Total visits 1999} + \text{Total visits 2000}} = \text{Average Cost Per Visit}$$

These base rates will then be indexed forward utilizing the MEI, from the midpoint of the cost report period being utilized, to the midpoint of the initial rate period (January 1, 2001 through September 30, 2001). Annually thereafter, the MEI for those FQHCs/RHCs selecting the BIPA methodology, or the PSI for those FQHCs/RHCs selecting the Alternative Payment Methodology, will be applied to the inflated-based rates at the beginning of the federal fiscal year (October 1st). AHCCCS and the FQHCs/RHCs have agreed to supplement payments to the FQHCs/RHCs payments once the PPS baseline is established, if necessary.

2) For a center/clinic that becomes a FQHC or RHC after FY 2000, AHCCCS will calculate the initial rate using data from an established FQHC or RHC in the same or adjacent area with a similar caseload. Absent an existing FQHC or RHC with a similar caseload, the center/clinic rate will be based on projected costs subject to tests of reasonableness. Costs would be subjected to reasonable cost definitions as outlined in Section 1833(a)(3) of the Act. If a center/clinic has inadequate cost data for one of the base periods, that

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center/clinic's rate will be established from the data that is available. If an existing center/clinic has inadequate data for both periods, they will be treated as a new center/clinic.

3) If the FQHC/RHC elects the BIPA methodology, and there is a change in scope of service, it will be the responsibility of the FQHC/RHC's to request AHCCCS to review services that have had a change to the scope of service. Adjustments will be made to the base rates on a case basis where the FQHC/RHC's can demonstrate that the increases or decreases in the scope of services is not reflected in the base rate and is not temporary in nature. If an FQHC/RHC requests a change in scope due to an increase in utilization for services included in the PPS, current utilization will be compared to the utilization used in the calculation of the PPS from appropriate rate adjustments. If it is determined that a significant change in the scope of service has occurred, the reasonable incremental cost per encounter from this change will be added to the PPS rate and a new rate will be established. A change will not be considered significant unless it impacts the base rate by 5% or more. This new rate will be effective on the date the change in scope of service was implemented.

4) If the FQHC/RHC elects the Alternative Payment Methodology, then every 3rd year, beginning with the federal fiscal year beginning October 1, 2004, AHCCCS will rebase the rate. The calculation will conform to section 1902(a)(15)(c) of the Social Security Act. AHCCCS will use the data from the center/clinic's fiscal years that end during the two previous calendar years for the rebase rate calculations. The baseline rates for the two previous years will be calculated utilizing the provider's cost data for the center/clinic's fiscal years that end during those two previous calendar years. Costs included in the rebase rate calculation will include Medicaid covered services provided by the FQHC/RHC pursuant to a contract with a MCE. The two calculated previous year base rates will be averaged by calculating a simple average of the costs per encounter for the two previous years. The calculation is as follows:

$$\frac{\text{Total Medicaid costs previous year 1} + \text{Total Medicaid costs previous year 2}}{\text{Total visits previous year 1} + \text{Total visits previous year 2}} = \text{Average Cost Per Visit}$$

These base rates will then be indexed forward utilizing the PSI from the midpoint of the cost report periods being utilized, to the midpoint of the initial rate period. For the next two years thereafter, the PSI will be applied to the inflated-based rates at the beginning of each federal fiscal year (October 1st).

5) FQHCs/RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services, that are an estimate of the difference between the payments the FQHC/RHC receives from MCEs and the payments the FQHC/RHC would have received under the BIPA PPS methodology. At the end of federal fiscal year, the total amount of supplemental and MCE payments received by each FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCEs would have yielded under the PPS. The FQHC/RHC will be paid the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC/RHC will refund the difference between the PPS amount calculated using the actual

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number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the PPS amount is less than the total amount of supplemental and MCE payments.

___ The payment methodology for FQHCs/RHCs will conform to section 702 of the BIPA 2000 legislation.

_X_ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for a Prospective Payment System.

___ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology.

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- **Care and Services in Religious Non-Medical Health Care Institutions (RNHCI)**

  Inpatient care and services are considered to be furnished by a RNHCI in its capacity as a hospital. Payment for such inpatient services may be no more than the Medicare cost reimbursement under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Extended care services are services furnished by a RNHCI in its capacity as a skilled nursing facility. Payment for such extended care services shall be made in accordance with the AHCCCS fee-for-service payment rates specified in Attachment 4.19-D of the State Plan.

When AHCCCS reimburses for the following services, payment is the lesser of the provider's charge or the capped fee amount established by AHCCCS. For both private and public providers, AHCCCS reimburses the following services using this methodology:

- **Clinic Services, including Freestanding Ambulatory Surgery Centers, Freestanding Dialysis Centers and Freestanding Birthing Centers**
- **Rural Health Clinic Services**
- **Migrant Health Center, Community Health Center and Homeless Health Center Services**
- **Home Health Services, including Durable Medical Equipment, Supplies and Prosthetic Devices**
- **Behavioral Health Services**
- **Family Planning Services**
- **Physician Services**
- **Nurse-Midwife services**
- **Pediatric and Family Nurse Practitioner Services**
- **Other Licensed Practitioner Services**
- **Dental Services**
- **Vision Services** (including eye examinations, eyeglasses and contact lenses)

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- **Therapies and Related Services**
- **Diagnostic, Screening and Preventive Services**
- **Respiratory Care Services**
- **Transportation Services**
- **Private Duty Nurse Services**
- **Services of Nurses in RNHCI**

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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The following is a description of the methods and standards for determining the payment rate for case management services to the target group identified in Supplement 1 to Attachment 3.1-A.

DES/DDD is reimbursed, on a per member per month basis beginning October 1, 1997, to provide case management services to persons with developmental disabilities enrolled in the acute care program. AHCCCSA developed the per member per month capitation rate based on an analysis of average per member per month case management expenditures during the twelve month period from October 1, 1996 through September 30, 1997. Annually, this base rate is reviewed and updated, as necessary, by applying the inflation factor developed for the case management component of the ALTCS developmentally disabled capitation rate. Both the ALTCS developmentally disabled and the target group members are assigned to the same case managers. The inflation rate is determined by AHCCCSA's consulting actuaries based on data sources that include analysis of historic and future trends in case management expenditures, audited financial statements and case load requirements.

DES/DDD will be paid monthly on a capitated basis. This payment will be based on the capitation rate times the number of recipients verified as enrolled in the acute care program, as of the first of each month. The capitation payment will be made no later than ten working days after receipt of the DES/DDD data transmission.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

Effective January 1, 2000, AHCCCS will reimburse the Indian Health Service (IHS) and tribal facilities based on the following reimbursement methodologies reflected in Tables 1 and 2.

As the Tables 1 and 2 reflect, the methodologies may differ depending on a specific situation. The various situations are whether:

- the services include or exclude professional services.
- the service is provided by the IHS or a tribal facility
- the tribal facility is set up to bill outpatient services with specific coding and requests this format
- based on specific HCFA guidance (transportation).

TABLE 1 - IHS OUTPATIENT REIMBURSEMENT METHODOLOGY

Eligibility Type	Service	Billing Form/Codes	Reimbursement
Title XIX (Acute)	Outpatient Hospital	1500 / 00099	OMB Outpatient Rate
	Clinic	1500 / 00099	OMB Outpatient Rate
	Ambulatory Surgery Center	1500 / 00090-00098	OMB ASC Rate
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
Title XIX (Long Term Care)	Outpatient Hospital	1500 / 00099	OMB Outpatient Rate
	Clinic	1500 / 00099	OMB Outpatient Rate
	Ambulatory Surgery Center	1500 / 00090-00098	OMB ASC Rate
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
Title XIX (Behavioral Health)	Outpatient Hospital	1500 / 00099	OMB Outpatient Rate
	Clinic	1500 / 00099	OMB Outpatient Rate
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

TABLE 2 - '638 TRIBAL FACILITY OUTPATIENT REIMBURSEMENT METHODOLOGY

Eligibility Type	Service	Billing Form/Codes	Reimbursement
Title XIX (Acute)	Outpatient Hospital (including professional services) (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 – Specific revenue codes	OMB Outpatient Rate (or) Statewide Cost to Charge Rate
	Clinic (including professional services) (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	OMB Outpatient Rate (or) AHCCCS Capped Fee Schedule
	Ambulatory Surgery Center (including professional services) (or) Ambulatory Surgery Center (excluding professional services)	1500 / 00090-00098 (or) 1500 / CPT codes	OMB ASC Rate (or) AHCCCS Capped Fee Schedule (Medicare ASC Rate)
	Professional Services (services included in procedure bill)	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
Title XIX (Long Term Care)	Outpatient Hospital (including professional services (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 / Specific revenue codes	OMB Outpatient Rate (or) Statewide Cost to Charge Rate
	Clinic(including professional services (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	OMB Outpatient Rate (or) AHCCCS Capped Fee Schedule
	Professional Services (services included in procedure billed)	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

Eligibility Type	Service	Billing Form/Codes	Reimbursement
	HCBS Services	1500 / HCPCS or AHCCCS specific codes	AHCCCS Capped Fee Schedule
	Transportation (Air & Ground)	1500 / HCPCS codes	AHCCCS Capped Fee Schedule
	Transportation (Non-Ambulance)	1500 / HCPCS/AHCCCS specific codes	AHCCCS Capped Fee Schedule
Title XIX (Behavioral Health)	Outpatient Hospital (including professional services) (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 / Specific revenue codes	OMB Outpatient Rate (or) Statewide Cost to Charge Rate
	Clinic (including professional services) (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	OMB Outpatient Rate (or) AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
	Transportation (Air & Ground)	1500 / HCPCS codes	AHCCCS Capped Fee Schedule
	Transportation (Non-Ambulance)	1500 / HCPCS/AHCCCS codes	AHCCCS Capped Fee Schedule

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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DIRECT MEDICAID REIMBURSEMENT FOR CERTAIN MEDICAID SERVICES PROVIDED BY A PARTICIPATING LOCAL EDUCATION AGENCY (LEA)

The following describes the reimbursement methodology for services provided pursuant to Attachment 3.1.A, 4.b.ix., Limitations under EPSDT services.

All reimbursable services must meet the service definitions as described in the provider registration criteria and based on the definition and scope contained in the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Fee-For Service Provider Manual. These services must be:

- Identified in an Individualized Education Plan (IEP) as a necessary service or provided as part of an assessment, diagnostic or evaluation service in order to determine a student's eligibility under IDEA, Part B. If the person is not eligible for IDEA, Part B, the assessment, diagnostic or evaluation service will not be eligible for direct reimbursement.
- Provided by a provider who is employed or under contract with the LEA. The provider must meet all applicable federal and state licensure and certification requirements and have a valid AHCCCS Provider Registration Number at the time the claim is submitted.
- Provided on school grounds unless the IEP specifies that an eligible student should be educated in an alternative setting and/or the IEP service can not appropriately be provided at the school.
- Ordered or prescribed by a qualified provider in accordance with the AHCCCS AMPM.
- Considered medically necessary as defined in the AMPM, notated in the IEP as medically necessary and supported with medical records that can be audited to establish medical necessity.

A LEA who requests reimbursement for approved Medicaid services must be registered with AHCCCS as a group billing entity and enter into a participation agreement with the Third Party Administrator under contract with AHCCCS. As an AHCCCS registered provider, the LEA is required to comply with all applicable federal and state laws and regulations.

Fee-For-Service Reimbursement Methodology

A LEA will be reimbursed an amount equal to the appropriate FMAP multiplied by the rate contained in the AHCCCS' fee-for-service schedule for covered Medicaid services or, the amount billed by the provider to a LEA, whichever is less. The administrative cost associated with operating the direct payment program will be deducted from the reimbursement to a LEA. AHCCCS shall process claims based on eligibility for Medicaid and whether the claim is for an approved service on the date of service. If HCFA or AHCCCS disallow a claim that previously has been reimbursed, the amount in dispute shall be withheld from a future payment to the LEA.

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Each participating LEA is responsible for providing the non-federal Title XIX match monies as a condition of participation and will certify the availability and expenditure of the required match monies for all billed Medicaid services.

Audit Functions

The Third Party Administrator, with AHCCCS approval, shall establish an annual compliance audit review program to ensure that LEAs are appropriately billing for medically necessary Medicaid services for Medicaid eligible students.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

2. For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

3. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

4. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

5. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item __ of this attachment (see 3. above).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMB Onlys:	Part A MR Deductibles	MR Coinsurance
	Part B MR Deductibles	MR Coinsurance
Other Medicaid Recipients (Non-QMBs)	**Fee-for-Service**	
	Part A MR Deductibles	MR Coinsurance
	Part B MR Deductibles	MR Coinsurance
	Health Plans/Program Contractors	
	Part A SPDeductibles	SP Coinsurance
	Part B SP Deductibles	SP Coinsurance
QMB Duals: (Medicare (and Medicaid)	**Fee-for-Service**	
	Part A MR Deductibles	MR Coinsurance
	Part B MR Deductibles	MR Coinsurance
	Health Plans/Program Contractors	
	Part A SP Deductibles	SP Coinsurance
	Part B SP Deductibles	SP Coinsurance

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Exceptions to Payment Method Shown on Chart on Page 2*

For non-QMBs: AHCCCS does not pay the Medicare deductible and coinsurance unless the services are:

(1) provided on a fee-for-service basis by a Medicare provider in the beneficiary's health plan or program contractor network;
(2) covered by AHCCCS under the State Plan.

For QMB Duals: Restrictions are the same as for non-QMBs, except with respect to services covered by Medicare but not by AHCCCS under the State Plan (e.g., chiropractic services). For such services, AHCCCS pays the Medicare coinsurance and deductible regardless of whether the provider is in the beneficiary's health plan or program contractor network.

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* Pursuant to an August 29, 1996 agreement with HCFA.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OTHER TYPES OF CARE

The following is a description of the methods and standards for determining the payment rate for case management services to the target group identified in Supplement 1 to Attachment 3.1-A.

Beginning October 1, 1996, DES/DDD will be reimbursed on a per member, per month basis to provide case management services to persons with developmental disabilities enrolled in the acute care program. The reimbursement rate is the same rate paid for case management services for the developmentally disabled population enrolled in the Arizona Long Term Care System (ALTCS). The ALTCS case management rate was developed using DES/DDD's audited financial data for the ALTCS program for the period July 1, 1995 through June 30, 1996. The case management line item of the audited report captures the following costs for case managers and supervisors: 1) salary; 2) travel; and 3) education. The total is then divided by enrollment for the same period to determine a per member, per month cost.

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ADDENDUM

METHODS AND STANDARDS USED TO DETERMINE PAYMENT
FOR EMERGENCY MEDICAL SERVICES FOR ALIENS

CITATION: Attachment 4.19-B
Page 66 of the State Plan

County eligibility offices and Department of Economic Security offices have been informed about the availability of emergency medical services and application procedures for aliens who have not been lawfully admitted for permanent residence or who are otherwise not permanently residing in the United States under color of law.

When a person receiving emergency services is indigent and an undocumented alien, the alien will be referred to the Department of Economic Security for application.

If the applicant meets all eligibility criteria other than citizenship, the Department of Economic Security eligibility worker will post the approval for the month of service, during the month of receipt of emergency services.

The AHCCCS Administration will be notified of approval and length of time for emergency coverage. The applicant, if approved, will request the provider to submit any bill for emergency services received during this period to AHCCCS.

A Medicaid card will not be issued; the applicant will not be enrolled in a health plan. [Subsequent bills for services related to the emergency must be submitted to the AHCCCS Claims Unit for authorization.]

The AHCCCS Administration will authorize payment only for care and services which are necessary for the treatment of an emergency medical condition of the alien. As defined in Section 1903(v), an "emergency medical condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in --

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part."

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PAYMENTS FOR RESERVED BEDS

1. Payment for a reserved bed will not be made in an acute care facility.

2. Payment for a reserved bed may be made in a nursing facility, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or a Residential Treatment Center licensed as a Level I behavioral health facility and accredited by an AHCCCS-approved accrediting body, subject to the following conditions:

   a. The purpose of the absence is to visit family or friends, to prepare the individual for discharge to community living or for an admission to an acute and/or psychiatric hospital;

   b. The member's plan of care provides for such an absence when therapeutic leave is utilized;

   c. The absence does not exceed nine therapeutic leave days and 12 bed hold days per contract year for adults age 21 and older, or a total of 21 days (therapeutic and/or bed hold) for persons under 21 years of age;

   d. Prior authorization is received from the designee for the Regional Behavioral Health Authority (RBHA) or Program Contractor.

3. Payment shall be denied for any absence that is:

   a. in excess of these limits;

   b. for purposes other than those listed; or

   c. not properly authorized.

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METHODS AND STANDARDS FOR ESTABLISHING FEE-FOR-SERVICE PAYMENT RATES FOR LONG TERM CARE FACILITIES

I. General Provisions

A. Purpose

This State Plan Amendment establishes the reimbursement system for fee-for-service payments to nursing facilities where payments are made directly by the Arizona Long Term Care System (ALTCS) or the acute care program. The method of updating the per diem rates established under this plan from year to year is amended effective for dates of service beginning October 1, 2005.

Under the ALTCS program, the fee-for-service rates established under this plan are used to reimburse facilities for services provided to Native American members with an on-reservation status (including prior period coverage). Under the acute care program, these fee-for-service rates are used to reimburse the acute care program's limited coverage of nursing facility services for Native American members.

B. Reimbursement Principles

1. Providers of nursing facility care are reimbursed based on a prospective per diem reimbursement system designed to recognize members in four levels:

   - Level 1
   - Level 2
   - Level 3
   - Ventilator dependent, sub-acute and other specialty care.

   Fee-for-service payments for services to members in nursing facilities who are ventilator dependent, sub-acute or receiving other specialty care are based on negotiated rates. Negotiated rates are based on the rates paid by program contractors for specialty care services and member service needs.

   Reimbursement for Levels 1, 2 and 3 is based on a three component system:

   - Primary Care - The primary care cost component reflects direct member care including wages, benefits and salaries for registered nurses (RNs), licensed practical nurses (LPNs), and nurse aides.

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METHODS AND STANDARDS FOR ESTABLISHING FEE-FOR-SERVICE PAYMENT RATES FOR LONG TERM CARE FACILITIES

- Indirect Care - Non-nursing, non-capital related activities of the nursing facility are included in the indirect care component. The activities reflected in this component are further removed from the delivery of member care and are less likely to vary based on the acuity level of an individual member (e.g., supplies, housekeeping, laundry, and food).

- Capital - The capital cost component includes depreciation, leases, rentals, interest and property taxes.

2. AHCCCS makes no fee-for-service payments to Intermediate Care Facilities for the Mentally Retarded (ICF/MR). ICF/MR services are reimbursed by the program contractor providing statewide Medicaid services for the developmentally disabled which is the Department of Economic Security/Division of Developmental Disabilities.

3. The AHCCCS fee-for-service program reimburses qualified providers of nursing facility services based on the individual Medicaid member's days of care multiplied by the lesser of the charge for the service or the applicable per diem rate for that member's classification, less any payments made by a member or third parties.

4. Reimbursement rates determined under this plan are effective for services rendered on or after October 1, 2005.

II. Rate Determination for Nursing Facilities

Per diem reimbursement for nursing facility services to members in Levels 1, 2 and 3 shall be the sum of three prospectively determined rate components:

A. Data Sources

1. Primary Care

When recalculation of the per diem reimbursement rates are determined appropriate by the Administration, several sources of data may be used in the calculation of the primary care rate component.

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- Arizona Pre-admission Screening (PAS) instruments (initial and reassessments) from the most recent six month period preceding the effective date of the rate. The data set excludes physician override cases. The PAS and reassessment instruments measure a member's level of functioning based on individual scores for Activities of Daily Living (ADL) items and medical service items.

- The Maryland Time and Motion Study of nursing time requirements by functional level and for specific nursing services and treatments.

- Salary and benefits for RNs, LPNs, and nurse aides from cost and/or wage reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.

- Primary care cost data from cost reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.

- BLS Employment Cost Index (ECI).

Because the primary care component varies by member level of care and geographic location, a total of six primary care rates are developed. An individual rate is developed for each of the member levels of care, 1 through 3, and these rates are adjusted for geographic wage variations in urban and rural areas. Maricopa, Pima and Pinal are defined as urban; the remaining 12 counties are defined as rural. Wage data is obtained from cost reports and does not depend in any way on Medicare wage indices.

2. Indirect Care Component

When recalculation of the per diem reimbursement rates is determined appropriate by the Administration, several sources of data may be used in the calculation of the indirect care component:

- The indirect care component from the previous rate year.

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- Indirect care cost data from cost reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.
- Consumer Price Index (Medical Care Services).

The indirect care component is a single statewide rate that does not vary by member level of care or geographic area.

3. Capital Component

When recalculation of the per diem reimbursement rate is determined appropriate by the Administration, several sources of data may be used in the calculation of the capital component:

- Capital component from the previous rate year.
- Capital cost data from cost reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.
- Skilled Nursing Facility Total Market Basket published by Data Resources Inc. (DRI).
- Construction cost index such as the RS Means Construction Cost Index.

The capital component also is a single statewide rate that does not vary by member level of care or geographic area.

The sections that follow provide specific details on the methodology used to calculate each of these rate components.

B. Rate Computation.

The following computations were used to update rates effective on and after October 1, 2005.

1. Primary Care

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METHODS AND STANDARDS FOR ESTABLISHING FEE-FOR-SERVICE PAYMENT RATES FOR LONG TERM CARE FACILITIES

The steps used to calculate the primary care component include:

- Step 1 - Classify Members. Members are grouped into Levels 1, 2, or 3 using a numeric score and weight assigned to each item on the PAS and reassessment instruments using a process called discriminant analysis. During the analysis each individual is assigned, based on their PAS record, to a member class reflecting the resources required by the member. In addition, a standard base amount of nursing minutes is assigned to each patient regardless of assessment score for meal preparation, night shift, etc.

- Step 2 - Evaluate Use of Services. After the ventilator dependent/sub-acute members are removed, the remaining members are evaluated using PAS data to quantify the types of services they need.

- Step 3 - Determine Nursing Time. Service needs are translated into time requirements using the Maryland Time and Motion Study. The linkage of member need and nursing time may be slightly modified based on a review of time assessments in prior years and variations in ADL measurements.

- Step 4 - Calculate Nursing Staff Times. Staff time equals the sum of nursing time, ADL weight plus an allocation of overhead. The result is an estimate of the fraction of an hour needed to provide nursing care in each member class. This is broken down into RN care, LPN care and nurse aide care.

- Step 5 – Assign Level of Care 1, 2, or 3. Medical and functional assessment data from the PAS instrument are used to assign each patient a medical and functional score. Based on these scores, patients are classified into a level of care. 4% of the members with the highest scores in each class are moved to the next highest level of care.

- Step 6 – Compute Average Nursing Minutes for each Level of Care. The total RN, LPN, and Nurse Aide time required for all patients in the same level of care are averaged.

- Step 7 - Translate Nursing Time into the Rate. In this step, the nursing times are translated into the rate component by multiplying the number of

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minutes for each nursing level for each level of care by average hourly wages.

Wage data information is obtained from cost report and/or wage data submitted by Arizona nursing facilities for reporting years ending in the calendar year preceding the effective date of the rate. Wage data for registry nursing is included in these wage calculations but is capped based on thresholds of average urban and rural registry hour utilization. All wages associated with registry hours at or below the thresholds are included in the rate calculations.

- Step 8 - Inflate. Using the DRI market basket index, wages are inflated to the midpoint of the fiscal year in which the rate becomes effective (the end of the first quarter of the calendar year). Inflation is applied before outliers are excluded.

- Step 9 - Calculate Level of Care Rates for Urban and Rural. At the conclusion of this Step, six primary care rates exist. Rates for the three levels of care vary by geographic area.

2. Indirect Care Component

The steps to calculate the statewide average indirect rate per day include:

a) For each facility total capital costs are subtracted from total facility costs to determine costs without capital.

b) These remaining costs are inflated to the midpoint of the rate year using the Consumer Price Index (Medical Care Services).

c) Facility specific inflated direct care wage costs are subtracted from the value above to derive facility specific indirect costs.

d) For each facility the total indirect costs are divided by the total nursing facility days to calculate an indirect cost per day. An adjustment factor is applied to those facilities with an occupancy rate of less than 85% (based on total nursing facility bed days).

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e) The facility-specific indirect costs per day are weighted by Title XIX nursing facility days to determine each facilities total Medicaid indirect costs. The sum of these weighted costs is used to calculate the statewide average indirect care cost per day. Facilities' with average indirect costs per day plus or minus 2 standard deviations from the mean are excluded.

3. Capital Component

The steps to calculate the statewide capital per day rate include:

a) The average cost of constructing a new nursing facility bed is determined by reference to a national source for construction costs such as the R. S. Means Construction Cost Index.

b) The weighted average age of nursing facility beds in use by each facility is calculated from data supplied by providers via survey and/or cost report.

c) Calculate the total current value of nursing facility beds by taking the current cost of a new bed and depreciating it by the average age of beds in each facility.

d) Apply a rate of return, such as the current Treasury Note rate plus a risk factor, to the total current value, to arrive at the fair rental value. The fair rental value method establishes a current value of the facility based on current construction costs and the age of the facility. The age of the facility is based on the original construction cost, adjusted for additions and capital improvements which effectively reduce the age of the facility. Depreciation is recognized at 1% per year.

When the current value of the facility has been determined based on current costs and the age of the facility adjusted for replacements and improvements, then a rate of return is applied to determine the fair rental value for a one year period. The imputed rate of return used to calculate the fair rental value is currently the ten-year Treasury Bond composite rate plus 2%

e) Add the total fair rental value of all facilities. Divide the total fair rental value by the nursing facility inpatient days, adjusted to a minimum occupancy rate of

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85% for each facility, then add in the per day historic costs for property taxes and insurance to determine the statewide average capital component.

4. Total Rate

The per diem nursing facility rates are calculated by summing the primary care, indirect care, and capital cost components. These rates vary by member level of care and geographic area due to the primary care components.

5. Rate Update

Effective October 1, 2002 and each year thereafter, fee-for-service rates for nursing facilities may be updated by applying an inflation factor or factors to the rate components in effect for the prior year. This method of adjusting fee-for-service rates is consistent with the method used by AHCCCS for other medical services.

III. Other Provisions

A. Provider Appeals

Nursing facility providers have the right to request an informal rate reconsideration in accordance with the ALTCS Rules. Appeals are allowed for the following reasons:

- Extraordinary circumstances (as determined by the Director).
- Provision of specialty care services directed at members with high medical needs.
- Unique or unusually high case mix.

Appeals are made in writing to the Director. Appeals which are granted become effective no earlier than the date the appeal was requested.

B. Cost and Wage Reporting

AHCCCS uses cost and wage reports filed by the nursing facilities in the State of Arizona as a basis for these rate calculations.

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C. Audit Requirements

The AHCCCS periodically conducts audits of the financial and statistical records of participating providers. Specifications for the audits are found in the Arizona Long Term Care System (ALTCS) Uniform Accounting and Reporting System and Guide for Credits of ALTCS Contractors and Providers.

D. Rates Paid

Fee-for-service reimbursement for nursing facilities is made in accordance with methods and standards which are specified in this attachment of the State Plan.

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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TIMELY-CLAIMS PAYMENT - DEFINITION OF CLAIM

The AHCCCS Administration defines Fee-For-Service (FFS) claims in the following manner:

1. For Inpatient or Outpatient Hospitals, Residential Treatment Centers, Hospices, Dialysis Centers or Nursing Facilities, a FFS claim is a single billing issued for a portion of, or all of, the services rendered for a period of time.

2. For prescription drugs, a FFS claim is a single line on the claim form. On the Universal Drug claim form, each line represents one prescription.

3. For all other services, a FFS claim is a single line on the claim form. On the HCFA 1500 form, a single line can consist of multiple services for multiple days. For example, if physician hospital visits were rendered twice a day from January 1 to January 15, the claim line can indicate the date span for thirty (30) units of service. On all forms, a single line represents a single claim.

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THIRD PARTY LIABILITY

4.22(b)(1):

Frequency of data exchanges required by 42 CFR 433.138 (d) (1), State Wage Information Collection Agency (SWICA), and SSA Wage and Earnings Files.

The Arizona Health Care Cost Containment System (AHCCCS) conducts data exchanges as required by federal law.

The State Wage and SSA Wage Earnings Information is provided to AHCCCS by the Arizona Department of Economic Security (DES), which is the State's designated Income and Eligibility Verification System (IEVS) agency. DES performs all matches against tapes which are provided by AHCCCS on a monthly basis. The State Wage and SSA Wage Earnings data requests, received from AHCCCS, are merged with those of DES and submitted on a monthly basis to the appropriate agency. DES forwards the "full file" response to AHCCCS for processing.

Frequency of data exchange required by 42 CFR 433.138(d)(3), IV-A Agency.

The DES refers TPL information to AHCCCS on a daily basis.

Frequency of data exchange required by 42 CFR 433.138(d)(4)(i), State Workers Compensation or Industrial Accident Commission.

Previously, AHCCCS was unable to accomplish a data match with the Industrial Commission for Worker's Compensation information and HCFA had deemed this requirement as having been met in a letter dated July 12, 1994. However, due to a data system change at the Industrial Commission, AHCCCS was able to complete its first data match for Workers' Compensation information in March 1998. The data has been referred to the AHCCCS TPL Contractor to begin a cost avoidance and recovery investigation. AHCCCS will conduct a data match on Workers' Compensation information on a quarterly basis.

Frequency of data exchange required by 42 CFR 433.138(d)(4)(ii), State Motor Vehicle accident report files.

The requirement that AHCCCS conduct a data match with MVD was deemed as having been met in a letter from HCFA, dated January 30, 1990.

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AHCCCS does not conduct a data match with the State Motor Vehicle Department (MVD) at this time. Previously, in attempting to conduct a data match, it was determined that MVD does not require the Social Security Number (SSN) to be included in the MVD record, and the SSN is necessary for matching to AHCCCS records. Additionally, a complete data match has not been feasible because the information collected by the MVD that AHCCCS needs to identify potential cases has been stored in separate data banks (computer systems).

For several years, the MVD has been working on a plan for implementing a new computer system which will merge all MVD data into one system. Although the MVD does not require the inclusion of an applicant's SSN, it can be and often is provided by the applicant and included in the applicant's record. Therefore, there is a possibility of matches to the MVD record, if and when, the three data banks are merged. Should a merged MVD computer system become reality, AHCCCS and its TPL Contractor will meet with the MVD representatives to discuss the feasibility and time frame for conducting future data matches.

Frequency of the diagnosis and trauma code edits 800-999 (excluding 994.6) per 42 CFR 433.138(e).

AHCCCS produces a monthly tape of paid claims showing diagnosis and trauma codes of 800-999 (excluding 994.6) and submits data to the TPL Contractor for processing.

4.22(b)(2):

Methods used for meeting the follow-up requirements contained in 42 CFR 433.138(g)(1)(i), SWICA, SSA Wage and Earnings Files, and IV-A Agency.

AHCCCS and the DES Division of Benefits and Medical Eligibility (DBME) workers identify and verify the employer group information, including the TPL information, by contacting the employer through IEVS leads based on information obtained from the SWICA and SSA Wage and Earnings files. The DBME eligibility interviewer (EI) obtains verification whenever TPL resources are indicated. Third Party Liability information is inputted into the DBME computer system. This information is transmitted nightly to AHCCCS. Once entered into the AHCCCS Prepaid Medical Management Information System (PMMIS), the information is communicated to the health plans via the enrollment roster which provides the insurance carrier name.

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The DES Division of Child Support Enforcement (DCSE), which is the State IV-D Agency, plays a major role in medical support enforcement. DCSE is responsible for transmitting relevant heath insurance information to AHCCCS when medical support is secured. Information is verified through the absent parent's employer via the CS-157 after using the locate service and is then entered into the Arizona Tracking and Location Automated System (ATLAS). DCSE transmits a monthly tape to AHCCCS which contains all TPL adds, changes, and deletes.

Method for meeting the follow-up requirements contained in 42 CFR 433.138(g)(2)(i), Health insurance information and Workers' Compensation data exchanges.

The DES and ALTCS eligibility workers request and document all medical coverage information on the application. DES sends a nightly eligibility tape to AHCCCS.

The valid information is entered and maintained in the appropriate PMMIS/TPL computer file. All updates to the member's TPL file occur within seven working days after receipt of the information. The AHCCCS Member File Integrity Section (MFIS) maintains the actual copies of the referrals received from the various agencies and the on-line updates document. The daily referrals are batched and filed by date of update, for future reference. If there is a need to verify to a particular TPL referral, PMMIS is checked for the original date of update and then compared with the original referral.

Once the tape is received and matched against PMMIS, any new information is transmitted to the health plan via its enrollment roster, which is a "yes" or "no" TPL indicator and includes the insurance carrier's name.

AHCCCS completed its first data match with the Industrial Commission of Arizona for Worker's Compensation information in March 1998. The AHCCCS TPL Contractor is analyzing the information for cost avoidance and recovery action.

4.22(b)(3):

Method used for meeting the follow-up requirements contained in 42 CFR 433.138(g)(3)(i)(iii), State motor vehicle accident report file data exchanges.

AHCCCS does not conduct a data match with the state Motor Vehicle Department (MVD) at this time. Previously, in attempting to conduct a data match, it was determined that MVD does not require the Social Security Number (SSN) to be included in the MVD record, and the SSN is necessary for matching to AHCCCS records. Additionally, a

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complete data match has not been feasible because the information collected by the MVD that AHCCCS needs to identify potential cases has been stored in separate data banks (computer systems).

For several years, the MVD has been working on a plan for implementing a new computer system which will merge all MVD data into one system. Although the MVD does not require the inclusion of an applicant's SSN, it can be and often is provided by the applicant and included in the applicant's record. Therefore, there is a possibility of matches to the MVD record, if and when, the data banks are merged. Should a merged MVD computer system become reality, AHCCCS and its TPL Contractor will meet with the MVD representatives to discuss the feasibility and time frame for conducting future data matches.

4.22(b)(4):

Method used for following up on paid claims contained in 42 CFR 433.138(g)(4)(i)(ii)(iii), diagnosis and trauma code edits.

AHCCCS contracts with a TPL Contractor to perform all of its TPL recovery activities and required TPL data matches.

AHCCCS conducts diagnosis and trauma code edits for codes 800 through 999, with the exception of code 994.6, for all fee-for-service claims. HCFA developed a list of codes shown to be unproductive and offered a blanket waiver to all states. AHCCCS adopted HCFA's recommendation and edited all of the ICD-9 codes listed. The following list of codes are currently being edited from the Trauma Code Edit Report: 900 - 919.5, 921.3, 930, 931 - 939.9, 942.22, 944.20, 945, 946.2, E950 - E958.8, 958.3, 960 - 979.9, 980 - 980.9, 981, 986, 989.5, 990 - 995.89, 996 - 998.9 and 999.8.

AHCCCS provides a monthly tape to the TPL Contractor which contains AHCCCS paid claims, including the diagnosis and trauma codes. The TPL Contractor matches the Trauma Code Edit tape against existing accounts on their Case Tracking System. If a match is not made, but the claim is over the $250.00 threshold, and the referral date is less than 120 days prior to the date the tape is received, then the account on the tape is loaded into the Case Tracking System for potential recovery.

A medical lien is filed against the member for possible third party recovery if the claims have a referral date that is less than 60 days prior to the date the tape is received. However, due to statutory provisions which require the filing of liens within 60 days from the date of notification of injury, a lien is not filed where the date of notification is more than 60 days

from the date the referral is received. In these cases, AHCCCS uses its subrogation rights or assignment of rights to pursue recovery.

A referral for subrogation is issued on claims where the date of notification is between 60 and 120 days from the date of referral and the total claim amount is $250.00 or more. Claims with a date of notification which is more than 120 days from the date of referral are not processed by the TPL Contractor, thereby avoiding duplication of cases which are received from other referral sources, i.e., contracted health plans, providers, attorneys, etc. The TPL Contractor mails a questionnaire to the member at the time the case is opened. The determination of third party liability is identified from the response to the questionnaire returned by the member and/or a responsible third party in those instances where a lien is filed or subrogation rights are used. Members are asked to respond within 10 days of receipt of the questionnaire. If the questionnaire is returned indicating an incorrect address, a letter is sent to the eligibility office where the member was determined eligible requesting the address be verified with the office records and that any difference be referred to the TPL Contractor for correction of their information. The TPL Contractor will then remail the questionnaire using the corrected address information.

If, after 30 days, the completed questionnaire is not returned by the member, a letter is sent asking the member to contact the TPL Contractor. If a response to the letter is not received within 30 days, the TPL Contractor will attempt to contact the member by telephone, if a telephone number is available. If the member cannot be contacted by telephone, another letter is sent to the member stating that AHCCCS is requesting that the member contact the TPL Contractor. If, after 30 days, there is no response to this letter, the case is filed and periodically reviewed. Additional attempts to contact the member are made at each review. If no contact occurs within two years, the file is closed and archived.

If the questionnaire or other referral source identifies Third Party Liability information, multiple efforts are made by the TPL Contractor to recover funds from the potentially liable source. All health insurance information obtained is immediately referred to the AHCCCS MFIS Unit for entering into the PMMIS Recipient Subsystem within seven working days of receipt. All casualty insurance information is entered into the TPL Contractor's case management system to track.

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THIRD PARTY LIABILITY

4.22(d)(1):

Method used in determining the provider's compliance with the billing requirements as specified in 42 CFR 433.139(b)(3)(ii)(A).

Providers are not required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

AHCCCS pays and chases all claims, regardless of submission time frames, for services furnished to AHCCCS members on whose behalf medical support enforcement is being carried out by the State IV-D agency.

4.22(d)(2): 433.139(f)(2)

Method used in determining cost effectiveness as specified in 42 CFR 143.139(f)(2).

A cost analysis was conducted to determine the cost of initiating and pursuing recoveries. The threshold was determined by first identifying the amount of work time each employee spends on the various activities for a typical case, to initiate and pursue recovery. Next, the salary for each employee was identified to calculate the employee cost for pursuing the recovery. The administrative cost for the filing of liens,.and legal fees were also included in the calculation to determine this threshold. On July 30, 1991, the threshold of $250.00 was implemented on all cases generated from the Trauma Code Edit Report and was implemented on all cases originating from referral sources on August 30, 1991. The $250.00 cost threshold continues to be used.

Commercial Insurance: AHCCCS' TPL Contractor, on behalf of AHCCCS, conducts commercial insurance data matches with numerous insurance companies. A cost analysis of commercial insurance billings was conducted by AHCCCS' TPL Contractor which determined an effective cost threshold of $50.00 per claim/$10.00 co-pay per member. The TPL Contractor's analysis was based, in part, on such factors as: systems operation costs (preparation, tracking, posting, and updating of claims); staffing costs (systems and support); and paper costs (reports, forms and mailing).

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4.22(d)(3):

Method used for determining billing accumulation as specified in 42 CFR 433.139(f)(3).

The TPL Contractor conducts diagnosis and trauma code edits for codes 800 through 999, with the exception of code 994.6 and those codes specified in 4.22 (b)(4), for all fee-for-service claims. AHCCCS generates a monthly extract tape of paid claims identifying diagnosis and trauma codes. Claims for a specific member must total $250.00 or more in order for a case to be considered for potential recovery.

Claims are not accumulated on members from one report to another via the Trauma Code Edit report. When a case is opened either via the Trauma Code Edit report or through another referral source, the expenses are accumulated beginning with the date of injury to, whichever occurs first, the last date of treatment or the case is settled, and listed in chronological order by individual provider. This accumulation is released to the interested third party via a Medical Payments Chronology Letter. This Chronology Letter reflects the total AHCCCS paid and liable medical claims and AHCCCS contractor's claims which relate to the member's injuries.

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State/Territory: Arizona

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

(NOT APPLICABLE)

☆ U.S. Government Printing Office : 1991 - 312-149/40352

State/Territory: Arizona

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State: Arizona

Citation	Sanctions for MCOs and PCCMs
1932(e) 42 CFR 438.726	(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below: AHCCCS monitors MCO/PIHP performance by setting contract requirements and reviewing deliverables, onsite Operational and Financial Reviews, and complaint tracking. (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management: The state may impose an order of temporary management if there is continued documented egregious behavior, substantial risk to enrollees' health due to non-compliance of the Contractor, or to ensure the health of enrollees while the Contractor corrects the non-compliance, reorganizes, or the contract is terminated. The state will impose an order of temporary management if a Contractor has repeatedly failed to meet substantive requirements. (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e). ___ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

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INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

Any income, resource or eligibility information not specified in 42 CFR 435.948 (a) (1) through (a) (5), concerning AHCCCS applicants and recipients is routinely requested and verified from other agencies within Arizona and other states administering the program described in 42 CFR 435.948 (a) (6).

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METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

- Once categorical eligibility is established by DES or SSA, that agency sends AHCCCS daily tapes verifying the eligibility.

- DES or SSA supplies AHCCCS with the member's residence address, and the address of the representative payee or where the assistance check is mailed or picked up.

*• AHCCCS sends a computer generated letter to the member at the site where the assistance check is picked up.

*• The letter notifies the member of AHCCCS eligibility and to go to an enrollment site to choose a health plan within 10 days of the date of the letter, or a health plan will be chosen for them.

- After the member is prospectively enrolled into a plan, an AHCCCS ID card with general program information is sent to the member to the site where they are mailed or pick up their assistance check (i.e. General Delivery, DES or SSA office).

- Once enrolled in a health plan, the plan must send information on how to use the plan to the member within ten (10) days of being notified that a member is theirs (R-9-22-518). This information is sent to the site where the member receives his assistance check.

* These two steps are not necessary where a member has made a choice and it is pending or they have been in enrollment suspense for less than 90 days.

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REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of Arizona law (whether statutory or as recognized by Arizona courts) concerning advance directives.

Since December 1, 1991, specified providers under the State Plan have provided adult members, in brochure form, information about their rights to accept or refuse medical treatment and to prepare a living will or similar advance directive. A copy of the most recent brochure, printed in both English and Spanish, is included in this Attachment.

In its 1992 session, the Legislature revamped state law to clarify health care powers of attorney, allow more flexibility when drawing up living wills and created the pre-hospital directive category.

While living wills allow patients a more general say about what treatments they will or will not accept if they become too ill to make those decisions, pre-hospital medical care directives are specific to five procedures: chest compression, defibrillation, assisted ventilation, intubation, and advanced life support medications.

Under Arizona law, providers receive protection from liability. If a provider makes a medical decision in good faith and relies on provisions of an advance directive, a court must take that into consideration if there is legal action. The law also creates a list of substitute decision makers, called "surrogates," who may act if a patient is unable to make his or her own health care decisions and has not made a health care power of attorney.

In 1994, the Legislature made technical changes to the pre-hospital medical care directive form. The pre-hospital directive, established in 1992, allowed individuals to choose up to five procedures which could be withheld by emergency medical personnel. The new simplified format is specific to cardiopulmonary resuscitation in the event of cardiac or respiratory arrest.

Sources Of Information And Forms

The following organizations provide health care directive forms and information:

Lugares de Información y Formas

Las siguiente organizaciones proveen formas de directivos de ciudado de salud e información:

Aging and Adult Administration
State of Arizona
1789 W. Jefferson
Site Code 950A
Phoenix, Arizona 85007
(602) 542-4446

Dorothy Garske Center
Your Health Care Choices Program
4250 East Camelback Road, Suite 185K
Phoenix, Arizona 85018
602) 952-1464

Arizona Medical Association
810 West Bethany Home Road
Phoenix, Arizona 85013
(602) 246-8901

Arizona Hospital Association
Communication Department
1501 West Fountainhead Parkway, Suite 650
Tempe, Arizona 85281
(602)968-1083

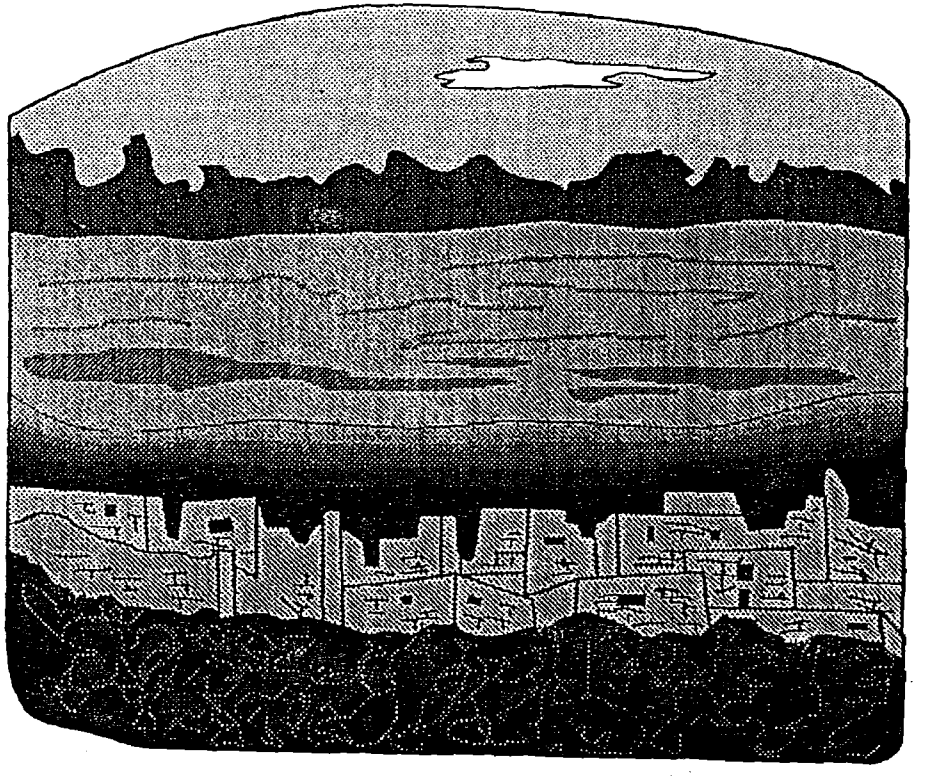
Arizona Senior Citizens Law Project
1818 S. 16th St.
Phoenix, Arizona 85034
(602)252-6710

Decisions About Your Health Care

Living wills and other health care directives

Decisiones Sobre Su Cuidado De Salud

Testamento en vida y otros directivos



You are getting this information about your rights to make or control your own health care decisions because of a 1991 federal law. We hope this information will help you. A description of this health care organization's policies about your right to make health care decisions must be given to you along with this information. You are also encouraged to talk with your family, your doctor, and anyone else who could help you in these matters.

Who makes your health care decisions?

You do, if you can make and communicate them. Your doctors should tell you about the treatment they recommend, other reasonable alternatives, and important medical risks and benefits of that treatment and the alternatives. You have the right to decide what health care, if any, you will accept.

What happens if you become unable to make or communicate your health care decisions?

You can still have some control over your health care decisions, if you have planned ahead. One way to plan ahead is by making a health care directive which names someone to make these decisions for you, or which guides or controls these decisions. If you have not named someone in a health care directive, your doctors must seek a person authorized by law to make these decisions. A person who makes health care decisions for you is called a surrogate.

Está recibiendo esta información sobre su derecho para hacer o controlar sus decisiones sobre su cuidado de salud por una ley federal pasada en 1991. Esperamos que esta información le ayude. Una descripción de la póliza de esta organización de cuidado de salud sobre su derecho de hacer decisiones le debe ser entregada con esta información. Usted tambien es animado a que hable con su familia, su médico, y cualquier otra persona que le pueda ayudar en esta cuestión.

Quien hace sus decisiones de cuidado de salud?

Usted, si las hace y las comunica. Sus médicos deben de decirle sobre el tratamiento que recomiendan, otros alternativos rasonables, los riesgos y beneficios medicinales importantes del tratamiento y el alternativo. Usted tiene el derecho de decidir que clase de cuidado médico, si alguno, aceptará.

Que pasa si llega a no poder hacer o comunicar sus decisiones sobre el cuidado de salud?

Usted puede tener algun control sobre sus decisiones sobre su cuidado de salud, si ha hecho planes anteriormente. Un modo de hacer planes de antemano es haciendo un directivo de cuidado de salud que nombra alguna persona que haga estas decisiones por usted, o que guie o controle estas decisiones. Si no ha nombrado a alguien en su directivo de cuidado de salud, su médico tiene que buscar a una persona autorizada por ley para hacer estas decisiones. Una persona que hace las decisiones de cuidado de salud por usted es llamada una substituta.

What is a health care directive?

It is a written statement about how you want your health care decisions made. Under Arizona law, there are three common types of health care directives. They are:

A health care power of attorney, which is a written statement in which you name an adult to make health care decisions for you. That person will make health care decisions for you only when you cannot make or communicate such decisions.

A living will, which is a written statement about health care you want or do not want that is to be followed if you cannot make your own health care decisions. For example, a living will can say whether you would want to be fed through a tube if you were unconscious and unlikely to recover.

A prehospital medical care directive, which is a directive refusing cardiopulmonary resuscitation, a type of lifesaving emergency care, if you have a heart attack or can't breathe outside a hospital or in a hospital emergency room. To make one, you must complete a special orange form.

These directives, used separately or together, can help you say "yes" to treatment you want and "no" to treatment you don't want.

Que es un directivo de cuidado de salud?

Es una declaración escrita sobre como quiere que sus decisiones de cuidado de salud sean hechas. Bajo la ley de Arizona, existen tres tipos comunes de directivos de cuidado de salud. Ellos son:

Un poder de cuidado de salud de abogado. Esta es una declaración escrita en la cual usted nombra a un adulto a que haga las decisiones de cuidado de salud por usted. Esa persona hará sus decisiones de cuidado de salud solamente cuando usted no pueda hacerlas o comunicarlas.

Un testamento en vida. Esta es una declaración escrita sobre el cuidado de salud que quiera o no quiera que sea usada si no puede hacer su propia decision sobre su cuidado de salud. Por ejemplo, un testamento en vida puede decir si quiere que sea dado de comer por medio de tubos si esta inconsiente y no recuperá.

Un directivo de cuidado médico pre-hospital. Este es un directivo que rechaza resucitación cardiáco dado fuera de un hospital o en una sala de emergencia. Para hacer uno, debe completar una forma especial de color anaranjado.

Estos directivos, usados separados o juntos, pueden ayudarle a decir "sí" a tratamientos que quiere y "no" a tratamientos que no quiere.

Must your health care directives be followed?

Yes. Both health care providers and surrogates must follow valid health care directives.

Can you be required to make a health directive?

No. Whether you make a health care directive is entirely up to you. A health care provider cannot refuse care based on whether or not you have a health care directive.

Can you change or revoke health care directives?

Yes. If you change or revoke a health care directive, you should notify everyone who has a copy.

Tiene que ser seguido su directivo de cuidado de salud?

Sí. Los provedores de cuidado de salud y substitutos tienen que seguir directivos de cuidado de salud validos.

Puede ser requerido a hacer un directivo sobre el cuidado de salud?

No. Si hace un directivo de cuidado de salud es completamente algo de usted. Un provedor de cuidado de salud no puede recharzarlo basado sobre si tiene o no tiene un directivo de cuidado de salud.

Puede cambiar o revocar el directivo de cuidado de salud?

Sí. Si cambia o revoca su directivo de cuidado de salud, debe notificar a todos que tienen una copia.

Who can legally make health care decisions for you if you are unable to make your own decisions and if you have not made a health care power of attorney?

A court may appoint a guardian to make health care decisions for you. Otherwise, your health care provider must go down the following list to find a surrogate to make health care decisions for you:

1. Your husband or wife, unless you are legally separated.
2. Your adult child. If you have more than one adult child, a majority of those who are available.
3. Your mother or father.
4. Your domestic partner, unless someone else has financial responsibility for you.
5. Your brother or sister.
6. A close friend of yours. (Someone who shows special concern for you and is familiar with your health care views).

Quien puede legalmente hacer una decision sobre el cuidado de salud si no puede hacer su propia decisión y si no ha hecho un poder de cuidado de salud de abogado?

Una corte puede nombrar a un guardián para hacer decisiones de cuidado de salud por usted. De otro modo, su provedór de cuidado de salud debe seguir la siguiente lista para encontrar a un substituto para hacer decisiones de cuidado de salud por usted:

1. Su esposo o esposa, a menos que estén legalmente separados.
2. Un hijo(a) que sea adulto. Si tiene mas que un hijo(a) que es adulto, la mayoria de los que están disponibles.
3. Su mamá o papá.
4. Su socio domestico, a menos que otra persona tenga responsabilidad economica por usted.
5. Su hermano o hermana.
6. Un buen amigo suyo. (Alguien que tenga preocupación por usted y este familiarizado con usted y su cuidado de salud.)

If your health care provider cannot find an available and willing surrogate to make health care decisions for you, then your doctor can decide with the advice of an ethics committee or, if this is not possible, with the approval of another doctor.

You can keep anyone from becoming your surrogate by saying, preferably in writing, that you do not want that person to make health decisions for you. A surrogate will not have the right to decide to have tubes withdrawn from you that are used to give you food or fluids unless:

- You have appointed that surrogate to make health care decisions for you in a health care power of attorney; or
- A court has appointed that surrogate as your guardian to make health care decisions for you; or,
- You have stated in a health care directive that you do not want this specific treatment.

Si su provedor de cuidado de salud no puede encontrar un substituto disponible para hacer decisiones por usted, entonces su médico con los consejos del comité de ética puede hacerlos o, si esto no es posible, con la aprobación de otro médico.

Usted puede detener a alguien que sea su substituto diciendo, preferiblemente por escrito, que usted no quiere que esa persona haga decisiones de cuidado de salud por usted. Un substituto no tendrá el derecho de negar el uso de tubos para darle comida o liquidos a menos que:

- Usted ha nombrado a ese substituto para hacer decisiones de cuidado de salud para usted en un poder de cuidado de salud de abogado; o,
- La corte ha nombrado a ese substituto como su guardián para hacer decisiones de cuidado de salud para usted; o,
- Usted ha dicho en un directivo de cuidado de salud que usted no quiere este tratamiento específico.

ADDITIONAL INFORMATION FOR ANYONE WHO ALREADY HAS OR WANTS TO MAKE A HEALTH CARE DIRECTIVE

What if you already have a living will or other health care directive?

A health care directive which was valid when made anywhere in the U.S. is valid under Arizona law. However, Arizona law changed on September 30, 1992, making new choices available to you. You should review your health care directives periodically and update them as needed.

Do you need a lawyer to make a health care directive?

No. Just be sure that your directive is valid under Arizona law.

INFORMACION ADICIONAL PARA CUALQUIERA QUE YA TIENE UNO O QUIERE HACER UN DIRECTIVO DE CUIDADO DE SALUD.

Que si ya tiene un testamento en vida o otro directivo de cuidado de salud?

Un directivo de cuidado de salud que es válido cuando fue hecho en cualquier parte de los Estados Unidos es válido bajo la ley de Arizona. De cualquier modo, la ley de Arizona cambió el 30 de Septiembre de 1992, disponiendo nuevas opciones para usted. Usted debe revisár su directivo de cuidado de salud de vez en cuando y ponerlo al día cuando es necesario.

Nesecita un abogado para hacer un directivo de cuidado de salud?

No. Nomas asegurese que su directivo es válido bajo la ley de Arizona.

What does the law require for a health care directive after September 30, 1992?

A health care power of attorney must:

- Name a person to make health care decisions for you if become unable to make your own decisions. You may also name an additional person or persons to make decisions for you if your first choice cannot serve. The person or persons must be at least 18 years old.
- Be signed or marked by you and dated.
- Be signed by a notary or by an adult witness or witnesses, who saw you sign or mark the document and who say that you appear to be of sound mind and free from duress. A notary or witness cannot be the person you name to make your decisions and cannot be providing health care to you. If you have only one witness, that witness cannot be related to you or someone who will get any of your property from your estate if you die.

Que se requiere por ley en un directivo de cuidado de salud despues del 30 de Septiembre de 1992?

Un poder de cuidado de salud de abogado tiene que:

- Nombrar una persona que haga las decisiones de cuidado de salud por usted si llega a no poder hacer sus propias decisiones. Usted tambien puede nombrar a una persona o personas adicionales para hacer sus decisiones si su primer selección no puede servir. La persona o personas tienen que tener por lo menos 18 años de edad.
- Ser firmado o marcado por usted y tener fecha.
- Ser firmado por un notario publico o por un testigo o testigos adultos, que lo vieron firmar o marcar el documento y que digan que usted estaba en mente sana y libre de coerción. El notario publico o el testigo no puede ser nombrado como la persona para hacer sus decisiones y no debe estar proviendo cuidado de salud para usted. Si nomas tiene un testigo, ese testigo no puede ser parte de su familia o tener derecho a recibir parte de su herencia si usted se muere.

A living will must:

- State how you want your health care decisions to be made in the future.
- Be signed or marked by you and dated.
- Be notarized or witnessed in the same way as described above for a health care power of attorney.

A prehospital medical care directive must:

- Be in the exact form required by law.
- Be printed on an orange background.
- Be signed or marked by you and dated.
- Be signed by a licensed health care provider and a witness.

Un testamento en vida tiene que:

- Declarar como quiere que se hagan sus decisiones de cuidado de salud en el futuro.
- Ser firmado o marcado por usted y tener fecha.
- Ser firmado por un notario publico o testigo en el mismo modo que un poder de cuidado de salud de abogado.

Un directivo de cuidado médico pre-hospital tiene que:

- Ser en la forma exacta que la ley requiere.
- Ser imprimido en una forma de color anaranjado.
- Ser firmado o marcado por usted y tener fecha.
- Ser firmado por un provedor de cuidado de salud con licencia y un testigo.

If you have signed an orange prehospital medical care directive, you may also wear a special orange bracelet. It must state your name, your doctor's name, and the words "do not resuscitate". This bracelet will call to the attention of emergency medical personnel that you have signed the form and that you do not want cardiopulmonary resuscitation outside a hospital or in a hospital emergency room.

You should talk to your doctor about prehospital directives if you are thinking about signing one. Forms are available through the Office of Emergency Medical Services in the Department of Health Services, although any prehospital directive which is in the exact form that meets the requirements of the law may be used.

Who should have copies of your health care directives?

It is very important that you give copies to your doctors at once and to any health care facility upon admission. You should give copies to anyone you have named to make health care decisions for you in a health care power of attorney. You may also want to give copies to close family members. Be sure to keep extra copies for yourself.

Si ha firmado un directivo de cuidado médico pre-hospital de color anaranjado,tambien puede usar una esclava de color anaranjado. La esclava debe declarar su nombre, el nombre de su médico, y las palabras "no resucite." Esta esclava le indicará al personal médico de emergencia que usted ha completado la forma y que no quiere el cuidado médico de emergencia que ha marcado en la forma.

Usted debe consultar con su médico si piensa firmar un directivo de cuidado médico pre-hospital. Las propias formas se pueden hallar en la oficina de Emergency Medical Services, que es parte del Department of Health Services. O, usted puede usar cualquier forma exacta que satisface los requisitos de la ley.

Quien debe tener copias de su directivo de cuidado de salud?

Es muy importante que usted le de copias a su médico inmediatamente y a cualquier facilidád de cuidado de salud cuando es admitido. Debe darle copias a cualquier persona que ha nombrado para que haga decisiones por su cuidado de salud en un poder de cuidado de salud de abogado. Tambien debe darle copias a sus familiares. Asegurese de quedarse con una copia extra para usted.

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State/Territory: ARIZONA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at 42 CFR §488.404(b)(1):

Not Applicable

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State/Territory: ARIZONA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

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State/Territory: ARIZONA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

____ Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

____ Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

____ Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy
(Will use the criteria and notice requirements specified in the regulation

____ Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of Residents; Transfer of Residents with Closure of Facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regualtions.)

____ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2 or category 3 as described in 42 CFR §488.408).

Not Applicable

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State/Territory: Arizona

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

The Board of Nursing shall include information on the registry on any individual if the Board of Nursing has knowledge that such person has been found guilty by a court of law of the act of abuse, neglect, or mistreatment of an individual.

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COLLECTION OF ADDITIONAL REGISTRY INFORMATION

The following are additional information items which are included on the registry in addition to the information required by 42 CFR 438.156(c):

1) The person's status;
2) Ethnic Code;
3) Reciprocity date;
4) Sponsor;
5) Registration method;
6) Written examination date;
7) Number of times the test was taken;
8) Employment status;
9) Last work date;
10) Employer; and
11) Fees.

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State/Territory: ARIZONA

DEFINITION OF SPECIALIZED SERVICES

N/A

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CATEGORICAL DETERMINATIONS

N/A

* U.S. G.P.O.:1993-342-239:60013

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State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures and policies.

The survey and certification agency (ADHS) will:

1) continue to actively participate in various private and public committees that deal with participation in Medicare of nursing facilities;

2) participate in educational training programs, such as advance directives and the Americans With Disabilities Act;

3) provide additional technical assistance, as needed, via telephone or by conference;

4) participate in training for the Ombudsman. Survey staff shall continue to include the Ombudsman in the certification process as outlined in the Omnibus Budget Reconciliation Act of 1987;

5) provide on an on-going basis, additional regulatory information to residents/provider staff during survey process;

6) disseminate, on an on-going basis, regulatory changes or clarifications to the provider/client community via informational newsletters/brochures and, as needed, through conferences or seminars;

7) provide assistance to educational institutions who train individuals employed or seeking employment in a certified nursing facility;

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State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

8) promote resident/client review of nursing facility records which are maintained within the certification agency. These records contain the last three (3) years of compliance with licensing/certification requirements by the nursing facility and reflect a nursing facility's ability to meet the needs of the residents;

9) disseminate and coordinate certification information through the ADHS Provider Advisory Council;

10) disseminate certification information through provider trade associations; and

11) advise providers at the time of on-site surveys, regarding the availability of the survey and certification agency to answer resident/family/public questions regarding Medicare certification.

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State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident's property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

The survey and certification agency (ADHS) maintains a formal Administrative Policy and Procedure Manual for the Office of Health Care Licensure which includes the following procedures:

a) Complaint Investigations;

b) Facility Self-Reported Incidents, Including Abuse, Neglect and Exploitation of Property; and

c) Client Abuse, Neglect and Misappropriation of Property by Nurse Aides.

The Administrative Policy and Procedures Manual is regularly reviewed and updated, as needed. The detailed Manual is available for inspection at the Office of Health Care Licensure, ADHS. Relevant portions of the policies identified above include, but are not limited to, the following general process:

1. Complaint Investigation
Any allegation of abuse, neglect or misappropriation of a resident's property is investigated by the survey and certification agency's Section Program Manager.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

Upon determining that the allegation merits further review by the survey and certification agency, a recommendation, complaint, field trip report and any other evidence is forwarded to the survey and certification agency's Nurse Aide (NA) Consultant. The NA Consultant reviews the allegation and initiates the process outlined in Section 1919 (g) of the Social Security Act.

A summary of the allegation is prepared and then reviewed by the survey and certification agency's Nurse Aide Compliance Review Committee (NACRC). At the request of the NACRC, the NA Consultant will prepare an investigative report for review by the Assistant Attorney General (AAG) who will review the report and notify the survey and certification agency of the AAG's recommendation. In the event of conflicting recommendations, the survey and certification agency shall make the final decision.

2. Notice Of Allegation
The NA Consultant shall send a certified letter to the Nurse Aide with notification that the survey and certification agency has found an act of client abuse, neglect or misappropriation of property to have merit. The letter shall include: a description of the conduct in question, the process for requesting a hearing and the notification of the Nurse Aide's right to make a statement if no hearing is requested.

3. Request For Hearing
The Nurse Aide must file a written request for a hearing with the survey and certification agency, Office of the Administrative Counsel, who shall subsequently schedule a hearing date. A notice confirming the hearing date, time and location shall be mailed to all involved parties.

4. Pre-Hearing Conference

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The NA Consultant shall act as a liaison and coordinate the pre-hearing activities with the AAG, investigating surveyors and witnesses.

5. Hearing and Findings
The survey and certification agency's Rules of Procedure for hearings shall apply to the hearing.

6. Notification of Findings To Nurse Aide
After the hearing and final decision, the NA Consultant shall send a certified letter informing the Nurse Aide of the findings of the hearing and the right to submit a written statement to the survey and certification agency which will be forwarded to the Board of Nursing for incorporation into the Nurse Aide Registry.

A letter shall also be sent if the Nurse Aide did not request a hearing that states the following: (a) no hearing was requested; (b) the finding of the investigation; (c) the fact that these findings will be placed on the Nurse Aide Registry; and, (d) the ability of the Nurse Aide to submit a written statement to the survey and certification agency which will be forwarded to the Board of Nursing for incorporation into the Nurse Aide Registry.

7. Reporting To The Nurse Aide Registry
The NA Consultant shall provide written notification to the Board of Nursing, which has oversight of the NA Registry, regarding:

a. if a hearing is held, the outcome of the hearing, within 10 working days of the decision; or

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

b. if no hearing is requested, of the findings of the investigation, within 10 working days of the expiration of the time to request a hearing.

In accordance with 42 CFR 483.156, the NA Consultant shall send a letter to the Board of Nursing requesting that the findings be withdrawn if any of the following occurs: 1) the Nurse Aide appeals the final decision to the Superior Court and the decision is reversed; 2) the Nurse Aide is found not guilty of criminal charges; or, 3) the Nurse Aide dies; or, 4) the finding found to be in error.

8. Notification To Cooperative Agencies
After completion of this process, the NA Consultant shall send notification of the substantiated complaint and a "washed" (i.e., confidential information has been deleted) copy of the Field Trip Report to select agencies, if applicable.

9. Tracking & Filing
The NA Consultant shall ensure that appropriate documentation regarding each case is maintained on file in the Public Files which contain "washed" documents and the Confidential Files which contain "unwashed" materials.

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State: Arizona

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

1) The survey and certification agency (ADHS) has in effect a Policy and Procedure titled "Licensure Process", for scheduling and conducting standard surveys. Specifically, the procedure provides assurance that all reasonable steps are taken to maintain confidentiality of the survey schedule, unless provided as an exception in State Operations Manaul §2700A;

2) All survey staff receive training in accordance with Survey Procedures for Long Term Care Facilities, Appendix P, R and N. Emphasis is provided to the surveyors concerning the announcement of of standard and Life Safety Code surveys;

3) Survey schedules are developed and distributed within the survey and certification agency as "confidential." During the orientation process, all survey staff are informed that disclosure of scheduling information is grounds for termination of employment. Survey staff are prohibited from divulging the nature of their business when making lodging/travel arrangements. Additionally, survey staff "sign out" of the survey and certification agency at the onset of survey; therefore, all incoming calls are routed through the agency, rather than directly to the surveyor on-site at a facility; and

4) Weekly survey schedules are developed in accordance with Transmittal 250.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

Programs and methods in place:

1) The survey and certification agency (ADHS) utilizes the data obtained from the State Agency Evaluation Program to measure and reduce inconsistencies of survey results. The survey and certification agency incorporates these findings into the in-service and training programs provided on a monthly basis to appropriate survey staff;

2) The survey and certification agency has established an internal review process whereby the Health Care Facility Inspection Team Leaders and the Program Managers review survey documents to ascertain their accuracy; and

3) All adverse actions are reviewed by the Quality Assurance(QA)/Enforcement Section of the survey and certification agency when requested by the Program Managers or the Office Chief. The QA/Enforcement Section also provides technical assistance to the Program Managers and Surveyors as requested or directed by the Office Chief.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

Process:

1) The survey and certification agency has established internal policies and procedures (available for review) to investigate complaints that allege possible violations of program requirements;

2) Surveyors are provided with training regarding complaint investigation procedures during orientation and routinely thereafter;

3) An internal review process is in place for the review of complaint investigations to determine conformance with the investigative procedure and to ascertain the need to monitor for verification of compliance;

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

4) The survey and certification agency utilizes the data obtained from the portion of the State Agency Evaluation Program relating to complaint investigations, to measure and reduce inconsistencies of complaint investigation results. The survey and certification agency incorporates these findings into the In-service and Training programs provided on a monthly basis to appropriate survey staff; and

5) The survey and certification agency has an internal review process in which complaint investigations which divulge findings of significant noncompliance with program requirements are reviewed by the Office Chief, the Program Manager and members of the Quality Assurance/Enforcement Section. The survey and certification agency distributes findings to the Regional Office and other appropriate entities.

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State: Arizona

4.42 EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

In accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis for employee education about false claims recoveries is as follows:

The State will identify "entities" as those who received or made payments at or above the annual threshold of $5,000,000 using claims and encounter data.

The State will send information about the requirements to new entities that did not previously meet the criteria by January 1 of each subsequent year, if the amount of payments an entity either received or made during the preceding Federal fiscal year meets the $5,000,000 threshold.

The State will use a web-based training tool to provide education about false claims recoveries. Additionally, the State will send written notification that includes an Audit Checklist, outlining the requirements and policy procedures for ensuring compliance. For CY 2007, the State will send written notice informing an entity that has met the $5,000,000 annual threshold of the false claims recoveries requirements, including the audit cycle, by July 2007. The State will begin reviewing entities for compliance by October 2007. The State will also include the requirement for compliance in the Acute and ALTCS contracts as well as in policy manuals.

The State will ensure compliance by conducting an annual statistically valid random sampling of entities that may be subject to the provision. The sample will consist of onsite inspections, document reviews and interviews. Each entity may be subject to the audit cycle at least once every three years.

The State will use the information compiled from the random sample to review whether the entity has mechanisms in place to educate employees about false claims recoveries. If the State finds that an entity is not compliant, the following measures will be pursued:

1st violation: The State will send written notification detailing the items that are out of compliance and advising corrective action. The State will provide 30 days to correct the incompliance and will re-visit the entity to check for compliance.

2nd and subsequent violations: The State will seek sanctions as provided under the existing contract language.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

Citation	
1902(a)(69) of the Act, P.L. 109-171 (section 6034)	4.43 Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

METHODS OF ADMINISTRATION

INTRODUCTION

In 1974, the Congress of the United States of America affirmed that:

> "The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government."

Resulting from this commitment, Congress promulgated Public Law 93-641, the National Health Planning and Resources Development Act of 1974, as amended in 1979 by Public Law 96-79. The Act provided for the development of recommendations for a national health planning policy to enlarge upon area wide and state planning for health services, manpower and facilities, and to authorize financial assistance for developing resources to advance that policy.

Before establishing the mechanism for health planning, Congress enacted Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975 which made it unlawful for any program or activity receiving Federal financial assistance to discriminate in the provision of services against any person on the ground of race, color, creed, sex, national origin, physical or mental handicap.

In response to these commitments, the Arizona Health Care Cost Containment System Administration has developed this document to govern the conduct of any program or activity operated with funds provided by or through the Administration.

PART ONE - BASIC PROVISIONS

A. PURPOSE AND POLICY

The Administration's intent is to provide nondiscriminatory services and publish these Methods of Administration in compliance with the requirements of Title VI of 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Title 9, Chapter 22 of the AHCCCS rules. No person in Arizona shall, on the ground of race, color, creed, sex, national origin or physical or mental handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination in the offering or provision of services by the Administration or by any contractor, subcontractor, provider, non-provider or facility receiving financial assistance from, or operating a program under a contract with, the Administration. The

Administration assures that the program shall be conducted in compliance with the applicable provisions of 45 C.F.R. Parts 80, 84 and 90.

B. APPLICABILITY

These guidelines apply to the Administration and any program and activity receiving financial reimbursement from the Administration.

C. DEFINITION OF TERMS

For purpose of these guidelines, the following definitions shall apply:

1. "Bilingual employee" means an employee who, in addition to possessing minimum job qualifications for a position, is proficient in oral and reading communication skills necessary to perform the requirements of the position in English and in a primary language of a non-English or limited-English speaking person served by a facility. Proficiency in oral and reading communication skills shall be determined by the facility according to criteria which accurately determines proficiency. An employee shall not be permitted designation as a bilingual employee, if there is refusal to use his or her oral and reading communication skills.

2. "Bilingual positions" means permanent budgeted positions which, in addition to minimum job qualifications, include as a prerequisite for employment, proficiency in a specified second language, including sign language.

3. "Focused recruitment" means efforts by a facility to identify and encourage application for employment by that target population not employed in public contact positions at the facility in numbers sufficient to comply with requirements of these guidelines.

4. "Minority" includes:

   a. American Indian - All persons having origins in any of the original peoples of North America, and who maintain cultural identification, through tribal affiliation or community recognition.

   b. Asian - All persons having origins in the Far East, Southeast Asia, or the Pacific Islands which includes China, Japan, Korea, the Philippine Islands, and Samoa.

   c. Black - All persons having origins in any of the Black racial groups.

d. Hispanic - All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultural origin.

5. "Non-English or limited-English speaking persons or groups" means persons or groups whose primary language is a language other than English and who cannot communicate effectively in English and for whom written English communications such as consent forms, are not understandable.

6. "Primary language" means the language which is spoken most fluently by a person and which is used by the person to communicate effectively in all exchanges of information with an agency pertinent to the recipient of any service under the agency's program.

7. "Public contact positions" means all staff positions in which the employee spends at least 50 percent of his or her time in direct interaction with patients or persons who are seeking health care or health care related information during intake, admission or when obtaining emergency medical services. In a health plan, examples would be persons assigned to the front desk or registration counter to give directions or respond to direct public inquiries, telephone operators who answer the public telephone number, admission personnel, and emergency room personnel; in nursing care facilities and residential care homes, nurses and nurse aides who are assigned to respond to patient health emergencies.

8. "Target population or group" means a group of persons which is identifiable by race, color, creed, age, sex, national origin or physical or mental handicap and as a group has been protected against discrimination by federal or state law.

D. DISCRIMINATION PROHIBITED

1. The Administration outlines its Employee Grievance Procedure in the AHCCCS Affirmative Action Plan. A copy of this plan is available for review in the AHCCCS' Director's Office.

2. With respect to the Administration and delivery of AHCCCS services, directly or through contractual or other arrangement, the following nondiscriminatory policy guidelines shall apply. A contractor, subcontractor, provider, non-provider or facility shall not on account of race, color, creed, sex, national origin, or physical or mental handicap:

> Treat a person differently from others in determining whether that person satisfies any admission, enrollment, quota, eligibility, membership, or other requirement or condition that person must meet in order to be provided any service.

3. No person shall directly or through contractual arrangements, utilize means or methods of administration which have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Title 9, Chapter 22, 28 and 29 of the AHCCCS Rules.

4. Service areas, sub-areas or attachment areas should not be established to promote segregation.

5. Deny access to any facility or service available at or by the facility.

6. Restrict a member in any way in the enjoyment of any health care service enjoyed by other members receiving any service provided.

7. Provide any service or benefit to any member which is different, or is provided in a different manner or at a different time from that provided to other members, except where necessary to provide services that are effective or available as those others.

8. A person shall not be restricted in the receipt of any health care service received by others from the facility due to language barriers.

9. Assign or refer a member to other facilities on the basis of race, color or national origin.

10. Assignments to rooms, wards, floors, sections, buildings, or areas of service delivery or transfers of persons to accommodations shall not be made on the basis of race, color, creed, sex or national origin.

11. Persons shall not be queried verbally or in writing whether they are willing to share accommodations with members of target populations.

12. Requests shall not be honored from a person for transfer to other accommodations unless such transfer is made for the purpose of facilitating care and treatment and enhancing the quality of care and is so certified in writing by the physician.

13. Qualified person shall not be denied on the basis of race, color, creed, sex, national origin, or physical handicap the opportunity to participate as a member of a planning or advisory body which is an integral part of the program or service.

E. RESPONSIBILITY AND DELEGATION OF AUTHORITY

The Director of the Administration has delegated to the Office of the Director the personal responsibility for the implementation of a comprehensive civil rights program which assures that the purposes of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Title 9, Chapter 22, 28 and 29 of AHCCCS Rules are followed.

1. Affirmative Action Officer

a. Serves as Civil Rights Coordinator and principal advisor to the Director, Deputy Director and Assistant Director's on all matters relative to these guidelines.

b. Develops standards and criteria for program activities which directly or indirectly involve civil rights equal opportunity efforts such as delivering services, compliance monitoring and data collection. Reviews program directives, policies, procedures and guidelines to ensure that they reflect and promote civil rights requirements.

c. Oversees voluntary compliance efforts when a determination of probable noncompliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Title 9, Chapter 22, 28 and 29 of AHCCCS Rules.

d. Provides current information and annual civil rights training to Assistant Directors within the Administration.

e. Implements the Administration's requirements of these guidelines within the programs overseen by the respective divisions.

f. Monitors contractor's compliance with these guidelines.

g. Conducts annual compliance reviews of each contractor's program for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Title 9, Chapter 22, 28 and 29 of AHCCCS Rules, and provides a report to the Assistant Deputy Director.

h. Assures that methods for selecting members of planning or advisory boards, councils and committees are non-discriminatory and that efforts are made to receive all segments of the community for their active participation on such organizations.

i. Consults and coordinates with the Director on all civil rights program changes proposed by each contractor.

2. Public Information Officer

a. Develops a public notification system to assure that all publications directed to applicants, potential applicants, eligibles, members, and their representatives are published in English and other languages as appropriate.

b. Assures that printed materials, when appropriate, portray persons from the diverse cultural backgrounds of Arizona.

c. Assures that all meeting notices to the general public and printed program announcements, when appropriate, produced or purchased by the Office of Public Information contain the following statement:

"The AHCCCS Administration or its contractors shall not discriminate on the basis of race, color, creed, sex, religion, age, national origin, ancestry, martial status, sexual preference, or physical or mental handicap."

3. Interdivisional Coordination

The purpose of this part is to eliminate, where feasible, duplication of effort when more than one Division assists or contracts with a common recipient. In general, the Division having direct oversight of the largest dollar amount of financial assistance or holding the largest aggregate dollar amount of financial assistance or holding the largest aggregate dollar amount of contracts, shall assume responsibility for assuring contract compliance according to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Title 9, Chapter 22, 28 and 29 of AHCCCS Rules. Should clarification be required for designation of responsibility, the Assistant Deputy Director will make such designation to assure compliance.